

SUMMARY PLAN DESCRIPTION

IRON WORKERS
TRI-STATE
WELFARE FUND

2008 EDITION

A MESSAGE FROM THE BOARD

Dear Participant:

We are pleased to provide you with this booklet that gives you and your family important details of your benefits under the Tri-State Welfare Plan.

This booklet is a summary of your benefit plan in effect on May 1, 2008. The benefits described in this booklet apply to active employees as of May 1, 2008 and to employees who retire or become disabled after May 1, 2008. The actual Plan Document contains the information upon which this summary booklet is based. This booklet replaces and supersedes all prior booklets summarizing your benefits, but does not replace the Plan Document. If a question arises that this summary booklet does not answer or if the booklet conflicts with the Plan Document, the Plan Document is the final authority.

Several important plan changes have been made since the previous Summary Plan Description (SPD) was printed (2003 Edition). We encourage you to review this booklet and keep it in a safe place for future reference.

We greatly value our participants and take pride in the protection offered by these benefits. We hope that you will find this booklet useful and informative. If you have any questions, please contact the Fund Office. You can also visit our web site at www.tristatewelfarefund.com for general benefit information and your eligibility and claims information.

Sincerely,

The Board of Trustees

Nothing in this Summary Plan Description is meant to interpret, extend, or change in any way the provisions expressed in the Plan Document or insurance policies.

The Trustees reserve the right in their sole discretion and without notice to Employees, Employers, the union and others affected to interpret, modify and terminate all or part of this Plan and to take any action they deem desirable to preserve the financial stability of the Plan. Benefits do not vest under this Plan and no employment rights are created as a result of these benefits.

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CONTACTS

If You Need...	Contact...
To find a network medical provider:	
Active and Retiree Plans of Benefits	BCBSIL: 1-800-571-1043 www.bcbsil.com
Medicare Advantage Plan	Humana Gold Choice Plan: 1-800-824-8242
To find a network pharmacy or to call about mail order:	
	Express Scripts www.express-scripts.com Call the number on your pharmacy ID card
To find a network dentist:	
	Guardian Life www.guardianlife.com Call the number on your dental ID card
Claims information or eligibility:	
	OBA Midwest: Toll-free: 866-463-9418 E-mail: tristate@abpa-tpa.com
Fund web site:	www.tristatewelfarefund.com

ACTIVE ELIGIBILITY



GENERAL INFORMATION

YOU ARE ELIGIBLE FOR BENEFITS IF:

- ◆ You work under the jurisdiction of any Iron Workers Local Union that participates in this Plan;
- ◆ The required contributions are made on your behalf by contributing Employers in accordance with their Collective Bargaining Agreement or Participation Agreement; and
- ◆ You meet the initial and continued Eligibility requirements described in the following sections.

The Schedule of Benefits in the back pocket lists the Active Plan of Benefits.

MANAGEMENT / SUPERVISORY EMPLOYEES

Employers who make contributions for management or supervisory Employees need to make contributions equal to at least 160 hours at the hourly contribution rate required in that worker's local union. This same rule applies for Employers making contributions on behalf of Employees who perform bargaining unit work and whose spouses are substantial shareholders of the Employer.

ACTIVE BENEFITS INCLUDE ALL OF THE FOLLOWING:

- ◆ Life Insurance Benefit (different levels for you and your Dependents);
- ◆ Accidental Death and Dismemberment Insurance Benefit (employee only);
- ◆ Weekly Accident and Sickness Benefit (employee only);
- ◆ Comprehensive Medical Benefit;
- ◆ Prescription Drug Benefit;
- ◆ Dental Expense Benefit (optional); and
- ◆ Vision Care Benefit (optional).

INITIAL ELIGIBILITY (FOR NEW EMPLOYEES)

You become Eligible for benefits on the first day of the month after you accumulate 500 contribution hours within a nine-month period. If you accumulate 500 contribution hours in less than nine months, you will become eligible on the first day of the month after you accumulate 500 hours. Contribution hours are the hours you work for which an Employer makes contributions to the Fund on your behalf. Hours from all contributing employers count toward Eligibility.

You need 500 contribution hours within nine months to become eligible.

BENEFIT QUARTERS

Eligibility for Plan benefits is earned in three-month periods, called benefit quarters. The Plan's benefit quarters are as follows:

- ◆ March, April, May
- ◆ June, July, August
- ◆ September, October, November
- ◆ December, January, February

Once you become Eligible for benefits, you will remain Eligible for benefits until the end of the benefit quarter. However, if your Eligibility commences on the date other than the first day of the benefit quarter, you will remain Eligible until the end of the following benefit quarter. If you are unable to work because of an Accident or illness when benefits should become effective,

the Weekly Accident and Sickness Benefit coverage will be delayed until you return to active employment. You and your Dependents will be eligible for all other Plan benefits on the effective date.

WHEN DEPENDENT ELIGIBILITY BEGINS

A Dependent become Eligible for coverage when you become Eligible. Future Dependents become Eligible when they meet the definition of "Dependent." See page 61 for a definition of Dependent.

CONTINUED ELIGIBILITY

Generally, you continue your Eligibility by accumulating contribution hours. The following chart lists the contribution hours needed to continue Eligibility.

Contribution Hours Requirement for Continued Eligibility

You continue your eligibility if you accumulate at least:	For This Benefit Period	Otherwise Eligibility Ends:
350 contribution hours from January through March, 700 contribution hours from October through March, 1,050 contribution hours from July through March, or 1,400 contribution hours from April through March.	June through August	May 31
350 contribution hours from April through June, 700 contribution hours from January through June, 1,050 contribution hours from October through June, or 1,400 contribution hours from July through June.	September through November	August 31
350 contribution hours from July through September, 700 contribution hours from April through September, 1,050 contribution hours from January through September, or 1,400 contribution hours from October through September.	December through February	November 30
350 contribution hours from October through December, 700 contribution hours from July through December, 1,050 contribution hours from April through December, or 1,400 contribution hours from January through December.	March through May	Last Day of February

If you do not accumulate the required contribution hours, you may be able to continue your eligibility with your reserve accumulation account or by self-paying for coverage. These options are described in this booklet on pages 9 and 15.

If you lose eligibility, you will need to meet the initial eligibility requirements to have your eligibility reinstated. To have your eligibility reinstated, you will need to accumulate 500 contribution hours in a nine-month period.

If you become disabled, you will be credited with 27 hours for each full week you are unable to work because of a certified disability. You may receive up to 700 disability hours during a 12-month period.

RESERVE ACCUMULATION ACCOUNT

At the end of each year, the Trustees estimate the number of contribution hours needed to support the cost for each Employee's Plan benefits. If, during the previous year, your contribution hours exceed the hours needed to support the Plan benefits, your reserve accumulation account is credited with reserve hours, as follows:

- ◆ For each of the first 500 excess contribution hours, you receive one reserve hour.
- ◆ For each two excess contribution hours after the first 500, you receive one reserve hour.

You may have up to 750 reserve hours in your reserve accumulation account at any one time.

Your reserve hours can be used to continue your benefits, if needed. When you use any of your reserve hours, you will need a total of 350 hours (reserve or contribution) to continue coverage for a benefit quarter.

FAMILY AND MEDICAL LEAVE

The Family Medical Leave Act (FMLA) requires certain Employers (but not all) to grant unpaid leave of up to 12 weeks during a 12-month period for specific reasons such as the birth of a child or a serious illness affecting you, your spouse, your Dependents or your parents.

Eligibility for this unpaid leave is determined by your **Employer** (not by the Plan Administrator or Trustees) in accordance with the requirements of the FMLA. The FMLA requires your Employer to inform you of your rights and obligations under the FMLA.

If you request FMLA leave from your Employer, the Employer must notify you in writing regarding whether or not you are Eligible for such leave.

If you are Eligible for FMLA leave, the Employer is also required under Plan rules to notify the Fund Office. You may also wish to notify the Fund Office yourself, but that is not required.

You must request FMLA leave from your Employer.

If you have been granted FMLA leave, you are entitled to a continuation of the health care benefits provided under the Plan throughout the period of leave. Your Employer will be asked to complete some forms to verify your Eligibility for continuation of these benefits. In addition, you will be asked to complete a medical certification form and/or provide sustaining documentation.

There is no charge to you for the extended health care coverage with the exception of deductibles, copayments or other out-of-pocket expenses, as currently required under the Plan of Benefits.

Your Employer is required to continue contributions during the period of FMLA leave for the benefits provided by the Plan. Failure of your Employer to submit contributions on a timely basis will result in a loss of coverage.

RECIPROCAL AGREEMENTS

If your employment is divided between local union jurisdictions or you move from one local union to another, your Eligibility for benefits may be continued under the Iron Workers International Reciprocal Health and Welfare Agreement. In certain instances, contributions made on your behalf may be transferred between funds to reinstate or continue Eligibility for benefits. Contact the Fund Office for more information.

If your Local Union's CBA provides for the optional Dental Expense and Vision Care Benefits, but you work outside the jurisdiction of your home local, the Fund will divide the total contributions made on your behalf by the home local's contribution rate to determine your eligibility for the optional benefits.

If you need more information, contact the Fund Office.

WHEN COVERAGE ENDS

Your Eligibility for coverage ends on the earliest of the following:

- ◆ This Plan ends;
- ◆ You are no longer a member of the classes of Persons Eligible under this Plan;
- ◆ On the Termination Date — May 31, August 31, November 30, or the last day of February — after you do not meet the continued Eligibility requirements;
- ◆ You do not make a required self-payment, if any, when due;
- ◆ You enter full-time active duty with the Armed Forces of any country. However, if you serve in the uniformed services of the United States, you may continue your coverage (other than Life, Accidental Death and Dismemberment and Weekly Accident and Disability) under USERRA. Call the Fund Office for additional information; or

Uniformed services means the:

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

If you are called to military service:

- *Notify your employer and the Fund Office.*
- *Make self-payments if you wish to continue your coverage.*

- ◆ The date you submit a fraudulent claim, as determined by the Trustees.

A Dependent's Eligibility ends on the earliest of the following dates:

- ◆ This Plan ends;
- ◆ Your Eligibility ends;
- ◆ The Plan is amended to exclude his or her particular class of Dependent;
- ◆ The Dependent no longer meets the definition of Dependent (You must notify the Fund Office within 60 days after your dependent's eligibility terminates due to age to be eligible for COBRA coverage.);
- ◆ The self-payments for that Dependent, if any, are not made on time;
- ◆ The Dependent enters into full-time, active duty with the Armed Forces of any country for more than 31 days.

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

REINSTATEMENT OF ELIGIBILITY

If your Eligibility ends because you do not accumulate enough contribution hours and do not make the active self-payments (see page 9), you must meet the initial eligibility requirements as described on page 1.

SERVING IN THE UNIFORMED SERVICES (FOR ACTIVE EMPLOYEES)

If you serve in the uniformed services (active duty or inactive duty training), you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Health coverage means medical, prescription drug, dental, vision, and hearing coverage provided under the Plan.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

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

If you elect to continue coverage and you are in the uniformed services for less than 31 days, you will continue to receive coverage in accordance with USERRA for up to 31 days. If your service continues for more than 31 days, you may elect to continue coverage under the Plan by making monthly self-payments. To continue coverage, you or your dependent must pay the required self-payment.

Payments will be made in the same manner and in the same amount as COBRA Continuation Coverage payments.

Your coverage will continue until the earlier of:

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

However, your coverage will end the earliest day:

- ◆ Your coverage would otherwise end as described above;
- ◆ Your former employer ceases to provide any health plan coverage to any employee;
- ◆ Your self-payment is due and unpaid; or
- ◆ You again become covered under the Plan.

Your coverage ends on the first day of the month following the date you enter the uniformed services and elect not to continue coverage. Your eligible dependents may continue coverage under the Plan by electing and making self-payments for COBRA Continuation Coverage.

You need to notify the Fund Office when you enter the military and when you return to covered employment. For more information about continuing coverage under USERRA, contact the Fund Office.

REINSTATING YOUR COVERAGE

Following discharge from military service, you may apply for reemployment with your former employer in accordance with USERRA. Reemployment includes the right to reinstatement in the existing health coverage provided by your employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

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

- ◆ Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a contributing employer;
- ◆ More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a contributing employer; or
- ◆ More than 180 days, you have up to 90 days after discharge to return to work for a contributing employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to or make yourself available for work for a contributing employer. If you do not return to work within the required timeframes, you must again meet the initial eligibility requirements to be eligible for coverage.

Reemployment

Following your discharge from service, you may be eligible to apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes your reinstatement of health care coverage provided by your employer.

IF YOU BECOME DISABLED

You will be credited with 27 disability hours for each full week you are unable to work because of a certified disability. You may receive up to 700 disability hours during a 12-month period. See page 60 for a definition of certified disability.

If your Eligibility ends while you are disabled, benefits for you and your Dependents may be extended for up to 18 consecutive months. Any hours remaining in your reserve accumulation account will then be used to offset the cost. After the 18 months and your reserve accumulation account have been exhausted, you may continue coverage under the Self-Pay Plan or the Retiree Plan of Benefits or COBRA continuation coverage. See “Self-Pay Options” on page 9 for more information.

WHEN DISABILITY COVERAGE ENDS

Your disability coverage continues until the earliest of the period when you:

- ◆ Are no longer disabled. However, if you return to work and within 30 consecutive calendar days you become Totally Disabled for the same illness, your Eligibility and your Dependent’s Eligibility will be reinstated for the remainder of the 18 month period.
- ◆ Become Entitled to Medicare.
- ◆ Do not make a self-payment when required, on time.
- ◆ Do not provide adequate proof of continued disability each quarter.

If you become Entitled to Medicare, you may continue your Dependents’ Eligibility by making self-payments for the Retiree Plan of Benefits until your Dependents are Entitled to Medicare or no longer meet the definition of a Dependent. See page 61 for a definition of Dependent. You and your spouse may also be eligible for the Humana Medicare Advantage Plan.

DEPENDENTS OF A DECEASED EMPLOYEE

In the event of your death, your covered Dependents will be Eligible for benefits until the later of:

- ◆ The day your Eligibility would have ended based on contribution hours and reserve hours in your reserve accumulation account; or
- ◆ The last day of the benefit quarter following the benefit quarter you died.

Surviving Dependents may continue Eligibility by making self-payments for COBRA continuation coverage or the Retiree Plan of Benefits, but not both. See “Self-Pay Options” on page 9 for more information. If a surviving Dependent chooses to waive coverage under COBRA, he or she may self-pay for the Retiree Plan of Benefits until the earlier of:

- ◆ The day he or she becomes Entitled to Medicare; or
- ◆ The day he or she no longer meets the definition of Dependent as described on page 62.



The Plan's self-pay options let you continue coverage for yourself and your Dependents by paying for coverage when it would otherwise end. Four self-pay options are available from the Plan:

- ◆ The Active Self-Pay Program;
- ◆ COBRA continuation coverage;
- ◆ The Retiree Plan of Benefits; or
- ◆ The Medicare Advantage Plan.

If your Plan coverage ends, you will be notified by the Fund Office. The Fund Office notifies you by sending a Termination Notice to your last address on file.

The Eligibility requirements, cost, and coverage provided for each option are different. The Active Self-Pay Program and COBRA continuation coverage options are generally available to most Employees. The Retiree Plan of Benefits option is generally available to Dependents of deceased Employees, and some Employees who retire or become disabled before age 65. The Medicare Advantage Plan is generally available to Employees and spouses entitled to Medicare not due to End Stage Renal Disease.

If you choose the Active Self-Pay Program, the Retiree Plan of Benefits, or the Medicare Advantage Plan, you waive coverage under COBRA. Once you choose a self-pay option, you cannot change your election. However, you may be Eligible for another self-pay option after you exhaust your Eligibility under the first option you elected.

The following sections explain the types of self-pay coverage available from the Plan.

THE ACTIVE SELF-PAY PROGRAM

You are Eligible to continue coverage under the Active Self-Pay Program if:

- ◆ Your Eligibility ends because of a lack of contribution hours and/or reserve hours in your reserve accumulation account; and
- ◆ You are available to work, and actively seeking work, as an Iron Worker in the Fund's jurisdiction.

Note: See "Retiree Plan of Benefits" on page 16 for more information if you retire or become disabled before age 65.

COVERAGE UNDER THE ACTIVE SELF-PAY PROGRAM

Each benefit quarter, three-month period, you can continue coverage for yourself and your Dependents for benefits for which you were Eligible when your coverage ended.

Note: Your coverage will be the plan of benefits you were covered for at the time your Eligibility terminated. In addition, the Weekly Sickness and Accident Benefit is not available to retired or disabled Employees.

You may self-pay for the Active Plan of Benefits under this Self-Pay Program for up to 16 consecutive benefit quarters. If you retire while eligible for benefits, you may continue the Self-Pay Program as described on page 11. Disabled or retired Employees may self-pay for the Retiree Plan of Benefits after this time.

To ensure that your address file is current, please contact the Fund Office.

PAYMENT INFORMATION

The cost to continue your coverage under this program equals the least amount determined by 1, 2, 3, and 4, below:

1. 350 minus (your hours worked in the last contribution quarter plus hours from your Reserve Accumulation Account, if any)
2. 700 minus (your hours worked in the last two contribution quarters plus hours from your Reserve Accumulation Account, if any)
3. 1,050 minus (your hours worked in the last three contribution quarters plus hours from your Reserve Accumulation Account, if any)

4. 1,400 minus (your hours worked in the last contribution year plus hours from your Reserve Accumulation Account, if any)

The hours that are used from your Reserve Accumulation Account above, will be subtracted from your Reserve Accumulation Account.

The amount that you would need to pay for the next quarter of coverage would be the number of hours that you have to make up toward the cost of coverage times the hourly contribution rate.

Self-payments for this program are due within ten days after a Termination Notice is sent to you.

FOR EXAMPLE:

Tom worked these hours in the four eligibility categories:

- ◆ 150 hours in the last contribution quarter
- ◆ 600 hours in the last two contribution quarters
- ◆ 975 hours in the last three contribution quarters
- ◆ 1,340 hours in the last four contribution quarters

Tom wants to continue coverage under the Active Self-Pay Program. The amount that Tom would have to pay for the next quarter of coverage will be based on the **lesser of**:

1. 350 hours - 150 hours = 200 hours
2. 700 hours - 600 hours = 100 hours
3. 1,050 hours - 975 hours = 75 hours
4. 1,400 hours - 1,340 hours = 60 hours

To calculate the amount that Tom would have to pay, multiply the hours by the hourly contribution rate in effect at the time. Tom will only need to make up the cost of 60 hours.

You can self-pay for a benefit quarter in one payment, or in three separate monthly payments. The first payment is due as stated in the letter you will receive. After the first payment, monthly payments are due by the 10th of each month. If a monthly payment is late, coverage for that entire quarter is cancelled and any monthly payments that were already made are credited as hours paid.

If you do not make the required self-payment on time, you will need to meet the initial eligibility requirements described on page 2 to be eligible again.

RETIRED EMPLOYEES UNDER AGE 65

If you retire while Eligible for Plan benefits, you may continue coverage under the Active Self-Pay Program if the Eligibility requirements outlined in the above section are met. You may also choose to self-pay for the Retiree Plan of Benefits or for medical coverage under COBRA (described on page 12).

ELIGIBILITY

When you retire, you may continue coverage under the Retiree Self-Pay Program if:

- ◆ You are at least age 52 but less than age 65 and not yet Entitled to Medicare;

- ◆ You do not have enough hours left in your Reserve Accumulation Account to pay for a quarter of coverage (By electing the Retiree Plan of Benefits, you forfeit any excess Reserve Accumulation Account hours.);
- ◆ You are receiving retirement benefits from the Iron Workers Mid-America Pension Plan;
- ◆ Before retiring, you were eligible for benefits by virtue of Contribution Hours under this Plan for some part of each of the last ten (10) calendar years; and
- ◆ For the quarter immediately prior to retiring, you were eligible for benefits under this Plan by virtue of any combination of the following: Contribution Hours, Reserve Accumulation Account hours, and Self-Pay Contributions.

RETIRED EMPLOYEES OVER AGE 65

If you are covered under the Tri-State Welfare Fund benefits (either by your employment or by self-payment), you and your eligible spouse may self-pay for the Medicare Advantage Plan. See the insert in the back pocket. You must be entitled to Medicare and self-pay monthly for this coverage. If you had end stage renal disease (ESRD) while covered under the Active or Retiree Plan of Benefits prior to age 65, your coverage under the Plan will continue through the Retiree Plan of Benefits rather than the Medicare Advantage Plan, provided you remain eligible and pay for coverage.

COBRA allows you to continue coverage under certain circumstances.

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, is a Federal law that requires plans to offer a temporary extension of plan benefits to Employees and Eligible Dependents who lose coverage under the Plan.

ELIGIBILITY FOR COBRA COVERAGE: QUALIFYING EVENTS

COBRA continuation coverage is offered to you and your Dependents in specific instances, called qualifying events, when coverage under the Plan would otherwise end.

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

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

Your spouse will become a qualified beneficiary if your spouse will lose your coverage under the Plan because any of the following qualifying events happens:

- ◆ You die;

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

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because of any of the following qualifying events happens:

- ◆ You die;
- ◆ Your hours of employment are reduced;
- ◆ Your employment ends for any reason, other than the parent-employee's gross misconduct;
- ◆ The parent-employee becomes enrolled in Medicare benefits (Parent-employee becoming entitled to Medicare means that the parent-employee was eligible for Medicare benefits and enrolled in Medicare under Part A, Part B, or both. The entitlement date is the date of enrollment.);
- ◆ The parents become divorced; or
- ◆ The child stops being eligible for coverage under the Plan as a dependent child.



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

If you or a covered dependent enters service in the uniformed services as defined by the Uniformed Services Employment and Reemployment Rights Act (USERRA) for at least 30 days, your service is considered a qualifying event under COBRA because it is a reduction in hours or end of employment. You or the dependent is entitled to elect to make self-payments for COBRA Continuation Coverage, regardless of any coverage provided by the military or government. Under USERRA, you are eligible to continue coverage for up to 24 months.

EMPLOYER MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

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

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or a dependent child losing eligibility for coverage as a dependent child), you must notify the Fund Office. You are required to notify the Fund Office within 60 days of the later of the date the qualifying event occurs or the date coverage is lost. You must send this notice to:

Iron Workers Tri-State Welfare Fund
c/o: OBA Midwest
1000 Burr Ridge Parkway, Suite 200
Burr Ridge, IL 68527

COVERAGE UNDER COBRA

Health care coverage is available through this COBRA option. Life Insurance, Accidental Death and Dismemberment Insurance and Weekly Accident and Sickness Benefits are not included.

PAYMENT INFORMATION

You pay for COBRA coverage on a monthly basis. The cost for COBRA coverage is an amount determined by the Trustees, not to exceed 102% of the cost to provide this coverage. The cost for extended disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

If you wish to continue coverage under COBRA, you must elect, in writing, to self-pay for COBRA continuation coverage within 60 days of the later of:

- ◆ The date you or your Eligible Dependent would otherwise lose coverage due to the qualifying event; or
- ◆ The date you or your Eligible Dependent are notified of the right to elect COBRA continuation coverage.

LENGTH OF COBRA COVERAGE

If coverage ends because of a lack of contribution hours, COBRA continuation coverage is available for 18 months. However, if a second qualifying event occurs within this 18-month period, the maximum period of coverage for you and your Dependents will be extended to 36 months.

If you (the Employee) have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while COBRA continuation coverage is in effect, you may add such child to your coverage. You must notify the Fund Office, in writing, of the birth or placement in order to have this child added to your coverage.

Children born, adopted or placed for adoption as described above, have the same COBRA rights as a spouse or Dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all

qualified beneficiaries with COBRA continuation coverage, their continued coverage depends on timely and uninterrupted payment of premiums on their behalf.

The maximum period of 18 months will be extended to 29 months for you and your Dependents if you or one of your Dependents is disabled and the disability started some time before the 60th day of COBRA continuation coverage and lasts at least until the end of the 18-month period of continuation coverage. Notice of the disability determination by the Social Security Administration must be given to the Fund Office within 60 days of the determination.

In addition, if you become enrolled in Medicare within 18 months before or after you lose coverage due to your lack of Contribution Hours, the maximum COBRA continuation period for your Dependents who are not entitled to Medicare will be 36 months beginning on the date you enroll in Medicare. The maximum period of COBRA continuation coverage for your Dependents if your employment terminates more than 18 months after your enrollment in Medicare is 18 months. If the qualifying event is any reason other than reduction in hours or loss of employment, the maximum period of continuation coverage is 36 months starting with the date COBRA continuation coverage first started.

If you are continuing coverage under a USERRA leave (Military service), your coverage lasts a total of 24 months. See page 22.

COBRA usually lasts for 18 months, but may be extended to 29 or 36 months, depending on the circumstances.

WHEN COBRA COVERAGE ENDS

COBRA continuation coverage ends on the earliest of the following dates:

- ◆ The last day of the last month for which contributions are made, if you and your Dependent fail to make the self-payments on a timely basis.
- ◆ The date on which you or your Dependent become covered as an Employee or as a Dependent under any other group health plan. However, coverage may continue for the maximum 18- or 36-month period if the other group health plan contains exclusions for preexisting conditions.
- ◆ The date on which you become entitled to benefits under Medicare. However, Dependents not entitled to Medicare can continue coverage for up to 36 months from your entitlement to Medicare, or 18 months from the date of the first qualifying event, whichever is longer.
- ◆ The date on which your Dependent becomes entitled to Medicare.
- ◆ The date that is 18, 29, or 36 months, as the case may be, after the date of the qualifying event as described in this section.
- ◆ The date on which the Plan ends.



RETIREE PLAN OF BENEFITS (RETIREES UNDER AGE 65)

For Dependents of Deceased Employees, and Employees Who Retire or Become Disabled Before Age 65 and their Dependents.

Contact the Fund Office when you apply for Medicare.

You must notify the Fund Office when you become Entitled to Medicare.

The self-pay option for this Retiree Plan of Benefits explained below is available to Dependents of deceased Employees, Employees who retire or become permanently and Totally Disabled before age 65, and the Dependents of such retired and disabled Employees.

BENEFITS PAYABLE

The benefits available under the Retiree Plan of Benefits are the same as those shown for the Active Plan of Benefits on the Schedule of Benefits (see insert inside the back pocket). However, the Retiree Plan of Benefits does not include Life Insurance, AD&D Insurance, and Weekly Accident and Sickness Benefits.

RETIRED EMPLOYEES

When you retire, you may choose to make self-payments under the Self-Pay Program (explained on page 9) or this Retiree Plan of Benefits if:

- ◆ You are at least age 52 but less than age 65 and not yet Entitled to Medicare;
- ◆ You do not have enough hours left in your Reserve Accumulation Account to pay for a quarter of coverage;
- ◆ You are receiving retirement benefits from the Iron Workers Mid-America Pension Plan or the Iron Workers Local 380 Retirement & Severance Plan;
- ◆ Before retiring, you were eligible for benefits by virtue of Contribution Hours under this Plan for some part of each of the last ten (10) calendar years; and

- ◆ For the quarter immediately prior to retiring, you were eligible for benefits under this Plan by virtue of any combination of the following: Contribution Hours, Reserve Accumulation Account Hours, and Self-Pay Contributions.

You may also choose this Retiree Plan of Benefits after you have exhausted the 16 consecutive benefit quarters or you are an early retiree under the Self-Pay Program. You may continue coverage under this Retiree Plan of Benefits until you become Entitled to Medicare. You may continue benefits for your covered spouse and/or Dependent children after you become Entitled to Medicare until your spouse and/or each child no longer meets the definition of Dependent or becomes Entitled to Medicare.

If you choose the Self-Pay Program, you waive COBRA continuation coverage. Instead of the Self-Pay Program, you may choose to continue coverage under COBRA continuation coverage explained on page 12.

DISABLED EMPLOYEES

If you become permanently and Totally Disabled while Eligible for active Employee benefits, you will be Eligible to make self-payments for the Retiree Plan of Benefits after your coverage was extended for 18 months. You may continue your Eligibility until you become Entitled to Medicare. You may continue benefits for your covered spouse and/or Dependent children after you become Entitled to Medicare until your spouse or child no longer meets the definition of Dependent or becomes Entitled to Medicare.

DEPENDENTS OF DECEASED EMPLOYEES

Dependents of deceased Employees (disabled or retired at the time of death) who were Eligible for benefits at the time of the Employee's death can continue Eligibility under the Retiree Plan of Benefits by making self-payments.

A spouse may continue his or her Eligibility until the earlier of becoming Entitled to Medicare or remarrying. Dependent children are Eligible to continue coverage until the surviving parent remarries or until they no longer meet the definition of a Dependent.

This self-payment option is only available if the spouse and/or Dependent children reject COBRA continuation coverage.

PAYMENT INFORMATION

Self-payments for the Retiree Plan of Benefits are paid each benefit quarter. The amount of the self-payment is determined by the Trustees.

Self-payments are due at the Fund Office by the first day of the benefit quarter for which payment is due. The date is determined by the postmark. If a self-payment is late, Eligibility will terminate as of the first day of that benefit quarter, and the payment will be returned to you. If eligibility terminates due to failure to make a full or timely self-payment, you and your dependent(s) cannot make future self-payments. COBRA continuation coverage is not available when the self-payments end for the Retiree Plan of Benefits because you waived COBRA.

If you are receiving a monthly pension check from the Iron Workers Mid-America Pension Plan, you may elect to have your self-payments deducted from your pension check. To make this election, call the Fund Office for the appropriate form.

MEDICARE ADVANTAGE PLAN (RETIRES AGE 65 & OLDER)

ELIGIBILITY

When you retire, you may choose to make self-payments under the Medicare Advantage Plan if:

- ◆ You are Entitled to Medicare;
- ◆ You do not have enough hours left in your Reserve Accumulation Account to pay for a quarter of coverage;
- ◆ You are receiving retirement benefits from the Iron Workers Mid-America Pension Plan or the Iron Workers Local 380 Retirement & Severance Plan;
- ◆ Before retiring, you were eligible for benefits by virtue of Contribution Hours under this Plan for some part of each of the last ten (10) calendar years; and
- ◆ For the quarter immediately prior to retiring, you were eligible for benefits under this Plan by virtue of any combination of the following: Contribution Hours, Reserve Accumulation Account Hours, and Self-Pay Contributions.

For Eligible Retired Employees and their Spouses who are Entitled to Medicare and Pay the Required Premium.

Contact the Fund Office when you apply for Medicare.

Pre-Funded Allowance Effective Dates

Local 444 — January 1, 2004

Local 465 — January 1, 2005

All others — January 1, 1999

If you choose the Medicare Advantage Plan, you waive COBRA continuation coverage, if applicable. Instead of the Medicare Advantage Plan, you may choose to continue coverage under COBRA continuation coverage, if applicable, as explained on page 12.

The self-pay option for the Medicare Advantage Plan is available to Employees and their eligible spouses who are Entitled to Medicare coverage. A description of the benefits is available from Humana. Under the Medicare Advantage Plan, your benefits under Medicare Parts A, B, and D (prescription drug coverage) are included. If you suffer from end-stage renal disease prior to coverage in the Medicare Advantage Plan, your coverage will be provided through the Retiree Plan of Benefits even if you are Entitled to Medicare coverage.

PAYMENT INFORMATION

The cost for the Medicare Advantage Plan is determined by the Trustees. The amount of the monthly premium may change at any time.

Monthly premiums are due by the 10th of each month or through pension check deductions. If a monthly payment is late, coverage will terminate. Once coverage terminates, it cannot be reinstated for any reason.

RETIREE PRE-FUNDED ALLOWANCE

If you are active on and earned at least one Quarter of Service after your effective date and retire before you reach age 65, you may be eligible to continue Eligibility with the Retiree Pre-Funded Allowance. You must waive COBRA Continuation Coverage in order to receive the Allowance, which is used as a discount toward the quarterly self-pay rate for the Retiree Plan of Benefits, the Medicare Advantage Plan, or another Medicare Supplement Plan. The allowance is applied toward the quarterly self-pay rate for you and your dependents' coverage.

To be eligible for the Retiree Pre-Funded Allowance, you must be:

- ◆ At least age 62 and have 40 Quarters of Service; or
- ◆ At least age 52 and have 60 Quarters of Service; or
- ◆ Totally and permanently disabled with at least 60 Quarters of Service.

See the brochure *Ironworkers Tri-State Welfare Fund Pre-Funded Allowance Plan* for more information.

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

GETTING MARRIED

When you get married, your spouse is eligible for medical, dental, and vision coverage, if you are an active employee or if you are a retiree. Once you provide any required information, coverage for your spouse begins on the date of your marriage. At this time, you also may want to update your beneficiary information for your Life and AD&D Insurance. **You must notify the Fund Office within 30 days of the date of your marriage to cover your spouse under the Plan.**

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

ADDING A CHILD

Your natural born child will be eligible for coverage on his or her date of birth. If you adopt a child, or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are

responsible for health care coverage and your child meets the Plan's definition of a dependent. Stepchildren are eligible for coverage on the date of your marriage, provided they are living in your home and dependent on you for support. Once you provide any required information, coverage for your child will begin. The child must meet the dependent eligibility requirements described on page 62.

GETTING LEGALLY DIVORCED

If you and your spouse get a divorce, your spouse will no longer be eligible for coverage as a dependent under the Plan. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse **must notify the Fund Office within 60 days** of the divorce or legal separation date for your spouse to obtain COBRA Continuation Coverage. At this time, you may also want to review your beneficiary designation for your Life and AD&D Insurance, if eligible.

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

When you add a child, provide the Fund Office with a complete enrollment form and:

- *The birth date, effective date of adoption or placement for adoption, or the date of your marriage (for stepchildren).*
- *When you add a stepchild, you must submit a copy of your spouse's divorce decree to establish if there is other coverage for that child.*
- *A copy of the birth certificate, adoption papers, court order, or marriage certificate (for stepchildren).*
- *A copy of your child's other medical insurance information, if he or she is covered under another plan.*

If you legally divorce, provide the Fund Office with:

- *A copy of your separation or divorce decree.*
- *If you have children for whom you do not have custody, a copy of any QMCSO.*

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

- *Contact the Fund Office; and*
- *Enroll for COBRA Continuation Coverage.*

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

- *Contact the Fund Office.*
- *Enroll for COBRA Continuation Coverage if he or she plans to continue coverage under the Plan.*
- *If your child is under 25, a full-time student and wants to continue coverage under the Plan, he or she must provide evidence of full-time student status to the Fund Office.*

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

- *Notify your employer and the Fund Office.*
- *Provide the Fund Office with proof of your disability.*
- *Apply for Weekly Income Benefits.*

LOSING ELIGIBILITY

A detailed description of the requirements needed to continue eligibility is shown on page 2. If you are an active employee and your eligibility ends under the Active Plan, you can become eligible again by meeting the initial eligibility requirements as described on page 1. When your coverage ends, you may be eligible to continue coverage by using your reserve accumulation account, making monthly self-payments for self-pay continuation coverage, or self-paying for COBRA Continuation Coverage (see page 12).

CHILD LOSING ELIGIBILITY

In general, your child is no longer eligible for coverage when he or she marries, is not dependent on you for support, or the day your child reaches age 19 (or the end of the month your child reaches age 25 if a full-time student). You must notify the Fund Office within 60 days of the date your child is no longer eligible for coverage. Your child may elect to continue coverage by making COBRA self-payments for up to 36 months.

WHEN YOU ARE OUT OF WORK DUE TO DISABILITY (FOR ACTIVE EMPLOYEES)

If you are out of work due to a non-work-related disability, you may receive Accident and Sickness Weekly Income Benefits until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first. In addition, you may be credited with 27 hours for each full week of disability, up to 700 hours during any consecutive 12-month period. If your Eligibility ends, benefits may be continued for up to 18 months (see page 2).

The Fund requires proof that you are under the care of a physician to be eligible for Accident and Sickness Weekly Income Benefits and the continued eligibility benefit. The Fund also has the right to require you to submit to a medical examination.

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

If you are out of work due to a work-related disability, you may be eligible for workers' compensation benefits. Contact your employer to file a workers' compensation claim. The Fund does not provide coverage for work-related disabilities.

After your disability ends, you must notify the Fund Office.

IN THE EVENT OF YOUR DEATH

If you are eligible for coverage on the date of your death, your beneficiary will receive a Life Insurance Benefit (and an AD&D Insurance benefit, for active employees only if your death is caused by an accident). See pages 41 for more information about Life and AD&D Insurance.

ACTIVE EMPLOYEES

If you die while you are an active employee, coverage for your eligible dependents will be continued until your reserve accumulation account is depleted. Then, coverage may be continued under the Retiree Plan of Benefits, if qualified, or COBRA Continuation Coverage.

RETIREES

If you are a retiree and die, your surviving dependents can continue coverage through self-payments. If the self-payments are discontinued for any month, or if your dependent does not elect to make self-payments when first eligible, your dependent will not be eligible to continue coverage by making self-payments. See page 9 for more information.

WHEN YOU LEAVE COVERED EMPLOYMENT: COBRA CONTINUATION COVERAGE

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

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

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

- *Notify the Fund Office.*
- *Provide the Fund Office with a copy of your death certificate.*
- *Apply for your Life Insurance (and AD&D Insurance, if applicable).*
- *If your dependents want to continue coverage under the Plan, enroll for self-pay continuation coverage or COBRA Continuation Coverage.*

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

Keep Plan Informed of Address Change. *To protect your family's rights, you should keep the Fund Office informed of any changes in the addresses for you and any family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.*

If you are called to military service:

- *Notify your employer and the Fund Office.*
- *Make self-payments if you wish to continue your coverage.*

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed on page 12. COBRA Continuation Coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

MILITARY SERVICE AND ELIGIBILITY

If your Eligibility ends because you enter or are drafted into active military service, your Eligibility is reinstated if you make application for reemployment with a contributing Employer within the time required by the applicable Federal law. Eligibility for you and your Dependents will be reinstated on the day you return to work.

The last Employer you worked for before you left for military service is responsible for making the required contributions on your behalf in order to continue coverage for you and your Dependents. Your right to continue coverage (except Life Insurance, Accidental Death & Dismemberment and Weekly Disability Benefits) depends on the length of your absence from employment.

If you leave employment to enter qualified military service for less than 31 days, you and your Dependents will continue to be covered under the Plan in the same manner you were covered on the day before you left employment.

If you leave employment to enter qualified military service for 31 days or more, you may elect to continue coverage under the Plan (except Life Insurance, Accidental Death & Dismemberment and Weekly Disability Benefits) for you and your Dependents until the earlier of:

- ◆ The end of the 24-month period beginning on the date you elected to continue coverage under USERRA when leaving employment to enter military service; or
- ◆ The date your reemployment rights under USERRA expire.

The cost to continue coverage is described in "Self-Pay Options" on page 9.

FAMILY AND MEDICAL LEAVE ACT (FOR ACTIVE EMPLOYEES)

The Family and Medical Leave Act (FMLA) of 1993 allows you to take up to 12 weeks of unpaid leave for your serious illness, to care for a child after the birth, adoption, or placement for adoption of a child, or to care for your seriously ill spouse, parent, or child. The Family and Medical Leave Act requires employers to maintain health coverage under any health plan for the length of a leave as if you were still employed. In addition, the Act states that if you take a family or medical leave, you may not lose any benefits that you had accrued before the leave.

ELIGIBILITY

To be eligible for FMLA benefits, you must:

- ◆ Work for a contributing employer, who is covered under FMLA;
- ◆ Have worked for the employer for at least 12 months;
- ◆ Have worked at least 1,250 hours over the previous 12 months; and
- ◆ Work at a location where at least 50 employees are employed by the employer within a 75-mile radius.

If you believe you are entitled to FLMA, please contact your employer, not the Fund Office. Your eligibility for a FMLA leave is determined by your employer. The Fund will not intervene in any employer-employee disputes.

MAINTENANCE OF HEALTH BENEFITS

A covered employer is required to maintain the same health coverage for you on FMLA leave as the coverage that was provided before the leave was taken and under the same terms as if you had continued work. Therefore, an employer covered under FMLA must continue to contribute on your behalf while you are on FMLA leave as though you had been continuously employed.

FMLA AND OTHER BENEFITS

You will not accrue additional benefits during an unpaid FMLA leave, but you cannot lose benefits you had accrued before your leave. Welfare benefits other than health care must be reinstated when you return to work without any new conditions or the need to meet eligibility requirements.

HOW FMLA WORKS WITH COBRA

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

If you do not return from leave, that is considered a COBRA qualifying event (a reduction in hours causing a loss of coverage). You will have up to 12 weeks of maintained health care coverage during FMLA leave and an additional 18 months (or 36 months, if applicable) of continued coverage under COBRA.

If you and your spouse both work for the same employer, you and your spouse are eligible for a combined total of 12 weeks of leave during a 12-month period.

Any employer that employs 50 or more Employees within a 75-mile radius for each working day during each of 20 or more calendar work-weeks in the current or preceding calendar year is covered by FMLA.

When you retire:

- *Notify the Fund Office in advance of your retirement.*
- *Apply for retiree benefits if you are eligible.*
- *If you want to continue coverage under the Plan, enroll for COBRA Continuation Coverage, unless you qualify for retiree coverage.*



WHEN YOU RETIRE

When you retire, you may be eligible for coverage under the Retiree Plan of Benefits or the Medicare Advantage Plan, if you meet the eligibility requirements described on page 11. In general, benefits under the retiree program are the same as those for active employees, except you are not eligible for Life Insurance, AD&D Insurance, or Accident and Sickness Weekly Income Benefits. If you choose coverage under the retiree medical benefits program, you waive your right to COBRA Continuation Coverage.

RETURNING TO WORK

ACTIVE EMPLOYEES

If your eligibility ended and you start working again for an employer that contributes to the Fund, your coverage will be reinstated as described on page 6. If you return to work following a military leave of absence, your coverage will be reinstated as described on page 7.

RETIREEES

Your retiree coverage under the Plan will end if you stop making self-payments even if you return to work. Once you retire and start making self-payments toward retiree coverage, even if you return to work, you cannot regain eligibility in the Active Plan.

COST SAVING FEATURES

WHEN YOU ARE HOSPITALIZED –THE PPO HOSPITAL NETWORK

If you or a covered Dependent is hospitalized, you will receive the Hospital benefits described in these sections when you use a PPO Hospital. If you receive services from a non-PPO Hospital, your share of the cost for services increases 20%. If you live more than 25 miles from the nearest PPO Hospital or if you are seeking Hospital care in an emergency situation, benefits will not be reduced. For an up-to-date list or a listing of PPO Hospitals in your area free of charge, please contact Blue Cross and Blue Shield (see page VI for contact information).

UTILIZATION REVIEW

The Utilization Review (UR) Company must pre-approve all Hospital care, except in an emergency situation or for childbirth if the length of the Hospital stay is within the guidelines described on page 31. The UR Company must be notified within two days (48 hours) of an emergency admission. If you do not receive pre-approval, you will have to pay an additional \$200 deductible penalty for the hospital stay.

The UR Company is also consulted in determining if charges are covered in specific situations. All bills received from an emergency room or outpatient facility for “observation” (or any similar term) in excess of 23 hours will automatically be sent to the UR Company for determination if the charges are Medically Necessary.

EMERGENCY ROOM COPAYMENT

If you use the Emergency Room, you will have to pay a \$50 copayment. However, if you are admitted to the Hospital based on your Emergency Room visit, the \$50 copayment will be waived.

RECOVERY INCENTIVE BENEFIT

If you find an overcharge on your Hospital bill and arrange for the overcharge to be paid back to the Plan, you will receive a Recovery Incentive Benefit. Hospital overcharges of less than \$25 are not Eligible for this Benefit.

The Recovery Incentive Benefit equals 25% of the overcharged amount that is recovered. You may receive up to \$500 from this Recovery Incentive Benefit in any calendar year.

SPECIAL EXTRA WORK BENEFIT

If you receive 2,000 or more Contribution Hours for work performed in a calendar year, you will be Eligible for this Special Extra Work Benefit. This benefit pays you back for up to the first \$100 of the family deductible for that year.

HOW THE PLAN WORKS

The Comprehensive Medical Benefit covers a wide range of medical expenses and provides financial protection when you and your family need medical care.

Both the Active and Retiree Plans of Benefits work similarly. Generally, after you pay an individual deductible (up to a family limit), the Plan and you share the cost of medical expenses. The Plan pays a percentage of the network charges or the usual and customary charges for non-network providers. Once your out-of-pocket expenses reach the annual limit, the Plan will then pay 100% for any additional network expenses for that year. The Plan pays benefits up to any annual or lifetime limits. The Plan pays for Wellness Benefits such as physicals, without a deductible, up to annual limits. Refer to the Schedule of Benefits in the back pocket for your deductibles, the percentages the Plan pays, out-of-pockets limits, annual limits, and lifetime maximums.

The Plan limits the amount you pay for covered medical expenses in a year.

DEDUCTIBLES

The deductible means the first dollars of expenses you must pay before the Plan begins paying benefits. The deductible does not apply to wellness benefits.

ANNUAL OUT-OF-POCKET LIMITS

The annual out-of-pocket limit is the maximum you will have to pay for covered expenses in a year. The following expenses do not count towards your out-of-pocket limits:

- ◆ Out-of-network expenses;
- ◆ Expenses that are not covered; and
- ◆ Expenses above any annual or lifetime limits, such as routine expenses over the \$500 Well Adult Physical Examinations and Immunizations annual limit (see the *Schedule of Benefits* in the back pocket for all annual and lifetime limits).

Once you reach the out-of-pocket limit, the Plan will pay 100% of covered expenses for the remainder of the year up to any annual or lifetime limit. Out-of-network expenses will continue to be paid at 60%. Amounts over annual or lifetime limits are not covered expenses.

USUAL & CUSTOMARY CHARGES

The usual charges for a specific treatment or service in the local area.

ANNUAL OR LIFETIME LIMITS

Some covered expenses are only covered up to an annual and/or lifetime limit. In addition, the lifetime limit for all covered expenses is \$1,000,000. All annual and lifetime limits are shown on the Schedule of Benefits in the back pocket.

WELLNESS BENEFITS

WELL CHILD CARE AND IMMUNIZATIONS

The Well Child Care and Immunizations benefit provides coverage to Dependent children for physical exams and immunizations in accordance with the American Academy of Pediatrics Immunization Guidelines. No deductible applies to this benefit.

Well child physical examinations and immunizations are covered up to Reasonable and Customary charges, up to the maximum listed in the Schedule of Benefits.

ROUTINE ADULT PHYSICAL EXAMINATIONS AND IMMUNIZATIONS

The Routine Adult Physical Examinations and Immunizations benefits provide coverage for annual physical examinations and immunizations for you and your spouse. No deductible applies to these benefits.

The following expenses are covered up to the calendar year maximums listed in the Schedule of Benefits.

- ◆ Annual physical examinations through the medical screening provider chosen by the Trustees or your Physician;
- ◆ Office visits, X-rays and laboratory charges in association with routine physical examinations; and
- ◆ Immunizations and flu shots according to acceptable medical guidelines.

Mammograms are covered under Wellness Benefits if they are used as a screening test without any prior diagnosis, family or personal history; for example, breast cancer, cysts, or tumors. If you have a family or personal history of breast maladies, then mammograms are covered as any other medical expense, subject to the deductible and coinsurance.

DIABETES EDUCATION

Diabetes Education covers programs for patients or parent(s) of child patients that teach the care and management of diabetes. The programs are designed to improve patient knowledge of diabetes and techniques for self-management and compliance with proper healthcare procedures required for the patient's wellbeing. The Plan pays expenses up to \$500 per lifetime only when the program is ordered by a Physician and when the patient or parent submits a receipt showing:

- ◆ The cost of the program;
- ◆ The name, address and telephone number of the program sponsor;
- ◆ The dates and times of classes that were held; and
- ◆ The classes actually attended by the patient or parent.

COVERED MEDICAL EXPENSES

The following expenses are payable under the Comprehensive Medical Benefit when Medically Necessary:

1. Room and board including any charges that are made by the Hospital as a condition of occupancy or on a regular daily or weekly basis such as for general nursing services. However, if private accommodations are used, any excess of daily board and room charges over the Hospital's average semi-private charge will not be counted as a covered medical expense unless documentation is presented from the attending Physician that a private room is Medically Necessary.
2. Miscellaneous Hospital Charges, other than room and board, furnished by the Hospital.
3. Outpatient surgical services.
4. The services of a legally qualified Physician for surgery, in-Hospital medical visits, and office visits.
5. The services of a registered graduate nurse (R.N.) other than the Employee or spouse who ordinarily resides in an Employee's home.
6. Diagnostic laboratory and X-ray examinations.
7. X-ray, radium and radioactive isotope therapy.
8. Chemotherapy.
9. Anesthetics and oxygen.
10. Rental of durable medical or surgical equipment.
11. Artificial limbs and artificial eyes, but not eye examinations, eye refractions, eyeglasses, or hearing aids.
12. The expense for Medically Necessary professional ambulance service to a Hospital within the jurisdiction of the Fund as certified by a Physician. Such transportation includes transfers between Hospitals if such transfer results in more highly specialized care.

13. Incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth, limited to:
- Alveolar abscesses;
 - Alveolectomies;
 - Apicoectomies (resection of root of tooth);
 - Cysts of jaws;
 - Epulis (fibrous tumor of the gum); or
 - Partially or completely unerupted impacted teeth.
14. For all other dental work and oral surgery, only the charges of a Hospital and anesthesia are included as covered medical expenses.
15. The expenses incurred in connection with cosmetic surgery that are necessary for the prompt repair of a non-occupational accidental injury.
16. In-patient and out-patient treatment for alcohol, drug and chemical dependency, subject to the percentage, calendar year and lifetime maximums stated in the Schedule of Benefits.
17. In-patient and outpatient treatment for mental and nervous disorders.
18. Expenses incurred for up to 100 Home Health Care visits from a Home Health Care Agency per calendar year. A visit consists of up to four consecutive hours of Medically Necessary care by one or more providers from the Home Health Care Agency.
19. Expenses incurred for room and board and miscellaneous services for an Eligible confinement in a Skilled Nursing Care Facility for up to a maximum of 120 days per calendar year. Such confinement is covered when:
- The confinement begins within seven days after a Hospital stay of at least three consecutive days;
 - The confinement is for the same or related cause; and
 - The Utilization Review (UR) company has pre-certified the confinement and will monitor the Person's progress on an on-going basis.
20. Up to \$25,000 per lifetime per family for the treatment of infertility or for promotion of pregnancy, including prescription drugs. The attending Physician must submit medical documentation accepted by the Board of Trustees and/or the UR company that less expensive treatment has not and is not expected to result in pregnancy before in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), embryo transfer or similar procedures are covered.

21. Treatment received in an immediate care or urgent care facility.
22. Well Child Examinations & Immunizations up to 100% of Reasonable & Customary charges up to \$500 for the first year of life and \$300 for each subsequent calendar year. Immunizations are paid based on the guidelines developed by the American Academy of Pediatrics.
23. Adult Physical Examinations are paid up to 100% of reasonable & customary charges up to \$1,000 per year.
24. Adult Immunizations and flu shots are paid up to 100% of Reasonable & Customary charges.
25. Modified solid food products that are low protein or which contain modified protein or other enteral formulas for home use, other than nutritional supplements taken selectively, provided that:
 - A Physician has provided a written prescription for the above items;
 - The prescription states that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for the individual;
 - In the absence of the above items, the individual is or will become malnourished or suffer from disorders, which if left untreated, will cause chronic physical disability, mental retardation or death; and
- The individual has been diagnosed with: inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility (such as chronic intestinal pseudo-obstruction); and multiple, severe food allergies which, if left untreated, will cause malnourishment, chronic physical disability, mental retardation or death.
26. The expenses incurred for Retin-A for an individual age 26 or older when a Physician furnishes documentation to the Board and/or Plan showing that Retin-A is Medically Necessary for the treatment of severe acne.
27. In the case of an individual who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, in consultation with the attending Physician, the Women's Health Cancer Rights Act requires coverage for the following:
 - Reconstruction of the breast on which the mastectomy was performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.



28. Outpatient self-management training and education for the treatment of type 1, type 2 and gestational diabetes.
29. Effective January 1, 1998, group health plans and health insurance issuers offering group health insurance coverage generally may not—under Federal law—restrict a mother's or a newborn child's benefits for any hospital length of stay related to childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section. In addition, a provider must not be required to obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.
30. Hospice Expenses – The Plan provides coverage to participants who are diagnosed as terminally ill with a life expectancy of six months or less. The Hospice benefit takes the place of all other Plan benefits. Benefits begin on the day the patient is diagnosed as terminally ill. If the patient is still living after six months, benefits may continue if the attending Physician confirms that the patient is still terminally ill.

The following expenses are covered, if approved by the attending Physician:

- ◆ In-patient confinement in a hospice facility. The Reasonable and Customary charge for room and board in a hospice facility is the most common semi-private room and board charge of a Hospital in the Person's area.
- ◆ Home visits by nurses and other health care professionals.
- ◆ Management of pain.
- ◆ Medical treatment.
- ◆ Local ambulance or special transport between patient's home and hospice facility.
- ◆ Instruction and supervision of family members in the care of the patient, including nutritional direction.
- ◆ Help in obtaining medical equipment, supplies or medication, including rental of wheel chairs and Hospital-type beds.
- ◆ Psychological counseling and emotional support to the patient and family.
- ◆ Spiritual support to the patient and family.
- ◆ Bereavement services up to a maximum charge of \$500.

EXPENSES NOT COVERED BY THE COMPREHENSIVE MEDICAL BENEFIT

Any treatment, services or supplies listed under "General Plan Exclusions and Limitations" on page 44.

THE PRESCRIPTION DRUG BENEFIT

Your Preferred Prescriptions[®], Formulary

*A formulary is a list of drugs that are preferred by your Plan. This list includes a wide selection of drugs that is preferred because it offers you choice while helping keep the cost of your prescription drug benefit affordable. Each drug is approved by the Food and Drug Administration (FDA) and reviewed by an independent group of doctors and pharmacists for safety and efficacy. Your Plan encourages the use of the preferred drugs on this list to help control rising drug costs. While we may remind your doctor when a formulary drug is available as a possible alternative for a drug that is not on our formulary, **your doctor will always make the final decision on your medication.***

For more information about your formulary, visit www.express-scripts.com or call the number on your pharmacy card.

The Prescription Drug Benefit features a retail pharmacy program and a mail-order program. The retail pharmacy program is for short-term prescriptions (up to a 34-day supply). The mail-order program is for long-term prescriptions (up to a 90-day supply).

RETAIL PHARMACY PROGRAM

The Trustees have contracted with a pharmacy network to provide prescription drug benefits to you and your family at reasonable costs. When you become Eligible for this benefit, you will receive a Prescription Drug Identification Card. When you fill your prescription, you need to present your ID card to the pharmacist.

When you use a participating pharmacy, you pay the co-payment amounts shown on the Schedule of Benefits. Generic drugs have the lowest copayment, followed by formulary drugs and non-formulary drugs.

Please call Express Scripts (see page VI for contact information) for the name of a participating pharmacy near you.

Generally, prescriptions and refills can be filled up to a 34-day or 100-unit doses supply through the retail pharmacy program.

MAIL-ORDER PROGRAM

You pay the co-payment amounts shown on the Schedule of Benefits. Generic drugs have the lowest copayment, followed by formulary drugs and non-formulary drugs.

You can receive up to a 90-day supply of a prescription drug through the mail-order program.

THERAPEUTIC CLASS BENEFIT

To encourage participants to use the medications prescribed by their physicians for the most common chronic diagnoses, the Plan provides lower copayments for medications used to treat diabetes, high blood pressure, heart disease, high blood cholesterol, and asthma. See the Schedule of Benefits for the copayments for these classes of drugs.

THERAPEUTIC TRANSFER PROGRAM

Our prescription drug provider has a program to help control costs and provide you and your family with the best prescription value. The prescription drug provider has a prescription drug formulary. A formulary is a list of prescription drugs that offer the same or better therapeutic benefit for less cost than other drugs for the same condition. Generic drugs are included in the

formulary. Since you pay less for generic and other formulary drugs than for non-formulary drugs, Express Scripts can help you keep costs down by suggesting a formulary drug when your doctor prescribes a medication that's not on the formulary.

Here's the process you can follow to save money:

- ◆ *At a retail pharmacy*, the pharmacist will ask you if you'd like to switch to a formulary (if available). If you agree, the pharmacist will call your doctor to confirm the change. Remember that your copayment is lower for generics and other formulary drugs.
- ◆ *Through mail order*, the pharmacist will change your prescription to a formulary. The pharmacist will usually ask your doctor if the prescription can be changed to a formulary. The pharmacist will send you and your doctor a letter confirming the change. Your copayment is lower for generics and other formulary drugs.

COVERED EXPENSES

The following supplies, when authorized by a Physician, are considered covered expenses under the Prescription Drug Benefit:

- ◆ Legend drugs which are lawfully obtainable only from an individual licensed to dispense drugs upon the Physician's prescription, including oral contraceptives;
- ◆ Injectable insulin;

- ◆ Prescribed syringes, hypodermic needles, test strips and other Medically Necessary supplies used for the administration of injectable insulin; and
- ◆ Compound medication of which at least one ingredient is a prescription legend drug.

EXCLUSIONS AND LIMITATIONS

The following expenses are not covered by the Prescription Drug Benefit:

1. Drugs or medicines lawfully obtainable without a prescription order of a Physician or Dentist, except insulin;
2. Therapeutic devices or appliances, support garments and other non-medical substances, regardless of their intended use;
3. Any charge for the administration of a prescription legend drug or injectable insulin;
4. Medication that is to be taken by or administered to the individual, in whole or in part, while he or she is an in-patient or out-patient in a licensed Hospital, rest home, sanitarium, Skilled Nursing Care Facility, convalescent Hospital, nursing home or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

5. A contraceptive device, other than oral contraceptives, regardless of the purpose for which it is prescribed;
6. Viagra or any other drugs for the treatment of erectile dysfunction;
7. Immunization agents, biological sera, blood or blood plasma;
8. Refilling of a prescription in excess of the number specified by the Physician or Dentist or any refill dispensed after one year from the order of a Physician or Dentist;
9. Prescription drugs that may be properly received without charge under local, state or federal programs, including Workers' Compensation;
10. Experimental drugs or medicines that are labeled "Caution—limited by Federal law to investigational use;"
11. Drugs dispensed from a Physician's office;
12. Prescription for the drug Retin-A for Employees or Dependents under age 26 unless documented by a Physician as Medically Necessary. Over age 26, if Medically Necessary for treating severe acne, paid at 80% under the Major Medical Benefit.
13. Prescription drugs for the treatment of infertility. These are covered under the Comprehensive Medical Benefit (see the Schedule of Benefits for limits).

DENTAL EXPENSE BENEFIT

(IF SHOWN ON YOUR SCHEDULE OF BENEFITS)

The Dental Expense Benefit will pay a percentage of covered expenses depending on the type of services you receive. The percentages are as follows:

Coverage A	Preventative And Diagnostic	100%
Coverage B	Restorative	80%
Coverage C	Prosthodontics	80%
Coverage D	Orthodontic	60%

Each coverage type is explained in more detail beginning on the next column. Benefits are paid each year up to the individual annual maximum of \$1,000. Benefits for Coverage D services are paid up to the lifetime orthodontic maximum of \$1,000, and are only available to covered Dependents under age 19.

PREDETERMINATION OF BENEFITS

If your Dentist recommends treatment that can be expected to cost \$250 or more, you are encouraged to submit a description of the treatment and the Dentist's charges to the Fund Office before treatment begins. The Fund Office will estimate your share of the cost for the treatment and determine what benefits can be expected to be paid by the Fund. This procedure can help you decide if alternative treatment is more appropriate, and whether you need to budget for your share of any dental costs.

COVERED EXPENSES

The following covered dental charges are reimbursed for Types A, B, C, and D dental services:

TYPE A

DIAGNOSTIC AND PREVENTATIVE DENTAL SERVICES

- ◆ Routine oral examinations twice in any calendar year.
- ◆ Dental prophylaxis twice in any calendar year, including cleaning, scaling and polishing.
- ◆ Full-mouth X-rays (of at least 14 films) once in any period of 36 consecutive months.
- ◆ Supplementary bitewing X-rays twice in any calendar year.
- ◆ Topical fluoride applications only to covered persons under 19 years of age and no more than one treatment in a calendar year.
- ◆ Space maintainers for a covered person up to age 19.
- ◆ Dental sealants for a covered person up to age 19.

TYPE B

RESTORATIVE DENTAL SERVICES

- ◆ Extractions (except for orthodontics).
- ◆ Restorative services using amalgam, synthetic porcelain and plastic filling material.

- ◆ Oral surgery and the administration of Medically Necessary general anesthetics. Benefits will first be payable under the medical plan and then any excess covered dental expenses will be payable under this Dental Expense Benefit.
- ◆ Injections of antibiotic drugs.
- ◆ Periodontal treatment.
- ◆ Endodontics including pulpal therapy and root canal filling.

TYPE C

PROSTHODONTIC DENTAL SERVICES

- ◆ Initial installation of fixed bridgework.
- ◆ Initial complete or partial dentures.
- ◆ Replacement of fixed bridgework or dentures when:
 - One or more natural teeth are extracted while the person is covered under this Plan; or
 - The existing bridge or denture is at least five years old and cannot be made usable.
- ◆ Inlays, onlays and crowns.
- ◆ Gold fillings.
- ◆ Repair or recementing of bridgework, dentures, crowns and inlays.
- ◆ Relining or rebasing dentures.

TYPE D

ORTHODONTIC SERVICES

- ◆ Orthodontic diagnostic procedures (including cephalometric X-rays).
- ◆ Appliance therapy (braces) including related oral exams, surgery and extractions.

EXCLUSIONS AND LIMITATIONS

The following expenses are not covered by the Dental Expense Benefit:

1. Any service rendered before coverage became effective.
2. Treatment other than by a licensed Dentist or licensed Physician, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the Dentist.
3. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
4. Replacement of a lost, missing or stolen prosthetic device.
5. Replacement or repair of an orthodontic appliance.

6. Any services which are covered by Workers' Compensation laws or employer's liability laws, or services which an employer is required by law to furnish in whole or in part unless a written subrogation and reimbursement in a form satisfactory to the Trustees is signed.
7. Service rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer.
8. Services or supplies for which no charge is made that the covered person is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.
9. Services or supplies that are not Medically Necessary according to accepted standards of dental practice.
10. Services or supplies that do not meet accepted standards of dental practice, including charges for services or supplies that are Experimental or Investigative in nature.
11. Services or supplies received as a result of dental disease, defect or Accident due to an act of war, declared or undeclared.
12. Any duplicate prosthetic device or any other duplicate appliance.
13. Oral hygiene and dietary instruction.
14. A plaque control program (a series of instruction on the care of the teeth).
15. Periodontal splinting.
16. Myofunctional therapy or correction of harmful habits.
17. Implantology.
18. Any orthodontic procedures performed after the first 24 months of treatment.
19. Any treatment, services or supplies listed under "General Plan Exclusions and Limitations" on page 44.

EXTENSION OF BENEFITS

If you are receiving dental treatment when your coverage ends, benefits will continue as follows:

- ◆ Charges for dentures will be considered if the impression was made before coverage ends and the device is placed within two months after coverage ends;
- ◆ Charges for crowns will be considered if the tooth or teeth were prepared before coverage ends and the crowns were placed within two months after coverage ends;
- ◆ Charges for endodontic treatment, to include root canal therapy, will be considered if the tooth was opened before coverage ends and treatment is completed within two months after coverage ends.

VISION CARE BENEFIT (IF SHOWN ON YOUR SCHEDULE OF BENEFITS)

The Vision Care Benefit will pay covered expenses for eye exams, including dilation of pupil and/or relaxing focusing muscles by drops, refraction for vision and examination for pathology, lenses, and frames up to the per person calendar year maximum of \$200. Prescription safety glasses are covered.

EXCLUSIONS AND LIMITATIONS

The following expenses are not covered by the Vision Care Benefit

1. Vision care treatment that was rendered before the person became Eligible under this Plan.
2. Services or supplies that are covered in whole or in part under other Plan benefits.
3. Covered services resulting from an accidental bodily injury arising out of and in the course of employment or from a disease compensable under any Workers' Compensation, Occupational Disease or similar law.
4. Covered services in a Hospital owned or operated by the Federal government or for any covered service furnished for which the person is not required to pay.
5. Non-prescription sunglasses, subnormal vision aids, aniseikonia lenses, multi-focal plastic lenses, and plano lenses.
6. Medical or surgical treatment of the eyes.

LIFE INSURANCE BENEFIT – FOR ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS

Your Plan provides financial assistance to your family in the event of death. The Plan provides Employee Life Insurance and Dependent Life Insurance through an insurance carrier, as described below. Life Insurance Benefits are not available under the Retiree Plan of Benefits or Medicare Advantage Plan.

EMPLOYEE LIFE INSURANCE

In the event of your death, a Life Insurance Benefit of \$10,000 will be paid to your beneficiary.

DESIGNATING YOUR BENEFICIARY

You may designate more than one beneficiary and indicate the percent of the benefit to be paid to each person. To designate a beneficiary, or to change your beneficiary at any time, contact the Fund Office for the proper form. If you do not designate a beneficiary, or if your beneficiary does not survive you, payment is made in equal shares to the members in the first appropriate surviving class:

- ◆ Your spouse;
- ◆ Your children;
- ◆ Your parents;
- ◆ Your brothers and sisters; or
- ◆ The executors or administrators of your estate.

IF YOU BECOME DISABLED

If you become permanently and Totally Disabled before age 60, you will be eligible for premium waiver if you are Totally Disabled for at least nine (9) months and your coverage continues due to your Total Disability or terminates because you no longer meet the eligibility requirements due to the disability.

You must apply for the Waiver of Premium and provide proof (Initial Proof). You must submit satisfactory written proof of Total Disability within 12 months from the date premium payments on your behalf cease, but in no event longer than 24 months from the date Total Disability began.

The Initial Proof must show that the Total Disability:

1. Began while you were insured under this Plan;
2. Began before you attained age 60; and
3. Has lasted for at least nine (9) consecutive months.

Initially, coverage will continue for up to 12 months (as long as you remain Totally Disabled) from the date premium payments on your behalf cease, but in no event longer than 24 months from the date Total Disability began.

Keep your beneficiary designation at the Fund Office current!

Your coverage will continue as long as you provide notice and remain disabled. You may continue the Waiver for additional 12-month periods, as long as you submit written proof of continued Total Disability each year within three (3) months of the anniversary of the insurer's receipt of the Initial Proof.

DEPENDENT LIFE INSURANCE

In the event of a covered Dependent's death, a Dependent Life Insurance Benefit is payable, as follows:

Spouse:	\$2,500
Child:	\$2,500

The Dependent Life Insurance Benefit is payable to you after proof of death is provided to the Fund Office. If you do not survive the Dependent, the benefit is paid to the executors of the Dependent's estate, or divided equally to the members in the first surviving class below:

- ◆ Parents;
- ◆ Children; or
- ◆ Brothers and sisters.

CONVERSION OF COVERAGE

If your Life Insurance coverage ends for you or your Dependents because your Eligibility ends, you may convert to an individual life insurance policy. You must apply to the insurance company within 31 days after your coverage ends. Contact the Fund Office for the telephone number of the insurance carrier. The cost of your coverage will be the premium that applies to your age and class of risk. Evidence of good health will not be required. A life insurance policy, but not term insurance, will be issued in the amount and form of coverage you had at the time your coverage ends.

If Life Insurance coverage ends for you or your Dependents because this Life Insurance Benefit is discontinued, and you have been covered by the Plan for at least five years, you can convert your coverage to an individual policy within 31 days. The amount of the life insurance coverage will be limited by any new group insurance benefit that is issued to you. If you or a Dependent dies within 31 days after coverage ends for any reason, death benefits will be paid whether or not you applied to convert to an individual policy.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFIT – FOR ELIGIBLE EMPLOYEES ONLY

The Accidental Death and Dismemberment (AD&D) Insurance Benefit is payable if you sustain a loss as a result of an Accident. The loss must occur within 90 days of the Accident. This benefit is in addition to any other benefits under this Plan. The AD&D Benefit is provided through an insurance carrier and is not available under the Retiree Plan of Benefits.

For the loss of life, the AD&D Benefit will be paid to your named beneficiary; otherwise, the benefit is payable to you. For information about designating a beneficiary, see page 39.

BENEFITS PAYABLE

The amount of the benefit paid depends on the severity of your loss, as follows:

For Loss Of:	Benefits Payable
Life	\$10,000
Both Hands, Both Feet, Or Sight Of Both Eyes	\$10,000
Any Two Of The Following: One Hand, One Foot, Sight Of One Eye	\$10,000
One Hand, One Foot, Sight Of One Eye	\$5,000

Loss of hands or feet means severance at or above the wrist joint or the ankle joint. Loss of sight means the total and permanent loss of sight.

WEEKLY ACCIDENT AND SICKNESS BENEFIT - FOR ELIGIBLE ACTIVE EMPLOYEES ONLY

The Weekly Accident and Sickness Benefit provides benefits when you are unable to work due to non-occupational sickness or injury. This benefit is payable if you:

- ◆ Become disabled as a result of non-occupational injury or sickness, and
- ◆ Are under the regular care of a Physician.

Benefits are payable only after you submit written proof of the sickness or injury to the Fund Office. Taxes will be withheld.

BENEFITS PAYABLE

NON-OCCUPATIONAL DISABILITY

The Weekly Accident and Sickness Benefit is shown on the Schedule of Benefits in the back pocket. Benefits begin:

- ◆ On the eighth day of a disability due to sickness; or
- ◆ On the first day of a disability due to an Accident.

During partial periods of disability, you will be paid a daily rate of 1/7th of the Weekly Benefit amount. Benefits may continue for up to 26 weeks for any one Period of Disability.

In addition, if you are receiving benefits for an occupational Accident you may continue to receive credit for hours as outlined on page 8.

PERIOD OF DISABILITY

Two Periods of Disability will be considered to be separate Periods of Disability if:

- ◆ They are due to related causes, but you return to active, full-time work for at least 350 hours in three calendar months or 700 hours in six calendar months before the second Period of Disability begins; or
- ◆ They are due to unrelated causes and the second Period of Disability begins after you return to active, full-time work for at least one day.

For any one Period of Disability, you may receive benefits for up to 26 weeks in total.

The Fund may request a medical examination to determine the relationship between disabilities, at the Fund's expense.



EXAMPLES:

Example 1: Dave broke his leg and had to have a pin put in surgically. He was out on disability for 12 weeks. Then he came back to work for a week and found out that his wound from surgery had an infection and he had to have more surgery and was out on disability for another 16 weeks. Even though Dave came back to work, both disabilities are related and Dave didn't work for at least 350 hours in three months. Therefore, Dave would only receive benefits for 26 of the 28 weeks that he was disabled.

Example 2: Sam slipped on ice and fell down his front steps, breaking his leg and wrist. He was out on disability for 12 weeks. Sam came back to work for two weeks and then was diagnosed with cancer and had to have surgery and treatments which kept him from work for 16 weeks. Because the two disabilities were unrelated and Sam came back to work between them, these were two Periods of Disability. Sam received benefits for all 28 weeks.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

The Plan, in general, does not pay benefits for the following:

1. Charges that would not have been made if no coverage existed or charges that neither the Employee nor his or her Dependents are required to pay.
2. Services or supplies that are furnished, paid for, or otherwise provided for by reason of the past or present service of any person in the armed forces of a government.
3. Any supplies or services for which no charge is made.
4. Services or supplies that are paid for, or otherwise provided for under any law of a government except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents.
5. Any expense that is in excess of the Reasonable and Customary charges.
6. Any expense or charge for services or supplies not recommended or approved by the attending Physician, or not Medically Necessary in treating the Accident or sickness. This exclusion does not apply to X-ray and laboratory charges for routine physical examinations, patch tests, scratch tests and pap smears.
7. Any expense or charge for failure to appear for an appointment as scheduled or charge for completion of claim forms or finance charges.
8. Services and supplies to treat an occupational Accident or sickness or for which a third party is or may be responsible unless the agreement to subrogate and reimburse is signed as described on page 58.
9. Organ transplants, unless there is medical documentation that conventional treatment could be unsatisfactory, unavailable and/or more hazardous than a transplant, and that the patient's condition could be life threatening, and that the patient be legally required to pay for the transplant procedure. If these criteria are met, the following organ transplants are covered: kidney, heart, heart/lung, cornea, bone marrow, bone, skin and liver.
10. Services and supplies that are for the treatment of any condition caused by war, or any act of war, declared or undeclared, or by participating in a riot or as the result of the commission of a felony.
11. Treatment considered Experimental or Investigative in terms of generally accepted medical standards.
12. Services and supplies that are not Medically Necessary in terms of generally accepted medical standards.
13. Covered services resulting from an accidental bodily injury arising out of and in the course of employment or from a disease compensable under any Workers' Compensation, Occupational Disease or similar law.

14. Any expense incurred before Eligibility for coverage begins or after Eligibility terminates unless specifically provided for under the Plan.
15. Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, home traction unit, tanning bed or water bed.
16. Special home construction or additions, such as the installation of a special ventilation system.
17. Speech therapy unless it is required because of a physical impairment caused by a disease or Accident.
18. Any charges incurred for education, training, or room and board while confined in an institution that is primarily an institution of learning or training.
19. Charges for expenses incurred more than 24 months before submission of the claim.
20. Charges incurred for Custodial Care, except under the Hospice Benefit.
21. Charges for hearing aids, eye refractions, eyeglasses or their fitting, unless specifically indicated as covered.
22. Charges incurred in connection with radial keratotomy or any other surgical procedure performed to correct myopia (nearsightedness) or hyperopia (farsightedness) unless medical documentation is provided and deemed acceptable by the Trustees and/or UR company that such treatment is Medically Necessary and that conventional treatment would be unsatisfactory.
23. Charges for the reversal of elective sterilization procedures.
24. Charges incurred for the treatment of Temporomandibular Joint Disorder.
25. Cosmetic or plastic surgery, unless these services are required for the repair of an accidental injury to a physical organ. Reconstructive surgery following a mastectomy is covered.
26. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined on page 64, or when you are on temporary work assignment for your Employer at a location outside the United States.
27. Charges for nutritional supplements or other enteral formulas for home use, except as specifically covered.
28. Charges related to weight loss, whether or not medically necessary.

29. Charges related to breast reduction surgery, even if medically necessary, unless:

- The breast reduction is in connection with a mastectomy to the other breast to create symmetry; or
- At least 350cc are taken from each breast and the surgery is medically necessary.

30. Expenses for hypnosis, hypnotherapy and/or biofeedback.

31. Expenses for Behavioral Health Care services related to:

- Dyslexia, learning disorders, vocational disabilities;
- Attention deficit disorders (with or without hyperactivity), except when the services are for diagnosis and/or medication as prescribed by a Physician or other Health Care Practitioner;
- Autism, developmental disabilities, or mental retardation;
- Court-ordered Behavioral Health Care services or custody counseling;
- Family planning/pregnancy/adoption counseling, marriage/couples counseling, transsexual/gender reassignment/sex counseling.
- Tests and related expenses to determine the presence of or degree of a person's attention deficit disorder, dyslexia or learning disorder.

This section describes the procedures for filing claims for medical care or weekly sickness or accident benefits from the Iron Workers' Tri-State Welfare Fund (the Fund). When you or your Dependents file a claim, follow these procedures to assure prompt service.

DEFINITION OF A CLAIM

1. A claim is a request for a benefit made by an individual (also referred to as "claimant" or "patient") or that individual's authorized representative in accordance with the Fund's reasonable claims procedures.
2. A pre-service claim is a claim for a benefit for which the Fund requires approval of the benefit (in whole or in part) before medical care is obtained. The Fund requires prior approval of services related to non-emergency hospital stays (except for childbirth).
3. A concurrent care claim is any claim for medical care or treatment, whether over a period of time or for a specific number of treatments, that has been previously approved.
4. A post-service claim is a request for benefits under the Fund that is not a pre-service claim. Post-service claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a post-service claim.

A request is not a claim if it is:

- ◆ Not made in accordance with the Fund's benefit claims filing procedures described in this section;
- ◆ Made by someone other than the individual or his or her authorized representative;
- ◆ Made by a person who will not identify himself or herself (anonymous);
- ◆ A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- ◆ For prior approval where prior approval is not required by the Fund;
- ◆ An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and you (or the covered individual) will be notified of the decision and allowed to file an appeal.
- ◆ The presentation of a prescription to a pharmacy that the pharmacy denies (where the pharmacy benefit manager has no discretion to make decisions on claims). After the denial by the pharmacy, a person may file a claim with the Fund.

To file a claim for benefits, you must submit an itemized bill detailing services and charges if your provider does not file the claim for you.

The Fund Office will at various times answer inquiries from participants or dependents that are eligible or may become eligible to participate in the Fund. Inquiries may also be made by providers. While the Fund Office will try to answer questions regarding eligibility and coverage, it is important to note that, as stated above, these questions are not considered claims. An individual must incur medical expenses before a claim can be filed. Any answers to questions provided by the Fund Office are not legally binding. Simple inquiries about the benefit provisions that are unrelated to any specific claim will not be treated as a claim for benefits. A phone call will not be considered a claim.

The following information must be provided in order for your request for benefits to be a claim, and for the Fund Office to be able to decide your claim.

- ◆ Participant name;
- ◆ Patient name;
- ◆ Patient date of birth;
- ◆ Social Security number of patient and participant;
- ◆ Date of service
- ◆ CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association)
- ◆ ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services);

- ◆ Billed charge;
- ◆ Number of units (for anesthesia and certain other claims);
- ◆ Federal taxpayer identification number (TIN) of the provider; and
- ◆ Billing name and address of the provider.

When you present a prescription to a pharmacy to be filled under the terms of this Fund, that request is not a “claim” under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal with the Fund regarding the denial by using these procedures.

WHEN CLAIMS MUST BE FILED

Claims must be filed within 24 months after the service is rendered.

WHERE TO FILE CLAIMS

Your claim will be considered to have been filed as soon as it is received. Most providers will file medical claims for you electronically. If your provider does not file claims for you, send medical claims to Blue Cross & Blue Shield at the address shown on your medical ID card. For all non-medical claims, you must submit a claim to the Fund Office at the following address:

Fund Administrator
 Iron Workers' Tri-State Welfare Fund
 OBA Midwest, Ltd.
 1000 Burr Ridge Parkway
 Suite 200
 Burr Ridge, Illinois 60527

Claims must be filed within 24 months of the service.

AUTHORIZED REPRESENTATIVES

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

SUBMITTING FALSE OR FRAUDULENT CLAIMS

You or your Dependents are required to inform the Plan truthfully as to the nature of any claim, without inaccuracy or omission. The following are examples of the types of information you must provide the Plan:

- ◆ Any other insurance that may be payable or that has been paid with respect to the claim;
- ◆ All aspects of the events that gave rise to the claim;
- ◆ When any Dependent no longer meets the requirements of a Dependent, including if you divorce or your child is no longer eligible due to age or student status;
- ◆ If a third party caused the Accident related to the claim; and
- ◆ If an Accident giving rise to a claim is work-related.

You and your Dependents' eligibility will be terminated under this Plan if the Board of Trustees determines that you or a Dependent submitted a fraudulent claim.

CLAIMS FOR MEDICAL SERVICES

The following procedure applies to claims for Medical Services.

1. Have your Physician complete the Attending Physician's Statement section of the claim form, submit a completed HCFA health insurance claim form, or submit an HIPAA-compliant electronic claims submission.
2. If your provider does not file your claim, then attach all itemized Hospital bills or doctor's statements that describe the services rendered.
3. Check that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim is delayed, delays in payment will result.



TIMEFRAMES

- ◆ Pre-service claims are decided within *15 days* after your claim is received. The time for deciding your claim may be extended by *15 days*, upon notice to you before the expiration of *15 days*. If a claim cannot be processed due to insufficient information, the claim will be pended and the time period for making the decision will be suspended. You will then have *45 days* to provide the additional information. The time period for deciding your claim will be suspended. You will be notified of the decision within *15 days* of the earlier of the date you respond to the request or the end of the *45-day* period.
- ◆ Concurrent care claims are decided with enough time before the reduction or termination of treatment to allow you enough time to make an appeal before the concurrent care claim is reduced or terminated. Any reduction or termination by the Plan of a previously approved concurrent care claim before the end of the approved period of time or approved number of treatments is considered to be a denied claim.
- ◆ Post-service claims are decided within *30 days* of the receipt of the claim. The time for deciding the claim may be extended by *15 days*, upon notice to you before the expiration of the initial *30 days*. If a claim cannot be processed due to insufficient information, the time period for deciding your claim will be suspended. You will then have *45 days* to provide the additional information. The time period will begin running again when the additional informa-

tion is provided or at the end of the *45 days*, if earlier. After *45 days* or, if sooner, after the information is received, the Plan will make a determination within *15 days*.

DISABILITY CLAIMS

A Disability Claim is a claim for weekly accident and sickness benefits.

TIMEFRAMES

For Disability Claims, the Fund will make a decision on the claim and notify you of the decision within *45 days*. If the Fund requires an extension of time due to matters beyond the control of the Fund, the Fund will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the initial *45-day* period. A decision will be made within *30 days* of the time the Fund notifies you of the delay. The period for making a decision may be delayed an additional *30 days*, provided the Fund Administrator notifies you, before the expiration of the first *30-day* extension period, of the circumstances requiring the extension and the date the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be decided on the

basis of the information that the Fund has and may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either *45 days* or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information, you will be notified of the Fund's decision on the claim within 30 days.

For Disability Claims, the Fund reserves the right to have a Physician examine you (at the Fund's expense) as often as is reasonable while a claim for benefits is pending.

LIFE INSURANCE AND AD&D CLAIMS

Call the Fund Office to request a Death Benefit Application for Life Insurance or AD&D claims. You may also print a copy of the form from the web site at www.tristatewelfarefund.com (go to the Forms section). You must complete the form and submit it with written proof of loss within 90 days of the date of the loss. If it can be shown that it was not reasonably possible to furnish proof within this timeframe, proof must be provided as soon as it is reasonably possible. The proof of loss must include the nature of the loss and the date of the loss. As part of the proof, the Fund Administrator may require authorization to obtain medical and non-medical information. The Fund Administrator will notify you if any additional information is necessary.

The Fund, at its own expense, has the right to have:

- ◆ You examined by a Doctor it has chosen for a dismemberment claim; or
- ◆ An autopsy performed, if it is not prohibited by law.

You or your authorized representative cannot start any legal action with respect to a claim until 60 days after proof of claim has been given, but no more than three years after the time proof of claim is required.

WAIVER OF PREMIUM

If you are disabled and meet the terms required for a waiver of premium for Life Insurance, you must submit an application with the required proof as described on page 39 to the life insurance company. If your application is approved, you must continue to provide annual documentation as to your continued Total Disability. As long as you continue to qualify, the waiver of premium will continue.

PROCEDURE TO APPEAL DENIED CLAIMS

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Fund Office within 180 days (60 days for Life or AD&D Benefits) after you receive notice of denial.

REVIEW PROCESS

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund in making the decision, it was submitted, considered or generated by the Fund in making the decision (regardless of whether it was relied upon), it demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making, or it constitutes a statement of Fund policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.

The Appeals Committee designated by the Board of Trustees will review your claim. The reviewer will not rely on the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

TIMING OF NOTICE OF DECISION ON APPEAL

A written notice of the appeal determination will be provided to you follows:

- ◆ **Pre-service claims.** The Fund Office (or authorized agent) will send you a notice of decision on review within 30 days of the receipt of the appeal.
- ◆ **Post-service claims.** The Board of Trustees must make a benefit determination no later than the date of the meeting of the Board of Trustees Appeals Committee that immediately follows the Fund's receipt of a request for review, unless the request for review is filed within *30 calendar days* preceding the date of such meeting. In such case, a benefit determination must be made no later than the date of the second meeting following the Fund's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting following the Fund's receipt of the request for review. If such an extension is necessary, the Fund

must provide the claimant with a Notice of Extension describing the special circumstances and date the benefit determination will be made. The Fund Administrator must notify the claimant of the benefit determination no later than five calendar days after the benefit determination is made.

- ◆ **Disability claims.** The Board of Trustees must make a benefit determination no later than the date of the meeting of the Board of Trustees Appeals Committee that immediately follows the Fund's receipt of a request for review, unless the request for review is filed within *30 calendar days* preceding the date of such meeting. In such case, a benefit determination must be made no later than the date of the second meeting following the Fund's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting following the Fund's receipt of the request for review. If such an extension is necessary, the Fund must provide the claimant with a Notice of Extension describing the special circumstances and date the benefit determination will be made. The Fund Administrator must notify the claimant of the benefit determination no later than five calendar days after the benefit determination is made.
- ◆ **Life and AD&D claims.** The Board of Trustees must make a benefit determination within 60 days of the receipt of the appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be rendered not later than another 60 days following the Fund's receipt of the request for review. If such an extension is necessary, the Fund must provide the claimant with a Notice of Extension describing the special circumstances and date the benefit determination will be made. The Fund Administrator must notify the claimant of the benefit determination no later than five calendar days after the benefit determination is made.

NOTICE OF DECISION ON REVIEW

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). The notice of a denial of a claim on review will state:

- ◆ The specific reason(s) for the determination;
- ◆ Reference to the specific benefit provision(s) on which the determination is based;
- ◆ A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;

- ◆ A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- ◆ If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- ◆ If the determination was based on Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No lawsuit may be started more than *three years* after the end of the year in which medical or dental services were provided, or, if the claim is for short-term disability, life or AD&D benefits, more than *three years* after the start of the disability or the loss.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Plan protect the confidentiality and security of your Protected Health Information (PHI). You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

The Plan will distribute its Privacy Notice periodically, as required by HIPAA rules, or when changes are made to the policies and procedures.

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

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

Your rights under HIPAA with respect to your PHI include the right to:

- ◆ See and copy your health information;
- ◆ Receive an accounting of certain disclosures of your health information;
- ◆ Amend your health information under certain circumstances; and
- ◆ File a complaint with the Plan or with the Secretary of Health and Human Services if you believe your rights under HIPAA have been violated.

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

COORDINATION OF BENEFITS

You or your Eligible Dependent may be entitled to receive benefits from this Plan and another group health insurance plan (for example, if your spouse works and has health care benefits). If your dependent does not meet the definition of an Eligible Dependent, then the Fund may require that you obtain a QMCSO for your dependent to be covered.

If this happens, the two plans will coordinate benefit payments so that the combined payments of both plans will not be more than your actual covered expenses. One plan (the first plan) will pay its full benefits. Then the second plan will consider any covered expenses that are not completely covered by the first plan's benefits. No plan pays more than it would without the coordination of benefits provision.

The order of payment between the plans is based upon the first of the following seven rules that apply:

- ◆ A plan without a coordination of benefits provision will always pay first.
- ◆ If both plans have a coordination provision, the plan covering the patient as an employee will pay before a plan that covers the patient as a dependent.
- ◆ A plan covering a Person as an active Employee will pay benefits before a plan that covers the Person as a retired or laid-off Employee.
- ◆ If your Dependent children are covered under the plans of both parents, the plan that covers the parent whose birthday falls earlier in the year pays first. If both parents have the same birthday, the plan that has covered the parent longer will pay first.
- ◆ If one plan uses the another type of rule and the other plan coordinates using the rule based on the parent's birthdays, the plan using the other type of rule will determine which plan pays benefits first.
- ◆ If you are legally separated or divorced, there are special rules regarding coverage for your children. If a court order known as a Qualified Medical Child Support Order (QMCSO) establishes the Fund's responsibility for the health care expenses of your children and the Fund has approved the QMCSO using their QMCSO procedures, benefits will be paid according to that order. It is the Fund's decision to require a QMCSO before paying benefits for stepchildren added after February 15, 2002.

- ◆ If your child is not eligible by definition as a dependent and there is no QMCSO, benefits are paid as follows:

Parents legally separated or divorced and remarried:

- The plan covering the parent with custody will pay first.
- The plan covering the stepparent with custody pays second.
- The plan covering the parent without custody pays last.
- If none of the above establishes the plan that pays first, the plan that has covered the Person for the longer period of time pays first.

The Plan coordinates benefits with Medicare when legally possible, but does not coordinate benefits with Medicaid.

If your dependent is covered under a Health Maintenance Organization (HMO) and voluntarily elects not to use the HMO's services or follow their referral guidelines, no benefits will be payable from this Plan. If your spouse has prescription drug coverage outside of this Plan, an Explanation of Benefits (EOB) from the other plan must be submitted to this Plan with any claim and this Plan will coordinate benefits payable with the benefits paid by the other plan.

COORDINATION OF BENEFITS WITH MEDICARE

GENERAL MEDICARE INFORMATION

Medicare is a four-part program. The first part is officially called "Hospital Insurance Benefits for the Aged and Disabled" and this part is commonly referred to as Part A of Medicare. The second part is officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled" and this part is commonly referred to as Part B of Medicare. The third part consists of Medicare Advantage plans, which generally involve coverage under a Medicare Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO), or a private fee-for-service plan for participants who live in a geographic area served by such a plan. The fourth part, Medicare Part D, covers prescription drug benefits. Part A of Medicare primarily covers hospital benefits, although other benefits are also provided. Part B of Medicare primarily covers physician's services, although it, too, covers a number of other items and services.

Typically, a person becomes Entitled to Medicare upon reaching age 65. Under certain circumstances a person may become Entitled to Medicare before age 65 if the person is a disabled worker, disabled widow or dependent widower or has chronic renal disease.

You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for Medicare anyway. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You are required to pay a monthly premium for Parts B and D of Medicare. If you are not yet receiving Social Security benefits, you must pay this premium to the Social Security Administration. If you are receiving Social Security Benefits, the premium will be deducted from your monthly check.

COORDINATION WITH MEDICARE FOR ACTIVE PARTICIPANTS

This Welfare Plan is the primary plan responsible for payment of your benefits and your dependents' benefits, if you are an eligible active employee. This means that if you are an active employee and you are also covered by Medicare, when you or your dependents incur covered medical expenses, the Plan will pay benefits first and then Medicare may (but probably will not) pay some of the remaining expenses not covered by the Plan.

COORDINATION WITH MEDICARE FOR RETIRED AND DISABLED PARTICIPANTS

If you retire or are disabled and choose the Medicare Advantage Plan, you will be covered under Medicare Parts A, B, and D. Since all of your benefits will be through Medicare, no coordination is needed. If you retire and choose a different Medicare plan, you will no longer be covered under this Plan. However, the Pre-Funded Allowance will still be available, if you qualify.

FUND'S RIGHT OF SUBROGATION AND REIMBURSEMENT

The Fund provides no benefits for claims related to injuries or illnesses that are caused by third parties or that are work-related. The Fund may deny any such claim(s). You and your attorney must establish a trust for the benefit of the Fund by depositing \$10 into the trust. If you or your attorney receives any payments from Workers' Compensation or a third party for the injury or illness, then these payments must be held in the trust and paid to the Fund up to the amount paid by the Fund. Your attorney must personally guarantee reimbursement to the Fund. In the event benefits are paid on behalf of such claim(s), the participant or eligible dependent:

1. agrees to **reimburse** the Fund from any recovery received from any third parties (including persons, corporations, or other entities) or from any no fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies, funds or other sources of recovery (hereinafter collectively "Coverage");
2. agrees, without limiting the preceding, to allow the Fund to **subrogate** to any and all claims, causes of action or rights that the participant and/or eligible dependent has against any third parties who have or may have caused, contributed to, or aggravated the injuries or conditions for which the participant and/or eligible dependent claims an entitlement to Fund benefits and to any claims, causes of action or rights of the participant and /or eligible dependent may have against any Coverage. The participant and eligible dependent agree to cooperate fully with the Fund in the prosecution of any claims under this provision;
3. grants the Fund a security interest and a lien in any recovery received from any third party or from any Coverage received on account of such accident or illness;
4. waives the common fund doctrine and agrees to hire an attorney who will also waive the common fund doctrine. The participant or eligible dependent agrees to be solely and exclusively responsible for any and all attorneys' fees, court costs and expenses involved in obtaining any recovery or any Coverage;
5. waives the make-whole rule. The Fund has the right of first reimbursement out of any recovery even if the participant or eligible dependent is not made whole;
6. agrees to not settle any claim which compromises the Fund's right of subrogation without the written consent of the Fund;
7. agrees that the Fund has the right to withhold future benefit payments until the Fund is fully reimbursed;
8. agrees to execute a subrogation agreement in a form acceptable to the Fund. This is how the trust (described above) is established. The Fund may require such an agreement as a condition precedent to the payment of benefits. The failure to execute the agreement does not alter the Fund's rights of reimbursement/subrogation as set forth above; and
9. recognizes that no loan transaction is intended to be created under any subrogation or reimbursement agreement.

Accident: A sudden and unforeseen event as a result of an external source that is not work-related.

Ambulatory Surgical Facility: A freestanding institution where surgery can be performed at minimal risk without an overnight Hospital confinement. The facility does not need to be part of a Hospital, but it must be permanently equipped and operated primarily to provide surgical services. A Physician's office may be considered an Ambulatory Surgical Facility for certain minor operations.

Behavioral Health Disorder: A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things, autism, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by Behavioral Health Practitioners as defined in this section. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the General Plan Exclusions section. See also the definition of Chemical Dependency.

Behavioral Health Practitioners: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a Master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; **and** acts within the scope of his or her license; **and** is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Behavioral Health Treatment: Behavioral Health Treatment includes all inpatient services, including room and board, given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health or Substance Abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code is considered a Behavioral Health Treatment for the purposes of this Plan.



Behavioral Health Treatment Facility:

A specialized facility that is established, equipped, operated, and staffed primarily for the purpose of providing a program for the diagnosis, evaluation and effective treatment of Behavioral Health Disorders and which fully meets one of the following two tests:

1. It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements: has at least one Physician on staff or on call **and** provides skilled nursing care by licensed Nurses under the direction of a full-time Registered Nurse (RN) **and** prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

A Behavioral Health Treatment Facility that qualifies as a Hospital is covered by this Plan as a Hospital and not a Behavioral Health Treatment Facility. A residential treatment facility, transitional facility, group home, halfway house or temporary shelter is not a Behavioral Health Treatment Facility under this Plan.

Chemical Dependency or Substance

Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders.

Certified Disability: A certified disability is one for which you receive a Weekly Accident and Sickness Benefit from the Fund or receive Workers' Compensation Benefits as a result of a disability incurred while Eligible for Benefits.

Collective Bargaining Agreement: A written agreement between one or more unions and one or more Employers providing for wages, hours and working conditions for specified Employees and which provides for contributions to this Welfare Fund for the purpose of providing Employees with benefits.

Cosmetic or Reconstructive Surgery:

Any surgical procedure performed primarily to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction.

Covered Person: A person who has satisfied the eligibility requirements under this Plan and whose coverage is in effect. A Covered Person includes a child(ren) who is named as an “alternate recipient” under a Qualified Medical Child Support Order (QMCSO).

Custodial Care: Care rendered to a patient who:

- ◆ Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- ◆ Requires a protected, monitored or controlled environment whether in an institution or in the home;
- ◆ Requires assistance to support the essentials of daily living; and
- ◆ Is not under active or specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected monitored or controlled environment.

Dentist: a Doctor of Dental Surgery (D.D.S.), a Doctor of Medical Dentistry (D.M.D.), or an individual who is licensed to practice dentistry by the proper governmental authority and is working within the scope of that license.

Dependent: Any one of the following individuals:

- ◆ The Employee’s spouse;
- ◆ The Employee’s unmarried children who (must meet all of the conditions):
 - Have not reached their 19th birthday; or
 - Are enrolled in an accredited and/or licensed school, college or university as a full-time student (proof of full-time student status will be required), were covered as a Dependent prior to his or her 19th birthday, and are less than age 25. If the student graduated, then the coverage continues for six months after graduation, but in no event will coverage continue beyond the 25th birthday. Any termination of full-time student status will cause a termination of coverage.
 - Are dependent on the Employee for more than 50% of the dependent’s support and maintenance during the calendar year.
 - Maintain a principal residence with the Employee for more than one-half of the calendar year. A child who is away at school is considered to maintain a residence with the Employee for more than one-half of the calendar year if the child uses the Employee’s residence for mail purposes and resides with the Employee during non-school time.

The Fund may require proof to determine that a child is Eligible as defined.

- ◆ An Employee's "children" include:
 - Natural children;
 - Step-children who were initially added as dependents prior to February 15, 2002 and who:
 - Were born to the spouse or who were legally adopted by the spouse before the marriage of the Employee and that spouse;
 - Live in the Employee's home;
 - Qualify as the Employee's dependents on the Employee's tax return; and
 - For whom the Employee has provided support continuously for at least 180 days before a claim is incurred.
- ◆ Step-children who were initially added as a dependent on or after February 15, 2002 and who:
 - Were born to the spouse or who were legally adopted by the spouse before the marriage of the Employee and the spouse;
 - Qualify as the Employee's dependents on the Employee's tax return; and
 - For whom the Employee provides a divorce decree or QMCSO that specifies that the Employee's current spouse is responsible for primary health coverage for the child.
- ◆ Adopted children or children placed for adoption;
- ◆ Foster children; and
- ◆ Unmarried children who are permanently and totally disabled, which means that they are unable to engage in any gainful activity by reason of a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more, who are incapable of self-sustaining employment by reason of the disability, and:
 - Such incapacity commenced while the child was less than age 19 or age 25 (if a full-time student or within 6 months of graduation) as described above; and
 - Such children are dependent upon the Employee for more than 50% of their financial support and maintenance during the calendar year and maintain a principal residence with the Employee during the calendar year; and
 - The Trustees may request due proof of such incapacity of such Dependent at any time.

The Employee must notify the Fund Office 60 days before the day such Dependent's Eligibility would otherwise terminate due to age.

Children who are named as alternate recipients in a medical child support order are covered once the Plan determines the order to be a Qualified Medical Child Support Order (QMCSO).

An unmarried Child who does not live with the Employee is covered, provided that:

- ◆ The child's parents are: 1) divorced or legally separated under a decree of divorce or separate maintenance; 2) separated under a written separation agreement; or 3) live apart at all times during the last six months of the calendar year;
- ◆ The child's parents provide over one-half of the child's support for the calendar year; and
- ◆ The child is in the custody of one or both of his or her parents for more than one-half of the calendar year.

Eligible or Eligibility: Entitlement to the benefits payable under the provisions of the Plan by virtue of having fulfilled the Eligibility requirements explained in this booklet.

Employee: Any Employee who is Eligible for benefits as explained in the Eligibility section of this booklet.

Employer: An Employer who by reason of a Collective Bargaining Agreement or Participation Agreement is obligated to make contributions to this Welfare Fund or to any welfare fund that has merged with this Welfare Fund.

Emergency Care: Treatment within 48 hours after an Accident or the onset of a sudden and serious illness. Services for the immediate diagnosis and treatment of an accidental injury or unforeseen medical condition that, if not immediately diagnosed and treated, could lead to permanently placing one's health in jeopardy, serious impairment of any body part, other serious medical consequences, or death.

Entitled to Medicare: Entitled to the benefits payable under Medicare if you apply when first eligible, whether or not you actually apply.

Experimental or Investigative: Any treatment procedure, facility, drugs, devices or supplies not yet recognized as acceptable medical practice and any such items requiring Federal or government agency approval for which such approval has not been granted at the time services are provided. The Trustees have the authority to determine whether a treatment, service, or supply is Experimental or Investigative. The fact that a Physician has prescribed, ordered, recommended or approved the treatment, service or supply does not in itself make it Eligible for payment.

Formulary Drug: The Plan's formulary lists brand name medications that are either more effective than others in their class are or as effective and less costly than similar medications. The Plan's prescription drug benefit provider determines the formulary list. A prescription medication that is on the Plan's formulary, is a Formulary Drug.

Home Health Care: Such care must be for the care or treatment of a sick or injured Person and must be:

- ◆ Ordered in writing by the Eligible Person's Physician; and
- ◆ Provided in the Eligible Person's home by a Home Health Care Agency.

Home Health Care consists of these services and supplies:

- ◆ Part-time or intermittent home nursing care from or supervised by a registered nurse;
- ◆ Part-time or intermittent home health aid services;
- ◆ Physical therapy, occupational therapy and speech therapy; and
- ◆ Laboratory services.

Home Health Care Agency: A public or private agency or organization that:

- ◆ Provides nursing or therapeutic services in the home; and
- ◆ Is Federally certified and/or duly licensed; and
- ◆ Operates within the scope of its license.

Hospital: Hospital means an institution that:

- ◆ Is primarily engaged in providing, by or under the supervision of Physicians, in-patient diagnostic and therapeutic services for the diagnosis, treatment and rehabilitation of injured, disabled or sick Persons;
- ◆ Maintains clinical records on all patients;
- ◆ Has bylaws in effect with respect to its staff of Physicians;
- ◆ Has a requirement that every patient be under the care of a Physician;
- ◆ Provides 24-hour nursing service rendered or supervised by a registered nurse;
- ◆ Has in effect a Hospital utilization review plan;
- ◆ Is licensed pursuant to any state or agency of the state responsible for licensing Hospitals; and
- ◆ Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

Unless specifically provided, the term “Hospital” does not include any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility, or facility for the aged, nor does it mean any institution that makes a charge that the Person is not required to pay.

Medically Necessary: A service or supply that:

- ◆ Is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; and
- ◆ Could not have been omitted without adversely affecting the Person’s condition or the quality of medical care.

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

Medicare: Benefits provided under Title XVIII of the United States Social Security Act of 1965, as currently constituted or later amended.

Mental Or Nervous Disorder: Neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

Miscellaneous Hospital Charges: Reasonable and customary charges furnished by a Hospital that are incurred for medical care and treatment, other than for room and board, special and floor nursing, professional services and other per diem charges.

Optional Benefits: Optional Benefits include Dental Benefits and Vision Care Benefits if the Employer is required to make the additional contribution on behalf of Employees in accordance with a Collective Bargaining Agreement.

Participation Agreement: A written agreement between an Employer and the Fund that provides for contributions to the Welfare Fund for the purpose of providing Employees with benefits.

Person: An Employee or the Employee’s Dependent(s).

Physician: An individual duly licensed to practice medicine by the governmental authority having jurisdiction over such licensing. Such individual must be working within the scope of his/her license.



Plan of Benefits or Plan: The plan, program, method and procedure adopted by the Trustees for the payment of medical, Hospital care and other health and welfare benefits from the said Welfare Fund in accordance with such rules and regulations relating to Eligibility and amount and nature of benefits, as are adopted by the Trustees and all amendments to the said plan, which may be adopted by the Trustees.

Qualified Medical Child Support Orders: A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. The Plan will provide benefits according to the requirements of a QMCSO. When the Fund Administrator receives a QMCSO, the Fund will notify affected participants and alternate recipients if a QMCSO is received. You can obtain a free copy of these procedures from the Fund Office.

Reasonable and Customary: An amount measured and determined by comparing the actual charge with the charge customarily made for a similar service or supply to individuals with a similar medical condition in the same geographic location.

Sickness: An illness or disease that causes loss; any loss incurred because of pregnancy, childbirth and related medical conditions are covered under the Plan to the same extent as any other sickness.

Skilled Nursing Care Facility: A licensed institution, other than a Hospital, that provides:

- ◆ In-patient medical care and treatment to convalescing patients;
- ◆ Full-time supervision by at least one Physician or registered nurse;
- ◆ 24-hour nursing service, by licensed professional; and
- ◆ Complete medical records for each patient.

Total Undiscounted Fee: The average wholesale (AWP) of the covered drug as set forth in the current price list plus the dispensing charge.

Totally Disabled: With respect to a Person, totally disabled means that, due solely to an Accident or illness, the Person is prevented from engaging in his or her regular or customary occupation. With respect to a Dependent, means that, due solely to an Accident or illness that is not employment-related, he/she is prevented from engaging in substantially all of the normal activities of a person of like age and gender who is in good health.

Trust Agreement or Trust: The Agreement and Declaration of Trust of the Iron Workers Tri-State Welfare Plan as amended from time to time.

Trustees or Board of Trustees: The Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees collectively are the “Administrator” of this Fund as that term is used in the Employee Retirement Income Security Act of 1974.

Welfare Fund or Fund: The Trust Fund formulated and created under the Agreement and Declaration of Trust and any amendments thereto and any trust fund established for similar purposes that merges with, and transfers its assets to, the Welfare Fund.

As a participant in Iron Workers-Tri-State Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You have the right to:

- ◆ 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, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- ◆ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- ◆ Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to provide to each participant.

CONTINUE GROUP HEALTH PLAN COVERAGE

You also have the right to:

- ◆ Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage; review this SPD and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- ◆ Reduce or eliminate exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
 - You lose coverage under the Plan;
 - You become entitled to elect COBRA Continuation Coverage; or
 - Your COBRA Continuation Coverage ends.

You must request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

