# IRON WORKERS TRI-STATE WELFARE PLAN

## PLAN AND SUMMARY PLAN DESCRIPTION

Restated and Effective January 1, 2026

# A MESSAGE FROM THE BOARD

Dear Participant:

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

This booklet is both the full plan document and the summary of your benefit plan in effect on January 1, 2026. The benefits described in this booklet apply to employees who are active on or after January 1, 2026, and to employees who retire or become disabled on or after January 1, 2026 but are not yet eligible for Medicare. This booklet replaces and supersedes all prior booklets summarizing your benefits.

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,**

**Iron Workers Tri-State Welfare Fund**

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 because of your participation in the Plan.

**Iron Workers Tri-State Welfare Fund**
c/o Group Administrators, Ltd.
20 N Martingale Road Suite 290
Schaumburg, IL 60173

Toll-free: 1-844-395-4467
Email:tristateiron@groupadministrators.com
www.tristatewelfarefund.com

| | |
|---|---|
| Fund Administrator | Group Administrators, Ltd. |
| Fund Counsel | McGann Ketterman & Rioux, Ltd. |
| Fund Consultant | Foster & Foster Consulting Actuaries |

| Union Trustees | Employer Trustees |
|---|---|
| Mr. Charles Black<br>Iron Workers Local #380<br>1602 East Butzow Drive<br>Urbana, IL 61801 | Ms. Amy McNally<br>Illinois Valley Contractors Association<br>1120 First Street<br>LaSalle, IL 61301 |
| Mr. Jason Emerick<br>Iron Workers Local #112<br>3003 North Main Street<br>East Peoria, Il 61611 | Ms. Carla Jockisch.<br>Greater Peoria Contractors & Suppliers Association<br>1811 West Altorfer Drive<br>Peoria, IL 61615 |
| Mr. Michael Olvera<br>Iron Workers Local #111<br>8000 29th Street West<br>Rock Island, IL 61201 | Mr. Michael Slagel<br>Vissering Construction Co.<br>175 Benchmark Industrial Dr.<br>Streator, IL 61364 |
| Mr. Kevin Hray<br>Iron Workers Local #444<br>2082 Oak Leaf Street<br>Joliet, IL 60436 | Mr. Mitch Harvey<br>Tri-City Ironworks<br>6225 North Brady Street<br>Davenport, IA 52806 |
| Mr. Paul Arambasich<br>Iron Workers Local #444<br>1708 Hosmer Lane<br>Crest Hill, IL 60403 | Mr. Michael Testa<br>Testa Steel Constructors, Inc.<br>Post Office Box 51<br>Channahon, IL 60410 |
| Mr. Mark Richeson<br>Iron Workers Local Union 498<br>5640 Sockness Drive<br>Rockford, IL 61109 | Mr. David Anspaugh<br>Northern Illinois Building Contractors Association<br>1111 South Alpine Road, Suite 202<br>Rockford, IL 61108 |

## CONTACTS

| If you need… | Contact… |
|---|---|
| **To find a network medical provider:**<br>Active and Retiree Plans of Benefits<br>Medicare Advantage Plan | BCBSIL: BCBS Customer Care Center 877-842-7564 |
| **To find a network pharmacy or to call about mail order:** | Express Scripts<br>www.express-scripts.com<br>1-866-312-9068 |
| **To find a VSP provider** | 1 800-877-7195<br>www.vsp.com |
| **EPIC Hearing** | 1-866-956-5400<br>www.Epichearing.com |
| **To check your HFA balance** | www.groupadministrators.com |
| **Claims information or eligibility:** | 1-844-395-4467<br>tristateiron@groupadministrators.com |
| **Fund web site:** | www.tristatewelfarefund.com |

# TABLE OF CONTENTS

# ARTICLE 1 - INTRODUCTION

## 1.01 ESTABLISHMENT OF PLAN

The Iron Workers Tri-State Welfare Plan ("Plan") was established under the terms of the Agreement and Declaration of Trust of the Plan in order to provide comprehensive health care benefits to Eligible Employees, Dependents and Qualified Beneficiaries and to prescribe the amount, extent, conditions and methods of payment under the Plan.

## 1.02 AMENDMENT AND RESTATEMENT

After its establishment under the Trust, the Plan was subsequently amended and/or restated on several occasions. This most recent restatement, effective January 1, 2026, combines the Plan document and Summary Plan Description into a single document.

# ARTICLE 2 - ELIGIBILITY

## 2.01 PLAN TYPES

The Plan offers two different Plans of Benefits: a plan for Active Employees and a plan for pre-Medicare retirees.

(a) The Active Plan offers the following benefits, described elsewhere in this SPD and the applicable Schedule of Benefits in Appendix A or Appendix B:

(i) Comprehensive Major Medical Benefits;
(ii) Prescription Drug Benefits;
(iii) Dental Benefits (except Local 380);
(iv) Vision Care Benefits (except Local 380);
(v) Weekly Accident and Sickness Benefits (Employee only);
(vi) Life Insurance Benefits (different levels of benefits for the Employee and the Employee's Dependents); and
(vii) Accidental Death and Dismemberment Benefits (Employee only).

(b) The pre-Medicare Retiree Plan for retirees under the age of 65 contains the following benefits, described in Article XI and the applicable Schedule of Benefits in Appendix A or Appendix B:

(i) Comprehensive Major Medical Benefits;
(ii) Prescription Drug Benefits;
(iii) Dental Benefits (except Local 380 and certain Local 498 Retirees); and
(iv) Vision Care Benefits (except Local 380 and certain Local 498 Retirees).

## 2.02 EMPLOYEES

An Employee's eligibility is contingent on three things:

(i) The Employee works in the jurisdiction of any Union participating in this Plan;
(ii) An Employer makes, on behalf of the Employee, contributions required by a Collective Bargaining Agreement or a Participation Agreement; and
(iii) The Employee meets the initial and continuing Eligibility requirements as described in this Article II.

<u>Management and Supervisory Employees:</u>

(i) Non-Bargaining Unit Employees (Former Journeymen Ironworkers)

The Employer may make contributions for all hours worked by non-bargaining unit employees who are owners, salaried workers, superintendents or other management personnel for whom contributions to the Iron Workers' Tri-State Welfare Plan were previously made when such individuals were employed as journeymen ironworkers. Such contributions shall be made in a monthly amount equal to at least one hundred and sixty (160) times the hourly contribution rate specified in the applicable collective bargaining agreement. Once the decision is made to contribute on such an employee, the Employer must always make contributions on a monthly basis. If the Employer stops making the required contributions for any reason, the Employer will be forever prohibited from submitting contributions on that individual employee in the future.

(ii) Bargaining Unit Employees

With respect to those Employers who are owners or employ salaried workers, superintendents or other management personnel, who also perform bargaining unit work, Employers have the following two contribution options.

(1) The Employer shall make contributions for all hours worked by those bargaining unit employees who are owners, salaried workers, superintendents or other management personnel. Such contributions shall be made in a monthly amount equal to at least one hundred and sixty (160) times the hourly contribution rate specified in the applicable collective bargaining agreement or the actual hours worked whichever is greater; or

(2) The Employer may choose to make contributions for all actual hours worked by those bargaining unit employees who are owners, salaried workers, superintendents or other management personnel. Such contributions shall be made pursuant to the hourly contribution rate specified in the applicable collective bargaining agreement.

(iii) Hourly Records Requirement

Employers who make contributions for all actual hours worked by those bargaining unit employees who are owners, salaried workers, superintendents or other management personnel, must maintain verifiable accurate hourly employee records stating the daily and weekly hours worked. At the request of the Iron Workers' Tri-State Welfare Plan or any of its designated representatives including its auditor and legal counsel, the Employer must produce these time cards to verify the accuracy of the required contributions and compliance with this article.

If the Employer fails to maintain accurate verifiable hourly records for such employees, the Employer shall be liable to submit contributions in a monthly amount equal to at least one hundred and sixty (160) times the hourly contribution rate specified in the applicable collective bargaining agreement or the actual hours worked whichever is determined to be greater.

## 2.03 ELIGIBILITY FOR COMPREHENSIVE MEDICAL BENEFITS

Benefits for Active Employees include Comprehensive Medical Benefits, as described in Article V; Prescription Drug Benefits detailed in Article VI; Dental Benefits as set forth in Article VII; Vision Care Benefits described in Article VIII; and Life Insurance benefits, Accidental Death and Dismemberment Benefits, and Weekly Accident and Sickness Benefits that are all described in Article IX, in Sections 9.01, 9.02, and 9.03, respectively.

Eligibility for Comprehensive Medical Benefits requires a contributing Employer to pay contributions at a rate determined by the Board of Trustees on an Employee's behalf for hours of work as determined by the Board of Trustees.

## 2.04 EMPLOYEE INITIAL ELIGIBILITY

An Employee becomes eligible for coverage on the first day of the benefit quarter that follows any nine-consecutive-month period during which an Employee has accumulated 350 Contribution Hours with participating Employers.

If the Employee accumulates 350 Contribution Hours in fewer than nine months, the Employee becomes Eligible on the first day of the benefit quarter that follows the date the Contribution Hours totaled 350 hours.

## 2.05 DEPENDENT INITIAL ELIGIBILITY

A Dependent's Eligibility and coverage is effective when the Employee becomes Eligible under this Plan. Any future Dependent(s) become Eligible under this Plan when such Dependent(s) meets the definition of "Dependent."

## 2.06 CONTINUATION OF ELIGIBILITY

Once an Employee has met the initial Eligibility requirements, the Employee remains Eligible until the end of the Benefit Quarter. Such Employee will also continue to remain Eligible for succeeding Benefit Quarters if they have accumulated the required Contribution Hours; Contribution Hours from all contributing Employers are taken into account for continuing Eligibility.

If the Employee is unable to work because of an Injury or Sickness when benefits should become effective, Eligibility for the Weekly Accident and Sickness Benefit under Section 9.03 only will be delayed until the Employee returns to active employment. The Employee and Dependent(s) will be eligible for all other benefits under the Plan on the Effective Date.

If an Employee does not have sufficient Contribution Hours, such Employee's Eligibility may terminate on one of the four (4) termination dates as described in the chart below:

### CONTRIBUTION HOURS REQUIREMENT FOR CONTINUED ELIGIBILITY

| An Employee continues eligibility if the Employee accumulates at least | For this Benefit Period: | Otherwise Eligibility Ends: |
|---|---|---|
| 350 Contribution Hours from January through March | June through August | May 31 |
| 700 Contribution Hours from October through March | June through August | May 31 |
| 1,050 Contribution Hours from July through March, or | June through August | May 31 |
| 1,400 Contribution Hours from April through March | June through August | May 31 |
| 350 Contribution Hours from April through June | September through November | August 31 |
| 700 Contribution Hours from January through June | September through November | August 31 |
| 1,050 Contribution Hours from October through June, or | September through November | August 31 |
| 1,400 Contribution Hours from July through June | September through November | August 31 |
| 350 Contribution Hours from July through September | December through February | November 30 |
| 700 Contribution Hours from April through September | December through February | November 30 |
| 1,050 Contribution Hours from January through September, or | December through February | November 30 |
| 1,400 Contribution Hours from October through September | December through February | November 30 |
| 350 Contribution Hours from October through December | March through May | Last day of February |
| 700 Contribution Hours from July through December | March through May | Last day of February |
| 1,050 Contribution Hours from April through December, or | March through May | Last day of February |
| 1,400 Contribution Hours from January through December | March through May | Last day of February |

If the Employee does not have sufficient contribution hours, the Employee may be able to continue Eligibility with the Employee's Reserve Accumulation Account or by self-paying for coverage. If the Employee loses Eligibility, the Employee must meet initial Eligibility requirements to have Eligibility reinstated, i.e. accumulate 350 Contribution Hours in a nine-consecutive-month period.

## 2.07 RESERVE ACCUMULATION ACCOUNT

At the end of each calendar year, the Trustees will determine the number of Contribution Hours needed to support the cost of the Plan for the next year. The Contribution Hours paid on an Employee's behalf that are in excess of this amount in the preceding calendar

year will be credited to an Employee's Reserve Accumulation Account for the next year, up to a maximum of 1,050 hours at any one time.

An Employee's Contribution Hours will be credited to such Employee's Reserve Accumulation Account as follows:

(i) One reserve hour for each excess Contribution Hour will be credited for each of the first 500 Contribution Hours; and

(ii) One reserve hour for each two excess Contribution Hours when the Employee's Reserve Accumulation Account exceeds 500 Contribution Hours.

The Employee's Reserve Hours may be used to continue the Employee's current level of benefits. When the Employee uses any of their Reserve Hours, the Employee must have a total of 350 hours (whether Contribution Hours or Reserve Hours) to continue coverage for a Benefit Quarter. The hours in the Reserve Accumulation Account will be used to continue the level of benefits provided under the applicable Collective Bargaining Agreement.

## 2.08 FAMILY AND MEDICAL LEAVE ACT (FMLA)

(a) FMLA requires certain Employers (but not all) to grant up to 12 weeks of unpaid leave during a 12-month period for specified reasons defined in the law, such as the birth, adoption or foster care placement of a child or a serious health condition affecting the Employee, the Employee's spouse, the Employee's Dependent, or Employee's parents, or because an Employee has an urgent need for leave because the Employee's spouse, son, daughter, or parent is on active duty or has been notified of an impending call or order to active duty in the armed services in support of a military operation. The Employee may take up to 26 weeks of unpaid leave during any 12-month period to care for a service member who is (1) the Employee's spouse, son, daughter, parent, or next of kin, (2) undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in military service, and (3) an outpatient, or on the temporary disability retired list of the armed services.

(b) Eligibility for FMLA leave is determined by the Employer (not by the Plan or Board) in accordance with the requirements of FMLA. The Plan or Board will not intervene in the event of any Employee/Employer dispute concerning FMLA leave. The FMLA requires the Employer to inform the Employee of their rights and obligations under FMLA.

(c) If the Employee requests FMLA Leave from the Employer, the Employer must notify the Employee in writing whether or not the Employee is eligible for FMLA Leave.

(d) If the Employee is eligible for FMLA Leave, the Employer is also required to notify the Plan.

(e) If the Employee is granted FMLA Leave, the Employee is entitled to a continuation of the health care benefits provided under the Plan throughout the period of FMLA Leave.

(f) The Employer shall complete the necessary forms, and/or provide substantiating documentation, verifying the Employee's eligibility for continuation of these benefits.

(g) There is no charge to the Employee for the extended health care coverage apart from the deductibles, co-payments or other out-of-pocket expenses otherwise required under the Plan.

(h) The Employer is required to continue Contribution Hours on the Employee's behalf during the period of FMLA Leave for the benefits provided by the Plan. Failure of the Employer to submit Contribution Hours on a timely basis will result in the Employee's loss of coverage under the Plan.

(i) The Plan will have no direct role in resolving any dispute regarding eligibility and coverage under the FMLA between the Employee and the Employer, and the Plan may suspend benefits pending resolution of the dispute if the Employer fails to submit the Contribution Hours to the Plan on a timely basis.

## 2.09 CONTINUED ELIGIBILITY DUE TO CERTIFIED DISABILITY

For the purpose of continued Eligibility, an Employee unable to work due to a Certified Disability will be credited with 29 disability hours for each full week that the Employee is unable to work, up to a maximum of 700 disability hours during any 12-consecutive-month period.

If Eligibility ends during a period of Certified Disability, benefits for the Employee and their Dependents may be extended for up to 18 consecutive months. After the 18 months and the exhaustion of the Reserve Accumulation Account, coverage may be continued under the Self-Pay Program, the Retiree Plan, or COBRA continuation coverage. See Article IV for more information.

Termination of coverage continued due to a Certified Disability terminates as provided in Section 3.03.

If an Employee recovers from a Certified Disability, after Eligibility terminated during the period of Certified Disability and then after which the Employee became eligible under the Pre-Medicare Retiree Plan, the Employee must re-establish Eligibility under the following rules on a one-time basis:

(i) The Employee must establish Eligibility for the Active Plan by satisfying the requirements Section 2.04 above.

(ii) If the Employee has made an election for the Retiree Pre-Funded Allowance described in Section 10.04, the initial election will continue upon their subsequent retirement.

(iii) Upon establishing Eligibility in the Active Plan, the Employee will continue to earn credit towards the Retiree Pre-Funded Allowance in accordance with the terms of the Plan.

## 2.10 MILITARY SERVICE

This Section describes continuation coverage available under USERRA.

An Employee serving in uniformed military service for less than 31 days will continue to be covered under the Plan. However, if the Employee serves in uniformed military service for 31 days or more, they may elect continued coverage under this Plan as described in this Section. Election and payment procedures under this Section are the same as the procedures for COBRA Continuation Coverage in Section 4.04, except that USERRA continuation coverage may continue for up to 24 months.

Absent an election under this section, an Employee's coverage terminates on the first day of the month following the date that the Employee enters uniformed military service. If the Employee does not elect to continue coverage, eligible Dependents may continue coverage under the Plan by electing and making self-payments for COBRA Continuation Coverage (see Section 4.04).

**Uniformed military service** means the United States Armed Forces; the Army National Guard or 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 service designated by the President in time or war or emergency. Service in the uniformed military service 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
- Periods for which the Employee is absent for an examination to determine fitness for duty.

If you are called to military service, remember to:

- Notify your Employer and the Fund Office.
- Make self-payments if you want to continue your coverage.

*Contribution Hours*: When an Employee leaves work with an Employer for uniformed military service, the Employee's last Employer is responsible for making Contribution Hours on the Employee's behalf necessary to continue coverage under this Plan for the Employee and their Dependents if the service

is for less than 31 days. If service is for 31 days or more and the Employee elects to continue coverage in this Plan under USERRA, the Employee is responsible for any necessary self-payments.

*Eligibility Period*: When an Employee's uniformed military service lasts for 31 days or longer, that Employee has the right to elect continuation coverage under this Plan for themselves and their Dependents. This right to continuation coverage is subject to the timely payment of premiums for health benefits (which may include medical, prescription drug, dental, vision, and hearing coverage). The right to continue coverage under the Plan lasts until the earlier of:

(i) The 24-consecutive month period after regular coverage under the Plan ends; or

(ii) The date the Employee's reemployment rights under USERRA expires.

*Reemployment/Reinstatement:* Following discharge from military service, an Employee may apply for reemployment with their former Employer, which includes the right to reinstate existing health coverage provided by the Employer. According to USERRA guidelines, deadlines for returning to or being available for work after discharge are based on the length of the uniformed military service. For service lasting:

- Fewer than 31 days, the Employee has one day after discharge (allowing eight hours for travel) to return to work;
- More than 30 days but fewer than 181 days, the Employee has up to 14 days after discharge to return to work; or
- More than 180 days, the Employee has up to 90 days after discharge to return to work.

However, if at discharge the Employee is hospitalized or recovering from an illness or injury incurred during uniformed military service, the deadline extends to the period necessary for recovery to return to or to be available for work for an Employer, up to a maximum of a five-year absence. Failure to return to work within the required timeframes requires reestablishment of initial eligibility for coverage.

*Termination:* While USERRA protects an Employee's right reemployment and benefits, the Employee's coverage will terminate on the earliest day that the:

(i) Employee's coverage would otherwise end, as provided herein;

(ii) Employee's former Employer ceases to provide any health plan coverage to any Employee;

(iii) Employee's self-payment is due and unpaid;

(iv) Employee loses USERRA rights, such as for a dishonorable discharge; or

(v) Employee again becomes covered under the Plan.

If coverage terminates during a period of uniformed military service, all benefits (except Life Insurance, Accidental Death and Dismemberment, and Weekly Accident and Sickness Benefits) will be immediately reinstated upon the Employee's return pursuant to USERRA.

*Non-health Benefits*: An Employee who leaves employment with an Employer to perform uniformed military service shall be entitled to non-health benefits in the same manner as an Employee who is on any non-military leave of absence.

## 2.11 MEDICAID ELIGIBILITY

An Employee or Dependent's eligibility for or receipt of medical assistance under a state plan approved under Title XIX of the Social Security Act will not be taken into account for enrollment purposes or in determining or making any payment for benefits for such Employee or Dependent.

## 2.12 SPECIAL ENROLLMENT

If an Employee or Dependent declined coverage under the Plan because they had other group health coverage, they may have a special enrollment right if they lose that other coverage, if employer contributions cease for the other coverage, or if they reached their lifetime maximum for all benefits under the other coverage. Special enrollment is also available for newly acquired Dependents, including a new spouse, newborn children, newly adopted children, and children newly placed for adoption with the Employee. If the Employee or Dependent was covered by COBRA continuation coverage under another plan, special enrollment is only available upon exhaustion of that COBRA coverage.

The special enrollment period is 31 days. Requests for special enrollment must occur within 31 days of the loss of other coverage or acquisition of a new Dependent through marriage, birth, adoption, or placement for adoption. An Employee's eligibility for coverage due to a special enrollment is effective the first day of the month following the Fund Office's receipt of a completed application form. If an Employee adds a new Dependent within the special enrollment period, the Dependent's coverage is retroactive to date of the marriage, birth, adoption, or loss of other coverage. If the Dependent is added after the special enrollment period, their coverage begins the first day of the month following the Fund Office's receipt of a completed application form.

Employees who initially decline coverage under the Plan but who later acquire a new Dependent are entitled to special enrollment during the same period as their newly acquired Dependent.

Special enrollment may also be available if an Employee or Dependent had coverage under Medicaid or a state Children's Health Insurance Program ("CHIP") and lost eligibility for that coverage; or if they became eligible for participant in a Medicaid or CHIP financial assistance program for coverage under this Plan. Special enrollment must be requested within 60 days of the loss of Medicaid/CHIP coverage or the determination of eligibility for financial assistance.

Special enrollments are not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation.

# ARTICLE 3 – TERMINATION OF ELIGIBILITY

## 3.01 EMPLOYEE

Unless otherwise specifically provided elsewhere in this SPD, an Employee's Eligibility ends upon the earliest of the following:

(i) The date this Plan terminates;

(ii) The date the Employee is no longer a member of the classes of persons Eligible under this Plan;

(iii) On the termination dates defined in Section 2.06 (May 31, August 31, November 30, or the last day of February), after the Employee does not meet the continued Eligibility requirements;

(iv) Failure to pay any required self-payment when due;

(v) The date the Employee enters full-time, uniformed military service with the armed forces of any country, as more fully set forth in Section 2.10; or

(vi) The date that the Employee submits a fraudulent claim, as determined by the Board of Trustees in their sole fiduciary discretion.

## 3.02 DEPENDENT

Unless otherwise specifically provided elsewhere in this SPD, a Dependent's Eligibility ends upon the earliest of the following:

(i) The date that this Plan terminates;

(ii) The date that the Employee's Eligibility terminates;

(iii) The date that this Plan is amended to exclude the class to which the Dependent belongs;

(iv) The Date that the Dependent no longer meets the definition of "Dependent." The Employee must notify the Plan 60 days before the day Eligibility would otherwise terminate due to age;

(v) Failure to pay any self-payment on behalf of such Dependent when due; or

(vi) Date that the Dependent enters full-time, active uniformed military service with the armed forces of any country for more than thirty-one (31) days, except as otherwise required by applicable law.

## 3.03 TERMINATION OF ELIGIBILITY DUE TO DISABILITY

An Employee's Eligibility that is continued under this Plan due to a Certified Disability terminates on the earliest of the following:

(i) The date that the Employee no longer has a Total Disability. However, if the Employee returns to work and within 30 calendar days again becomes Totally Disabled as a result of the same Injury or Sickness, the Employee's Eligibility will be reinstated for the remainder of the 18-month period;

(ii) Failure to pay any required self-payment when due; or

(iii) The date that the Employee fails to provide adequate proof of continued Total Disability each Benefit Quarter.

If an Employee's Eligibility terminates while on a Certified Disability, and then the Employee recovers and returns to work, Eligibility is determined per Section 2.09.

## 3.04 TERMINATION OF DEPENDENT ELIGIBILITY AFTER EMPLOYEE'S DEATH

If an Employee dies while Eligible under this Plan, the deceased's Dependents remain Eligible until the date that the Employee's Eligibility would have terminated based on the Contribution Hours and Reserve Hours made on their behalf.

The Dependent may make self-payments for COBRA coverage or the Retiree Plan, but not both. If the Dependent waives COBRA coverage, they may self-pay for the Retiree Plan until the earlier of the day that such Dependent becomes entitled to Medicare, or the day that such Dependent no longer meets the Plan's definition of Dependent.

## 3.05 REINSTATEMENT OF ELIGIBILITY

If the Employee's Eligibility terminates due to the Employee not accumulating sufficient Contribution Hours, the Employee must again meet the initial Eligibility requirements under the Plan.

## 3.06 FRAUDULENT CLAIMS

An Employee's and/or Dependent's eligibility terminates under this Plan upon the determination that the Employee and/or Dependent submitted a fraudulent claim, as determined by the Board of Trustees in their sole fiduciary discretion.

## 3.07 RESCISSION OF COVERAGE

A rescission of coverage is a retroactive cancellation of coverage due to fraud, intentional misrepresentation of a material fact, or material omission, effective back to the time of the fraud, misrepresentation, or omission. The Plan has the right to rescind coverage only after the Plan provides 30 days advance written notice of the rescission to the Employee or Dependent. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission.

Some coverage terminations are not recissions. Coverage provided to an Employee or Dependent due to an unintentional mistake will be terminated prospectively when the error is discovered and without the 31-day advance notice. Some retroactive cancellations of coverage are also not considered rescissions under this Section 3.07 and therefore do not require 30 days advance written notice, including retroactive termination of coverage:

- To the date of termination of employment when there is a delay in administrative recordkeeping between the termination of employment and notification to the Plan of the termination of employment;
- Due to failure to timely pay required premiums or contributions; and
- For an Employee's former spouse to the date of divorce.

# ARTICLE 4 – SELP-PAY OPTIONS

## 4.01 AVAILABLE OPTIONS

Upon the termination of coverage under this Plan, an Employee may self-pay for themselves and their Dependents to continue coverage, subject to the terms of the specific self-pay option listed below:

(i) The Active Self-Pay Program described in Section 4.02;

(ii) The Retiree Self-Pay Program described in Section 4.03; or

(iii) COBRA Continuation Coverage, as described in Section 5.03;

Once the Employee elects one of the options, the election cannot be changed, i.e. if COBRA coverage is not elected, the COBRA coverage option is waived. Note however, that the Employee or Dependent may be eligible for another option after exhaustion of coverage under the option originally elected.

## 4.02 ACTIVE SELF-PAY PROGRAM

The Active Self-Pay Program is available to Employees if their Eligibility terminates due to a lack of sufficient Contribution Hours or Reserve Hours, and they are available for and actively seeking work as an Iron Worker (as defined in the Trust Agreement) in the jurisdiction of the Fund.

Each Benefit Quarter, the Employee may continue coverage for the benefits that they were Eligible for at the time coverage terminated. Except as otherwise provided elsewhere in this SPD, coverage under the Active Self-Pay Program will provide the benefits provided at the time the Employee's Eligibility terminated. Notwithstanding anything in this SPD to the contrary, retired or disabled Employees are not eligible for Weekly Accident and Sickness Benefits.

*Self-Payment Limitations and Amounts:* The following describe the number of self-payments allowed by the Plan and the determination of how such payments are made.

(i) For an Employee who is not performing bargaining unit work and not receiving contribution hours on their behalf, the maximum number of consecutive self-payments to maintain Eligibility will be limited to four (4) consecutive Benefit Quarters following their termination date.

(ii) An Employee may use hours from the Employee's Reserve Accumulation Account, if any, toward the self-payments.

(iii) Self-payments must be received by the Plan by the last day of the month prior to the termination date. A termination notice will be sent to the Employee's last known address on file with the Plan. The Employee must notify the Plan of a new address as soon as possible following an address change to ensure timely self-payments. Self-payments are due without regard to whether the Employee received actual notice.

(iv) Self-payment for a Benefit Quarter may be made in a single payment or in three equal monthly payments. For monthly installments, the second and third monthly installments must be received by the Plan by the first day of each subsequent month. If any monthly payment is late, any monthly payments already made will be credited as hours paid. Coverage for the Benefit Quarter will only be reinstated when the full payment for the Benefit Quarter is received by the Plan.

(v) The cost of coverage under the Active Self-Pay program equals the lowest amount determined by (1), (2), (3), or (4) below:

(1) 350 hours minus the Employee's Contribution Hours worked in the last Benefit Quarter; or

(2) 700 hours minus the Employee's Contribution Hours worked in the last two (2) Benefit Quarters; or

(3) 1,050 hours minus the Employee's Contribution Hours worked in the last three (3) Benefit Quarters; or

(4) 1,400 hours minus the Employee's Contribution Hours worked in the last four (4) Benefit Quarters (i.e., the contribution year).

The amount that the Employee needs to pay for the next Benefit Quarter is the number of Contribution Hours that the Employee needs to make times the hourly contribution rate. See the below example for more information.

**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.

## 4.03 RETIREE SELF-PAY PROGRAM

*Retirees under Age 65:* Employees retiring prior to age 65 while Eligible for the Plan may continue coverage if they meet the requirements set forth below and more fully in Article XI.

(i) The Employee is at least age 52 but less than age 65 and not yet Entitled to Medicare;

(ii) There is not a sufficient balance in the Employee's Reserve Accumulation Account for a Benefit Quarter of coverage (election of the Retiree Self-Pay Program results in forfeiture of the Reserve Accumulation Account);

(iii) The Employee is receiving some form of retirement benefits; and

(iv) At any time during the 12 months prior to retiring, the Employee was Eligible for benefits under this Plan by virtue of any combination of the following: Contribution Hours, Reserve Accumulation Account hours, and Self-Pay Contributions.

*Retirees Age 65 or Older and Enrolled in Medicare:* Retirees enrolled in Medicare Parts A and B are eligible to self-pay for a Medicare Plan that provides prescription drug coverage. Medicare Plan coverage and COBRA continuation coverage are available, but the election of one waives the other. This Medicare Plan is provided by the Trustees and may change from time to time. Contact the Fund Office for further information.

If an Employee or Dependent suffers from end stage renal disease (ESRD), coverage under the Plan will continue through the Pre-Medicare Retiree Plan of Benefits as primary payer with Medicare the secondary payer during the 30-month coordination period, provided the Employee or Dependent remains eligible and pays for coverage.

## 4.04 COBRA CONTINUATION COVERAGE

(a) Election of Coverage: A Covered Person may elect continuation coverage under COBRA as described in this Section 4.04 only for those health benefits described under COBRA and provided under this Plan.

(b) Definitions: For purposes of this Section 4.04 only, the following definitions apply:

(i) **Qualified Beneficiary**. An Employee and/or their Dependents who are covered under the Plan on the day before a Qualifying Event, and who would otherwise lose such coverage as a result of such Qualifying Event except for COBRA eligibility. A child born to an Employee or adopted or placed for adoption with an Employee during the Employee's COBRA coverage period shall be considered a Qualified Beneficiary.

(ii) **Qualifying Event**. Any of the following events that would otherwise result in loss of coverage for a Qualified Beneficiary:

(1) The death of the Employee;

(2) The termination (other than by reason of the Employee's gross misconduct) of the Employee's employment, or the reduction of hours in employment with respect to the Eligible Employee, including if the Employee enters uniformed military service pursuant to USERRA for more than 31 days;

(3) The divorce or legal separation of the Employee from the Employee's spouse. The Employee or the Qualified Beneficiary must notify the Plan of the divorce or legal separation within 60 days of the later of the date of the Qualifying Event or the date that the Qualified Beneficiary would lose coverage as a result of the Qualifying Event. If notification pursuant to this subsection (3) is not made within 60 days, the Qualified Beneficiary waives the right to elect COBRA coverage;

(4) The Employee enrolling in benefits under Medicare;

(5) A Dependent child (including a Dependent child who is a beneficiary under the Plan pursuant to a QMCSO) ceasing to meet the definition of "Dependent." The Employee or the Qualified Beneficiary must notify the Plan of the Dependent child ceasing to meet the definition within 60 days of the later of the date of the Qualifying Event or the date that the Qualified Beneficiary would lose coverage as a result of the Qualifying Event. If notification pursuant to this subsection (5) is not made within 60 days, the Qualified Beneficiary waives the right to elect COBRA coverage; and

(6) The failure of the Employee to return to work at the expiration of an FMLA Leave. The Qualifying Event occurs on the last day of the FMLA Leave. Notwithstanding anything contained herein to the contrary, taking FMLA Leave does not in and of itself constitute a Qualifying Event. For this subsection (6) to apply, the Employee or Dependent must have been covered by the Plan on the day before the first day of the FMLA Leave, or must have become covered by the Plan during the FMLA Leave, except if the Employer eliminates, on or before the last day of the FMLA Leave, coverage under the Plan for the class of Employees (while continuing to employ that class of Employees) to which the Employee would have belonged absent the FMLA Leave.

Any lapse of coverage under the Plan during an FMLA Leave does not affect the determination of whether a Qualifying Event has occurred under this subsection (6), or when the Qualifying Event begins, pursuant to this subsection (6). Any state or local law that requires that coverage under this Plan be maintained during a leave of absence for a period longer than required under the FMLA shall be disregarded for purposes of determining when a Qualifying Event occurs under this subsection (6).

(iii) **Election Period**. The period that:

(1) Begins not later than the date the Qualified Beneficiary would otherwise lose coverage under the Plan by reason of the Qualifying Event;

(2) Is of at least 60 days' duration; and

(3) Ends the later of 60 days after the date described in subsection (1) above, the date of receipt the COBRA election notice pursuant to ERISA Section 606(a)(4), or the date of the COBRA election notice.

(c) Notice and Election Requirements:

(i) The Trustees shall provide written notice of the COBRA Continuation Coverage provisions of this Section to each Employee and Dependent at the time coverage under the Plan commences.

(ii) An Employer shall notify the Administrative Manager of the Qualifying Events described in subparagraphs (b)(ii)(1), (2), (4), or (6) of this Section within 30 days of the Qualifying Event. Completion of the Employer remittance form identifying the Qualifying Event will be deemed sufficient notice.

(iii) The Employee or other Qualified Beneficiary shall be responsible for notifying the Administrative Manager within 60 days of the Qualifying Events described in subparagraphs (b)(ii)(3) or (5) of this Section. Failure to provide such notice in writing within 60 days of the Qualifying Event will result in loss of Eligibility for continuation coverage.

(iv) Upon receipt of the notices described in paragraphs (ii) and (iii) of this subsection (c), the Fund Administrator shall notify each affected Qualified Beneficiary of his right of Continuation Coverage and provide the Qualified Beneficiary with an enrollment form. Notice to a Qualified Beneficiary who is the spouse of the Employee shall be deemed notice to all other Qualified Beneficiaries residing with the spouse at the time notification is made.

(v) Upon receipt of such notice of entitlement to Continuation Coverage, each Qualified Beneficiary may elect such coverage by completing and returning the enrollment form to the Fund Administrator within the Election Period. Failure to return the enrollment form within the Election Period will result in loss of eligibility for COBRA Continuation Coverage.

(vi) If coverage should end prior to the maximum period due to any of the reasons described in subsection (d) of this Section, the Fund Administrator shall notify each affected Qualified Beneficiary of early termination of COBRA Continuation Coverage.

(vii) If a Qualified Beneficiary who was determined to be disabled by the Social Security Administration is determined to no longer be disabled, the Qualified Beneficiary must notify the Administrative Manager within 30 days of the determination.

(d) Maximum Period of Coverage:

(i) For a Qualifying Event described in subsection (b)(ii)(2), the maximum period of continuation coverage shall be 18 months. If a second Qualifying Event (except for a bankruptcy) occurs within such 18-month period, the maximum period of coverage for the Employee's Eligible Dependents shall be 36 months.

(ii) In the case of a Qualifying Event that is a termination of, or a reduction of, a covered Employee's employment, any Qualified Beneficiary who is determined to be disabled under Title II or Title XVI of the Social Security Act and pursuant to Treasury Regulation 54.4980B-7, Q&A 5(c), and to have been disabled by the date of the Qualifying Event (and not subsequently determined to be no longer disabled) or at any time during the first 60 days of COBRA continuation coverage (such 60-day period to be determined pursuant to Treasury Regulation 54.4980B-7, Q&A 5(c)), the maximum period of COBRA continuation coverage for such Qualified Beneficiary and such Qualified Beneficiary's family members shall be 29 months.

The extended 29-month period is available only if the Qualified Beneficiary provides the Plan with notice of the disability determination on a date that is both within 60 days after the date that the disability determination is issued and before the end of the original 18-month maximum coverage period. In the event that the Qualified Beneficiary is determined under the Social Security Act to no longer be disabled before the end of the twenty-nine (29) month period, the period of COBRA continuation coverage beyond 18 months terminates at the end of the month following 30 days after the final determination that the Qualified Beneficiary is no longer disabled. However, if an event occurs that triggers the 36-month maximum coverage period, in that case, the 36-month maximum coverage period shall apply.

(iii) Except as otherwise provided in subsection (iv) below, if the Qualifying Event is an event described in this Section 4.04 other than the Qualifying Event described in subsection (b)(ii)(2) and (b)(ii)(6), the maximum period of coverage shall be 36 months from the date of the Qualifying Event.

(iv) Notwithstanding anything contained herein to the contrary, for a Qualifying Event described in subsection (b)(ii)(6), the maximum period of coverage is measured from the last day of the FMLA Leave or from the date that coverage is lost under the Plan, if coverage is lost under the Plan on a date later than the last day of the FMLA Leave.

(e) COBRA Payment Information:

(i) COBRA premium payments are due monthly. Except for the initial payment, which is due within 45 days of the date the Qualified Beneficiary elects COBRA, a 30-day grace period applies to each monthly payment. If a monthly payment is made later than the first of the month to which it applies, but before the end of the grace period, coverage under the Plan will be suspended on the first of the month and then retroactively reinstated to the first of the month when the payment is received.

(ii) The cost for coverage under this Section 4.04 is determined by the Trustees not more often than annually, not to exceed 102% of the cost to provide coverage under this Plan.

(iii) The cost for extended disability coverage described in subsection (d)(ii), from the 19th month through the 29th month, is determined by the Trustees not more often than annually, not to exceed 150% of the cost to provide coverage under this Plan.

(iv) For a Qualifying Event described in subsection (b)(ii)(6), the right to COBRA coverage shall not be conditioned on the Employee's reimbursement to the Employer for premiums that the Employer paid to maintain coverage during the FMLA Leave, even if recovery of premiums is permitted as described in Section 3.08(i) of this SPD.

(f) Termination of COBRA Continuation Coverage: COBRA continuation coverage shall terminate on the earliest of the following:

(i) The last date of the last month for which COBRA payments are timely made, including the applicable grace period, if the Qualified Beneficiary fails to make any COBRA payments as described herein;

(ii) The date on which the Qualified Beneficiary first becomes covered as an Employee or as a Dependent under any other group health plan of an employer after the date that the Qualified Beneficiary elects COBRA continuation coverage, except for a group health plan with a pre-existing condition limitation or exclusion with respect to the Qualified Beneficiary;

(iii) The date on which the Qualified Beneficiary first becomes enrolled in benefits under Medicare after the date that the Qualified Beneficiary elects COBRA continuation coverage. However, Dependents not enrolled in Medicare can continue coverage for up to 36 months from the Employee's enrollment in Medicare, or 18 months from the date of the first qualifying event, whichever is longer;

(iv) The date that is 18 months, 29 months or 36 months, as applicable, after the date of the Qualifying Event; or

(v) The date on which the Plan is discontinued by the Trustees.

# ARTICLE 5 – COMPREHENSIVE MAJOR MEDICAL BENEFITS

## 5.01 ELIGIBILITY AND BENEFITS

If a Covered Person incurs cost due to an Injury or Sickness, benefits will be paid according per this Article V and the applicable Schedule of Benefits in Appendix A or Appendix B. Benefits will be paid after the satisfaction of the annual deductible, as applicable; thereafter, benefits will be paid at the percentage rate and subject to the out-of-pocket limit and calendar year maximum, as described in the applicable Schedule of Benefits.

Except as otherwise required by the No Surprises Act, out-of-network expenses, expenses that this Plan does not cover, and expenses in excess of the annual limits generally do not count towards the out-of-pocket limit.

## 5.02 DEDUCTIBLE AMOUNT

(a) Individual Deductible: The calendar year deductible is the initial amount of covered medical expenses that the Covered Person must pay before they are entitled to benefits.

(b) Family Deductible: When a family unit has collectively satisfied the calendar year family deductible, no further deductible will be required for covered charges incurred by members of that family for the remainder of that calendar year.

(c) Special Extra Work Benefit: An Employee who received 2,000 or more Contribution Hours for work performed in a calendar year will be reimbursed for the first $100 of the Family Deductible described above for the immediately preceding year.

(d) Deductible Carryover: Any portion of the calendar year deductible expense incurred in the last three months of the calendar year will be carried over and will also be applied to the calendar year deductible for the following calendar year.

## 5.03 MAXIMUM BENEFIT

The Plan provides calendar year visit maximums or day maximums for certain benefits. Calendar year maximums apply to the following benefits, as shown in the Schedule of Benefits:

(a) Home Health Care visits. A visit consists of up to four (4) consecutive hours of Medically Necessary care by one or more providers from the Home Health Care Agency; and

(b) Skilled Nursing Facility days.

## 5.04 COST MANAGEMENT PROGRAMS

(a) *Preferred Provider Organization (PPO)/Utilization Review (UR):* The Plan maintains agreements with a PPO and a UR company to reduce medical costs for benefits under the Plan.

(b) *20% Reduction:* Except as otherwise required by the No Surprises Act, the Plan pays 20% less for Hospital charges at a non-PPO Hospital. The 20% reduction in benefits is in addition to any deductibles or co-payments. The reduction does not apply when the Covered Person lives more than 25 miles from the nearest PPO Hospital or if the Covered Person seeks Emergency Services.

(c) *Pre-approval:* All Hospital care as described in this Article V must be pre-approved by the UR company prior to treatment, except for hospitalizations related to maternity admissions or childbirth, hospice services as provided in Section 5.05(b), or an emergency situation. For emergency admissions, the UR company must be notified within forty-eight (48) hours of the

admission. Failure to obtain pre-approval will result in a monetary penalty. For the purposes of this SPD, the terms pre-approve(al), pre-certify(ication), and pre-authorize(ation) are used interchangeably and mean the same thing.

(d) *Recovery Incentive Benefit:* The recovery incentive benefit provides a cash incentive to a Covered Person if they find and arranges for the recovery of overcharges on their Hospital bill. The amount of the cash incentive is equal to 25% of the overcharge amount. Hospital overcharges totaling less than $25 are not eligible for this recovery incentive benefit. In no event will the total recovery incentive benefit paid for any overcharge exceed $500 in a calendar year.

(e) *Emergency Room Copayment:* A Covered Person must pay an emergency room copayment as listed in the applicable Schedule of Benefits; however, if the Covered Person is admitted to the Hospital based on the emergency room visit, the emergency room copayment will be waived.

## 5.05 COVERED EXPENSES

(a) The following Medically Necessary services and supplies authorized by a Physician, to the extent that charges for such services and supplies do not exceed the Allowable Charge, are covered medical expenses:

(i) 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.

(ii) Miscellaneous Hospital Charges, other than room and board, furnished by the Hospital.

(iii) Outpatient surgical services.

(iv) The services of a Physician.

(v) The services of a registered graduate nurse (R.N.), other than a nurse who ordinarily resides in an Employee's home or who is a member of the Employee's or his/her spouse's family.

(vi) Chiropractic and acupuncture services.

(vii) Diagnostic laboratory and X-ray examinations.

(viii) X-ray, radium, and radioactive isotope therapy.

(ix) Chemotherapy.

(x) Anesthetics and oxygen.

(xi) Rental of durable medical or surgical equipment.

(xii) Artificial limbs and artificial eyes, but not eye examinations or eyeglasses (which may be covered under Article VIII).

(xiii) The expense incurred for Medically Necessary professional ambulance service to a Hospital within the jurisdiction of the Plan as certified by a Physician. Such transportation includes transfers between Hospitals, if such transfer results in more highly specialized care. For claims incurred on or after June 1, 2018, eligible air ambulance services will be covered at 300% of the Medicare reimbursement rate at the time the services are rendered. For out-of-network claims incurred on or after January 1, 2022, eligible air ambulance claims are paid in accordance with the No Surprises Act as addressed in Section 5.09.

(xiv) 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:

(1) Alveolar abscesses;

(2) Alveolectomies;

(3) Apicoectomies (resection of root of tooth);

(4) Cysts of jaws;

(5) Epulis (fibrous tumor of the gum); or

(6) Partially or completely unerupted impacted teeth.

(xv) For all other dental work and oral surgery, only the charges of a Hospital and anesthesia, and dental occlusal mouth guards when Medically Necessary due to sleep apnea are included as covered medical expenses under this Article V. Other dental benefits are available under Article VII.

(xvi) The expenses incurred in connection with Cosmetic Surgery, to the extent such Cosmetic Surgery is necessary for the prompt repair of a non-occupational Injury.

(xvii) The expenses incurred for inpatient and outpatient treatment for alcohol, drug and chemical dependency.

(xviii) The expenses incurred for inpatient and outpatient treatment of Behavioral Health Disorders. See the definition of "Behavioral Health Disorder" in the Definitions section.

(xix) The expenses incurred for Home Health Care visits from a Home Health Care Agency up to the limit set forth in the applicable Schedule of Benefits. A visit consists of up to four consecutive hours of Medically Necessary care by one or more providers from the Home Health Care Agency.

(xx) The expenses incurred for room and board and miscellaneous services for a covered confinement in a Skilled Nursing Care Facility, up to the limit set forth in the applicable Schedule of Benefits. A confinement in a Skilled Nursing Care Facility is covered only if the:

(1) Confinement begins within seven days after a Hospital confinement of at least three consecutive days;

(2) Confinement is due to the same or a related cause as the Hospital confinement; and

(3) The UR company has pre-certified the confinement and will monitor the Covered Person's progress on an on-going basis.

(xxi) The expenses incurred for treatment of infertility or for the promotion of pregnancy. The Covered Person may be required to have the attending Physician 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.

(xxii) Treatment received in an immediate care facility or urgent care facility.

(xxiii) 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:

(1) A Physician has issued a written prescription for such items;

(2) The prescription shall state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for a Covered Person;

(3) In the absence of such item, the Covered Person is or will become malnourished or suffer from disorders, which if left untreated, will cause chronic physical or mental disability or death; and

(4) The Covered Person has been diagnosed with inherited diseases of amino-acid or organic acid metabolism; Crohn's Disease; gastro-esophageal 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 or mental disability, or death.

(xxiv) The expenses incurred for Retin-A for a Covered Person age 26 or older when a Physician furnishes documentation to the Board and/or the Plan showing that the Retin-A is Medically Necessary for the treatment of severe acne.

(xxv) Human organ and tissue transplants.

(b) Hospice Expenses:

(i) The Plan provides coverage to Covered Persons who are diagnosed as terminally ill with a life expectancy of six months or less. This Hospice Benefit replaces all other health benefits of the Plan.

(ii) 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.

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

(1) In-patient confinement in a hospice facility. The Allowable Charges for room and board in a hospice facility is the most common semi-private room and board charge of a Hospital in the Covered Person's area.

(2) Home visits by nurses and other health care professionals.

(3) Management of pain.

(4) Medical treatment.

(5) Local ambulance or special transport between patient's home and hospice facility.

(6) Instruction and supervision of family members in the care of the patient, including nutritional direction.

(7) Help in obtaining medical equipment, supplies or medication, including rental of wheel chairs and Hospital-type beds.

(8) Psychological counseling and emotional support to the patient and family.

(9) Spiritual support to the patient and family.

(10) Bereavement services up to a maximum charge of $500.

(c) Maternity Admissions: Pursuant to the Newborns and Mothers Health Protection Act of 1996, benefits under this Plan in relation to childbirth will be provided for a mother and her newborn to remain in the Hospital for at least 48 hours following a normal vaginal delivery and at least 96 hours following a cesarean delivery. However, the attending health care provider, in consultation with the mother, may decide to discharge the mother or newborn earlier. No pre-certification or pre-authorization shall be imposed for the said 48-hour or 96-hour requirement, respectively.

## 5.06 BREAST RECONSTRUCTION

(a) In the case of a Covered Person who is receiving benefits under the Plan and who elects breast reconstruction in connection with a mastectomy, the Women's Health and Cancer Rights Act (WHCRA) requires coverage, in a manner determined in consultation with the attending Physician and the patient, for:

(i) Reconstruction of the breast on which the mastectomy was performed;

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(iii) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

(b) Benefits under this Section 5.06 are paid as provided on the applicable Schedule of Benefits.

## 5.07 WELLNESS BENEFITS

The Plan covers certain wellness care services at 100% if a PPO provider is used. The Plan intends to comply with the provisions of the Affordable Care Act.

(a) Well Child Care and Immunizations:

(i) 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. The Plan covers certain wellness care services at 100% if a PPO provider is used. The Plan intends to comply with the provisions of the Affordable Care Act.

(ii) The HPV vaccine for Dependent female child(ren) is covered in accordance with the American Academy of Pediatrics Immunization Guidelines. No deductible applies to this benefit.

(b) Routine Adult Physical Examinations and Immunizations:

(i) The Routine Adult Physical Examinations and Immunizations benefits provide coverage for annual physical examinations and immunizations for the Employee and the spouse. No deductible applies to these benefits.

(ii) The following expenses are covered under this benefit, up to the limits set forth in the applicable Schedule of Benefits:

(1) Annual physical examinations through the medical screening provider chosen by the Trustees or the Physician;

(2) Office visits, X-rays and laboratory charges in association with routine physical examinations;

(3) Immunizations and flu shots for the Employee and spouse only, according to acceptable medical guidelines.

(c) Diabetes Education: The Plan pays expenses for diabetes education only when a diabetes education program is ordered by a Physician and when the patient or parent submits a receipt showing the information required by the Trustees for payment.

## 5.08 NO SURPRISES ACT SERVICES

(a) Air Ambulance Services

Air ambulance services are medical transport for patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605. The No Surprises Act requires Air Ambulance Services, to the extent covered by the Plan, to be covered as follows:

(i) Air ambulance services from an out-of-network provider are covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a network provider;

(ii) The cost-sharing amount will be calculated as if the total amount that would have been charged for the services by a network provider of air ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services;

(iii) Any cost-sharing payments the Participant or Dependent makes with respect to covered Air Ambulance Services will count toward their network deductible and network out-of-pocket maximum in the same manner as those received from a network provider; and

(iv) In general, a Participant or Dependent cannot be balance billed for these Air Ambulance Services.

(b) Continuing Care Patients

A Continuing Care Patient is an individual who is: (a) receiving a course of treatment for a Serious and Complex Condition, (b) scheduled to undergo non-elective surgery (including any post-operative care); (c) pregnant and undergoing a course of treatment for the pregnancy; (d) determined to be terminally ill and receiving treatment for the illness; or (e) undergoing a course of institutional or inpatient care from the provider or facility.

In the case of an acute illness, a Serious and Complex Condition is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness or condition, a Serious and Complex Condition that is a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

If an Employee or Dependent is a Continuing Care Patient, and the Plan terminates its contract with a network provider or a network facility or Hospital, or benefits are terminated because of a change in terms of providers' and/or facilities' participation in the Plan, the Plan will do the following:

(i) Provide notice of the Plan's termination of its contracts with the network provider or facility and inform the patient or their representative of the patient's right to elect continued transitional care from the provider or facility; and

(ii) Allow the Patient 90 days of continued coverage at the network cost sharing level to allow for a transition of care to a network provider or facility.

(c) Emergency Services

The No Surprises Act requires Emergency Services to be covered as follows:

(i) Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;

(ii) Without regard to whether the health care provider furnishing the Emergency Services is a network provider or a network facility, as applicable, with respect to the services;

(iii) Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from network providers and network facilities;

(iv) Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a network provider or a network facility;

(v) By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services;

(vi) By counting cost-sharing payments made by the Participant with respect to out-of-network Emergency Services toward their network provider Deductible and network provider out-of-pocket maximum in the same manner as those received from a network provider; and

(vii) In general, Participants and Beneficiaries cannot be balance billed for these Emergency Services.

(d) Non-Emergency Services

The No Surprises Act requires non-Emergency Services performed by an out-of-network provider at a network Health Care Facility to be covered as follows:

(i) With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a network provider;

(ii) By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such network provider were equal to the recognized amount for the items and services; and

(iii) By counting any cost-sharing payments made toward any network provider deductible and network provider out-of-pocket maximums applied under the Plan (and the network provider Deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a network provider.

(iv) In general, Participant and Beneficiaries cannot be balance billed for these items or services.

(e) Notice and Consent Exception: Non-emergency items or services provided or performed by an out-of-network provider at a network Health Care Facility will be covered based on the Plan's out-of-network provider benefits and forgo the financial protections of the No Surprises Act if:

(i) At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the patient (or their representative) is provided with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, the estimated charges for the treatment and any advance limitations that the Plan may put on treatment, the names of any network providers at the facility who are able to provide the treatment, and that the patient may elect to be referred to one of the network providers listed; and

(ii) The patient gives written informed consent to continued treatment by the out-of-network provider acknowledging that the patient understands that continued treatment by the out-of-network provider result in greater expenses.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the out-of-network provider satisfied the notice and consent criteria and, therefore, these services will be covered as follows:

(1) With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a network provider;

(2) With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services;

(3) By counting any network provider Deductible and network provider out-of-pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a network Provider; and

(4) In general, Participants and Beneficiaries cannot be balance billed for these items or services.

(f) Provider Directory: The provider directory will be updated at least every 90 days. If a Participant or Dependent is informed by the Plan through a telephone, electronic, or internet-based inquiry, or receives information from a print or electronic provider directory that a provider is a network provider, but, in fact, the provider is an out-of-network provider and services are furnished by the out-of-network provider, the Plan will:

(i) Apply a cost-sharing amount that is no greater than the cost-sharing amount that would have been assessed if the provider was a network provider; and

(ii) Apply the out-of-pocket limit, if any, as if the services were provided by a network provider.

## 5.09 SUPPLEMENTAL ACCIDENT BENEFIT

(a) In general, if a Person sustains an accidental injury while eligible under this Plan and, as a result of the accident, incurs expenses within 90 days after the date of the accident, benefits are payable subject to the provisions of this Section. The amount payable under this Section will be any amount that is in excess of the total amount paid for hospital, surgical, or out-patient x-ray and laboratory expenses.

(b) Benefits are payable for 100% of the Allowable Charges for the covered services listed below after such expenses are paid under the hospital, surgical, or out-patient x-ray and laboratory expenses.

(c) Covered services under this Section include:

(i) Hospital room and board and other services and supplies required for the purpose of treatment;

(ii) The professional services of a Physician including the cost of supplies and drugs in connection with the treatment;

(iii) X-ray and laboratory tests ordered by the attending Physician; and

(iv) The services of a graduate registered nurse.

(d) No benefits shall be payable under this Section for:

(i) Expenses resulting from the treatment of a sickness or disease;

(ii) Treatment rendered more than 90 days after the date of the accident; or

(iii) Any treatment, services, or supplies as set forth in Article XII – General Exclusions and Limitations.

## 5.10 HEALTHY FOUNDATIONS WELLNESS, DISEASE MANAGEMENT, AND ACCOUNT

The Plan provides a variety of benefits and resources to help Employees and their families maintain the best health possible. The Plan provides resources for preventive and disease-management services. In addition, after completing specific wellness activities, the Plan will deposit money into an Employee's Healthy Foundations Account ("HFA") for use toward out-of-pocket healthcare expenses.

### Preventive 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 (AAP) Immunization Guidelines. No deductible applies to this benefit. The schedule of immunizations is available on the AAP website at www.aap.org.

### Routine Adult Physical Examinations and Immunizations

The Routine Adult Physical Examinations and Immunizations benefits provide coverage for annual physical examinations and immunizations for the Employee and their spouse. No deductible applies to these benefits. In addition, the Plan periodically arranges for screenings at Local Union Halls. These screenings are free to Covered Persons and count toward the wellness rewards through their HFA.

The following are covered expenses under this benefit:

- Annual physical examinations from either your Physician or the provider chosen by the Trustees for on-site screenings;
- Office visits, X-rays, and laboratory charges in association with routine physical examinations; and
- Immunizations and flu shots according to medical guidelines.

Mammograms are also covered preventive benefits if they are used as a screening test without any prior diagnosis or due to family or personal history such as 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 seek to improve the patient's knowledge of diabetes and understanding of techniques for self-management and compliance. The Plan pays expenses up to $500 per lifetime 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.

## Healthy Foundations Account ("HFA"):

### How the HFA Works

The HFA is a health reimbursement arrangement. Employers contribute to the Employee's HFA. In addition, for completion of certain wellness activities, the Plan will contribute toward Employee's HFA account. The HFA balance can pay for medical expenses that the Plan does not cover, such as:

- Out-of-pocket plan costs, including deductibles, copayments, and coinsurance;
- Payments for group coverage, including self-payments, retiree self-payments, and COBRA premiums;
- Healthcare not covered, or only partially covered, under the Plan or any other healthcare plan in which the Employee or Dependent participates, and expenses that exceed benefits maximums; and
- Premiums for other group healthcare coverage or insurance, Medicare, and long-term care insurance. HFA funds cannot be used to purchase any type of individual health insurance coverage, whether through an exchange or otherwise.

Although the Employee and spouse are the only family members who can earn money for the HFA, the account balance can be used for IRS-qualified medical expenses for the Employee and all Eligible Dependents.

### Right to Opt Out of HFA

Employees have the right to opt out of the HFA benefit permanently, at any time, including upon termination of Covered Employment. Opting out constitutes waiver any right to future reimbursement; Employees may not re-enroll later.

### How Your HFA Grows

The HFA account is funded in two ways: through Employer contributions and through Plan incentives for the completion of certain wellness activities. Employers contribute on behalf of Employees based on hours worked and the bargained wage package.

The balance in their HFA remains in the Employee's account for as long as they remain eligible for the benefit. Balances in the HFA rolls over from year to year, and there is no limit on the amount that can be earned and carried forward each year. Employees can:

- Save the account balance for future healthcare needs;
- Pay for current healthcare expenses; or
- Make self-payments for either COBRA continuation coverage or coverage under the Active or Retiree Self-Pay Plan.

### Reimbursement from the HFA

Participants can pay for eligible expenses at the time of service with the HFA debit card or can file claims for reimbursement by remitting a form and copies of receipts.

### Using the Debit Card

Erroneous use of the HFA debit card for a non-medical item or a purchase that cannot be properly substantiated requires the Employee to repay the Plan.

### Reimbursement Forms

Employees who prefer not to use the debit card can also file claims for reimbursement from the HFA balance. To file a claim, an Employee must complete a reimbursement form (titled "*Healthy Foundations Account (HFA) Reimbursement Form"*) and mail it with all pertinent documentation, such as receipts and explanation of benefits ("EOBs"), to the Fund Office. The mailing address is listed on the form, which can be printed from the "Forms" link on www.tristatewefarefund.com. Approved reimbursements are withdrawn from the HFA reimbursed by direct deposit to the Employee.

## 5.11 HEARING BENEFITS

Hearing benefits are available only to Active and Retired Employees and are available only through EPIC HealthCare ("EPIC"). Benefits obtained outside of EPIC will generally not be eligible for the discounts offered by EPIC. The Plan will cover hearing aids for eligible individuals up to a maximum of $2,500 per ear or $5,000 for a pair every 36 months. Routine hearing exams are covered benefits when provided subject to a referral from EPIC. More extensive hearing tests may be covered as medical benefits subject to any deductibles or coinsurance.

# ARTICLE 6 – PRESCRIPTION DRUG BENEFITS

## 6.01 ELIGIBILITY AND BENEFITS

If a Covered Person incurs expenses for prescription drugs, benefits will be paid according to this Article and as shown in the applicable Schedule of Benefits. Benefits under this Article consist of a retail pharmacy program described in Section 6.02 and a mail-order program described in Section 6.03.

## 6.02 RETAIL PHARMACY PROGRAM

The Plan participates in a pharmacy network of participating pharmacies. If a pharmacy does not participate in the pharmacy network, it is a "non-participating pharmacy." Employees and Dependents are encouraged to utilize participating pharmacies, as those location will result a much lower out-of-pocket cost.

At participating pharmacies, Covered Persons will pay only the co-payment amounts on the applicable Schedule of Benefits for the category of drug dispensed – generic drugs, brand-name drugs, Formulary Drugs, or non-Formulary drugs. After such co-payment, the Plan pays the remainder of drug's cost.

At non-participating pharmacies on the other hand, the Covered Person must pay the full cost of the prescription up front. The pharmacy network will then reimburse the Covered Person for only the amount that a participating pharmacy would charge for that drug. Reimbursement is only available after the pharmacy network's receipt of a claim for reimbursement with proper substantiation.

Prescriptions and refills are available up to a maximum 34-day supply or 100 unit doses through the retail pharmacy program.

## 6.03 MAIL-ORDER PHARMACY PROGRAM

Long-term maintenance prescriptions and refills are available up to a 90-day supply through the mail-order pharmacy. A co-payment is required for each category of drug dispensed (generic, formulary, and non-formulary drugs) as shown on the applicable Schedule of Benefits.

## 6.04 COVERED EXPENSES

The following supplies, authorized by a Physician, will be considered covered expenses under Article VI:

(a) Legend drugs that are lawfully obtainable only from an individual licensed to dispense drugs upon the prescription of a Physician, including oral contraceptives;

(b) Injectable insulin;

(c) Prescribed syringes, hypodermic needles, test strips, and other Medically Necessary supplies used exclusively for administration of injectable insulin;

(d) Compound medication of which at least one ingredient is a prescription legend drug; and

(e) Erectile dysfunction drugs, with a limit of six pills per month.

## 6.05 EXCLUSIONS AND LIMITATIONS

The following expenses are not payable under this Article VI:

(a) Contraceptive devices (other than oral contraceptives), regardless of the purpose for which they are prescribed;

(b) Drugs or medicines lawfully obtainable without a prescription, except insulin;

(c) Therapeutic devices or appliances, support garments, and other non-medical substances, regardless of their intended use;

(d) Any charge for the administration of a prescription legend drug or injectable insulin;

(e) Medication that is to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is an inpatient or outpatient in a Hospital, licensed 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;

(f) Immunization agents, biological sera, blood or blood plasma, except as otherwise set forth in this SPD;

(g) Refills of a prescription in excess of the number specified by the Physician or Dentist or any refill dispensed after one year from the prescription order of a Physician or Dentist;

(h) Prescription drugs that may be properly received without charge under local, state, or federal programs, including workers' compensation;

(i) Experimental or Investigative drugs or medicines that are labeled "Caution: limited by federal law to investigational use";

(j) Drugs dispensed from a Physician's office;

(k) Prescriptions for the drug Retin-A for Employees or Dependents under age 26 unless documented by a Physician as Medically Necessary. For Employees or Dependents over age 26, Retin-A is a covered benefit if it is Medically Necessary to treat severe acne. Prescriptions for Retin-A are covered by the Plan at eighty percent (80%) under Article V: Comprehensive Major Medical Benefits;

(l) Prescriptions for fertility treatment, which are otherwise covered under the Major Medical Benefit as provided in the Schedule of Benefits and Article V; and

(m) Prescription drugs, indications and/or dosage regimens determined to be not Medically Necessary or Experimental, Investigational or unproven medication or therapies, or drugs not approved by the United States Food and Drug Administration (FDA) for the intended use (off label).

# ARTICLE 7 – DENTAL BENEFITS

## 7.01 ELIGIBILITY AND BENEFITS

If a Covered Person incurs expenses for covered dental services, which are performed by a Dentist and necessary and customary as determined by the standards of generally accepted dental practice, benefits are payable according to this Article VII and pursuant to the applicable Schedule of Benefits.

Notwithstanding anything in this Article VII or elsewhere in the SPD to the contrary, Type D Orthodontic Services, as described in Section 7.03(d) below, are payable only for Dependents under age 19. Covered Persons age 19 or older are not eligible for benefits described under that Section.

Benefits for each type of covered dental expense described Section 7.03 are payable per the payment percentage specified and up to the applicable calendar year maximum limit, each as provided in the applicable Schedule of Benefits. Note however, that benefits under this Article are payable only if specified in the applicable Schedule of Benefits.

## 7.02 PREDETERMINATION OF BENEFITS

The Plan recommends that patients obtain a predetermination of benefits from the Plan in cases where a Dentist's recommended course of treatment can reasonably be expected to result in covered expenses of $250 or more. A description of the procedure(s) to be performed and the Dentist's charge(s) can be submitted to the Plan prior to commencing the treatment; the Plan will provide the Covered Person with an estimate of the benefits payable for the course of treatment.

## 7.03 COVERED EXPENSES

Benefits are payable under this Article VII and pursuant to the applicable Schedule of Benefits for four types of covered dental services:

(a) **Type A**: Diagnostic and Preventative Dental Services:

- (i) Routine oral examinations twice in any calendar year;
- (ii) Dental prophylaxis twice in any calendar year, including cleaning, scaling and polishing;
- (iii) Full-mouth X-rays (of at least 14 films) once in any period of 36 consecutive months;
- (iv) Supplementary bitewing X-rays twice in any calendar year;
- (v) Topical fluoride applications only to Covered Persons under age 19 and no more than one treatment in a calendar year;
- (vi) Space maintainers for a Covered Person up to age 19;
- (vii) Dental sealant for Covered Persons up to age 19; and
- (viii) Emergency palliative treatment

(b) **Type B**: Restorative Dental Services:

- (i) Extractions (except for Type D: Orthodontic Services);

(ii) Restorative services using amalgam, synthetic porcelain and plastic filling material;

(iii) Oral surgery and the administration of Medically Necessary general anesthetics. Benefits are payable for these services first under the Major Medical Benefits of Article V; any excess covered dental expenses are then payable under this Article VII:

(iv) Injections of antibiotic drugs;

(v) Periodontal treatment; and

(vi) Endodontics, including pulpal therapy and root canal filling.

(c) **Type C**: Prosthodontic Dental Services:

(i) Initial installation of fixed bridgework;

(ii) Initial complete or partial dentures;

(iii) Replacement of fixed bridgework or dentures when:

(1) One or more natural teeth are extracted; or

(2) The existing bridgework or denture is at least five (5) years old and cannot be made usable;

(iv) Inlays, onlays and crowns;

(v) Gold fillings;

(vi) Repair or recementing of bridgework, dentures, crowns, and inlays; and

(vii) Relining or rebasing dentures.

(d) **Type D**: Orthodontic Services (only a covered benefit for Dependent under age 19):

(i) Orthodontic diagnostic procedures (including cephalometric x-rays); and

(ii) Appliance therapy (braces), including related oral exams, surgery, and extractions.

## 7.04 EXCLUSIONS AND LIMITATIONS

The following expenses are not payable under this Article VII:

(a) Any service rendered before coverage became effective;

(b) Treatment by anyone other than by a Dentist or 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, a Dentist;

(c) Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;

(d) Replacement of a lost, missing or stolen prosthetic device;

(e) Replacement or repair of an orthodontic appliance;

(f) Any services 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 agreement is signed pursuant to Article XVI.

(g) Services rendered through a medical department, clinic, or similar facility provided or maintained by the patient's employer;

(h) 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 coverage under this Article or Plan;

(i) Services or supplies that are not Medically Necessary according to accepted standards of dental practice;

(j) 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;

(k) Services or supplies received as a result of dental disease or defect;

(l) Any duplicate prosthetic device or any other duplicate appliance;

(m) Oral hygiene and dietary instruction;

(n) A plaque control program;

(o) Periodontal splinting;

(p) Myofunctional therapy, or correction of harmful habits, except that, to the extent provided in Section 6.05(a)(xv), the Plan will cover dental occlusal mouth guards related to the treatment of sleep apnea under Article V;

(q) Implantology;

(r) Any orthodontic procedures performed after the first twenty-four (24) months of treatment; or

(s) Expenses for services other than those specifically indicated as covered.

## 7.05 EXTENSION OF BENEFITS

(a) If a Covered Person is incurring covered Type B or Type C dental expenses under Section 7.03(b) or (c), benefits are payable after the Person's Coverage terminates under the Plan as follows:

(i) Charges for dentures are payable if the impression was made prior to the coverage's termination date, and the dentures are fitted within two consecutive calendar months following termination of coverage;

(ii) Charges for crowns are payable if the tooth or teeth were prepared prior to the coverage's termination date, and the crowns are seated within two consecutive calendar months following termination of coverage;

(iii) Charges for endodontic treatment, including root canal therapy, are payable if the tooth was opened prior to the coverage's termination date, and if treatment is completed within two consecutive calendar months following termination of coverage.

# ARTICLE 8 - VISION CARE BENEFITS

## 8.01 GENERAL

If a Covered Person incurs expenses for covered vision care services, benefits are payable according to this Article VIII and as shown in the applicable Schedule of Benefits.

## 8.02 COVERED EXPENSES

Covered expenses include charges for eye exams, including dilation of the pupil and/or relaxing focusing muscles by drops, refraction for vision, examination for pathology, prescription safety glasses, lenses, and frames up to the per-person calendar year maximum described in the applicable Schedule of Benefits.

## 8.03 EXCLUSIONS AND LIMITATIONS

The following expenses are not payable under this Article VIII:

(a) Vision care treatment that was rendered prior to the date the individual became a Covered Person under this Plan;

(b) Services or supplies that are covered in whole or in part under any other Article of this Plan;

(c) Covered services resulting from a bodily injury arising out of or in the course of employment or from a disease compensable under any workers' compensation, occupational disease or similar law;

(d) Covered services in a Hospital owned or operated by the U.S. government or for any covered service furnished for which the person is not required to pay;

(e) Non-prescription glasses, sunglasses, subnormal vision aids, aniseikonia lenses, multi-focal plastic lenses and plano lenses; or

(f) Medical or surgical treatment of the eyes.

## 8.04 ACCESSING VSP BENEFITS

(This Section 8.04 is only applicable to Covered Persons whose Schedule of Benefits indicates participation in the VSP network.)

Covered Persons are encouraged to use VSP providers (in-network), as many services are provided at no cost to the patient. When non-VSP providers (out-of-network) are utilized, benefits are still available up to the $200 per-person annual allowance. See the Schedule of Benefits for specific coverage.

### Finding a VSP Provider

A directory of VSP providers is available online at www.vsp.com; select the "Find a VSP Doctor" button on the left of the screen. VSP Member Services can be reached at 1-800-877-7195 or, for the hearing impaired, 1-800-428-4833.

| | |
|---|---|
| **Member Services Hours:** | 7 a.m. - 10 p.m. Central Time Monday – Friday<br>8 a.m. - 7 p.m. Saturday |

### Using the VSP Website

In addition to finding a doctor, Covered Persons can use the VSP website, www.vsp.com, to view available benefits and claims, and access a variety of information about vision benefits generally.

### Using VSP Benefits

When making an appointment with a VSP doctor, tell them that you are a VSP member. No ID card is required for the appointment. After the appointment, the VSP doctor's office will send claims to VSP directly; you do not have to do anything.

If you go to a non-VSP doctor, you will have to pay for all services at the time of the appointment. Contact VSP Member Services for guidance on how to file for reimbursement.

The Vision Care Benefit will pay covered expenses up to the per-person calendar year maximum of $200, including for the cost of prescription safety glasses.

# ARTICLE 9 – LIFE INSURANCE, AD&D, AND WEEKLY ACCIDENT/ SICKNESS BENEFITS

## 9.01 LIFE INSURANCE BENEFITS

(a) Life insurance benefits are provided as set forth in this Section 9.01 pursuant to the applicable Schedule of Benefits.

(b) **Employee:**

(i) Upon receipt by the Plan of written proof of the death of an Employee, the Plan will pay benefits under this Section as set forth in the applicable Schedule of Benefits.

(ii) Benefits under this Section are provided through an insurance contract, which the Plan has entered with a life insurance company.

(iii) The Employee may designate more than one beneficiary and indicate the percent of the benefit to be paid to each such beneficiary. To designate a beneficiary, or to change a beneficiary at any time, the Employee must designate a beneficiary in writing on a form provided by the Plan. If the Employee does not designate any beneficiary, or if the designated beneficiary does not survive the Employee, payment is made to, in order and in equal shares as applicable if the category of default beneficiary contains more than a single individual:

(1) The Employee's spouse;

(2) The Employee's child(ren);

(3) The Employee's parents;

(4) The Employee's siblings; or

(5) The Employee's estate.

(c) **Dependent:**

(i) This Section applies to Dependent(s) of Employees only. Dependents receiving benefits under Article XI are not eligible for benefits under this Section.

(ii) Upon receipt by the Plan of written proof of the death of a Dependent, the Plan shall pay benefits under this Section as set forth in the applicable Schedule of Benefits.

(iii) Benefits under this Section are provided through an insurance contract with a company selected by the Trustees.

(iv) Benefits under this Section are payable to the Employee. If the Employee does not survive the Dependent, benefits under this Section are payable to, in order and in equal shares as applicable if the category of default beneficiary contains more than a single individual:

(1) The Employee's spouse;

(2) The Employee's child(ren);

(3) The Employee's parents;

(4) The Employee's siblings; or

(5) The Employee's estate.

## 9.02 ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

(a) The benefits described in this Section 9.02 are provided only in the Active Plan.

(b) Only Active Employees are eligible for benefits under this Section 9.02. Disabled Employees and Retirees who are receiving benefits under Article XI are not eligible for benefits under this Section. Notwithstanding anything contained in this SPD to the contrary, no benefits under this Section are payable for any Dependent. Benefits under this Section are provided in addition to any other benefits provided under this Plan.

(c) Benefits Payable:

(i) Benefits under this Section are provided through an insurance contract, which the Plan has entered into with a life insurance company.

(ii) Benefits under this Section are payable, as shown on the applicable Schedule of Benefits, if the covered Employee sustains a covered loss because of an Accident. The loss must occur within ninety (90) days of the Accident, unless the covered loss is death, which can occur at any time after the accident. Covered losses are paid according to the following schedule:

| Covered Loss | Percentage of Principal Sum |
|---|---|
| Loss of Life | 100% |
| Loss of a hand | 50% |
| Loss of a foot | 50% |
| Loss of the sight in one eye | 50% |
| Loss of any combination of hand, foot, or sight of one eye | 100% |
| Additional Seat Belt Use Benefit (in accident resulting in loss of life) | Additional 100% |
| Additional Air Bag Use Benefit (in accident resulting in loss of life) | Additional 50% |
| Additional Dependent Student Benefit | Up to 100% |
| Additional Common Carrier Benefit (if accident results in loss of life within 365 days of accident) | 100% |

(iii) For the loss of the Employee's life, benefits under this Section are payable to the Employee's designated beneficiary. If the Employee does not designate any beneficiary, or if the designated beneficiary does not survive the Employee, benefits under this Section are payable to, in order and in equal shares as applicable if the category of default beneficiary contains more than a single individual:

(1) The Employee's spouse;

(2) The Employee's child(ren);

(3) The Employee's parents;

(4) The Employee's siblings; and

(5) The Employee's estate.

(d) For purposes of this Section:

(i) Loss of a hand means permanently severed at or above the wrist;

(ii) Loss of a foot means permanently severed at or above the ankle;

(iii) Loss of the sight in one eye means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees;

(e) An Employee will be presumed to have died because of an accidental injury if:

(i) The aircraft or other vehicle in which the Employee was traveling disappears or sinks,; and

(ii) The body of the Employee is not found within one year of the date the aircraft or other vehicle was scheduled to have arrived at its destination if traveling in an aircraft or other vehicle operated by a common carrier, or the date the Employee is reported missing to the authorities if traveling in any other aircraft or other vehicle.

(f) Additional benefits will be paid in accordance with subsection (c)(ii) for the following:

(i) Seat belt use benefit, if proof is provided that the deceased person was in an accident while driving or riding as a passenger in a passenger car, was wearing a seat belt that was properly fastened at the time of the accident, died as a result of injuries sustained in the accident, and the investigating police officer certifies that the seat belt was properly fastened. A child restraint device that meets state law safety standards is included in the term seat belt.

(ii) Air bag use benefit, if proof is provided that the deceased person was in an accident while driving or riding as a passenger in a passenger car equipped with an air bag, was riding in a seat protected by an air bag, was wearing a seat belt that was properly fastened at the time of the accident, died as a result of injuries sustained in the accident, and the investigating police officer certifies that the seat belt was properly fastened and the passenger car was equipped with air bags. A child restraint device that meets state law safety standards is included in the term seat belt.

(iii) Dependent student benefit, if proof is provided that on the date of the Employee's death, the Employee's child was enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level, or was at the 12th grade level and within one year enrolls as a full-time student in an accredited college, university or vocational school.

(iv) Common carrier benefit, if the Employee dies as a result of an accidental injury, the insurance company pays a loss of life benefit, and proof is provided that the injury resulting in the Employee's death occurred while traveling in a common carrier, which is a government regulated entity that is in the business of transporting fare paying passengers.

(g) The following are excluded from coverage under the Accidental Death and Dismemberment Insurance benefit:

(i) Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;

(ii) Infection, other than infection occurring in an external accidental wound;

(iii) Suicide or attempted suicide;

(iv) Intentionally self-inflicted injury;

(v) Service in the armed forces of any country or international authority, except the United States National Guard;

(vi) Any incident related to:

(1) Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;

(2) Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;

(3) Parachuting or otherwise exiting from an aircraft while it is in flight, except for self-preservation;

(4) Travel in an aircraft or device used for testing or experimental purposes, by or for any military authority, or for travel or designed for travel beyond the earth's atmosphere;

(vii) Committing or attempting to commit a felony;

(viii) The voluntary intake or use by any means of any drug, medication, or sedative, unless it is:

(1) Taken or used as prescribed by a Physician;

(2) An over-the-counter drug, medication, or sedative taken as directed;

(3) Alcohol in combination with any drug, medication, or sedative; or

(4) Poison, gas or fumes; or

(ix) War, whether declared or undeclared, or act of war, insurrection, rebellion, or riot.

## 9.03 WEEKLY ACCIDENT AND SICKNESS BENEFITS

(a) Benefits under this Section 9.03 apply only to Active Employees, as indicated on the applicable Schedule of Benefits.

(b) Eligibility:

(i) This Section applies only to Employees who are Actively At Work, as defined under subsection (c) below. Notwithstanding anything contained in this SPD to the contrary, no benefits shall be paid under this Section for a Dependent or for an Employee who fails to meet the requirements of subsection (c) below.

(ii) Benefits under this Section are payable only for a non-occupational Injury or Sickness. No benefits are payable under this Section for an occupational Injury or Sickness, but credit may be given pursuant to subsection (f).

(c) Definitions: The definitions described in this subsection (c) shall apply only to the benefits provided under this Section.

(i) **Actively At Work/Active Work**: For purposes of this Section 10.03 only, an individual is Actively At Work if the individual is performing all the usual duties of his employment with his/her Employer on a full-time basis in the customary manner at any business establishment or location of the Employer, including any travel required by the Employer on a day which is a scheduled work day of the Employer.

(ii) **Period(s) of Disability**:

(1) All injuries received in an Accident will be considered one Period of Disability. A Certified Disability that results from both an Injury and a Sickness will be considered one Period of Disability. The Board shall have the right, at the Plan's expense, to have the Employee examined by a Physician to determine the cause and extent of the disability.

(2) Successive Periods of Disability shall be considered separate Periods of Disability if:

(A) The successive Periods of Disability are due to related causes, and the Employee has returned to Active Work for at least 350 hours in three (3) consecutive calendar months (except as otherwise provided in subsection (3) below) or 700 hours in six (6) consecutive calendar months; or

(B) The successive Periods of Disability are due to unrelated causes and the second Period of Disability begins after the Employee has returned to Active Work for at least one (1) day.

(3) An Employee may receive up to a maximum of twenty-six (26) weeks of benefits under this Section for a single Injury or Sickness regardless of a single return-to-work period for less than 350 hours in three (3) calendar months.

(4) The Plan reserves the right to request that the Employee undergo a medical examination to determine the relationship between the successive Periods of Disability.

(d) Benefits Payable: Benefits will be payable under this Section as shown in the applicable Schedule of Benefits, if the Employee is Totally Disabled and has a Certified Disability.

(e) Non-Occupational Injury or Sickness: Benefits shall be payable in the amount set forth in the applicable Schedule of Benefits. Benefits shall be payable to the Employee beginning on the first day of a Certified Disability due to an Injury and/or the eighth (8th) day of a Certified Disability due to Sickness, up to a maximum of twenty-six (26) weeks, except as otherwise provided in subsection (f) below, for any one Period of Disability. During partial weeks of a Certified Disability, the Employee shall be paid a daily rate of one-seventh (1/7th) of the weekly benefit amount set forth in the applicable Schedule of Benefits.

(f) Occupational Injury or Sickness: In the event that the Employee incurs a Certified Disability as a result of an occupational Injury or Sickness, no benefits are payable under this Section, but the Employee will continue to receive credit for hours as described under Section 2.09.

(g) Disability Guidelines: Notwithstanding anything contained in this Section to the contrary, the length of disability for purposes of receiving benefits under this Section shall be based upon the disability guidelines, established by and generally accepted by, the medical community. If the Employee's disability lasts longer than such disability guidelines indicate, the Trustees reserve the right to have the Employee examined by a Physician of the Trustees' choosing, at the Plan'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.

# ARTICLE 10 – PRE-FUNDED ALLOWANCE

## 10.01 GENERAL

The Pre-Funded Allowance described in this Article X is intended to offset the monthly self-payment due under Article XI.

## 10.02 DEFINITIONS

For purposes of this Article X only, the following definitions apply:

(a) Disqualifying Employment: "Disqualifying Employment" is employment or self-employment not covered under a Collective Bargaining Agreement and is in:

(i) The industry covered by the Plan when the Employee retired;

(ii) The geographic area covered by the Plan when the Employee retired; and

(iii) Any occupation in which the Employee worked while covered under the Plan at any time, or any occupation covered by the Plan at the time that the Employee retired.

(b) Quarter of Service: A "Quarter of Service" is any calendar year quarter in which the Iron Workers Tri-State Welfare Fund receives Contribution Hours on the Employee's behalf for 250 or more hours of work in covered employment.

(c) Medicare Plan: "Medicare Plan" is defined as the benefits under the Plan that the Board of Trustees has made available for Retirees and spouses enrolled in Medicare. The Pre-Funded Allowance is applied automatically toward the premium for the Medicare Plan as addressed under Section 10.04.

## 10.03 ELIGIBILITY

(a) To be eligible for the Pre-Funded Allowance, the Employee must earn one quarter of a year of Eligibility (i.e., a Quarter of Service) based on Contribution Hours after:

(i) January 1, 2004, if their Employer is contributing on their behalf under a Collective Bargaining Agreement with Local 444 of the Union; or

(ii) January 1, 2005, if their Employer is contributing on their behalf under a Collective Bargaining Agreement with Local 465 of the Union; or

(iii) January 1, 2019, if their Employer is contributing on their behalf under a Collective Bargaining Agreement with Local 498 of the Union; or

(iv) January 1, 1999, if their Employer is contributing on their behalf under a Collective Bargaining Agreement with any other local of the Union; and

(v) The Employee meets one of the following requirements at the time of their retirement:

(1) The Employee is at least age 62 and has forty (40) Quarters of Eligibility; or

(2) The Employee is at least age 52 and has sixty (60) Quarters of Eligibility; or

(3) The Employee is Totally Disabled and has at least sixty (60) Quarters of Eligibility.

(b) If the Employee was not active by virtue of Contribution Hours on the applicable date above, only the Quarters of Eligibility earned after the Employee reestablished active eligibility (by virtue of Contribution Hours) are used to determine his/her Pre-Funded Allowance.

(c) The Employee must be Eligible for the Pre-Medicare Retiree Plan under Article XI or must enroll in Medicare and be eligible to self-pay for the Medicare Plan. Subject to the payment of the required self-payment, the Employee is eligible if the Employee is (a) a Retired Employee; and (b) at least age 52; (c) does not have enough hours left in the Reserve Accumulation Account to pay for a quarter of coverage (any excess Reserve Accumulation Account hours will be forfeited); (d) receiving some form of retirement benefits; (e) for the twelve months immediately prior to retiring, was eligible under this Plan by virtue of any combination of contribution hours, reserve accumulation hours, and self-pay contributions.

## 10.04 OPTIONS

The Retiree Pre-Funded Allowance is only available to Employees who waive COBRA. They may choose one of three options:

(i) **Option 1**: A quarterly subsidy for each Quarter of Service (up to 120 Quarters of Eligibility) towards the retiree welfare benefits until the retiree, including a Totally Disabled retiree, reaches age 65 and then the Retiree Allowance ends. The Pre-Funded Allowance continues, at the same amount, for the retiree's spouse and/or Dependents for up to five years if the retiree becomes age 65 or dies. The Pre-Funded Allowance for the spouse ends when the spouse reaches age 65 or, if earlier, the end of five years. The Pre-Funded Allowance for Dependent children ends when they are no longer Dependents or, if earlier, the end of five (5) years.

(ii) **Option 2:** A quarterly subsidy for each Quarter of Service (up to 120 Quarters of Eligibility) towards the retiree welfare benefits from the time the retiree reaches age 65 but not before age 65. The Pre-Funded Allowance continues, at the same amount, for the retiree's spouse and/or Dependents for up to five years if the retiree dies. The Pre-Funded Allowance for the spouse ends when the spouse reaches age 65 or, if earlier, the end of five years. If the spouse is more than five years younger than the Employee, the spouse would receive the Allowance for up to five years and then would have to pay the full cost if their coverage until they turned 65. At that point the spouse would receive the post-65 Allowance. Alternatively, the spouse could enroll for coverage elsewhere (opt out) until they turned 65, then they could return to the Plan and receive the post-65 Allowance. The Pre-Funded Allowance for Dependent children ends when they are no longer Dependents, if earlier, the end of five years.

(iii) **Option 3**: A quarterly subsidy for each Quarter of Service (up to 120 Quarters of Eligibility) towards the retiree welfare benefits while retired before and after age 65. In this case, the amount of the subsidy will be different before and after Medicare. The Pre-Funded Allowance continues, at the same amount, for the retiree's spouse and/or Dependents for up to five years if the retiree dies. The Pre-Funded Allowance for the spouse ends when the spouse reaches age 65 or, if earlier, the end of five years. The Pre-Funded Allowance for Dependent children will end when they are no longer Dependents or, if earlier, the end of five years.

## 10.05 AMOUNT OF PRE-FUNDED ALLOWANCE

The Board of Trustees determines the accrual rate for the Allowance annually. The rate used for the retiree is based on the option selected and the family members covered at the time the Employee retires. The amount of the Pre-Funded Allowance is the accrual rate multiplied by the number of Quarters of Eligibility. These rates will change in the future.

## 10.06 QUARTERLY SELF-PAY RATES

The Board of Trustees determines the quarterly self-pay rates annually. The rate used for the retiree is based on the option selected and the family members covered at the time that the Employee retires. The retiree's self-pay amount is the quarterly self-pay rate minus the Pre-Funded Allowance determined under Section 10.05.

## 10.07 SUSPENSION OF PRE-FUNDED ALLOWANCE

A retired Employee may return to work covered under an applicable Collective Bargaining Agreement and still receive the Pre-Funded Allowance. However, the Pre-Funded Allowance described in this Article X will be suspended if the Employee works in Disqualifying Employment, as defined in Section 10.02(a) above.

## 10.08 SURVIVOR BENEFITS

If the Employee dies with a spouse or other Dependents who remain eligible for coverage, the Employee's spouse and/or Dependents continue to receive the Allowance for up to five years. When the spouse becomes eligible for Medicare, the retiree allowance ends; however, the spouse may elect coverage in a Medicare Plan. Coverage for the Employee's Dependent child(ren) ends on the earlier of five years, their eligibility for Medicare, or when the Dependent child(ren) no longer meet the definition of Dependent.

If the Employee retired due to a Total Disability, their surviving Dependents continue to receive the retiree allowance, adjusted for the Employee's age at death, either until the Employee would have reached age 65, or until the Employee's Dependents no longer meet the definition of a Dependent.

If an Employee is eligible for the Pre-Funded Allowance, has not retired, and dies, their eligible Surviving Spouse is eligible for the Allowance the Employee would have received had they lived and retired, based on their quarters of service at the time of his death. The spouse can elect one of the options under the Pre-Funded Retiree Allowance, which will offset the cost of coverage. Dependent children can use the Employee's reserve accumulation account until it is depleted and then can continue coverage in the Plan.

A spouse can choose to opt out of coverage in this Plan and later return to the Iron Workers Tri-State Welfare Plan, if the Employee and his spouse meet these conditions:

(i) The Employee retires on or after June 1, 2013 and

(ii) The Employee elects the post-65 only Allowance option (Option 2); and

(iii) The spouse is under age 65 but has coverage under another plan.

The spouse can continue their other coverage and remain eligible to return to this Plan either when the other coverage ends, or when they turn 65 and can benefit from the Allowance. If a spouse returns before age 65, they are eligible for a pre-65 Allowance for up to five years. Upon returning, e spouse must provide proof of continuous group coverage from the time of opt-out to the time they want to resume Plan coverage.

> **Example**
>
> Stan was eligible for the Pre-Funded Retiree Allowance when he died. Stan's wife, Gina, has coverage under the Active Plan and wants to continue that coverage. Once Gina depletes Stan's reserve accumulation account, she can select an Allowance option and receive the Allowance that Stan would have received had he retired on the date of his death. Gina's Allowance will offset her cost for coverage and could save her thousands of dollars a year.

# ARTICLE 11 – PRE-MEDICARE RETIREE PLAN

## 11.01 ELIGIBILITY

Employees meeting the following descriptions are Eligible to make self-payment as described in Section 11.02 for coverage in the Pre-Medicare Retiree Plan:

(a) A Retired Employee who:

(i) Is at least age 52 but less than age 65 and not yet entitled to Medicare;

(ii) Does not have enough Contribution Hours in their Reserve Accumulation Account to pay for a Benefit Quarter;

(iii) Is receiving some form of retirement benefits; and

(iv) For the 12 months immediately prior to retiring, was Eligible under this Plan by virtue of any combination of the following: Contribution Hours, Reserve Hours, and self-pay contributions.

(b) A Retired Employee who has exhausted their self-payment maximum of four (4) consecutive benefit quarters or is an early retiree under the Self-Pay Program.

(c) Disabled Employee: An active Employee who becomes Totally Disabled while Eligible for benefits under this Plan is Eligible for benefits under this Article XI at the end of the 18-month extension as described in Section 2.09, should the Employee elect not to self-pay for coverage under Section 4.02 or 4.03.

(d) Dependent of Deceased Employee: A Dependent of a deceased Employee (who was active, disabled, or retired at the time of their death) is Eligible for benefits under this Article 11 if they are Eligible for benefits under the Plan at the time of the Employee's death and do not elect COBRA continuation coverage under Section 4.04.

## 11.02 SELF-PAYMENTS AND/OR PENSION DEDUCTION

Payments for the Pre-Medicare Retiree Plan are made through self-payment (i.e., a check delivered to the Fund) or by deduction from the pensioner's monthly pension payment from either the Iron Workers Mid-America Pension Plan or Local 498 Pension Plan. Should the monthly pension payment stop for any reason or not cover the full self-payment, the pensioner is subject to the rules for self-payments. Those rules are:

(a) To maintain Eligibility for benefits under this Article XI, the full amount of the self-payment must be paid on or before the first day of the Benefit Quarter for which self-payments are due.

(b) The date due will be determined by the postmark and as determined by the self-payment notice sent to the Covered Person by the Plan. Self-payments received after this deadline will not be accepted, Eligibility terminates as of the first day of the Benefit Quarter for which the full amount of the self-payment was due.

(c) If Eligibility for benefits terminates for failure to make full, timely self-payments, the Employee and/or Dependents cannot make future self-payments.

(d) When the Employee begins making self-payments for the Retiree Plan, any hours remaining in their Reserve Accumulation Account will be forfeited.

## 11.03 EFFECTIVE DATE OF COVERAGE

A Retired Employee's coverage under this Article XI is effective upon retirement, if they do not elect coverage under Section 4.02 or COBRA Continuation Coverage under Section 4.04.

A Totally Disabled Employee's coverage is effective after such Employee's Eligibility as an active Employee terminates at the end of the 18-month extension described in Section 2.09, and the Employee elects not to self-pay for coverage under Sections 4.02 or 4.03.

Coverage for a Dependent of a deceased Employee (who was Eligible for benefits under this Plan at the time of the Employee's death) is effective on the date the Dependent elects coverage under this Article XI and does not elect COBRA Continuation Coverage under Section 4.04.

## 11.04 BENEFITS

The Pre-Medicare Retiree Plan provides Comprehensive Major Medical Benefits (Article V), Prescription Drug Benefits (Article VI), Dental Benefits (Article VII), and Vision Care Benefits (Article VIII), limited to the amounts, limits and maximums as set forth on the applicable Schedule of Benefits.

## 11.05 DURATION OF COVERAGE

Retired Employees or the Totally Disabled Employees can continue coverage in the Pre-Medicare Retiree Plan until they become eligible for Medicare. Dependents of Retired or Totally Disabled Employees can continue coverage under this Article XI after the Employee becomes eligible for Medicare either until the Dependents no longer meet the definition of Dependent or until the Dependent becomes eligible for Medicare.

The Dependent spouse of a deceased Employee can continue coverage in this Pre-Medicare Retiree Plan until the earlier of the Dependent spouse becoming eligible for Medicare or the date the spouse remarries. Dependent children of a deceased Employee are Eligible for benefits under this Article XI until their surviving parent remarries or until the Dependent children no longer meet the definition of Dependent.

# ARTICLE 12 – GENERAL EXCLUSIONS AND LIMITATIONS

## 12.01 EXCLUSIONS

Notwithstanding any statement elsewhere in this SPD, the following are not covered expenses, and the Plan will not make payment under any benefit detailed herein, for the following:

(a) Charges that would not have been made if no coverage existed or charges that neither the Employee nor the Employee's Dependents are required to pay.

(b) Services or supplies that are furnished, paid for or otherwise provided for because of the past or present service of any person in the armed forces of any government.

(c) Any supplies or services for which no charge is made.

(d) Services or supplies that are paid for or otherwise provided for under any law of any 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.

(e) Any expense that is in excess of the Allowable Charge, unless subject to the No Surprises Act.

(f) Any expense or charge for services or supplies not recommended or approved by the attending Physician, or not Medically Necessary in treating the Injury or Sickness, except that this exclusion does not apply to X-ray and laboratory charges for routine physical examinations, patch tests, scratch tests, and Pap smears.

(g) Any expense or charge for failure to appear for a scheduled appointment or charge for completion of claim forms or finance charges.

(h) Charges for any services and supplies to treat an occupational Injury or Sickness, or for which a third party may responsible, unless the Covered Person completes the requirements under Article XVI, "Subrogation." The Covered Person must inform the Plan whether an Injury or Sickness is occupational and/or whether a third party caused or is responsible for an Injury or Sickness.

(i) Human organ and tissue transplants, absent medical documentation that conventional treatment could be unsatisfactory, unavailable, and/or more hazardous than a transplant; that the patient's condition could be life threatening; and that the patient is legally required to pay for the transplant procedure. Subject to these restrictions, kidney transplants, heart transplants, heart/lung transplants, cornea transplants, bone marrow transplants, bone transplants, skin transplants, stem cell transplants, and liver transplants are covered, including expenses for harvesting donor organs needed for the transplant, whether the donor is alive or not.

(j) Services and supplies for the treatment of any condition caused by war, or any act of war, declared or undeclared, by participating in a riot, or as the result of the commission of any crime which is a felony, except that Injury or Sickness caused by acts of domestic violence or that occur as a result of a diagnosed Behavioral Health or Substance Use Disorder are covered.

(k) Treatment considered Experimental or Investigative in terms of generally accepted medical standards. However, to the extent required under the Affordable Care Act, the Plan will not deny you the right to participate in certain approved clinical trials; deny, limit or impose additional conditions on the coverage of routine patient costs furnished in connection with participation in the clinical trial; and will not discriminate against you for participating in the clinical trial.

(l) Services and supplies that are not Medically Necessary in terms of generally accepted medical standards.

(m) Covered services resulting from an injury arising out of and in the course of employment or from a disease compensable under any workers' compensation, occupational disease or similar law.

(n) Any expense incurred before the individual becomes a Covered Person or after the Covered Person's coverage under this Plan terminates, unless otherwise specifically provided for under the Plan or as otherwise required by applicable law.

(o) 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 waterbed.

(p) Special home construction or additions.

(q) Any charges incurred for education, training, or room and board while confined in an institution that is primarily an institution of learning or training.

(r) Charges for expenses incurred more than 24 months before submission of a claim.

(s) Charges incurred for Custodial Care, except for benefits under Section 5.05(b), Hospice Expenses.

(t) Charges for eye refractions, eyeglasses or their fitting, unless otherwise specifically indicated as covered under this Plan.

(u) 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 showing that such treatment is Medically Necessary, and that conventional treatment would be unsatisfactory.

(v) Charges for the reversal of elective sterilization procedures.

(w) Charges for the treatment of Temporomandibular Joint Disorder (TMJ).

(x) Charges for Cosmetic Surgery or plastic surgery, unless these services are required to repair an Injury, except as provided under Section 5.06.

(y) Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for an Emergency or when the Covered Person is on temporary work assignment for an Employer at a location outside the United States.

(z) Charges for nutritional supplements or other enteral formulas for home use, except as specifically provided in Section 5.05(a)(xxiii).

(aa) Charges related to weight loss, whether or not Medically Necessary.

(bb) Charges related to breast reduction surgery, even if medically necessary, unless:

(i) The breast reduction is in connection with a mastectomy to the other breast to create symmetry; or

(ii) At least 350cc are taken from each breast and the surgery is Medically Necessary.

(dd) Charges for hypnosis, hypnotherapy, and/or biofeedback.

(ee) Charges for services related to:

(i) Dyslexia, learning disorders, vocational disabilities;

(ii) 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;

(iii) Court-ordered behavioral health care services or custody counseling;

(iv) Family planning/pregnancy/adoption counseling, marriage/couples counseling, transsexual/gender reassignment/sex counseling; and

(v) Tests and related expenses to determine the presence of or degree of a person's attention deficit disorder, dyslexia, or learning disorder.

(ff) Routine foot care.

(gg) Notwithstanding anything contained herein to the contrary, no benefits shall be paid under the Plan with respect to any claim to the extent that the Covered Person fails to comply with Section 17.15.

(hh) Expenses excluded under the Plan's Coordination of Benefits provision.

(ii) Charges for court-ordered physical examinations.

# ARTICLE 13 – CLAIMS PROCEDURES

## 13.01 DEFINITION OF A CLAIM

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. Medical claims under the Plan consist of the following types of claims:

(a) An urgent care claim is a claim for medical care or treatment with respect to which the application of the periods for making non-urgent care claims determinations: (1) could seriously jeopardize a Person's life or health or the ability of a Person to regain maximum function, or (2) would subject the Person to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a physician with knowledge of the Person's medical condition.

(b) 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).

(c) 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.

(d) 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.

The Fund Office receives inquiries about Eligibility and benefits from Employees, Dependents, and providers. The Fund Office answers these questions as completely as possible. However, these questions are not claims, and 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 Covered Person must incur medical expenses before a claim can be filed. A phone call is not considered a claim. Further, any request is not a claim if it is:

(a) Not made in accordance with the Fund's benefit claims filing procedures described in this Section;

(b) Made by someone other than the patient or his or her authorized representative;

(c) Made by a person who will not identify himself or herself (anonymous);

(d) 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;

(e) For prior approval where prior approval is not required by the Fund;

(f) 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 the claimant will be notified of the decision and allowed to file an appeal; or

(g) 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 claimant may file a claim with the Fund.

## 13.02 FILING CLAIMS FOR BENEFITS

To file a claim for benefits, a claimant must submit an itemized bill detailing services and charges, if the provider does not file the claim with an itemized bill on the claimant's behalf. The claimant's Physician must complete the Attending Physician's Statement section of the claim form, submit a completed CMS health insurance claim form, or submit a HIPAA-compliant electronic claims submission.

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

(a) Participant name;

(b) Patient name;

(c) Patient date of birth;

(d) Identification number of patient and participant;

(e) Date of service;

(f) 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);

(g) the current ICD (the diagnosis code found in the *International Classification of Diseases, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services), or when effective, the newest edition;

(h) Billed charge;

(i) Number of units (for anesthesia and certain other claims);

(j) Federal taxpayer identification number (TIN) of the provider; and

(k) Billing name and address of the provider.

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

All claims must be submitted to the Plan within two (2) years from the date of service. No Plan benefits will be paid for any claim not submitted within this period.

Non-medical claims must be filed at the Fund Office. Medical claims must be filed at the office indicated on the Participant's medical ID card. A claim will be considered to have been filed as soon as it is received.

## 13.03 AUTHORIZED REPRESENTATIVES

An authorized representative is the person who can act on the claimant's behalf to file claims or appeals under this Plan. Subject to the written statement requirement discussed below, the following individuals may be recognized as the claimant's authorized representative:

(a) Health care provider;

(b) Legal spouse;

(c) Dependent child age eighteen (18) or over;

(d) Adult emancipated children;

(e) Parents or adult siblings;

(f) Grandparent;

(g) Legal representative, such as an individual with power of attorney for health care, legal guardian, or conservator; or

(h) Other adult.

The Plan requires a written statement from the individual that they have designated one of the individuals listed above as the authorized representative; the written statement must contain the representative's name, address, and phone number. If the individual is unable to provide a written statement, the Plan must require written proof (e.g., power of attorney for health care, court order of guardianship, or court order of conservatorship) that the proposed authorized representative has been authorized to act on the individual's behalf. A health care provider with knowledge of the claimant's medical condition may act as their authorized representative in connection with an urgent care claim without the claimant filing a written statement.

Once the individual names an authorized representative, the Plan must route all future correspondence related to claims and appeals to the authorized representative and not to the individual. The Plan must honor the designated authorized representative for one year, or as mandated by a court order, before requiring a new authorization. The individual may revoke a designated authorized representative by submitting a signed statement.

The Plan reserves the right to withhold information from a person who claims to be the authorized representative if there is suspicion about the qualifications of the individual claiming to be the authorized representative.

## 13.04 SUBMITTING FALSE OR FRAUDULENT CLAIMS

An Employee or the Employee's 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 that must be provided to the Plan:

(i) Any other insurance that may be payable or that has been paid with respect to the claim;

(ii) All aspects of the events that gave rise to the claim;

(iii) When any Dependent no longer meets the requirements of a Dependent, including situations of divorce or of a child is no longer being eligible due to age or student status;

(iv) If a third party caused the Injury related to the claim; and

(v) If an Injury giving rise to a claim is work-related.

As detailed in Section 3.07, an Employee's and their Dependents' Eligibility will be terminated under this Plan if the Board of Trustees determines that the Employee or a Dependent submitted a fraudulent claim.

## 13.05 DECISION TIMEFRAMES FOR MEDICAL SERVICES CLAIMS

(a) For No Surprises Act Services claims, the out-of-network provider will receive an initial payment or denial of payment from the Plan for No Surprise Act Services within 30 days receipt of all information necessary to adjudicate the claim. If a claim is subject to the No Surprises Act, the Participant or Dependent cannot be required to pay more than the cost-sharing amount under the network Plan and the provider or facility is prohibited from billing the Participant or Dependent in excess of the

required cost-sharing amount. The Plan will pay a total plan payment directly to the out-of-network provider that is equal to the amount by which the Out-of-Network Rate for these services exceeds the cost-sharing amount for the services, less any initial payment amount.

(b) Urgent care claims will be decided as soon as possible and no later than 72 hours after the claim is received by the Plan. However, if the claim is received with insufficient information to determine whether or to what extent benefits are covered or payable, the Plan will notify the claimant no later than 24 hours after receipt of the claim of the specific information needed to process the claim. The claimant must provide the specified information within five days. If the information is not provided by the claimant, the claim will be decided on the basis of the information that the Plan has, and may be denied. Notice of the decision will be provided no later than 48 hours after the Plan receives the specified information, or the end of the period given for the claimant to provide the information, whichever is earlier.

(c) Pre-service claims will be decided within 15 days after the claim is received by the Plan. The time for deciding the claim may be extended by 15 days, upon notice to the claimant 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. The claimant will then have 45 days to provide the additional information. The time period for deciding the claim will be suspended. The claimant will be notified of the decision within 15 days of the earlier of the date the claimant responds to the request or the end of the 45-day period.

(d) Concurrent care claims will be decided with enough time before the reduction or termination of treatment to allow the claimant 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.

(e) Post-service claims will be 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 the claimant before the expiration of the initial 30 days. If a claim cannot be processed due to insufficient information, the time period for deciding the claim will be suspended. The claimant will then have 45 days to provide the additional information. The time period will begin running again when the additional information 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.

## 13.06 DECISION TIMEFRAMES FOR WEEKLY ACCIDENT AND SICKNESS CLAIMS

(a) For Weekly Accident and Sickness Claims, the Fund will make a decision on the claim and notify the claimant 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 the claimant of the reason for the delay and the time 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 the claimant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund Administrator notifies the claimant, 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.

(b) If an extension is needed because the Fund needs additional information from the claimant, the extension notice will specify the information needed. In that case, the claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be decided on the basis of the information that the Fund has and may be denied. During the period in which the claimant is 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 the claimant responds to the request (whichever is earlier). Once the claimant responds to the Fund's request for the information, the claimant will be notified of the Fund's decision on the claim within 30 days.

(c) For Weekly Accident and Sickness Claims, the Fund reserves the right to have a Physician examine the claimant (at the Fund's expense) as often as is reasonable while a claim for benefits is pending.

## 13.07 DECISION TIMEFRAMES FOR LIFE INSURANCE AND AD&D CLAIMS

(a) The Fund Office will provide an application for Life Insurance or Accidental Death and Dismemberment claims, upon request and make a copy of the form available on the Fund's web site. The claimant 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 the claimant if any additional information is necessary.

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

(i) The claimant examined by a Doctor it has chosen for a dismemberment claim; or

(ii) An autopsy performed, if it is not prohibited by law.

## 13.08 NOTICE OF CLAIM DENIAL OR ADVERSE BENEFIT DETERMINATION

The Fund will provide the claimant with a written notice of a denial of a claim (whether denied in whole or in part). The notice of a denial of a claim will state:

(a) The specific reason(s) for the determination;

(b) Reference to the specific benefit provision(s) on which the determination is based;

(c) A statement that the claimant is entitled to receive reasonable access to and copies of all documents relevant to the claim, upon request and free of charge;

(d) A statement of the claimant's right to request a review of the decision under the procedures described in Article XV;

(e) A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

(f) If an internal rule, guideline or protocol was relied upon by the Fund, the Fund will provide the claimant with either a copy of the guideline or protocol, or a statement that it is available upon request at no charge; and

(g) If the determination was based on Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, the Fund will provide an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to the claim, or a statement that it is available upon request at no charge.

In addition to the above, adverse benefit determinations for a Weekly Accident and Sickness Benefit or for retroactive terminations of Weekly Accident and Sickness Benefits will be provided in accordance with the following:

(a) Prior to the date that the Plan issues an adverse benefit determination on an appeal of a Weekly Accident and Sickness Benefit claim, the Plan shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination (or at the discretion of the Plan insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date; and

(b) Prior to the date the Plan can issue an adverse benefit determination on an appeal of a Weekly Accident and Sickness Benefit claim based on a new additional rationale, the Plan shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse

benefit determination on a review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

(c) The Fund will provide the claimant with a written explanation for disagreeing with or not following:

(i) The views presented by the claimant to the Plan of the health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in conjunction with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or

(iii) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

(d) Effective for Weekly Accident and Sickness Benefit, generally, if the Plan fails to establish or follow claims procedures consistent with the requirements of this Section, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under ERISA §502(a).

(e) In addition, if the Plan fails to strictly adhere to all the requirements of this Section with respect to disability benefit claims, the claimant is deemed to have exhausted the administrative remedies available under the Plan (unless the violations are "de minimis" in accordance with DOL Reg. §2560.503-1(l)(2)(ii)). Accordingly, the claimant is entitled to pursue any available remedies under ERISA §502(a). If a claimant chooses to pursue remedies under ERISA §502, in these circumstances the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(f) To ensure that all claims and appeals for Weekly Accident and Sickness Benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

# ARTICLE 14 – APPEALS PROCEDURES

## 14.01 DEADLINE FOR FILING AN APPEAL

(a) If a medical or Weekly Accident and Sickness claim is denied in whole or in part, or if the claimant disagrees with the decision made on such a claim, the claimant must send a request for review of the decision in writing to the Fund Office within 180 days after the claimant receives notice of the denial.

(b) If a Life Insurance or Accidental Death and Dismemberment Benefit claim is denied in whole or in part, or if the claimant disagrees with the decision made on such a claim, the claimant must send a request for review of the decision in writing to the Fund Office within 60 days after the claimant receives notice of the denial.

## 14.02 REVIEW PROCESS

(a) The claimant has the right to review documents relevant to the 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, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on the claim, without regard to whether their advice was relied upon in deciding the claim.

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

(c) If the claim was denied based on 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.

## 14.03 TIMING OF NOTICE OF DECISION ON APPEAL

(a) *Urgent care medical claims*. The Fund Office will send the claimant a notice of decision on review within 72 hours of receipt of the appeal by the Fund Office.

(b) *Pre-service medical claims*. The Fund Office (or authorized agent) will send the claimant a notice of decision on review within 30 days of the receipt of the appeal.

(c) *Post-service medical claims and Weekly Accident and Sickness Benefit 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 the appeal, 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 date of the meeting at which the benefit determination is made.

(d) *Life and Accidental Death and Dismemberment 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 date of the meeting at which the benefit determination is made.

## 14.04 NOTICE OF DECISION ON REVIEW

The Fund will provide the claimant with a written notice of a denial of a claim on review (whether denied in whole or in part). The notice of a denial of a claim on review will state:

(a) The specific reason(s) for the determination;

(b) Reference to the specific benefit provision(s) on which the determination is based;

(c) A statement that the claimant is entitled to receive reasonable access to and copies of all documents relevant to the claim, upon request and free of charge;

(d) A statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

(e) If an internal rule, guideline or protocol was relied upon by the Fund, the Fund will provide the claimant with either a copy of the guideline or protocol, or a statement that it is available upon request at no charge; and

(f) If the determination was based on Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, the Fund will provide an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to the claim, or a statement that it is available upon request at no charge.

In the case of an adverse benefit determination on an appeal with respect to a claim for a Weekly Accident and Sickness Benefit, the determination shall include:

(a) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

  (i) The views presented by the claimant to the Plan of the health care professionals treating the claimant and vocational professionals who evaluated the claimant;

  (ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

  (iii) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

(b) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the applicant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(c) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

(d) The notification will be provided in a culturally and linguistically appropriate manner pursuant to Department of Labor Regulation Section 2560.503-1(o).

## 14.05 EXTERNAL REVIEW OF CLAIMS FOR NO SURPRISES ACT SERVICES

If the Claimant's initial claim for health care benefits that are subject to the No Surprises Act has been denied (i.e., an adverse benefit determination) in whole or in part, and the Claimant is dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, the Claimant may (under certain circumstances) be able to seek external review of the claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the No Suprises Act.

### Claims Eligible for the External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if the denial involves surprise billing or cost-sharing issues that are protected under the No Surprises Act for Emergency Services, Air Ambulance Services, and non-Emergency Services provided by an out-of-network provider at a network Health Care Facility.

A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or Dependent fails to meet the requirements for eligibility under the Plan is not eligible for external review.

In general, the Claimant may only seek external review after receiving a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny the Claimant's initial claim in whole or part and the Claimant has exhausted the Plan's internal claims and appeals process.

Under limited circumstances, the Claimant may be able to seek external review before the internal claims and appeals process has been completed:

(a) If the Plan waives the requirement that the Claimant complete the Plan's internal claims and appeals process first.

(b) In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which the Claimant's health may be in serious jeopardy or, in the opinion of the Claimant's health care professional, the Claimant may experience pain that cannot be adequately controlled while waiting for a decision on their internal appeal.

(c) If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and the Claimant may proceed to external review. If the Claimant thinks that this situation exists, and the Plan disagrees, the Claimant may request that the Plan explain in writing why the Claimant is not entitled to seek external review at this time.

### External Review of a Standard (Non-Urgent Care) Claim

The claimant's request for external review of a standard (not Urgent Care) claim must made in writing within four months after the Claimant receives notice of an adverse benefit determination. Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after the Claimant receives a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, contact the Plan at:

**Iron Workers Tri-State Welfare Fund**
20 N Martingale Rd Suite 290
Schaumburg, IL 60173
Toll-free: 844-395-4467
F: 855-978-2331
Email: tristateiron@groupadministrators.com

**Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan**

Within five business days of the Plan's receipt of Claimant's request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

(a) The claimant is/was covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, the Claimant was covered at the time the health care item or service was provided;

(b) The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan;

(c) The Claimant has exhausted the Plan's internal claims and appeals process (or a limited exception allows the Claimant to proceed to external review before that process is completed); and

(d) The Claimant's request is complete, meaning that the Claimant has provided all of the information or materials required to process an external review.

Within one business day of completing its preliminary review, the Plan will notify the Claimant in writing whether:

(a) The Claimant's request is complete and eligible for external review;

(b) The Claimant's request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).); or

(c) The Claimant's request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. The Claimant must provide the necessary information or materials within the four-month filing period, or, if later, within 48 hours after the Claimant receives notification that the request is not complete.)

**Review of a Standard (Not Urgent Care) Claim by the IRO**

If the Claimant's request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

(a) The IRO will timely notify the Claimant in writing that your request is accepted for external review.

(b) The IRO will explain how the Claimant may submit additional information regarding the claim. In general, the Claimant must provide additional information within 10 business days. The IRO is not required to, but may, accept and consider additional information submitted after the 10-business-day deadline.

(c) Within five business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim "de novo," meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

(e) To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from the Claimant's medical records, any recommendations or other information

from the Claimant's treating health care providers, any other information from the Claimant or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

(f) In a standard case, the IRO will provide written notice of its final decision to the Claimant and the Plan within 45 days after the IRO receives the request for the external review.

**The IRO's decision notice will contain:**

(a) A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial;

(b) The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon;

(e) A statement that the IRO's decision is binding on the Claimant and the Plan, except to the extent that other remedies may be available to the Claimant or the Plan under applicable state or federal law;

(f) A statement that judicial review may be available to the Claimant; and

(g) A statement regarding assistance that may be available to the Claimant from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

**Expedited External Review of an Urgent Care Claim**

The Claimant may request an expedited external review in the following situations if:

(a) The Claimant receives an adverse benefit determination regarding their initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the Claimant's life or health, or would jeopardize the ability to regain maximum function, and has filed a request for an expedited internal appeal; or

(b) The Claimant receives a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize the Claimant's life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, and has not yet been discharged from a facility.

To begin a request for expedited external review, contact the Plan at:

**Iron Workers Tri-State Welfare Fund**
20 N Martingale Rd Suite 290
Schaumburg, IL 60173
Toll-free: 844-395-4467
F: 855-978-2331
Email: tristateiron@groupadministrators.com

**Preliminary Review of an Urgent Care Claim by the Plan**

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to the Claimant's attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify the Claimant (e.g., telephonically, via fax) whether their request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

**Review of an Urgent Care Claim by the IRO**

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as the Claimant's medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to the Claimant in writing, the IRO must provide written confirmation of the decision to the Claimant and the Plan within forty-eight (48) hours after it is made.

**What Happens After the IRO Decision is Made?**

If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

## 14.06 LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

A claimant must exhaust the remedies provided under Articles XIII and XIV and may not start a lawsuit or other administrative proceeding to obtain benefits until after the claimant has requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since the claimant filed a request for review and has 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 Weekly Accident and Sickness, Life Insurance or Accidental Death and Dismemberment benefits, more than three years after the start of the disability or the loss.

# ARTICLE 15 – COORDINATION OF BENEFITS

## 15.01 PURPOSE

The benefits payable to a Covered Person under this Plan shall be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the benefits payable by any Other Plan, as defined in Section 15.02(b), shall not exceed the total of such Allowable Expense, as defined in Section 15.02(a).

The terms of the Plan expressly obligate all Covered Persons to truthfully inform the Plan as to the nature of any claim, without inaccuracy or omission, and to inform the Plan whether or not any other insurance is payable or has paid any benefits with respect to any claim so that the Plan may accurately determine whether or not any benefits are payable under this Plan for a claim after the application of this Article XV.

## 15.02 DEFINITIONS

For purposes of this Article XV only, the following definitions apply:

(a) "Allowable Expense" shall mean any Medically Necessary Allowable Charges incurred by an Employee or Dependent under Article V, Article VI, Article VII, and/or Article VIII during a calendar year, part or all of which would be covered under any of the Other Plans.

(b) "Other Plan" shall mean any plan providing benefits or services to the Employee or Dependent, for or by reason of, medical care, dental care, vision care or treatment for which benefits or services are provided by:

(i) Group blanket or franchise insurance coverage;

(ii) Group Blue Cross or group Blue Shield coverage and other prepayment coverage;

(iii) Any coverage under labor-management trustees plans, union welfare plans, employer organization plans, employee benefits organization plans or any other arrangement of benefits for individuals or a group;

(iv) Any coverage under governmental programs, and any coverage required or provided by any statute, except as provided at Section 15.09;

(v) Any automobile insurance policies (including no fault coverage) containing personal injury protection provisions;

(vi) Health maintenance organization; or

(vii) With respect to the Participant's spouse, any prescription drug coverage that covers the Participant's spouse.

(c) "Primary Plan" shall mean the plan that is obligated to pay benefits first, prior to any payment from any Secondary Plan, under this Article XV.

(d) "Secondary Plan" shall mean the plan that is obligated to pay benefits after the Primary Plan has paid its benefits, pursuant to this Article XV. When this Plan is a Secondary Plan, benefits will be determined after those of the Other Plan(s) and will be reduced so that the total amount paid by this Plan and the Primary Plan does not exceed 100% of the Allowable Expense.

If the Employee or spouse is eligible to elect other coverage through an Employer and does not elect such coverage, then this Plan will follow the coordination of benefit rules of the coverage that the Employee or spouse were eligible to elect but failed to elect.

## 15.03 ORDER OF BENEFIT PAYMENT

The first of the following rules that apply will determine which plan is the Primary Plan, thereby determining the order of benefit payment under this Plan and the Other Plans:

(a) A plan without a coordination of benefits provision is the Primary Plan and shall pay its benefits before a plan that contains a coordination of benefits provision.

(b) A plan that covers a person as an employee (i.e., other than as a dependent) is the Primary Plan and shall pay its benefits before a plan that covers the person as a dependent.

(c) For claims on behalf of a dependent child(ren) who are covered under both parents' plans and the parents:

(i) Are not separated or divorced:

(A) The plan that covers the parent whose birthday falls earlier in the calendar year is the Primary Plan and shall pay its benefits before the plan that covers the parent whose birthday falls later in the calendar year;

(B) If both parents have the same birthday, the plan covering the parent for the longer period of time shall be the Primary Plan; or

(C) If one plan uses another rule other than the birthday rule, and the other plan uses the birthday rule, the plan using the other rule shall determine which plan is the Primary Plan;

(ii) Are separated or divorced:

(D) If there is a QMCSO, the plan covering the dependent children of the parent who has legal responsibility shall be the Primary Plan;

(E) If there is no QMCSO, the plan that covers the parent with custody shall be the Primary Plan and pay its benefits before the plan that covers the parent not having custody; or

(F) If there is no QMCSO and the parent with custody has remarried, the order of benefit coordination shall be:

I. The plan that covers the parent with custody is the Primary Plan;

II. The plan that covers the step-parent with custody pays it benefits second; and

III. The plan of the parent without custody pays its benefits last.

(d) A plan that covers a person as an active employee is the Primary Plan and shall pay its benefits before a plan that covers the person as a retired or laid-off employee.

(e) If none of the rules in this Section 15.03 establishes the Primary Plan, the plan that has covered the person for the longer period of time is the Primary Plan and pays its benefit before the plan that has covered the person for the shorter period of time.

## 15.04 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Trustees have the right to obtain or provide information needed to coordinate benefit payments with Other Plans. In compliance with the Privacy Policy set forth in this SPD, this information may be obtained from or provided to any insurance company, organization, or person without notice to the Employee or Dependent and without the Employee's or Dependent's consent.

## 15.05 RIGHT TO MAKE PAYMENT

The Trustees have the right to pay benefits to any other organization or person as needed to properly carry out the requirements of this Article XV. Benefits will be paid in accordance with an assignment of benefits. Such payments that are made in good faith are deemed to be benefits paid under this Plan.

## 15.06 RIGHT OF RECOVERY

Whenever payments have been made by the Trustees that exceed the maximum amount of covered charges under this Plan, the Trustees shall have the right to recover such over payments from among one or more of the following, as the Trustees shall determine:

(a) Any persons to or for whom, or with respect to whom, such payments were made either through direct reimbursement or right to offset from future claims;

(b) Any insurance company(ies); and

(c) Any other organizations.

The Trustees have the right to recover any payments made under this Plan pursuant to Article XVI.

The Trustees have the right to recover any payments made under this Plan as the result of the Covered Person having failed to comply with Section 15.01 and or Section 17.15.

## 15.07 EFFECT ON BENEFITS

When this Plan is the Primary Plan, benefits shall be determined before those of the Other Plan(s) and without considering the Other Plan's benefits.

## 15.08 EFFECT ON MEDICARE

This Plan coordinates benefits with Medicare when permitted, and as required under applicable law. When an active Employee has reached age 65 and is eligible for Medicare, this Plan is the primary Plan responsible for payment of benefits for purposes of coordination of benefits with Medicare, provided the Employer has at least 20 employees. Regardless of the Employer's size, for participants enrolled in Medicare due to end stage renal disease (ESRD), this Plan is the primary payor, and Medicare is the secondary payor for the coordination of Medicare.

## 15.09 MEDICAID COORDINATION

(a) Pursuant to ERISA Section 609(b)(1), payment for benefits with respect to a Participant under this Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant or a beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of the Social Security Act (as in effect on the date of enactment of the Omnibus Budget Reconciliation Act of 1993).

(b) Pursuant to ERISA Section 609(b)(3), to the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act in any case where this Plan has a legal liability to make payment for items and services constituting such assistance, payment for benefits under this Plan will be made in accordance with any state law that provides that the state has acquired the rights with respect to a participant to such payment for such items and services.

# ARTICLE 16 – SUBROGATION AND REIMBURSMENT

## 16.01 EXCLUSION OF CLAIMS

The Fund provides no benefits for Claims of a Covered Individual that are related to any Illness or Injury either that is caused by any third party, which is Work-Related, or that is the responsibility of any other entity. The Fund will deny any Claim for an Illness or Injury that is caused by a third party, which is Work-Related, or that is the responsibility of any other entity except as otherwise provided in this Article XVI.

## 16.02 DEFINITION

For purposes of this Article XVI, the term "Covered Individual" includes the Covered Person as well as representatives, guardians, trustees, estate representatives, heirs, executors, administrators of special needs trusts, and any other agents, persons, or entities that may receive a benefit on behalf of or for a Covered Person.

## 16.03 RIGHT OF REIMBURSEMENT AND SUBROGATION

The Fund may advance benefits for Injuries and Illnesses that are caused by or the responsibility of any other person, party, or entity. Prior to the Fund's advancing benefits, and as a condition thereof, a Covered Individual recognizes and agrees to Fund's absolute right of reimbursement and subrogation, the terms of which are set forth in this Article XVI.

**Reimbursement**
The Fund has a right be reimbursed up to the total amount of benefits advanced from any payment that a Covered Individual or their attorney receives from any third party related to the Injury or Illness. Therefore, upon final adjudication, settlement, and/or receipt of case proceeds, the Covered Individual agrees to reimburse the Fund up to the amount of benefits paid by this Fund. This reimbursement obligation also attaches to any future benefits the Fund pays related to the Illness or Injuries caused by the third party or for which a third party is responsible. The Fund must be reimbursed from any recovery received from any third party, insurer or any other source (including but not limited to persons, insurance carriers, estates, special trusts or other entities, hereinafter collectively referred to as "Source") or from any no fault coverage, uninsured motorist coverage, underinsured motorist coverage, employers' Workers Compensation insurance policies, personal injury protection coverage, medical payments coverage, financial responsibility, other insurance policies, funds, or any other sources of recovery (hereinafter collectively referred to as "Coverage").

Any such payments received by a Covered Individual or their attorney must be held in trust by until the Fund is reimbursed in whole. Any attorney must personally guarantee reimbursement to the Fund to the extent that they receive on behalf of the Covered Individual or related to the Injury or Illness.

**Subrogation**
Without limiting the preceding, the Fund also has a right of subrogation to any claim, cause of action, or any other right a Covered Individual has against any third party related in any manner to the Injury or Illness giving rise the Fund's advance of benefits. Therefore, without limiting the above, the Covered Individual agrees to allow the Fund to subrogate against or seek reimbursement with regard to

(a) Any and all claims, causes of action, or rights that a Covered Individual has against any Source who has or who may have caused, contributed to, aggravated, or assumed any responsibility for the Injury or Illness for which a Covered Individual claims benefits from this Fund; and

(b) Any Claims, causes of action, or rights that a Covered Individual may have against any Coverage.

The Covered Individual agrees to cooperate fully with the Fund in the prosecution of any Claims, causes of action, or rights against any Source and/or Coverage.

The Fund's reimbursement and subrogation rights are not subject to, and the Fund specifically disavows, the common fund doctrine, attorney's fund doctrine, fund doctrine, the double-recovery rule, the make-whole doctrine, or any similar doctrine or theory, including the contractual defense of unjust enrichment. This means that the Fund's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery by the Covered Individual from any Source or Coverage without regard to legal fees and expenses of the Covered Individual and without regard to whether there is a partial or full recovery and regardless of whether the Covered Individual believes they did not receive the amount they are entitled to receive, or if the amounts are categorized or described as medical expenses or as amounts other than for medical expenses.

**Subrogation Agreement**

No benefits will be advanced by the Fund under this Article (hereinafter referred to as "Advance") unless and until a Covered Individual enter into a subrogation and reimbursement agreement (hereinafter collectively referred to as "Agreement"). If the Fund suspects third-party responsibility for any Injury or Illness, it may withhold benefits from a Covered Individual until an Agreement is signed by the Covered Individual; if the Agreement is modified in any way without the consent of the Fund, the Fund may refuse to make any Advance. However, in its sole discretion, if the Fund makes an Advance in the absence of an Agreement, or if the Fund makes an Advance in error, that Advance does not waive, compromise, diminish, release, or otherwise prejudice any of the Fund's rights to reimbursement or subrogation.

The Agreement shall be in a form provided by or on behalf of the Fund. If the Covered Individual is a minor or incompetent to execute the Agreement, that person's parent, the Employee (in the case of a minor Dependent child), the Employee's spouse, or a legal representative (in the case of an incompetent adult) must execute the Agreement upon request by the Fund. A Covered Individual must comply with all of the terms of the Agreement, including the establishment of a trust for the benefit of the Fund, and agrees that:

(a) Any recovery received from any Source or Coverage up to the amount that the Fund has Advanced or is obligated to Advance in benefits will be immediately deposited into the trust for the Fund's benefit; and

(b) The Fund shall have an equitable lien by agreement in the amount set forth herein which shall be enforceable as part of an action to enforce the Plan terms under ERISA Section 502(a)(3), including injunctive action to ensure that these amounts are preserved and not disbursed.

The Fund's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Covered Individual, as opposed to the general assets of the Covered Individual and regardless of their compliance with the deposit to a trust described above. Enforcement of the equitable lien by agreement does not require that any of these particular assets received be traced to a specific account or other destination after they are received by the Covered Individual.

The Agreement grants the Fund a priority, first-dollar security interest and a lien in any recovery received from any Source or from any Coverage, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses. The Agreement recognizes and acknowledges that the Fund's rights are not subject to the common-fund doctrine or the make-whole doctrine, or any other similar doctrine or theory. This means the Covered Individual is solely responsible for paying all legal fees and expenses in connection with any recovery from any Source or Coverage for the underlying Illness or Injury, and the Fund's recovery shall not be reduced by such legal fees or expenses. In the event that the Covered Individual retains an attorney or law firm to prosecute a claim on their behalf, that attorney or law firm also waives the common fund doctrine.

The Agreement also memorializes the Covered Individual's agreement that:

(a) If the recovery is reduced due to a Covered Individual's negligence (sometimes referred to as contributory negligence) or any other common law defense, the amount of the Plan's reimbursement is not affected or reduced;

(b) They not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Fund's reimbursement rights or subrogation rights;

(c) They will notify and consult with the Fund or its designee in writing before starting any legal action or administrative proceeding against a third party alleged to be responsible for the Illness or Injury that resulted in the Advance, and before entering into any settlement agreement with that third party or third party's insurer based on those allegations;

(d) The Fund has the right to suspend all benefit payments due to the Covered Individual and family member of the Covered Individual arising out of the current incident or any other unrelated future Illness or Injury until the Fund is fully reimbursed related to the Covered Individual; and

(e) They will not assign their rights with respect to subrogation and reimbursement to anyone (except as otherwise stated in this Section). This means that a Covered Individual cannot give anyone else the right to pursue whatever rights that a Covered Individual has or had with respect to subrogation and reimbursement. Any attempt to do so will be void and have no effect.

The Fund's subrogation and reimbursement rights and the Covered Individual's obligation set forth in this Article XVI apply regardless of whether the Covered Individual executes a subrogation and reimbursement agreement. For purposes of this Article XVI, benefits that are paid for medical, Hospital, behavioral health and substance use disorders, dental, vision, prescription drug, and the Short Term Disability benefit are recoverable through subrogation or reimbursement.

# ARTICLE 17 – MISCELLANEOUS PROVISIONS

## 17.01 AMENDMENT AND TERMINATION

The Trustees expressly reserve the right to, and have the authority to, amend, increase, decrease, change or otherwise modify, at any time or from time to time, any benefits, Eligibility rules, or other specific provisions of the Plan as they may find it necessary in their sole fiduciary discretion for the benefit of Employees and Dependents, and for the sound and efficient administration of the Plan, provided that the amendments, changes or modifications are not inconsistent with ERISA, HIPAA, or any other applicable law. The Trustees may implement the actions described in this paragraph without prior notice to anyone having a legal interest in the Plan and others who may be affected, except as required by applicable law. Such action shall be applied to each Employee or Dependent in a non-discriminatory manner to those similarly situated.

The Trustees expressly reserve the right to, and have the authority to, terminate this Plan at any time. If the Plan is terminated, benefits for covered expenses incurred before the termination date will be paid to Employees, Dependents and beneficiaries as long as the Plan's assets exceed the Plan's liabilities, except as otherwise required by applicable federal law. If there are any excess assets remaining after the payment of all liabilities of the Plan, those excess assets will be used for a purpose for which this Plan was established, or in a manner as permitted by applicable federal law. Such excess assets may also be transferred to another employee benefit welfare trust fund governed by ERISA as permitted by applicable law.

Notice: The Trustees will notify Plan Participants in writing of any Plan amendment or termination in accordance with the law.

## 17.02 INTERPRETATION

The Trustees have broad fiduciary discretion to decide all questions, controversies or ambiguities of whatever nature arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including resolving any ambiguities which may arise under the Plan with respect to eligibility or benefits or any other provision of the Plan, or the construction of the language of the Plan. Benefits under this Plan shall be paid only if the Board of Trustees decides in its discretion that the applicant is entitled to them. The decision of the Trustees will be accorded judicial deference in any subsequent court or administrative proceeding, unless it is determined to be arbitrary and capricious.

Notwithstanding anything contained in this SPD to the contrary, no benefits shall be payable under this Plan unless the Trustees, in their sole fiduciary discretion, determine that such benefits are payable under the terms of the Plan.

The decision of the Trustees pursuant to the above shall be binding upon all persons dealing with the Plan or claiming any benefits under the Plan, except to the extent that the Trustees may subsequently determine, in their sole fiduciary discretion, that their original decision should be changed.

## 17.03 QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

The Plan shall provide benefits to an "alternate recipient" as defined in ERISA Section 609(a)(2)(C) in accordance with a QMCSO or a National Medical Support Notice that has been deemed to be a QMCSO. Any payment of benefits made by the Plan pursuant to a QMCSO shall be made to the alternate recipient's custodial parent or legal custodian.

Upon receipt of a medical child support order, the Plan shall promptly notify the Employee and each "alternate recipient" of the receipt of such medical child support order and the Plan's procedures for determining whether the medical child support order is a QMCSO. The Plan shall then determine whether the medical child support order is a QMCSO pursuant to the Plan procedures and notify the Employee and each alternate recipient of the determination.

Claims received for an "alternate recipient" before the medical child support order is determined to be a QMCSO shall not be processed or paid until the medical child support order is determined to be a QMCSO. Upon the determination that the medical child

support order is a QMCSO, all claims incurred on or after the date of the QMCSO shall be processed according to the terms of the Plan.

## 17.04 SEVERABILITY

If any provision of this Plan or any amendment made to the Plan is determined or judged to be unlawful or illegal, such illegality will apply only to the provision in question and will not apply to any other provisions of the Plan and the remainder of the provisions of the Plan shall be valid and enforceable.

## 17.05 BINDING EFFECT

The Plan, and all actions and decisions hereunder, shall be binding upon the heirs, executors, administrators, successors and assigns of any and all parties hereto and persons who become covered under this Plan, present and future.

## 17.06 GOVERNING LAW

The validity of this Plan or any of its provisions shall be determined under and construed according to ERISA, HIPAA, and any other applicable federal law, and only to the extent applicable and not preempted, to the laws of the State of Illinois.

## 17.07 NO EMPLOYMENT CONTRACT

Nothing herein contained shall be construed as giving any Covered Person the right to be retained in the service of the any Employer, nor upon dismissal or upon voluntary termination, to have any right or interest in this Plan other than as provided herein.

## 17.08 NO VESTING

Nothing herein contained shall be construed as giving any Covered Person any vested right to any benefits under this Plan.

## 17.09 RECOVERY OF OVERPAYMENT

In the event that any payment is made by the Plan to or for an Employee, Dependent, any beneficiary under the Plan or any other individual who is not entitled to such payment, in whole or in part, the Plan shall have the right to suspend or withhold payment of incurred claims and to reduce future payments due to such Employee, Dependent, any beneficiary under the Plan or any other individual by the amount of any erroneous payment and by the amount incurred by the Plan in pursuing the overpayment(s). The Plan and/or the Board of Trustees may take other actions to recover the erroneous payments and other amounts, including but not limited to, referring the matter to legal counsel, for such action as may be permitted under ERISA or any other applicable federal law. The Fund shall be permitted to pursue legal and equitable remedies to recover overpayments. The Plan has the right to pursue this recovery of an overpayment from any individual who improperly benefited from the overpayment.

## 17.10 WORKERS' COMPENSATION

The Plan is not in lieu of, and does not affect, any requirements for coverage by the applicable worker's compensation laws of any state.

## 17.11 PAYMENT OF CLAIMS AND LEGAL DISABILITY

Except as otherwise specifically in any other provision of this Plan, all benefits under this Plan shall be paid to the Employee unless the Employee authorizes such payment to be made to the Physician, Dentist or other health care provider.

In the event that the Employee is judicially determined to be legally incompetent, and a legal guardian, conservator or other person is judicially charged with the care of such Employee or his estate, all benefits to which such Employee is entitled shall be paid to such legal guardian, conservator or other person. The receipt of such benefits under the Plan by such legal guardian, conservator or other person shall be a full and complete discharge of the liability of the Plan.

## 17.12 NOTICES

Any notice or direction to be given pursuant to the Plan shall be deemed to have been effectively given if mailed to the recipient at the recipient's last known address on file with Plan. Participants should therefore notify the Plan as soon as possible when there is an address change to ensure timely receipt of notices. Notice to the Board of Trustees may be given by giving actual notice to any one or more of the Trustees.

## 17.13 CONSTRUCTION

The titles, headings and subheadings of this Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

## 17.14 GENDER AND NUMBER

Whenever a personal pronoun is used in the masculine gender, it shall be deemed to include the feminine also, unless the context clearly indicates the contrary. Words in the singular form shall be deemed to include the plural form and vice versa.

## 17.15 AFFIRMATIVE DUTY OF TRUTHFUL DISCLOSURE

Notwithstanding anything contained in this SPD to the contrary, the Covered Person is expressly obligated to fully and accurately inform the Plan of all aspects of the events giving rise to a claim under this Plan so that the Plan has all of the information necessary to make a correct and accurate determination whether the claim is in fact covered under the terms of the Plan. Compliance with this Section includes, but is in no way limited to, the Covered Person's obligation to inform the Plan that a spouse is no longer a spouse; that a Dependent no longer meets the definition of "Dependent"; that a third party caused an injury giving rise to a claim; that an injury giving rise to a claim is work-related, etc. The Trustees reserve the right, pursuant to their fiduciary discretionary authority and pursuant to Section 17.02, to determine whether or not a Covered Person has complied with this Section.

Failure of the Covered Person to comply with this Section 17.15 shall give the Trustees the right to a refund of any benefits that were paid, and to recover any payments that were paid, as a result of the Covered Person's noncompliance with this Section. Failure of the Covered Person to comply with this Section shall constitute a Fraudulent Claim pursuant to Section 3.06.

## 17.16 RECIPROCITY

The plan shall reciprocate hours worked for its Participants as provided in any applicable reciprocity agreement to which the Plan is a party. If the Employee's employment is divided between Union jurisdictions or the Employee moves from one Union to another, the Employee's Eligibility may be continued under the Iron Workers International Reciprocal Health and Welfare Agreement. In certain instances, Contributions made on the Employee's behalf may be transferred between funds to reinstate or continue Eligibility.

In certain circumstances, the Plan will divide the total contributions made on the Employee's behalf by the home local's hourly contribution rate and will credit hours to the Employee's home local. The Plan will also divide the total HRA contributions made on the Employee's behalf by the home local's HRA contribution rate for the home local and will credit HRA contributions.

## 17.17 SECURITY REQUIREMENTS

Pursuant to 45 CFR Part 164, Subpart C, Section 164.314(b)(2), the Board of Trustees shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
(b) Ensure that the adequate separation required by Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
(c) Ensure that any agent, including a subcontractor, to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the PHI; and
(d) Report to the Plan any security incident of which the Trustees become aware.

## 17.18 WITHDRAWAL OF EMPLOYER

If any Employer withdraws from participation in this Plan because that Employer's Participation Agreement is terminated, the coverage of that Employer's Employees under this Plan shall terminate according to the terms of the Employer's Participation Agreement, subject to applicable law. Unless the Participation Agreement requires otherwise, any remaining bank hours for the Employees of the Employer whose Participation Agreement was terminated shall be forfeited.

# ARTICLE 18 – HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

## 18.01 ESTABLISHMENT OF HRA

The Board of Trustees of the Fund establishes a Health Reimbursement Arrangement (HRA), effective January 1, 2009 (the "Effective Date"). Capitalized terms used in this SPD that are not otherwise defined shall have the meanings set forth in Section 18.03. The HRA is designed to permit an Employee to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the HRA Account.

## 18.02 LEGAL STATUS

The HRA is intended to qualify as a medical reimbursement plan under Code Sections 105 and 106 and regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the HRA are intended to be eligible for exclusion from the gross income of Employees and Beneficiaries under Code Section 105(b).

## 18.03 DEFINITIONS

The following words and phrases as used in this Article XVIII shall have the meanings set forth in this Section 18.03, unless a different meaning is clearly required by the context.

(a) "Beneficiary" shall mean a surviving Spouse or eligible Dependent designated by an Employee, or by the terms of the Plan, who is or may become entitled to a benefit thereunder.

(b) "Benefits" means the reimbursement benefits for Medical Care Expenses described in this Article.

(c) "Claim Form" means the form provided by the Plan for the purpose of allowing an eligible Employee, surviving Spouse or eligible Dependent to request reimbursement under the HRA.

(d) "Compensation" means the wages or salary paid to an Employee by an Employer.

(e) "Contributions" as used in this Article shall mean the money paid or payable into the Fund by an Employer pursuant to a Collective Bargaining Agreement (CBA) or pursuant to a Participation Agreement.

(f) "Health FSA" means a health flexible spending arrangement as defined in Prop. Treas. Reg. Section 1.125-2, Q/A-7(a).

(g) "HRA" means a Health Reimbursement Arrangement as defined in IRS Notice 2002-45.

(h) "HRA Account" or "Account" means the HRA Account described in Section 18.09.

(i) "Medical Care Expenses" means expenses incurred by an Employee or his or her Spouse or eligible Dependents for medical care, as defined in Code Sections 105 and 213(d) (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs), but shall not include expenses that are described in subsection 105(c) of the Code. Medical Care Expenses includes premiums for coverage from the Fund, COBRA premiums, or premiums for any qualified long term care insurance contract. Reimbursements due for Medical Care Expenses incurred by the Employee or his or her Spouse or eligible Dependents shall be charged against the Employee's HRA Account or surviving eligible Dependent's Account.

(j) "Period of Coverage" means the Calendar Year and for:

(i) Employees who first become eligible to participate, it shall mean the portion of the Calendar Year following the date eligibility for Plan coverage under the terms of the Plan commences; and

(ii) Employees who terminate eligibility for Plan coverage, it shall mean the portion of the Calendar Year prior to the date coverage terminates.

(k) "Spouse" means an individual who is legally married to an Employee as determined under applicable state law (and who is treated as a spouse under the Code) but shall not include any common law spouse or former spouse.

## 18.05 BENEFITS OFFERED

When an Employee becomes eligible for coverage under the Plan, an HRA Account will be established for them, and they will become eligible to receive Benefits in the form of reimbursements for Medical Care Expenses. In addition, the Employee will be eligible to have Contributions credited to his or her HRA Account, as described in Sections 18.04 and 18.06. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

Reimbursements are only payable to an Employee (or to the surviving Spouse or eligible Dependent of a deceased Employee). There will be no assignment of benefits to providers and no benefit payments may be paid by the Fund to providers.

## 18.06 EMPLOYER CONTRIBUTIONS

Employer Contributions will fund the full amount of the HRA Accounts. There are no Employee contributions allowed in the HRA. Under no circumstances will HRA Benefits be funded with salary reduction contributions, employee contributions (e.g., flex credits), or otherwise under a cafeteria plan pursuant to Code Section 125, nor will salary reduction contributions or employer contributions under a cafeteria plan be treated as Employer Contributions for the purposes of the HRA.

## 18.07 FUNDING

All of the amounts payable under the HRA shall be paid from the general assets of the Fund. Nothing herein shall be construed to require the Fund to maintain any fund or to segregate any amount for the benefit of any Employee, and no Employee, Beneficiary, or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Fund from which any payment under the HRA may be made. The Fund has no obligation to fund the HRA or its nominal accounts beyond the amounts attributable to Employer Contributions adjusted for losses and administrative expenses, if applicable.

## 18.08 BENEFITS AND REIMBURSEMENT PROCEDURES

The HRA will reimburse Employees for Medical Care Expenses up to the amount in the Employee's HRA Account. An Employee may receive reimbursement for Medical Care Expenses incurred by the Employee or a Beneficiary during a Period of Coverage. A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed or pays for it. Medical Care Expenses incurred before an Employee first becomes covered by the Plan are not eligible for reimbursement from the HRA. However, a Medical Care Expense incurred during one Period of Coverage may be paid during a later Period of Coverage, provided that the Employee was covered under the Plan during both Periods of Coverage.

**Exclusions**

"Medical Care Expenses" shall meet the definition of "medical care" under Code Section 213 and may otherwise be reimbursable under IRS guidance pertaining to HRA.

Medical Care Expenses can only be reimbursed to the extent that the Employee or other person incurring the expense is neither reimbursed or reimbursable through another health insurance plan, other insurance, or any other accident or health plan. If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because another health insurance plan imposes co-payment or deductible limitations), the HRA Account can reimburse the remaining portion of such expense if it otherwise meets the requirements of this Article.

## 18.09 ESTABLISHMENT OF ACCOUNT

The Trustees will establish and maintain an HRA Account for each eligible Employee. The HRA Account is a recordkeeping account with the purpose of keeping track of Contributions and available reimbursement amounts; it is not a separate fund and does not have assets segregated for it.

HRA Accounts are credited each year when the requirements of Section 18.04 are satisfied. Employer Contributions shall be added to such amount. HRA Account are debited during each Period of Coverage for any reimbursements of Medical Care Expenses incurred during the Period of Coverage. The amount available for reimbursement of Medical Care Expenses is the amount credited to their HRA Account, reduced by reimbursements debited from the account.

The Trustees shall determine, in their sole discretion, the maximum amount of carryover of unused balances in the HRA account from one Period of Coverage to another. Upon termination of employment, coverage will continue without further Employer contributions, and expenses submitted for reimbursement after such time will be reimbursed to the extent that a balance remains in the HRA Account.

HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) after the 12-month period following the close of the Period of Coverage in which the Medical Care Expense was incurred will revert to the general assets of the Fund.

A forfeiture of Employee's HRA Account occurs if the HRA Account balance is $500 or less and dormant for at least a 36-month (3 year) period, or upon termination of coverage. Any amount in an HRA Account that is forfeited will revert to the general assets of the Fund.

## 18.10 REIMBURSEMENT PROCEDURE

All claims for reimbursement must be submitted within twelve months of the date of service to be eligible for reimbursement. The minimum amount of any reimbursement claim is $50.

Claims for reimbursement under the HRA are treated as post-service medical claims. Reimbursement will occur within 30 days of receipt by the Fund of a claim for reimbursement, provided the Fund approves the claim.

If a claim is denied, the Employee may appeal this denial pursuant to Claims Procedures and Appeal Procedures set forth earlier in this SPD. If a claim is denied because there are not enough funds in the HRA, the claim may be re-submitted at a later date. The Fund will notify the Employee of a denial of a claim for reimbursement.

A claim for reimbursement of a Medical Care Expense must be submitted on a claim form to the Fund that includes:

(a) The person or persons on whose behalf Medical Care Expenses have been incurred;

(b) The nature and date of the Medical Care Expenses so incurred;

(c) The explanation of benefits (EOB), itemized bill or invoice, or other statements from an independent third party showing that the Medical Care Expenses have been incurred; the amount charged for the Medical Care Expense; and any additional documentation that the Fund may request;

(d) The amount of the requested reimbursement; and

(e) A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that any available Health FSA coverage for the Medical Care Expense has been exhausted.

## 18.11 RIGHT TO OPT-OUT

At any time, an Employee may permanently opt-out of HRA coverage and waive future reimbursement from the HRA. This applies to both Active and former Employees. Upon termination of employment, an Employee shall be given the opportunity to permanently opt-out of HRA coverage and waive future reimbursements from the HRA. Once an Employee has opted-out of HRA coverage, they may not later re-enroll in HRA coverage under the Plan.

# APPENDIX A: SCHEDULE OF BENEFITS FOR LOCALS 111, 112, 444 AND 498

**Schedule of Benefits for Locals 111, 112, 444, and 498**

- Active Plan of Benefits for Employees and Dependents
- Pre-Medicare Retiree Plan of Benefits for Eligible Retirees, Disabled Employees, their Dependents, Widows, and Dependents of Deceased Employees
- Plan of Benefits for Dependents of Medicare Eligible Retirees (Who Are Not Eligible for Medicare)

| Type | Coverage |
|---|---|
| **Life Insurance-Active Plan of Benefits for Employees and Dependents Only** | |
| **Employee** | $10,000 |
| **Eligible spouse** | $2,500 |
| **Dependent child** | $2,500 |
| **AD&D Insurance-Active Plan of Benefits for Employees Only** | |
| **Accidental death and dismemberment principal sum (employee only)** | $10,000 |
| **Weekly Accident and Sickness Benefit (non-occupational) Active Plan of Benefits for Employee Only** | |
| **Weekly benefit** | $250 |
| **Maximum number of weeks** | 26 |
| **Comprehensive Medical Benefits (for all)** | |
| **Annual deductible** | |
| **Individual** | $300 |
| **Family** | $600 |
| **Emergency Room Copayment** | |
| **Emergency room copayment, waived if admitted** | $50 |
| **Penalty for Failure to Obtain Pre-Approval** | |
| **For Hospitalization (without obtaining pre-approval)** | $200 |
| **Annual Out-of-Pocket limit** | |
| **Individual** | $5,000 |
| **Family** | $10,000 |

The annual out-of-pocket limits only apply to in-network charges. Out-of-network charges are not applied toward the out-of-pocket limits.

| Type | Coverage |
|---|---|
| **Comprehensive Medical Benefits (for all), continued** | |
| **Plan Pays…** | |
| In-network charges and claims subject to the No Surprises Act | 80% |
| Out-of-network Allowable Charges for claims not subject to the No Surprises Act | 60% |
| Well child examinations and immunizations | Does not require payment of deductible |
| Well adult examinations and immunizations | Does not require payment of deductible |
| **Calendar Year Maximums (per person)** | |
| Home health care visits | 100 |
| Days of treatment in a skilled nursing care facility | 120 |
| **Supplemental Accident Benefit** | |
| Maximum benefit per Accident | 100% of Allowable Charges up to 90 days |
| **Special Extra Work Benefit – Active Plan of Benefits for Employees Only** | |
| Reimbursement for an Employee who receives 2,000 or more Contribution Hours for work performed in a calendar year | First $100 of family deductible for preceding calendar year |

| **Prescription Drug Benefits (for all)** |
|---|
| Therapeutic Class of Drugs Copayments (To treat diabetes, high blood pressure, heart disease, high blood cholesterol, and asthma) |

| Type of Prescription | Retail Pharmacy | Mail Order |
|---|---|---|
| Generic copayment | $0 | $0 |
| Preferred brand copayment | $10 | $20 |
| Non-Preferred brand copayment | $20 | $40 |
| Prescription Supply Limit | Up to 34-day or 100 units | Up to 90-day |

| Type of Prescription | Coverage |
|---|---|
| **Participating Retail Pharmacy Copayments** | |
| Generic drug copayment | $7.50 |
| Preferred brand drug copayment | 20% up to $50 |
| Non-preferred brand drug copayment | 30% up to $75 |
| **Mail Order Program** | |
| Generic drug copayment | $15.00 |
| Preferred brand drug copayment | 20% up to $100 |
| Non-preferred brand drug copayment | 30% up to $150 |

*Note: If the Participant has a prescription filled for a brand name drug that has a generic equivalent, the Participant will need to pay the difference between the brand name and generic drug as well as the brand name copayment.*

| Type | Coverage |
|---|---|
| **Hearing Aid Benefit** | |
| Hearing Exam (referral through EPIC Hearing Healthcare) | Paid at 100% |
| Hearing Aid (discounted) Limit per Ear (through EPIC) | Paid at 100% up to $2,500 |
| **Dental Benefit (for all)** | |
| Preventative and diagnostic services | 100% |
| Restorative and prosthodontic services | 80% |
| Orthodontic services | 60% |
| Calendar year maximum for preventive, diagnostic, restorative and prosthodontics | $1,000 (not applicable to Dependent children under age 19) |
| Lifetime maximum for orthodontics | $1,000 |
| **Vision Care (for all)** | |
| Calendar year maximums for all covered services | $200 (not applicable to Dependent children under age 19) |

# APPENDIX B: SCHEDULE OF BENEFITS FOR LOCAL 380

**Schedule of Benefits for Local 380**

- Active Plan of Benefits for Employees and Dependents
- Pre-Medicare Retiree Plan of Benefits for Eligible Retirees, Disabled Employees, their Dependents, Widows, and Dependents of Deceased Employees
- Plan of Benefits for Dependents of Medicare Eligible Retirees (Who Are Not Eligible for Medicare)

| Type | Coverage |
|---|---|
| **Life Insurance-Active Plan of Benefits for Employees and Dependents Only** | |
| Employee | $10,000 |
| Eligible spouse | $2,500 |
| Dependent child | $2,500 |
| **AD&D Insurance-Active Plan of Benefits for Employees Only** | |
| Accidental death and dismemberment principal sum (employee only) | $10,000 |
| **Weekly Accident and Sickness Benefit (non-occupational) Active Plan of Benefits for Employee Only** | |
| Weekly benefit | $250 |
| Maximum number of weeks | 26 |
| **Comprehensive Medical Benefits (For All)** | |
| **Annual deductible** | |
| Individual | $300 |
| Family | $600 |

An Employee who receives 2,000 or more Contribution Hours for work performed in a calendar year will be reimbursed for the first $100 of the family's deductible.

| Type | Coverage |
|---|---|
| **Emergency Room Copayment** | |
| Emergency room copayment, waived if admitted | $50 |
| **Penalty for Failure to Obtain Pre-Approval** | |
| For Hospitalization (without obtaining pre-approval) | $200 |
| **Annual Out-of-Pocket limit** | |
| Individual | $5,000 |
| Family | $10,000 |

The annual out-of-pocket limits only apply to in-network charges. Out-of-network charges are not applied toward the out-of-pocket limits.

| Type | Coverage |
|---|---|
| **Comprehensive Medical Benefits (for all), continued** | |
| **Plan Pays…** | |
| In-network charges and claims subject to the No Surprises Act | 80% |
| Out-of-network Reasonable and Customary Charges for claims not subject to the No Surprises Act | 60% |
| **Supplemental Accident Benefit** | |
| Maximum benefit per accident | 100% of reasonable and customary charges up to 90 days |
| **Calendar Year Maximums (per person)** | |
| Well adult examinations and immunizations (does not require deductible | $1,000 |
| Home health care visits | 100 |
| Days of treatment in a skilled nursing care facility | 120 |
| **Special Extra Work Benefit – Active Plan of Benefits for Employees Only** | |
| Reimbursement for an Employee who receives 2,000 or more Contribution Hours for work performed in a calendar year | First $100 of deductible for preceding calendar year |

| **Prescription Drug Benefits (for all)** |
|---|
| Therapeutic Class of Drugs Copayments (To treat diabetes, high blood pressure, heart disease, high blood cholesterol, and asthma) |

| **Type of Prescription** | **Retail Pharmacy** | **Mail Order** |
|---|---|---|
| Generic drug copayment | $0 | $0 |
| Preferred brand drug copayment | $10 | $20 |
| Non-Preferred brand drug copayment | $20 | $40 |

| | |
|---|---|
| **Participating Retail Pharmacy Copayments** | |
| Generic drug copayment | $7.50 |
| Preferred brand drug copayment | 20% of TUF* up to $50 |
| Non-preferred brand drug copayment | 30% of TUF* up to $75 |
| **Mail Order Program** | |
| Generic drug copayment | $15.00 |
| Preferred brand drug copayment | 20% of TUF* up to $100 |
| Non-preferred brand drug copayment | 30% of TUF* up to $150 |

*Note: If you have a prescription filled for a brand name drug that has a generic equivalent, you will need to pay the difference between the brand name and generic drug as well as the brand name copayment.*

**Total Undiscounted Fee (TUF)*

| Type | Coverage |
|---|---|
| **Hearing Aid Benefit** | |
| Hearing Exam (referral through EPIC Hearing Healthcare) | Paid at 100% |
| Hearing Aid (discounted) Limit per Ear (through EPIC) | Paid at 100% up to $2,500 |
| **Dental Expense Benefit Not Included in Plan** | |
| **Vision Care Benefit Not Included in Plan** | |

# STATEMENT OF ERISA RIGHTS

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.

## Prudent Actions By Plan Fiduciaries Coverage

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. Please note that you or any other claimant may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and review procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within *30 days*, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
Chicago Regional Office
200 West Adams Street, Suite 1600
Chicago, IL 60606

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA:

- By calling 1-866-444-3272;
- Sending electronic inquires to www.askebsa.dol.gov; or
- Visiting the Web site of the at www.dol.gov/ebsa/.

# PRIVACY POLICY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Plan protect the confidentiality and security of your protected health information.

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 protected health information 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 protected health information 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 health care 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 protected health information 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.

## Protection and Security of Protected Health Information (PHI)

The Plan Sponsor:

- Implements administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensures that an adequate separation between the Plan and Plan Sponsor, specific to electronic PHI, by supporting reasonable and appropriate security measures;
- Ensures that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI; and
- Reports to the Plan any security incident of which it becomes aware concerning electronic PHI.

## Plan's Use and Disclosure of Protected Health Information (PHI)

The Plan will use your PHI to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The Plan will use and disclose your PHI as required by law and as permitted by your authorization or the authorization of your beneficiary. With an authorization, the Plan will disclose PHI to a retirement plan, disability plan, reciprocal benefit plan, and/or workers' compensation insurers for purposes related to administration of these plans.

## Payment Defined

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for Plan coverage and provision that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g., benefit cost, Plan maximums, and copayments as determined for an individual's claim);
- Coordination of Benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions for continuation of coverage options;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to Participant (and/or authorized representatives) inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including Preauthorization, concurrent review, and retrospective review;
- Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: Name and address, date of birth, Social Security Number, payment history, account number, and name and address of the provider and/or health plan); and
- Reimbursement to the Plan.

## Health Care Operations Defined

Health Care Operations include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives, and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration or development or improvement of methods of payment or coverage policies; and
- Business management and general administrative activities of the entity, including, but not limited to:
  - Management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;
  - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
  - Resolution of internal grievances; and
  - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

## Plan's Disclosure of Protected Health Information (PHI) to the Board of Trustees

For purposes of the Plan's privacy rules, the Board of Trustees is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only as long as this Plan Document incorporates the following provisions. With respect to PHI, the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by this Summary Plan Description/Plan Document or as otherwise required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
- Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;
- Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures provided for in this document;
- Make PHI available to the individual in accordance with the access requirements of HIPAA;

- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make the information available that is required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the Plan Sponsor will be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees will be given access to PHI:

- The Plan Administrative Manager; and
- Staff designated by the Plan Administrative Manager.

The persons described above will only have access to and will only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this Summary Plan Description/Plan Document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

# PLAN INFORMATION

## Plan Name

The Plan is known as the Iron Workers Tri-State Welfare Plan.

## Plan Year

The Plan Year is January 1 through December 31.

## Type Of Plan

This Plan is maintained for the purpose of providing health, prescription drug, dental, wellness, vision, weekly accident and sickness, death and accidental death and dismemberment benefits in the event of sickness, accident or death. The Plan benefits are shown in the Schedule of Benefits in the back pocket of this booklet.

## Plan Sponsor/Board of Trustees

A Board of Trustees, listed at the beginning of this SPD, is the Plan Sponsor and is responsible for the operation of this Welfare Plan. The Board of Trustees has delegated the day-to-day administrative tasks of administering the Plan to Group Administrators, LTD. The Board of Trustees consists of an equal number of Union and Employer representatives, selected by the Union and the Employers who have entered into Collective Bargaining Agreements that relate to the Welfare Plan.

You may receive a copy of the collective bargaining agreements by contacting the Board of Trustees using the address and phone number below:

Board of Trustees
Iron Workers Tri-State Welfare Plan
c/o Group Administrators, LTD.
20 N. Martingale Road, Suite 290
Schaumburg, IL 60173
844-395-4467

## Plan Number

The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The Employer Identification Number (EIN) is 36-6599036.

## Agent for Service of Legal Process

The Plan's agent for service of legal process is the Board of Trustees. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board at the address of the Iron Workers Tri-State Welfare Plan shown above. However, such documents may also be served upon the individual Trustees at the address of the Iron Workers Tri-State Welfare Plan.

## Contributions

The benefits described in this booklet are financed by Employer contributions and participants' self- payments. The amount of Employer contributions and the employees on whose behalf contributions are made are determined by the relevant provisions of Collective Bargaining Agreements or Participation Agreements accepted by the Trustees. The Fund Office will provide, upon written request, information as to whether a particular Employer is contributing to this Fund on behalf of Employees working under the Collective Bargaining Agreements or Participation Agreements.

## Plan Interpretation

The Board of Trustees has broad discretionary power to make factual findings, to fix omissions, to resolve Plan ambiguities, to construe the terms of the Plan, and to make benefit Eligibility determinations. Such determinations will be given judicial deference in any later court proceeding, unless they represent an arbitrary or capricious decision. This power may be delegated by the Trustees to an appropriate Committee of Trustees.

## Contribution Termination

If a Participating Employer is no longer obligated under the terms of a Collective Bargaining Agreement to make contributions to the Welfare Fund, that Employer will cease to be a Participating Employer in the Welfare Fund on the date the obligation to contribute terminates.

The Employees of an Employer who no longer has an obligation to contribute to the Welfare Fund will not be considered Eligible Employees with respect to any claims incurred on and after the 31st day after the Employer's obligation to contribute terminates.

## Amendment of Plan

The Board of Trustees reserves the right to amend, modify, revoke, suspend or terminate the Plan in whole or part at any time, by resolution duly passed in accordance with the Trust Agreement. You will be notified in writing of any amendment or termination of the Plan.

## Termination

The Trustees reserve the right to and have the authority and broad discretion to terminate the Plan at any time. If the Plan is terminated, benefits for covered expenses incurred before the termination date will be paid to Employees, Dependents and beneficiaries as long as the Plan's assets exceed the Plan's liabilities, except as otherwise required by federal law. You will be notified in writing of any termination of the Plan.

If there are any excess assets remaining after the payment of all liabilities of the Plan, those excess assets will be used for the purpose the Plan was established, or in a manner as permitted by federal law. The excess assets may also be transferred to another employee benefit welfare trust fund governed by ERISA and as permitted by law.

## Funding of Benefits

The benefits of the Welfare Plan are provided on a self-funded basis, except for the Life and Accidental Death and Dismemberment Insurance Benefits, directly from the assets of the Fund. The Life and Accidental Death and Dismemberment Insurance Benefits are provided through an insurance policy with:

The Union Labor Life Insurance Company
8403 Colesville Road
Silver Springs, MD 20910

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to participants and Dependents who meet the Eligibility requirements and defraying reasonable administrative expenses. The Fund's assets and reserves are invested in banks, government securities and other investments.

# DEFINITIONS

The following words and phrases as used in the Plan shall have the meanings set forth in this Article II, unless a different meaning is clearly required by the context.

### ACCIDENT

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

### ACTIVE EMPLOYEE

An Employee who is not retired.

### ACTIVE PLAN

The Active Plan of Benefits for Employees and Dependents, including the Schedule of Benefits for Locals 111, 112 and 444, as described in Appendix A, and the Schedule of Benefits for Local 380, as described in Appendix B.

### ALLOWABLE CHARGE

(a) With respect to a network provider, the Allowable Charge is the negotiated fee/rate set forth in the agreement with the participating network health and/or dental provider, facility, or organization and the Plan.

(b) With respect to an out-of-network provider, the Allowable Charge means the amount as determined by the Board of Trustees, unless subject to the No Surprises Act, for a particular service or supply. Except as required by the No Surprises Act, the Plan shall not pay any Allowable Charge for out-of-network services or supplies that is determined by any provider, facility, or other person or organization, other than the Board of Trustees.

### AMBULATORY SURGICAL FACILITY

A freestanding institution where surgery can be performed at minimal risk without an overnight Hospital confinement. The facility need not 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.

### ANCILLARY SERVICES

Subject to rulemaking by the Secretary of the U.S. Department of Health and Human Services and with respect to services furnished by a network provider at an out-of-network Health Care Facility, Ancillary Services means the following:

(a) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner,

(b) Items and services provided by assistant surgeons, hospitalists, and intensivists;

(c) Diagnostic services, including radiology and laboratory services;

(d) Item and services provided by other specialty practitioners, as specified through rulemaking by the federal government; and

(e) Items and services provided by an out-of-network provider if there is no network provider who can furnish such item or service at such facility.

### BEHAVIORAL HEALTH DISORDER

A Behavioral Health Disorder is any illness or condition which is described and coded in the current behavioral health section of the International Classification of Diseases (ICD), the current edition of the Diagnostic and Statistical Manual of Mental Disorders DSM-V or the current edition of either the International Statistical Classification of Diseases and Related Health Problems or the Diagnostic and Statistical Manual of Mental Disorders. Substance Use Disorder includes a disorder that is described and coded in the mental or behavioral disorder due to psychoactive substance use disorder or equivalent section of the ICD, or that is listed as a Substance-Related and Addictive Disorder (or equivalent category) in the most current version of the DSM. Certain Behavioral Health Disorders,

conditions, and diseases are specifically excluded from coverage as noted in Article XIII: General Exclusions and Limitations. See also the definition of Behavioral Health Practitioners and Chemical Dependency.

## BEHAVIORAL HEALTH PRACTITIONERS

The Plan generally relies upon the licensing and credentialing standards adopted by its network administrator.

## 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 Use Disorder treatment for a mental disorder identified in the current edition of the International Classification of Diseases (ICD) manual, or 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) 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:

  (i) 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

  (ii) The facility meets the criteria established by the Plan's network.

(b) 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 transitional facility, group home, halfway house, or temporary shelter is not a Behavioral Health Treatment Facility unless the facility provides medically necessary clinical treatment for a covered expense under this Plan.

## BENEFIT QUARTER(S)

The three-month periods in which Eligibility for benefits under the Plan is earned by the Employee. The Benefit Quarters under this Plan are the following three-month periods:

(a) March, April, May;

(b) June, July August;

(c) September, October, November; and

(d) December, January, February.

## BOARD OR BOARD OF TRUSTEES OR TRUSTEES

The Board of Trustees of the Iron Workers Tri-State Welfare Plan. 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 ERISA.

## CERTIFIED DISABILITY

A Certified Disability is one for which the Employee receives a benefit under Section 10.03 or receives workers' compensation benefits as the result of a disability incurred while Eligible.

## DEPENDENCY OR SUBSTANCE USE DISORDER

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 DSM manual. See the definition of Behavioral Health Disorder at Section 2.06.

## COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and the regulations thereunder.

## CODE

The Internal Revenue Code of 1986, as amended, and any successor statute and the regulations thereunder.

## 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 the Welfare Fund for the purpose of providing such Employees with benefits.

## CONTRIBUTION HOURS

Hours that the Employee works for which an Employer makes contributions to the Fund on the Employee's behalf. Contribution Hours from all contributing Employers count towards Eligibility. Contribution Hours shall be credited upon the Plan's receipt of a properly completed remittance report demonstrating that the Employee actually worked the hours, if such remittance report is submitted by an Employer that has previously contributed Contribution Hours on behalf of any Employees.

## COSMETIC/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 also includes a child(ren) who is named as an "alternate recipient" under a Qualified Medical Child Support Order, as defined in ERISA Section 609(a)(2)(C), or under a National Medical Support Notice.

## CUSTODIAL CARE

Any care rendered to a patient who:

(a) Is disabled mentally or physically and such disability is expected to continue and be prolonged;

(b) Requires a protected, monitored or controlled environment whether in an institution or in the home;

(c) Requires assistance to support the essentials of daily living; and

(d) 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.) or a Doctor of Medical Dentistry (D.M.D.) or an individual who is licensed to practice dentistry by the governmental authority having jurisdiction over such licensing. Such individual must be working within the scope of his/her license.

## DEPENDENT

A "Dependent" shall include any one of the following individuals:

(a) The Employee's spouse;

(b) The Employee's children who have not yet reached age 26:

(i) Children under age 26 who otherwise meet the definition of Dependent child under the Plan

(ii) Children include the Employee's natural children, adopted children, children placed with the Employee for adoption, stepchildren, and foster children.

(iii) For natural children, a birth certificate with the name of a parent who is a Plan Participant is sufficient to verify Dependent status.

(c) An Employee's unmarried children who have reached age 26, and who are:

(iii) 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

(iv) Such disability commenced prior to reaching age 26; and

(v) Such children are dependent upon the Employee for more than fifty percent (50%) of their financial support and maintenance during the calendar year and maintain a principal residence with the Employee during the calendar year; and

(vi) Such children maintain a principal residence with the Employee for more than one-half of the calendar year. If such a child does not maintain a principal residence with the Employee for more than one-half of the calendar year, the child will still be the Employee's Dependent, provided that:

(1) The child's parents are: A) divorced or legally separated under a decree of divorce or separate maintenance; B) separated under a written separation agreement; or C) live apart at all times during the last six months of the Calendar Year;

(2) The child's parents provide over one-half of the child's support during the Calendar Year;

(3) The child is in the custody of one or both of their parents for more than one-half of the Calendar Year; and

(4) The child is not the Dependent of any person other than the Employee or the Employee's spouse during the Calendar Year.

(vii) The Trustees may request due proof of such Total Disability of such Dependent at any time.

(d) The Employee must notify the Plan sixty (60) days before the day such Dependent's Eligibility would otherwise terminate due to age.

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

(f) Notwithstanding anything contained in this SPD to the contrary, the Employee or Dependent have the affirmative duty to inform the Plan if and when an individual ceases to be a Dependent under this Section 2.21 within sixty (60) days of such event.

## EFFECTIVE DATE

The effective date of this amended and restated Plan is January 1, 2026.

## ELIGIBLE OR ELIGIBILITY

Entitlement to the benefits payable under the provisions of the Plan by virtue of having met the requirements in Article III – Eligibility.

## EMPLOYEE

Any Employee who is Eligible for benefits according to the standards set forth in Article III – Eligibility.

## EMPLOYER

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

## EMERGENCY MEDICAL CONDITION

A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

## EMERGENCY SERVICES

(a) An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency department meaning, a Health Care Facility that is geographically separate and distinct from a Hospital under applicable state law and provides Emergency Services, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(b) Within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

(c) Emergency Services furnished by an out-of-network provider or at an out-of-network Hospital (regardless of the department of the Hospital in which such items or services are furnished) or an independent freestanding emergency department also include post stabilization services (i.e., items and services provided after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

  (i) The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation; and

  (ii) The patient or their representative is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, an estimate of the charges for treatment and any advance limitations that the Plan may put on the treatment, the names of any network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the network providers listed; and

  (iii) The Patient or their representative gives informed written voluntary consent to continued treatment by the out-of-network provider, acknowledging that the patient understands that continued treatment by the out-of-network provider may result in greater costs to the patient.

## ENTITLED TO MEDICARE

For purposes of this Plan, means entitled to the benefits payable under Medicare if the participant applies when first eligible, whether or not the participant actually applies for Medicare.

## ERISA

The Employee Retirement Income Security Act of 1974, as amended.

## EXPERIMENTAL OR INVESTIGATIVE

The use of any treatment, procedure, facility, equipment, drugs, devices, or supplies not recognized as acceptable medical practice, in terms of generally accepted medical standards, and including 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 shall 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.

## FMLA/FMLA LEAVE

The Family and Medical Leave Act of 1993 (FMLA). FMLA Leave shall mean a leave taken by the Employee pursuant to the FMLA and such leave meets the requirements of the FMLA.

## FORMULARY DRUG

The Plan's formulary lists brand name medications that are either more effective than others in their class are, or as effective as 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.

## HEALTH CARE FACILITY

Health Care Facility (for non-Emergency Services) means each of following:

(a) A Hospital (as defined in section 1861(e) of the Social Security Act);

(b) A Hospital Outpatient department;

(c) A critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

(d) An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

## HIPAA

The Health Insurance Portability and Accountability Act of 1996, as it may be amended.

## HOME HEALTH CARE

(a) Home Health Care must be for the care or treatment of a sick or injured person and must be:

  (i) Ordered in writing by the Covered Person's Physician; and

  (ii) Provided in the Covered Person's home by a Home Health Care Agency.

(b) Home Health Care consists of these services and supplies:

  (i) Part-time or intermittent home nursing care from or supervised by a registered nurse;

  (ii) Part-time or intermittent home health aide services;

  (iii) Physical therapy, occupational therapy and speech therapy; and

  (iv) Laboratory services.

## HOME HEALTH CARE AGENCY

A public or private agency or organization which:

(a) Provides nursing or therapeutic services in the home;

(b) Is federally certified and/or duly licensed; and

(c) Operates within the scope of its license.

## HOSPITAL

(a) An institution or facility that generally meets the accreditation, or certification standards and requirements of the Plan's network administrator, or other appropriate accreditation or certification standards, or is otherwise licensed by the proper authority of the state in which it is situated;

(b) 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.

## INJURY

Injury means a bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

## MEDICALLY NECESSARY

(a) A service or supply, which, in terms of generally accepted medical standards:

(i) Is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; and

(ii) Could not have been omitted without adversely affecting the Covered Person's condition or the quality of medical care.

(b) 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 expense under this Plan.

## MEDICARE

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

## MISCELLANEOUS HOSPITAL CHARGES

Allowable 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.

## NATIONAL MEDICAL SUPPORT NOTICE

A National Medical Support Notice as described in Section 401(b) of the Child Support Enforcement and Incentive Act of 1998, ERISA Section 609(a)(5)(C) and DOL Regulation 2590.609-2.

## NO SURPRISES ACT SERVICES

The No Surprises Act (Public Law 116-260, Division BB) was signed into law on December 27, 2020, as part of the Consolidated Appropriations Act of 2021. The term "No Surprises Act Services" means the following, to the extent covered under the Plan: (1) out-of-network Emergency Services, (2) out-of-network Air Ambulance Services; (3) non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by an out-of-network provider at a network facility; and (4) other out-of-network non-Emergency Services performed by out-of-network provider at a network facility with respect to which the provider does not comply with written federal notice and consent requirements.

## 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 the Collective Bargaining Agreement.

## OUT-OF-NETWORK RATE

With respect to No Surprises Act Services, the term "Out-of-Network Rate" means one of the following in order of priority:

(a) If the state has an All-Payer Model Agreement, the amount that the state approves under that system;

(b) Applicable state law;

(c) The amount parties negotiate; or

(d) The amount approved under the independent dispute resolution (IDR) process pursuant to the No Surprises Act when open negotiations fail.

## 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 Retiree or his/her 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 OR PLAN OF BENEFITS

This Iron Workers Tri-State Welfare Plan, as amended and restated, effective January 1, 2026, including amendments, if any, which describes 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 Welfare Fund in accordance with the rules and regulations relating to Eligibility and the amount and nature of benefits, as adopted by the Trustees.

## PLAN YEAR

The Plan Year is the twelve (12) consecutive month period beginning January 1 and ending December 31.

## QUALIFIED MEDICAL CHILD SUPPORT ORDER OR QMCSO

A qualified medical child support order, as defined in Section 609(a) of ERISA.

## QUALIFYING PAYMENT AMOUNT

The amount calculated using the methodology described in 29 CFR § 2590.716-6(c), which is generally the median of the contracted rates of the Plan or issuer for the item or service in the geographic region.

## RESERVE HOURS

The hours in the Employee's Reserve Accumulation Account as described in Section 3.07.

## RECOGNIZED AMOUNT

Recognized Amount means (in order of priority) one of the following:

(a) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

(b) An amount determined by a specified state law; or

(c) The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

For Air Ambulance Services furnished by out-of-network provider, the Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

## SICKNESS

An illness or disease that causes loss. Any loss incurred because of pregnancy, childbirth and related medical conditions is 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:

(a) In-patient medical care and treatment to convalescing patients;

(b) Full-time supervision by at least one Physician or registered nurse;

(c) 24-hour nursing service by licensed professional nurses; and

(d) Complete medical records for each patient.

### TOTALLY DISABLED OR TOTAL DISABILITY

With respect to an Employee, due to injury or Sickness the Employee is prevented from engaging in his/her regular or customary occupation. With respect to a Dependent, due solely to injury or Sickness that is not employment-related, such Dependent 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.

### UNION

A local union affiliated with the International Association of Bridge, Structural, Ornamental, Reinforcing Iron Workers (AFL-CIO) that has or will become bound by this Plan.

### USERRA

The Uniformed Services Employment and Reemployment Act of 1994, as amended, and any regulations thereunder.

### 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.

### WHCRA

The Women's Health and Cancer Rights Act of 1998.

### WIDOW

The surviving spouse of a deceased person. The term "Widow" includes a widower.

# EXECUTION

IN WITNESS WHEREOF, the undersigned Employer Trustees and the undersigned Union Trustees hereby accept this Iron Workers Tri-State Welfare Plan and have caused this Iron Workers Tri-State Welfare Plan to be executed on behalf of each of them by their duly authorized officers and the Trustees have also executed this Plan, to be effective as first set forth above, all on this _____ day of _____, 20_____.

**Employer Trustees**

_____

_____

_____

_____

_____

_____

**Union Trustees**

_____

_____

_____

_____

_____

_____