IRON WORKERS'
Tri-State Welfare Fund

Summary Plan Description

2015

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 Tri-State Welfare Plan.

This booklet is a summary of your benefit plan in effect on January 1, 2015. The benefits described in this booklet apply to employees who are active on or after January 1, 2015 and to employees who retire or become disabled on or after January 1, 2015, but are not yet eligible for Medicare. The actual Plan Document contains the information upon which this summary booklet is based. This booklet replaces and supersedes all prior booklets summarizing your benefits, but does not replace the Plan Document. If a question arises that this summary booklet does not answer or if the booklet conflicts with the Plan Document, the Plan Document is the final authority.

Several important plan changes have been made since the previous Summary Plan Description (SPD) was printed (2008 Edition). These include:

- Changes associated with the Affordable Care Act, such as covering children to age 26 and eliminating many annual and lifetime maximums;
- The addition of Healthy Foundations benefits that help you get and stay healthier and the Healthy Foundations Account to help pay for your out-of-pocket healthcare costs;
- Increases to the Life Insurance and AD&D benefits to $10,000;
- Increase to the weekly disability benefit to $250.
- Lowering the annual medical deductibles so you can receive benefits faster, but increasing the annual out-of-pocket limits.

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

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

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

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The Plan's "Grandfathered" Status

The Trustees of the Iron Workers' Tri-State Welfare Fund believe that this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for external claims review. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding the protections that apply and those that do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office at 1-866-463-9418. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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Contacts

If you need…	Contact…
To find a network medical provider: Active and Retiree Plans of Benefits Medicare Advantage Plan	 BCBSIL: 1-800-571-1043 or www.bcbsil.com AmWINS Customer Care Center: 1-888-883-3757
To find a network pharmacy or to call about mail order:	Express Scripts www.express-scripts.com 1-866-312-9068
To find a VSP provider	1-800-428-4833 www.vsp.com
EPIC Hearing	1-866-956-5400
To check your HFA balance	https://zenith-americanil.lh1ondemand.com
Claims information or eligibility:	Zenith American Solutions: Toll-free: 1-866-463-9418 E-mail: tristate@abpa-tpa.com
Fund web site:	www.tristatewelfarefund.com
Healthy Foundations Information: Mayo Clinic Embody-Health Optimal Health Healthy Foundations Account	 www.mcmhealthsolutions.com 1-800-367-9938 1-630-960-3322

Eligibility

General Information

You are Eligible for benefits if:

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

The Schedule of Benefits lists the Plan of Benefits.

Management/Supervisory Employees

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

Active Benefits include all of the following:

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

You need 350 contribution hours within nine months to become eligible.

Initial Eligibility (For New Employees)

You will become Eligible for benefits on the first day of the eligibility quarter after you accumulate 350 contribution hours within a nine-month period or less. Contribution hours are the hours you work for which an Employer contributes to the Fund on your behalf. Hours from all contributing employers count toward Eligibility. Eligibility quarters are June through August, September through November, December through February and March through May.

Benefit Quarters

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

- January through March
- April through June
- July through September
- October through December

Once you become Eligible for benefits, you will remain Eligible for benefits until the end of the benefit quarter. If you are unable to work because of an Accident or illness when benefits should become effective, the Weekly Accident and Sickness Benefit coverage will be delayed until you return to active employment. You and your Dependents will be eligible for all other Plan benefits on the effective date.

When Dependent Eligibility Begins

A Dependent will become Eligible for coverage when you become Eligible. Future Dependents will become Eligible when they meet the definition of "Dependent." See page 66 for a definition of Dependent.

Continued Eligibility

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

CONTRIBUTION HOURS REQUIREMENT FOR CONTINUED ELIGIBILITY

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

If you do not accumulate the required contribution hours, you may be able to continue your eligibility with your reserve accumulation account or by self-paying for coverage. These options are described in this booklet on pages 4 and 11.

If you lose eligibility, you will need to meet the initial eligibility requirements to have your eligibility reinstated. To have your eligibility reinstated, you will need to accumulate 350 contribution hours in a nine-month period.

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

Reserve Accumulation Account

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

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

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

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

Family and Medical Leave

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

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

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

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

The Family Medical Leave Act (FMLA) requires certain Employers (but not all) to grant unpaid leave of up to 12 weeks during a 12-month period for specific reasons such as the birth of a child or a serious illness affecting you, your spouse, your Dependents or your parents. In addition, the FMLA allows you to take up to 26 weeks to care for a service member who is your son, daughter, parent, or next of kin, who is undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in the armed services, and who is an outpatient or on the temporary disability retired list of the armed services. You must request FMLA leave from your Employer.

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

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

Reciprocal Agreements

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

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

If you need more information, contact the Fund Office.

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days advance written notice of that rescission of coverage. 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. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you written notice 30 days in advance:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage.
- The Plan retroactively terminates your former spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively—going forward—once the mistake is identified. Such cancellation will not be considered a rescission of coverage and does not require the Plan to give you 30 days advance written notice.

Special Enrollment

If you or your eligible Dependent declined coverage under this Plan because you have other health coverage, you may be eligible for a special enrollment if you:

- Lose the other health coverage; or
- Acquire a Dependent through marriage, birth, adoption, or placement for adoption.

Adding a Dependent: If you are adding a dependent within the special enrollment period, your dependent's coverage will begin retroactively to the date of the event, such as date of birth, marriage, adoption, or loss of coverage. If you are adding a dependent after the special enrollment period has expired, coverage for your dependent will begin on the first on the month following the Fund Office receipt of the completed application form.

For special enrollments due to loss of other coverage, you, or your Dependent must:

- Otherwise be eligible for coverage; and
- Have been covered under another group plan or must have had other health coverage when coverage under this Plan was declined, and enrollment must have been declined on the enrollment form.

If the other health coverage was COBRA continuation coverage, a special enrollment is only available after the COBRA continuation coverage has been exhausted. If the other coverage is not COBRA continuation coverage, a special enrollment is available if you or your Dependent is no longer eligible for coverage or employer contributions for the other coverage.

If you are declining enrollment for your Dependents (including your spouse) because of other health insurance coverage, you must request enrollment within 31 days after coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your Dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Coverage of a newborn or newly adopted Dependent child who is enrolled within 31 days after birth will become effective as of the date of birth. Coverage of a newly adopted Dependent child, who is enrolled more than 31 days after birth, but within 31 days after the child's adoption or placement for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first. Charges for a newborn child's routine nursery care and an inpatient Hospital physical examination are covered by the Plan, provided the child is enrolled as necessary. To enroll your new Dependent, you will need to complete, sign, and submit an enrollment form to the Fund Office. You will also need to provide proof of Dependent status, for example a copy of the birth certificate.

Special enrollments are not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation. To be eligible for a special enrollment, you must notify the Fund Office within 31 days of the loss of other coverage or the date of marriage, adoption, or placement for adoption.

You and your dependents are also eligible for special enrollment in this Plan if you (or your eligible Dependents):

- Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or

- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after you (or your dependents) are determined to be eligible for such premium assistance.

When Coverage Ends

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

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

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

- This Plan ends;
- Your Eligibility ends;
- The Plan is amended to exclude his or her particular class of Dependent;
- The Dependent no longer meets the definition of Dependent (You must notify the Fund Office within 60 days after your dependent's eligibility terminates due to loss of dependent status to be eligible for COBRA coverage.);
- The self-payments for that Dependent, if any, are not made on time;
- Until January 1, 2014, the Dependent enters into full-time, active duty with the Armed Forces of any country for more than 31 days.

Certification of Coverage

When your coverage ends or when your Dependent's coverage ends, you (or your Dependent) may request certification of the length of coverage under this Plan in writing within 24 months after losing coverage. This certification may help you avoid paying a penalty, if you are enrolling for Medicare Part B or Part D later than when you are first eligible.

Reinstatement of Eligibility

If your Eligibility ends because you do not accumulate enough contribution hours and do not make the active self-payments (see page 11), you must meet the initial eligibility requirements as described on page 2.

If you are called to military service:

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

Uniformed services means the:

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

Serving In the Uniformed Services (For Active Employees)

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

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

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

If you elect to continue coverage and you are in the uniformed services for less than 31 days, you will continue to receive coverage in accordance with USERRA for up to 31 days. If your service continues for more than 31 days, you may elect to continue coverage under the Plan by making monthly self-payments. To continue coverage, you or your dependent must pay the required self-payment. Payments will be made in the same manner and in the same amount as COBRA Continuation Coverage payments. Continuation coverage under USERRA will be administered in the same manner as COBRA Continuation Coverage, except that only you, the employee, may elect continuation coverage under USERRA for yourself and your eligible Dependents.

Your coverage will continue until the earlier of:

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

However, your coverage will end the earliest day:

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

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

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

Reinstating Your Coverage

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

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

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

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

Reemployment

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

If You Become Disabled

You will be credited with 27 disability hours for each full week you are unable to work because of a certified disability. You may receive up to 700 disability hours during a 12-month period. See page 65 for a definition of certified disability.

If your Eligibility ends while you are disabled, benefits for you and your Dependents may be extended for up to 18 consecutive months. Any hours remaining in your reserve accumulation account will then be used to offset the cost of coverage. After the 18 months and your reserve accumulation account have been exhausted, you may continue coverage under the Self-Pay Plan or the Retiree Plan of Benefits or COBRA continuation coverage. See “Self-Pay Options” on page 11 for more information.

When Disability Coverage Ends

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

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

If you become Entitled to Medicare, you may continue your Dependents’ Eligibility by making self-payments for the Retiree Plan of Benefits until your Dependents are Entitled to Medicare or no longer meet the definition of a Dependent. See page 66 for a definition of Dependent. You and your spouse may also be eligible for the AMWINS Medicare Advantage Plan.

Dependents of a Deceased Employee

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

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

Surviving Dependents may continue Eligibility by making self-payments for COBRA continuation coverage or the Retiree Plan of Benefits, but not both. See “Self-Pay Options” on page 11 for more information. If a surviving Dependent chooses to waive coverage under COBRA, he or she may self-pay for the Retiree Plan of Benefits until the earlier of:

- The day he or she becomes Entitled to Medicare; or
- The day he or she no longer meets the definition of Dependent as described on page 66.

Self-Pay Options

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

- The Active Self-Pay Program and
- COBRA continuation coverage.
- The Pre-Medicare Retiree Plan of Benefits; or
- The Medicare plans available through the Iron Workers Tri-State Retiree Welfare Plan, which is a separate plan for Medicare-Eligible Retirees.

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

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

The Eligibility requirements, cost, and coverage provided for each option are different. The Active Self-Pay Program and COBRA continuation coverage options are generally available to most Employees.

If you choose the Self-Pay Program, you waive coverage under COBRA. Once you choose a self-pay option, you cannot change your election. However, you may be Eligible for another self-pay option after you exhaust your Eligibility under the first option you elected. For example, you can elect the Active Self-Pay Program and then decide to retire and elect the Pre-Medicare Retiree Plan of Benefits or the Medicare plans, as appropriate.

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

The Active Self-Pay Program

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

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

Coverage for disabled Employees is explained under "If You Become Disabled" on page 10.

Note: See "Pre-Medicare Retiree Plan of Benefits" on page 17 for more information if you retire before age 65.

Coverage Under The Active Self-Pay Program

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

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

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

Payment Information

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

1. 350 minus (your hours worked in the last contribution quarter plus hours from your Reserve Accumulation Account, if any)
2. 700 minus (your hours worked in the last two contribution quarters plus hours from your Reserve Accumulation Account, if any)
3. 1,050 minus (your hours worked in the last three contribution quarters plus hours from your Reserve Accumulation Account, if any)
4. 1,400 minus (your hours worked in the last contribution year plus hours from your Reserve Accumulation Account, if any)

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

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

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.

Self-payments for this program are due by the last day prior to the termination date.

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

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

Retired Employees

If you retire while Eligible for Plan benefits, you may continue coverage under the Active Self-Pay Program if the Eligibility requirements outlined in the above section are met. You may also choose to self-pay for the Retiree Plan or for medical coverage under COBRA (described on page 14). For more information about the Pre-Medicare or Medicare Retiree Plan, see pages 17 and 19, respectively.

Eligibility

When you retire, you may continue coverage under the Retiree Self-Pay Program (Pre- or Post-Medicare) if:

- You are at least age 52;
- You do not have enough hours left in your Reserve Accumulation Account to pay for a quarter of coverage (By electing the Retiree Plan of Benefits, you forfeit any excess Reserve Accumulation Account hours.);
- You are receiving retirement benefits from the Iron Workers Mid-America Pension Plan or the Iron Workers Local 380 Retirement & Severance Plan;
- Before retiring, you were eligible for benefits by virtue of Contribution Hours under this Plan for some part of each of the last ten (10) calendar years; and
- For the quarter immediately prior to retiring, you were eligible for benefits under this Plan by virtue of any combination of the following: Contribution Hours, Reserve Accumulation Account hours, and Self-Pay Contributions.

Pre-Medicare Retired Employees

If you are eligible for the Retiree Self-Pay Program, as described above, but are not yet eligible for Medicare, you may continue coverage under the Pre-Medicare Retiree Program by self-paying for coverage. You must waive COBRA coverage to elect the Pre-Medicare Retiree Program. See page 17 for information on Pre-Medicare Retiree Benefits.

Medicare Retired Employees

If you are covered under the Tri-State Welfare Fund benefits (either by your employment or by self-payment), you and your eligible spouse may self-pay for the Medicare options available under the Iron Workers Tri-State Retiree Welfare Plan. See page 19 for information about the Medicare Advantage Plans. You must be Entitled to Medicare and self-pay monthly for this coverage.

If you had end stage renal disease (ESRD) while covered under the Active or Pre-Medicare Retiree Plan of Benefits prior to age 65, your coverage under the Plan will continue through the Retiree Plan of Benefits rather than a Medicare plan, provided you remain eligible and pay for coverage.

COBRA allows you to continue coverage under certain circumstances.

COBRA Continuation Coverage

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

Eligibility for COBRA Coverage: Qualifying Events

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

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

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

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

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

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

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason, other than the parent-employee's gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (Parent-employee becoming Entitled to Medicare means that the parent-employee was eligible for Medicare benefits and enrolled in Medicare under Part A, Part B, or both. The entitlement date is the date of enrollment;

- The parents become divorced; or
- The child stops being eligible for coverage under the Plan as a dependent child.

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

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

Employer Must Give Notice Of Some Qualifying Events

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

You Must Give Notice Of Some Qualifying Events

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

Fund Administrator
Iron Workers Tri-State Welfare Fund
c/o: Zenith American Solutions
18861 90th Avenue, Suite A
Mokena, IL 60448

Coverage Under COBRA

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

Payment Information

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

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

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

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

Length of COBRA Coverage

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

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

Children born, adopted or placed for adoption as described above, have the same COBRA rights as a spouse or Dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, their continued coverage depends on timely and uninterrupted payment of premiums on their behalf.

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

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

If you are continuing coverage under a USERRA leave (Military service), your coverage lasts a total of 24 months. See page 8.

When COBRA Coverage Ends

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

- The last day of the last month for which contributions are made, if you and your Dependent fail to make the self-payments on a timely basis.

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

Pre-Medicare Retiree Plan of Benefits

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

The self-pay option for this Pre-Medicare Retiree Plan of Benefits explained below is available to Dependents of deceased Employees, Employees who retire or become permanently and Totally Disabled before age 65, and the Dependents of such retired and disabled Employees. If you qualify, the Retiree Pre-Funded Allowance can lower your self-payments. See page 20.

Benefits Payable

The benefits available under the Pre-Medicare Retiree Plan of Benefits are the same as those shown for the Active Plan of Benefits on the Schedule of Benefits. However, the Retiree Plan of Benefits does not include Life Insurance, AD&D Insurance, and Weekly Accident and Sickness Benefits.

Retired Employees

When you retire, you may choose to make self-payments under the Self-Pay Program (explained on page 11) or this Pre-Medicare Retiree Plan of Benefits if:

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

- For the quarter immediately prior to retiring, you were eligible for benefits under this Plan by virtue of any combination of the following: Contribution Hours, Reserve Accumulation Account Hours, and Self-Pay Contributions. If you retire on or after January 1, 2014, but before August 1, 2015, you will still be eligible for the Pre-Funded Allowance if you are available for work during that Benefit Quarter, even if you are not eligible for coverage in the Benefit Quarter immediately prior to retirement. In addition, if you have had health coverage elsewhere continuously since you lost coverage under the Fund until your retirement, you will still be eligible for the Retiree Pre-Funded Allowance.

Contact the Fund Office when you apply for Medicare.

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

If you choose the Self-Pay Program, you MUST waive COBRA continuation coverage. Instead of the Self-Pay Program, you may choose to continue coverage under COBRA continuation coverage explained on page 14.

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

Disabled Employees

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

Dependents of Deceased Employees

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

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

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

Medicare Advantage Program

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

As you and/or your dependents become eligible for Medicare, you may continue coverage under the Plan's Medicare Advantage Program if you qualify for retiree coverage and make the self-payments. Retirees who are eligible for Medicare and meet the eligibility requirements below may choose from two Medicare Advantage Plans sponsored by the Iron Workers Tri-State Welfare Fund.

Eligibility

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

- You are Entitled to Medicare;
- You do not have enough hours left in your Reserve Accumulation Account to pay for a quarter of coverage;
- You are receiving retirement benefits from the Iron Workers Mid-America Pension Plan or the Iron Workers Local 380 Retirement & Severance Plan;
- Before retiring, you were eligible for benefits by virtue of Contribution Hours under this Plan for some part of each of the last ten (10) calendar years; and
- For the quarter immediately prior to retiring, you were eligible for benefits under this Plan by virtue of any combination of the following: Contribution Hours, Reserve Accumulation Account Hours, and Self-Pay Contributions. If you retire on **or after January 1, 2014, but before August 1, 2015**, you will still be eligible for the Pre-Funded Allowance if you are available for work during that Benefit Quarter, even if you are not eligible for coverage in the Benefit Quarter immediately prior to retirement. In addition, if you have had health coverage elsewhere continuously since you lost coverage under the Fund until your retirement, you will still be eligible for the Pre-Funded Allowance.

If you choose the Medicare Advantage Plan, you waive COBRA continuation coverage, if applicable. Instead of the Medicare Advantage Plan, you may choose to continue coverage under COBRA continuation coverage, if applicable, as explained on page 14.

The self-pay option for the Medicare Advantage Plan is available to Employees and their eligible spouses who are Entitled to Medicare coverage. Under the Medicare Advantage Plan, your benefits under Medicare Parts A, B, and D (prescription drug coverage) are included. You have two Medicare Advantage Plans from which to choose, Medicare Advantage Plan 1 and Medicare Advantage Plan 2.

If you suffer from end-stage renal disease prior to coverage in the Medicare Advantage Plan, your coverage will be provided through the Pre-Medicare Retiree Plan of Benefits even if you are Entitled to Medicare coverage.

Payment Information

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

Retiree Pre-Funded Allowance

Pre-Funded Allowance Effective Dates

Local 444—
January 1, 2004

Local 465—
January 1, 2005

All others—
January 1, 1999

If you are active on, and earned at least one Quarter of Service, after your effective date and retire before you reach age 65, you may be eligible to continue Eligibility with the Retiree Pre-Funded Allowance. You must waive COBRA Continuation Coverage in order to receive the Allowance, which is used as a discount toward the quarterly self-pay rate for the Pre-Medicare Retiree Plan of Benefits or one of the two Fund-sponsored Medicare Advantage Plans. Please note that if you choose a Medicare plan that is not sponsored by the Fund, you will not be eligible for the Retiree Pre-Funded Allowance. The allowance is applied toward the quarterly self-pay rate for your and your dependents' coverage.

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

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

For more information, see the brochure, Ironworkers Tri-State Welfare Fund Pre-Funded Allowance.

Life Events

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

Getting Married

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

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

Adding A Child

Your natural born child will be eligible for coverage on his or her date of birth. If you adopt a child, or have a child placed with you for adoption, coverage will become effective on the date of placement as long as you are responsible for health care coverage and your child meets the Plan's definition of a dependent. Stepchildren are eligible for coverage on the date of your marriage, provided they are living in your home and dependent on you for support. Once you provide any required information, coverage for your child will begin. The child must meet the dependent eligibility requirements described on page 66.

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

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

If you legally divorce, provide the Fund Office with:

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

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

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

Getting Legally Divorced

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

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

Losing Eligibility

A detailed description of the requirements needed to continue eligibility is shown on page 3. If you are an active employee and your eligibility ends under the Active Plan, you can become eligible again by meeting the initial eligibility requirements as described on page 2. When your coverage ends, you may be eligible to continue coverage by using your reserve accumulation account, making monthly self-payments for self-pay continuation coverage, or self-paying for COBRA Continuation Coverage (see page 14).

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

- Contact the Fund Office.
- Enroll for COBRA Continuation Coverage if he or she plans to continue coverage under the Plan.

Child Losing Eligibility

In general, your child is no longer eligible for coverage when he or she reaches age 26 or has access to medical coverage through his/her own employer. You must notify the Fund Office within 60 days of the date your child is no longer eligible for coverage. Your child may elect to continue coverage by making COBRA self-payments for up to 36 months.

When You Are Out of Work Due to Disability Continuing Eligibility

If you are out of work due to a disability (whether work related or not), you may be credited with 27 hours for each full week of disability, up to 700 hours during any consecutive 12-month period. If your Eligibility ends, benefits may be continued for up to 18 months under COBRA Continuation Coverage. After your disability ends, you must notify the Fund Office.

Accident & Sickness Weekly Income Benefits

If you are out of work due to a non-work-related disability, you may receive Accident and Sickness Weekly Income Benefits until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first.

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

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

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

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

Accidental Death & Dismemberment (AD&D)

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

In The Event of Your Death

Actives

If you are eligible for coverage on the date of your death, your beneficiary will receive a Life Insurance Benefit (and an AD&D Insurance benefit, for active employees only if your death is caused by an accident). See page 46 for more information about Life and AD&D Insurance.

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

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

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

Pre-Funded Retiree Allowance

If you are eligible for the Retiree Pre-Funded Allowance, are an active participant, and die, your eligible surviving spouse can receive the Allowance that you would have received had you lived and retired. The Allowance is based on your quarters of service at the time of your death. Your dependents can continue coverage under the Active Plan until their costs deplete your reserve accumulation account. At that point, your dependents can continue coverage in the Pre-Medicare Retiree Plan. Your spouse

can elect one of the options under the Retiree Pre-Funded Allowance, which will offset the cost of 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.

Retirees

If you are a retiree and die, your surviving dependents can continue coverage through self-payments for up to five years or when they become eligible for Medicare, whichever comes first. If the self-payments are discontinued for any month, or if your dependent does not elect to make self-payments when first eligible, your dependent will not be eligible to continue coverage by making self-payments. Remember, your dependent(s) must waive COBRA to elect any self-payment option.

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

When You Leave Covered Employment: COBRA Continuation Coverage

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you would otherwise lose your group health coverage. See page 14 for more information about COBRA.

Military Service and Eligibility

If your Eligibility ends because you enter or are drafted into active military service, your Eligibility is reinstated if you make application for reemployment with a contributing Employer within the time required by the applicable Federal law. Eligibility for you and your Dependents will be reinstated on the day you return to work. See page 8 for more information.

If you are called to military service:

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

Family and Medical Leave Act (For Active Employees)

The Family and Medical Leave Act (FMLA) of 1993 allows you to take up to 12 or 26 weeks of unpaid leave for your serious illness, to care for a child after the birth, adoption, or placement for adoption of a child, or to care for your seriously ill spouse, parent, or child. See page 4 for more information.

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

When You Retire

When you retire, you may be eligible for coverage under the Pre-Medicare Retiree Plan of Benefits or the Medicare Advantage Plan, if you meet the eligibility requirements. If you choose coverage under the Pre-Medicare Retiree Plan, you must waive your right to COBRA Continuation Coverage.

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

Returning to Work

If your eligibility ended and you start working again for an employer that contributes to the Fund, your coverage will be reinstated as described on page 2. If you return to work following a military leave of absence, your coverage will be reinstated as described on page 8.

Your Medical Benefits

Cost Saving Features

When You Are Hospitalized—The PPO Hospital Network

If you or a covered Dependent is hospitalized, you will receive the Hospital benefits described in these sections when you use a PPO Hospital. If you receive services from a non-PPO Hospital, your share of the cost for services increases 20%. If you live more than 25 miles from the nearest PPO Hospital or if you are seeking Hospital care in an emergency situation, benefits will not be reduced. For an up-to-date list of PPO Hospitals in your area, please contact Blue Cross and Blue Shield (see page 1 for contact information).

Utilization Review

The Utilization Review (UR) Company must pre-approve all Hospital care, except in an emergency situation or for childbirth if the length of the Hospital stay is within the guidelines described on page 67. The UR Company must be notified within two days (48 hours) of an emergency admission. If you do not receive pre-approval, you will have to pay an additional $200 deductible penalty for the hospital stay.

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

Emergency Room Copayment

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

Recovery Incentive Benefit

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

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

Special Extra Work Benefit

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

How the Plan Works

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

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

Deductibles

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

Annual Out-of-Pocket Limits

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

- Out-of-network expenses;
- Expenses that are not covered; and
- Expenses above any annual or lifetime limits, such as Diabetes education over the $500 lifetime limit.

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

Allowable Charge

The maximum amount the health care plan will reimburse a doctor or hospital for a given service. These amounts are based on the rates negotiated by the network.

Annual or Lifetime Limits

Some covered expenses are only covered up to an annual and/or lifetime limit. All annual and lifetime limits are shown on the Schedule of Benefits in the back pocket.

Healthy Foundations

Healthy Foundations Benefits

The Plan provides a variety of benefits and resources to help you and your family maintain the best health possible. We all want to be healthy; but it takes some effort on an individual basis. It's really up to you. The Plan provides resources for preventive services and for disease management services. In addition, if you complete specific wellness activities, the Plan will put aside money into your Healthy Foundations Account for you to 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 you and your spouse. No deductible applies to these benefits. Talk to your doctor to see how often you should have a physical. In addition, the Fund arranges for screenings at Local Union Halls periodically. These screenings are free to you and count toward your wellness rewards through your Healthy Foundations Account (HFA).

The following expenses are covered:

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

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

Take the Health Assessment

When you and your spouse take the Mayo Clinic Health Assessment on the Embody-Health website, you and your spouse can each earn $100 for deposit in your Healthy Foundations Account (HFA). The assessment takes about 12 minutes and consists of a simple fill-in-the-blanks and multiple-choice questionnaire. You will need your biometric information, such as blood pressure and cholesterol levels that you can get from your annual physical or a LifeLine screening.

Registering and Logging In

You (and your spouse, if married) first need to go online to register. You and your spouse must register separately. Just follow these quick and easy steps:

1. Log on to www.mcmhealthsolutions.com
2. Click *Register now*

3. Enter a valid email address and create a password
4. Input a few basic facts about yourself (such as gender, location, and age) to enable initial personalization of your homepage. Enter your SSN if you are the primary policyholder. If you are the spouse, use the primary policyholder's SSN followed by an "S" (i.e. 123456789S).
5. Agree to the terms of service and check whether you'd like to receive the free weekly newsletter
6. Click *Confirm* when you receive the email confirmation of your registration

That's all there is to it. You're now ready to take the next step.

1. You can access the health assessment from your personalized page on Embody-Health by:
2. Logging onto www.mcmhealthsolutions.com
3. Entering your email address and user password
4. Selecting *I'm ready to take the Health Assessment now* on the *Welcome to the Mayo Clinic Health Assessment* screen.
5. Answer the questions as accurately and honestly as you can

Assessment Results

After you have finished the health assessment, you will instantly receive a results summary showing your health strengths and risks, as well as an overall risk level. When you are directed back to your personalized homepage, an individual Action Plan for healthier living appears. Follow the links for more information about available programs. From there, it's up to you to decide how to best utilize the site's suggestions for enhancing your health and wellness.

If you are married, you and your spouse should register separately on Mayo Clinic Embody-Health and each take the Health Assessment. If both you and your spouse complete the assessment, you'll receive $200 in your Healthy Foundations Account (HFA) to be used for out-of-pocket medical expenses such as those outlined on page 31.

Chronic Disease Management with Optimal Health

Whether you've been previously diagnosed with a chronic medical condition or are at high risk for developing one due to family history or other factors, the Optimal Health disease management program is designed to help you stay well or to get better. All it takes is one simple call to Optimal Health at 1-800-367-9938 to get started.

Coaching You to Better Health…

When you participate in the Optimal Health program, a Registered Nurse (RN) Health Coach is assigned to you to assist you in taking charge of your health and lifestyle through regular telephone counseling sessions. He or she will work with you to identify any gaps in your current care, offer suggestions, and educational materials to help close those gaps, and consult with your physician to coordinate care. Together, you and your coach will set mutually agreed upon goals and determine appropriate timeframes for follow-up calls.

Your coach will also assist you in:

- Learning how to monitor your symptoms and make better decisions about your health;
- Answering any questions or concerns about your medical condition;
- Helping you prevent emergency room visits or hospital stays; and
- Supporting you in making lifestyle changes that can improve your quality of life.

Optimal Health Coaches are available from 7:30 am to 5:30 pm Central Time, Monday through Friday. If night or weekend telephone appointments meet your needs better, these can be arranged as well.

The Optimal Health program is confidential and available at no cost to you. In fact, you can even earn money for participating. For every calendar quarter you maintain contact with your RN Health Coach, you earn an extra $25 for deposit in your HFA.

Optimal Health understands having a chronic condition can be difficult, and that medical information can be confusing. They also understand that changing habits can be hard. That's why they are always on call with sound information, advice, and support—so you can lead the healthiest and most productive life possible.

Diabetes Education

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

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

Optimal Health or Embody-Health: Which Is Right for You?

If you have been previously diagnosed with a chronic condition, are currently taking medications for one, or have been identified as being at high risk for developing one in your lifetime, Optimal Health will give you a courtesy call to set up an initial phone appointment with a health coach if they do not hear from you. Participation is voluntary, but highly recommended.

Healthier Living Through Mayo Clinic Embody-Health

Mayo Clinic Embody-Health is an interactive web site that promotes wellness by offering a vast array of articles, tools, videos, and healthy recipes from the experts at Mayo Clinic. It also provides help if you or a family member are ill, featuring a symptom checker, information on medical conditions, treatment and treatment alternatives, and 24/7 access to the HealthInfoLine, which is staffed by a nurse to answer all your health-related questions no matter what time of day or night.

Your Embody-Health Homepage

When you register on Mayo Clinic Embody-Health, your home page will be personalized with information specific to your gender, age, and interests. After you take the assessment, it will be further tailored to your needs with specific suggestions based on your current health status.

If the Mayo Clinic Health Assessment shows you are generally healthy and do not have a chronic condition or risk of developing one, Embody-Health will recommend exploring one or more of the five lifestyle centers to enhance your wellness. The available programs are:

- Fitness for EveryBody;
- My Weight Solution;
- Healthy Pregnancy;

- My Smoke-Free Future; and
- My Stress Solution.

You may enroll in one or more of these, depending on your situation. All are multi-week programs encouraging lifestyle and behavior change, and include goal-setting and tracking tools, articles, videos, and supportive emails to help you along the way.

Once you complete one or more of these modules, as evidenced by tracking your progress throughout the duration of the program, an additional $100 will be deposited in your HFA.

Healthy Foundations Account (HFA)

How the HFA Works

The HFA is a type of account known as a health reimbursement arrangement. Your Employer contributes toward your HFA (both on an hourly and discretionary basis). In addition, if you and your spouse complete certain wellness activities, the Fund will contribute toward your family HFA account. You can use your HFA balance to pay for certain medical expenses that your health care plan does not cover. In general, you can use the money in your account to pay for costs the IRS considers eligible medical expenses, such as:

- Out-of-pocket plan costs, including deductibles, copayments, and coinsurance;
- Payments for group coverage, including self-payment, retiree self-payment and COBRA contributions;
- Healthcare and expenses not covered, or only partially covered, under the Active and Pre-Medicare Retiree Plan or any other healthcare plan, and expenses that exceed benefits maximums; and
- Premiums paid for other group healthcare coverage or insurance, Medicare, and long-term care insurance. You may not use the HFA to purchase any type of individual health insurance coverage whether through an exchange or otherwise.

Although you and your spouse are the only family members who can earn money for the HFA, you can use your account balance to pay for expenses for yourself, your spouse, and your eligible dependents.

Right to Opt Out of HFA

You have the right to opt out of the HFA benefit permanently, at any time, including upon termination of Covered Employment. If you opt out, you waive any right to future reimbursement and you may not re-enroll at a later date.

How Your HFA Grows

You receive HFA dollars in two ways: through Employer contributions and through incentives when you and your spouse complete certain wellness activities. Your Employer contributes on your behalf through the hours you work and on a discretionary basis. When your Employer makes discretionary contributions, you will be notified.

As an incentive to promote better health and wellness, a Healthy Foundations Account (HFA) will be established for every member who participates in the Embody-Health and/or Optimal Health programs. You and your spouse each receive $100 for registering on Mayo Clinic Embody-Health and taking the Mayo Clinic Health Assessment. In addition, you may receive up to an extra $100 each by actively participating in the recommended Optimal Health disease management program or Embody-Health online wellness program. That's up to $400 a year to use toward eligible out-of-pocket health care costs for your family!

You earn money for your account by participating in eligible Healthy Foundations programs, such as Mayo Clinic Embody-Health and Optimal Health. If a balance remains in your HFA at the end of the year, it rolls over into the next year, allowing you to use it for reimbursement of future expenses. There is no limit on the amount that can be carried forward from year to year.

As long as you are eligible to participate in the HFA, the balance in your account is available for you to use as you see fit. You can:

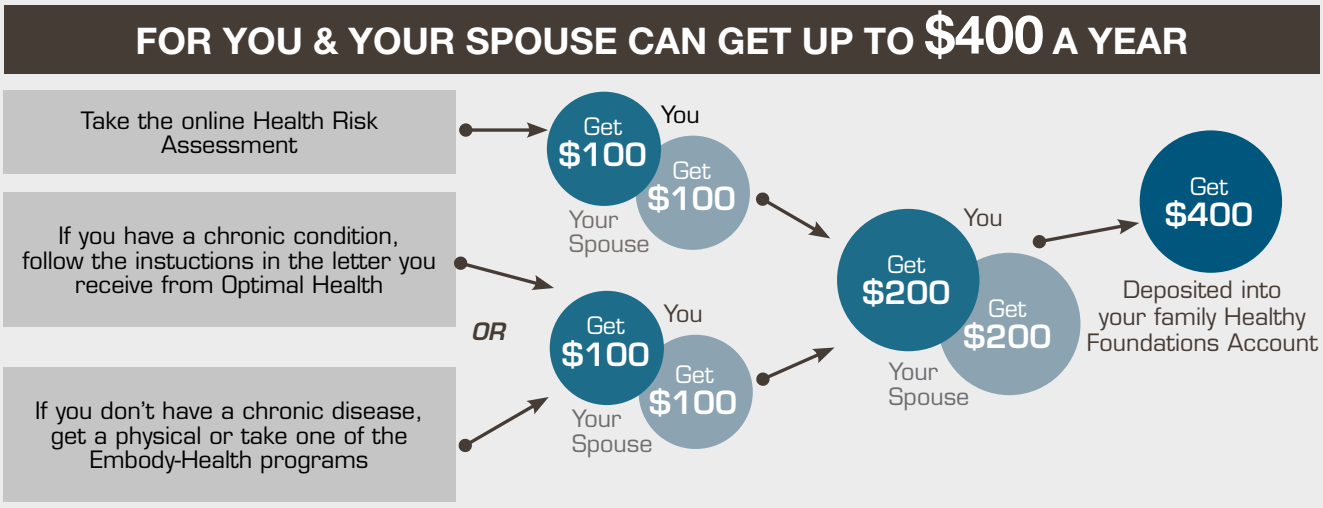
- Save the balance in your account for future healthcare needs;
- Pay for current healthcare expenses; or
- Make any necessary self-payments for either COBRA continuation coverage or coverage under the Active or Retiree Plan, if you are eligible for and elect coverage.

How You and Your Spouse Earn HFA Dollars

By participating in a disease management or wellness program, whichever is applicable, you'll be on your way to better health, along with up to another $100 per covered person (you and your spouse) for your HFA.

Here's how it works. You and your spouse each can earn $100 toward your HFA by completing the online Health Risk Questionnaire (HRQ). In addition, if you and/or your spouse:

- ***Have been diagnosed with a chronic illness or identified as being high risk for developing one,*** you can earn an additional $25 per quarter when you enroll and actively participate in the Optimal Health one-on-one disease management coaching.
- ***Are currently in good health and have not been identified as being at high risk for a chronic illness,*** you can earn an extra $100 per person by enrolling and participating in one of the Embody-Health wellness programs or by getting an annual physical from the physician of your choice or LifeLine Screening. To enroll in an online program, go to www.mcmhealthsolutions.com and select the *Improve Lifestyle Habits* tab.



Getting Reimbursed

When you need to pay for eligible expenses through the HFA at the time of service, you can use your debit card. If you would like to be reimbursed for amounts you paid for example your deductible or coinsurance, you will need to apply for reimbursement.

Using the Debit Card

Your HFA balance will be on the debit card that you will receive. You may pay for eligible HFA expenses through your debit card. For example, you can pay for prescription drugs with your debit card.

If you erroneously use your debit card for a non-medical item or an item that cannot be properly substantiated, you will need to repay the Welfare Plan.

You can view your balance and transactions by going to www.tristatewefarefund.com and clicking on the HFA benefit link. You will need to login to access your account balance.

If you do not have access to the Internet, call the Fund Office at 1-630-960-3322.

Getting Reimbursement

Alternatively, you may file claims to have expenses that count toward your deductible or your coinsurance paid by your HFA balance. To file claims for reimbursement, go online to www.tristatewefarefund.com and click the link to Forms. Select the *Healthy Foundations Account (HFA) Reimbursement Form.* Print and complete the form, attach all pertinent documentation such as receipts, bills, and/or Explanation of Benefits (EOBs), and mail it to the address listed on the form. Once approved, your reimbursement will be debited from your HFA balance and a check will be mailed to you.

Hearing Aid Benefits

For Active and Retired Employees Only

You are eligible for a hearing aid benefit of up to $2,500 per ear, once every 36 months. You must go through EPIC Hearing Healthcare. EPIC will refer you to a hearing care professional for a free basic hearing exam. If you need a more extensive hearing exam, it is covered under the Medical Benefit, subject to the deductible and coinsurance. EPIC provides access to hearing technology at a discount and provides free hearing aid extended warranties and batteries at no charge. If you need hearing services or just suspect you do, call EPIC at 1-866-956-5400.

Covered Medical Expenses

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

1. Room and board including any charges that are made by the Hospital as a condition of occupancy or on a regular daily or weekly basis such as for general nursing services. However, if private accommodations are used, any excess of daily board and room charges over the Hospital's average semi-private charge will not be counted as a covered medical expense unless documentation is presented from the attending Physician that a private room is Medically Necessary.
2. Miscellaneous Hospital Charges, other than room and board, furnished by the Hospital.
3. Outpatient surgical services.
4. The services of a Physician.
5. The services of a registered graduate nurse (R.N.) other than a nurse who resides in the Employee's home or who is a member of the Employee's or his/her spouse's family
6. Chiropractic and acupuncture services.
7. Diagnostic laboratory and X-ray examinations.
8. X-ray, radium and radioactive isotope therapy.
9. Chemotherapy.
10. Anesthetics and oxygen.
11. Rental of durable medical or surgical equipment.
12. Artificial limbs and artificial eyes, but not eye examinations, eye refractions, eyeglasses, or hearing aids.
13. Medically Necessary professional ambulance service to a Hospital within the jurisdiction of the Fund as certified by a Physician. Such transportation includes a transfer between Hospitals if such transfer results in more highly specialized care.
14. Incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth, limited to:
    - Alveolar abscesses;
    - Alveolectomies;
    - Apicoectomies (resection of root of tooth);
    - Cysts of jaws;
    - Epulis (fibrous tumor of the gum); or
    - Partially or completely unerupted impacted teeth.
15. For all other dental work and oral surgery, only the charges of a Hospital, anesthesia, and dental occlusal mouth guards when Medically Necessary due to sleep apnea are included as covered medical expenses.
16. Cosmetic Surgery that is necessary for the prompt repair of a non-occupational accidental injury.
17. In-patient and outpatient treatment for alcohol, drug and chemical dependency.
18. In-patient and outpatient treatment for Behavioral Health Disorders.

19. Up to 100 Home Health Care visits from a Home Health Care Agency per calendar year. A visit consists of up to four consecutive hours of Medically Necessary care by one or more providers from the Home Health Care Agency.

20. Room and board and miscellaneous services for an Eligible confinement in a Skilled Nursing Care Facility for up to a maximum of 120 days per calendar year. Such confinement is covered when:

- The confinement begins within seven days after a Hospital stay of at least three consecutive days;
- The confinement is for the same or related cause; and
- The Utilization Review (UR) company has pre-certified the confinement and will monitor the Person's progress on an on-going basis.

21. The treatment of infertility or for promotion of pregnancy, including prescription drugs. The attending Physician must submit medical documentation accepted by the Board of Trustees and/or the UR company that less expensive treatment has not and is not expected to result in pregnancy before in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), embryo transfer or similar procedures are covered.

22. Modified solid food products that are low protein or which contain modified protein or other enteral formulas for home use, other than nutritional supplements taken selectively, provided that:

- A Physician has provided a written prescription for the above items;
- The prescription states that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for the individual;
- In the absence of the above items, the individual is or will become malnourished or suffer from disorders, which if left untreated, will cause chronic physical disability, mental retardation or death; and
- The individual has been diagnosed with: inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophaegeal reflex with failure to thrive; disorders of gastrointestinal motility (such as chronic intestinal pseudo-obstruction); and multiple, severe food allergies which, if left untreated, will cause malnourishment, chronic physical disability, mental retardation or death.

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

24. Treatment received in an immediate care or urgent care facility.

25. In the case of an individual who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, in consultation with the attending Physician, the Women's Health Cancer Rights Act (WHCRA) requires coverage for the following:

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

26. This Plan complies with the requirement that group health plans and health insurance issuers offering group health insurance coverage generally may not—under Federal law—restrict a mother's or a newborn child's benefits for any hospital length of stay related to childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean

section. In addition, a provider must not be required to obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

27. Hospice Expenses—The Plan provides coverage to participants who are diagnosed as terminally ill with a life expectancy of six months or less. The Hospice benefit takes the place of all other Plan benefits. Benefits begin on the day the patient is diagnosed as terminally ill. If the patient is still living after six months, benefits may continue if the attending Physician confirms that the patient is still terminally ill.

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

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

28. Supplemental Accident Benefit—The Supplemental Accident Benefit offers additional benefits if you are injured in an accident. This benefit pays 100% of the Allowable Charges. The expenses must be incurred within 90 days of the accident for:

- Hospital room and board charges, including required services and supplies;
- Physician services, supplies, and drugs; and
- Physician ordered X-rays and laboratory tests.

The Supplemental Accident Benefit does **not** cover:

- Expenses for the treatment of an illness;
- Expenses associated with treatment received more than 90 days after the accident; or
- Any exclusion listed in the section General Plan Exclusions and Limitations on pages 51-52.

29. Organ transplants, only if there is medical documentation that conventional treatment could be unsatisfactory, unavailable and/or more hazardous than a transplant, and that the patient's condition could be life threatening, and that the patient be legally required to pay for the transplant procedure. If these criteria are met, the following organ transplants are covered: kidney, heart, heart/lung, cornea, bone marrow, bone, skin and liver. The Plan also covers expenses for the harvesting of donor organs needed for a Participant's transplant, whether the donor is alive or not.

Expenses Not Covered By the Comprehensive Medical Benefit

Any treatment, services or supplies listed under General Plan Exclusions and Limitations on page 51-52.

The Prescription Drug Benefit

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

Deductible

Your individual and family deductibles for the Prescription Drug Benefit are shown on the Schedule of Benefits. The Prescription Drug Benefit deductible is separate from the Comprehensive Medical Benefit deductible.

Retail Pharmacy Program

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

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

Please call Express Scripts (see page 1 for contact information) for the name of a participating pharmacy near you.

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

Mail-Order Program

After you meet your deductible, you pay the co-payment amounts shown on the Schedule of Benefits. Generic drugs have the lowest copayment, followed by formulary drugs and non-formulary drugs.

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

Your Preferred Prescriptions Formulary

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

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

Therapeutic Transfer Program

Our prescription drug provider has a program to help control costs and provide you and your family with the best prescription value. The prescription drug provider has a prescription drug formulary. A formulary is a list of prescription drugs that offer the same or better therapeutic benefit for less cost than other drugs for the same condition. Generic drugs are included in the formulary. Since you pay less for generic and other formulary drugs than for non-formulary drugs, Express Scripts can help you keep costs down by suggesting a formulary drug when your doctor prescribes a medication that's not on the formulary. Here's the process you can follow to save money:

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

Covered Expenses

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

- Legend drugs which are lawfully obtainable only from an individual licensed to dispense drugs upon the Physician's prescription, including oral contraceptives;
- Injectable insulin;
- Prescribed syringes, hypodermic needles, test strips and other Medically Necessary supplies used for the administration of injectable insulin;
- Up to six pills per month of erectile dysfunction (ED) medication; and
- Compound medication of which at least one ingredient is a prescription legend drug.

Exclusions and Limitations

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

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

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

Dental Expense Benefit

(If Shown On Your Schedule of Benefits)

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

Preventative And Diagnostic	100%
Restorative and prosthodontics	80%
Orthodontic	60%

Each coverage type is explained in more detail in the *Covered Expenses* section below. Benefits are paid each year up to the individual annual maximum of $1,000. This maximum does not apply to preventive services for children under the age of 19. Benefits for Orthodontic services are paid up to the lifetime orthodontic maximum of $1,000, and are only available to covered Dependents under age 19.

Predetermination of Benefits

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

Covered Expenses

The following covered dental charges are reimbursed for these dental services:

Diagnostic and Preventative Dental Services

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

Restorative Dental Services

- Extractions (except for orthodontics).
- Restorative services using amalgam, synthetic porcelain and plastic filling material.
- Oral surgery and the administration of Medically Necessary general anesthetics. Benefits will first be payable under the medical plan and then any excess covered dental expenses will be payable under this Dental Expense Benefit.

- Injections of antibiotic drugs.
- Periodontal treatment.
- Endodontics including pulpal therapy and root canal filling.

Prosthodontic Dental Services

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

Orthodontic Services

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

Exclusions and Limitations

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

1. Any service rendered before coverage became effective.
2. Treatment other than by a licensed Dentist or licensed Physician, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by the Dentist.
3. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
4. Replacement of a lost, missing or stolen prosthetic device.
5. Replacement or repair of an orthodontic appliance.
6. Any services that are covered by Workers' Compensation laws or employer's liability laws, or services that an employer is required by law to furnish in whole or in part unless a written subrogation and reimbursement in a form satisfactory to the Trustees is signed.
7. Service rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer.
8. Services or supplies for which no charge is made that the covered person is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.
9. Services or supplies that are not Medically Necessary according to accepted standards of dental practice.
10. Services or supplies that do not meet accepted standards of dental practice, including charges

for services or supplies that are Experimental or Investigative in nature.

11. Services or supplies received as a result of dental disease, defect or Accident due to an act of war, declared or undeclared.
12. Any duplicate prosthetic device or any other duplicate appliance.
13. Oral hygiene and dietary instruction.
14. A plaque control program (a series of instruction on the care of the teeth).
15. Periodontal splinting.
16. Myofunctional therapy or correction of harmful habits.
17. Implantology.
18. Any orthodontic procedures performed after the first 24 months of treatment.
19. Any treatment, services or supplies listed under General Plan Exclusions and Limitations on page 51-52.

Extension of Benefits

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

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

Vision Care Benefit

(If Shown On Your Schedule of Benefits)

When you use VSP providers (in-network), many of your services are provided at no cost to you. When you go to a non-VSP provider (out-of-network), you will continue to receive the $200 per person annual allowance. See the Schedule of Benefits for specific coverage.

Finding a VSP Provider

To find a VSP provider near you, either go online to www.vsp.com and select the "Find a VSP Doctor" button to the left of the screen or call Member Services at 1-800-877-7195 or if you are hearing impaired,1-800-428-4833.

Member Services Hours:	7 a.m. - 10 p.m. Central Time Monday – Friday 8 a.m. - 7 p.m. Saturday

Using the VSP Website

The VSP website, www.vsp.com, is easy to use and allows you to find a VSP doctor and view your benefits, claims, and answers to a variety of questions. The first time you go to the website, you should register so that you can access this Plan's vision benefits and your claims.

- To register, click on the "REGISTER FOR A VSP.COM ACCOUNT."
- The next screen will ask you to choose an "Identification Method", choose "Last four of SSN," which is the method used by our Plan.
- You will then choose a Member User Name and Password.
- After you are registered, when you enter the site again, you can use just your Member User Name and Password to login.

Using Your Benefits

When you make an appointment with a VSP doctor, tell them that you are a VSP member. When you visit the doctor, you don't need to have an ID card. Your VSP doctor will send claims to VSP directly; you don't have to do anything.

If you go to a non-VSP doctor, contact VSP and they will guide you on how to file for reimbursement.

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

Exclusions and Limitations

The following expenses are not covered by the Vision Care Benefit

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

Life Insurance Benefit

For Eligible Active Employees and Their Dependents

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

Employee Life Insurance

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

Keep your beneficiary designation at the Fund Office current!

Designating Your Beneficiary

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

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

If You Become Disabled

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

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

The Initial Proof must show that the Total Disability:

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

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

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

Dependent Life Insurance

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

- Spouse: $2,500
- Child (as defined by the insurance policy): $2,500

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

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

Conversion of Coverage

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

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

Accidental Death & Dismemberment (AD&D) Insurance Benefit

For Eligible Active Employees Only

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

For the loss of life, the AD&D Benefit will be paid to your named beneficiary; otherwise, the benefit is payable to you. For information about designating a beneficiary, see page 46.

Benefits Payable

The amount of the benefit paid depends on the severity of your loss; see the summary below:

For Loss Of:	Percentage of Principal Sum
• Life • Both Hands, Both Feet, Or Sight Of Both Eyes • Any Two Of The Following: One Hand, One Foot, Sight Of One Eye • Speech and Hearing • Paralysis of Both Arms and Both Legs • Brain Damage	**100%**
One Arm or One Leg	**75%**
• One Hand, One Foot, Sight Of One Eye • Speech or Hearing • Paralysis of Both Legs, or the Arm and Leg on one Side of the Body	**50%**
Paralysis of One Arm or One Leg	**25%**

Loss of hands or feet means severance at or above the wrist joint or the ankle joint. Loss of sight means the total and permanent loss of sight. Loss of an arm means severance at or above the elbow. Loss of a leg means severance at or above the knee. Other benefits are available; see the Insurer's certificate of coverage.

Weekly Accident and Sickness Benefit

For Eligible Active Employees Only

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

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

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

Benefits Payable

Non-Occupational disability

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

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

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

In addition, if you are receiving benefits for an occupational Accident you may continue to receive credit for hours as outlined on page 10.

Period of Disability

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

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

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

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

Examples:

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

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

General Plan Exclusions and Limitations

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

1. Charges that would not have been made if no coverage existed or charges that neither the Employee nor his or her Dependents are required to pay.
2. Services or supplies that are furnished, paid for, or otherwise provided for by reason of the past or present service of any person in the armed forces of a government.
3. Any supplies or services for which no charge is made.
4. Services or supplies that are paid for, or otherwise provided for under any law of a government except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents.
5. Any expense that is in excess of the Allowable Charge.
6. Any expense or charge for services or supplies not recommended or approved by the attending Physician, or not Medically Necessary in treating the Accident or sickness. This exclusion does not apply to X-ray and laboratory charges for routine physical examinations, patch tests, scratch tests and pap smears.
7. Any expense or charge for failure to appear for an appointment as scheduled or charge for completion of claim forms or finance charges.
8. Services and supplies to treat a non-occupational Accident or sickness or for which a third party is or may be responsible unless the agreement to subrogate and reimburse is signed as described on page 64.
9. Organ transplants unless they fulfill the requirements as stated under Covered Medical Expenses on page 37.
10. Services and supplies that are for the treatment of any condition caused by war, or any act of war, declared or undeclared, or by participating in a riot or as the result of the commission of a felony, except that treatment of illness or injuries arising from acts of domestic violence will be covered by the Plan.
11. Treatment considered Experimental or Investigative in terms of generally accepted medical standards.
12. Services and supplies that are not Medically Necessary in terms of generally accepted medical standards.
13. Covered services resulting from an accidental bodily injury arising out of and in the course of employment or from a disease compensable under any Workers' Compensation, Occupational Disease or similar law.
14. Any expense incurred before Eligibility for coverage begins or after Eligibility terminates unless specifically provided for under the Plan.
15. Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, home traction unit, tanning bed or water bed.
16. Special home construction or additions, such as the installation of a special ventilation system.
17. Speech therapy unless it is required because of a physical impairment caused by a disease or Accident.

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

19. Charges for expenses incurred more than 24 months before submission of the claim.

20. Charges incurred for Custodial Care (long-term care), except under the Hospice Benefit.

21. Charges for hearing aids, eye refractions, eyeglasses or their fitting, unless specifically indicated as covered.

22. Charges incurred in connection with radial keratotomy or any other surgical procedure performed to correct myopia (nearsightedness) or hyperopia (farsightedness) unless medical documentation is provided and deemed acceptable by the Trustees and/or UR company that such treatment is Medically Necessary and that conventional treatment would be unsatisfactory.

23. Charges for the reversal of elective sterilization procedures.

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

25. Cosmetic or plastic surgery, unless these services are required for the repair of an accidental injury to a physical organ. Reconstructive surgery following a mastectomy is covered.

26. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency under the section Definitions, or when you are on temporary work assignment for your Employer at a location outside the United States.

27. Charges for nutritional supplements or other enteral formulas for home use, except as specifically covered.

28. Charges related to weight loss, whether or not medically necessary.

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

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

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

31. Expenses for Behavioral Health Care services related to:

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

32. Routine foot care.

How to File A Claim

This section describes the procedures for filing claims for medical care or weekly sickness or accident benefits from the Iron Workers' Tri-State Welfare Fund (the Fund). When you or your Dependents file a claim, follow these procedures to assure prompt service. All claims under the Medicare Advantage Plans will be billed directly through to Medicare by your provider. These procedures do not apply to Medicare Advantage claims.

Definition of a Claim

1. A claim is a request for a benefit made by an individual (also referred to as "claimant" or "patient") or that individual's authorized representative in accordance with the Fund's reasonable claims procedures.
2. An urgent care claim is a claim for medical care or treatment such that the use the standard timeframes for making 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.
3. 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).
4. 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.
5. A post-service claim is a request for benefits under the Fund that is not a pre-service claim. Post-service claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a post-service claim.

A request is not a claim if it is:

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

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

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

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

- Participant name;
- Patient name;
- Patient date of birth;
- Social Security number of patient and participant;
- Date of service
- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition,* as maintained and distributed by the American Medical Association)
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition,* Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services) or, when effective, ICD-10;
- Billed charge;
- Number of units (for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider; and
- Billing name and address of the provider.

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

When Claims Must be Filed

Claims must be filed within 24 months of the service.

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

Where to File Claims

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

Fund Administrator
Iron Workers' Tri-State Welfare Fund
c/o: Zenith American Solutions
18861 90th Avenue, Suite A
Mokena, IL 60448

Authorized Representatives

The following people may be recognized as your authorized representatives:

- Health care provider;
- Legal spouse;
- Dependent child age eighteen (18) or over;
- Adult emancipated children;
- Parents or adult siblings;
- Grandparent;
- Court ordered representative, such as an individual with power of attorney for health care, legal guardian, or conservator; or
- Other adult.

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim (defined on page 53) without your having to complete the special authorization form.

Submitting False or Fraudulent Claims

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

- Any other insurance that may be payable or that has been paid with respect to the claim;
- All aspects of the events that gave rise to the claim;
- When any Dependent no longer meets the definition of a Dependent, such as when you and your spouse divorce or your child reaches age 26;
- If a third party caused the Accident related to the claim; and
- If an Accident, which gives rise to a claim, is work-related.

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

Expedite your claims processing:

- ✔ Remember to complete the Other Insurance Information part of the claim form at least once a year.
- ✔ For injury claims due to an accident, complete the Sickness/Injury Information Required for all Claims section on the claim form.
- ✔ Remember to sign the bottom of page one and page two (twice).

Claims for Medical Services

The following procedure applies to claims for Medical Services.

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

Timeframes

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

Disability Claims

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

Timeframes

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

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be decided on the basis of the information that the Fund has and may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either *45 days* or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information, you will be notified of the Fund's decision on the claim within *30 days*.

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

Life Insurance and AD&D Claims

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

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

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

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

Waiver of Premium

If you are disabled and meet the terms required for a waiver of premium for Life Insurance, you must submit an application with the required proof as described on page 46 to the life insurance company. If your application is approved, you must continue to provide annual documentation as to your continued Total Disability. As long as you continue to qualify, the waiver of premium will continue.

Notice of Decision

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

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

Assignment of Benefits

You may not anticipate, alienate, sell, transfer, pledge, assign, or otherwise encumber any interest in benefits to which you are or may become entitled under the Plan. The Trustees may, however, honor your assignment of benefits to the provider of covered services.

Neither you nor your beneficiary may transfer or assign any Life Insurance Benefit payments in anticipation of receiving them.

Benefit Payment to an Incompetent Person

Benefit payments under the Plan may become payable to a person who is adjudicated incompetent. In this event, the Trustees may make such payments for the benefit of the incompetent person as they deem best. The Trustees will have no duty or obligation to see that the funds are used or applied for the purpose or purposes for which paid if they are paid:

- Directly to the person;
- To the legally appointed guardian or conservator of such person;
- To any spouse, child, parent, brother, or sister of such person for the welfare, support, and maintenance of the person; or
- By the Trustees directly for the support, maintenance and welfare of the person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Plan, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

Improper or False Claims

If you (as the claimant) furnish false information on any material subject to the Plan, or to any of its agents or employees, the Trustees may deny all or part of your claim and may charge you for any expenses incurred relating to the false information. If benefits have already been paid, based on the false information on a material subject, the Trustees may recover the benefits from you, plus expenses incurred in such recovery, including attorney's fees, costs and any and all other expenses, and/or may reduce future benefits for your claims until the Plan has recovered.

Procedure to Appeal Denied Claims

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

Review Process

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

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

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

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

Timing of Notice of Decision on Appeal

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

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

for processing, a benefit determination will be rendered not later than the third meeting following the Fund's receipt of the request for review. If such an extension is necessary, the Fund must provide the claimant with a Notice of Extension describing the special circumstances and date the benefit determination will be made. The Fund Administrator must notify the claimant of the benefit determination no later than five calendar days after the benefit determination is made.

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

Notice of Decision on Review

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

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

Limitation on When a Lawsuit May be Started

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

Coordination of Benefits

You or your Eligible Dependent may be entitled to receive benefits from this Plan and another group health insurance plan (for example, if your spouse works and has health care benefits). If this happens, the two plans will coordinate benefit payments so that the combined payments of both plans will not be more than your actual covered expenses. One plan (the first plan) will pay its full benefits. Then the second plan will consider any covered expenses that are not completely covered by the first plan's benefits. No plan pays more than it would without the coordination of benefits provision.

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

- A plan without a coordination of benefits provision will always pay first.
- If both plans have a coordination provision, the plan covering the patient as an employee will pay before a plan that covers the patient as a dependent.
- A plan covering a Person as an active Employee will pay benefits before a plan that covers the Person as a retired or laid-off Employee.
- If your Dependent children are covered under the plans of both parents, the plan that covers the parent whose birthday falls earlier in the year pays first. If both parents have the same birthday, the plan that has covered the parent longer will pay first.
- If one plan uses the another type of rule and the other plan coordinates using the rule based on the parent's birthdays, the plan using the other type of rule will determine which plan pays benefits first.
- If you are legally separated or divorced, there are special rules regarding coverage for your children. If a court order known as a Qualified Medical Child Support Order (QMCSO) establishes the Fund's responsibility for the health care expenses of your children and the Fund has approved the QMCSO using their QMCSO procedures, benefits will be paid according to that order.
- If your child is not eligible by definition as a dependent and there is no QMCSO, benefits are paid as follows:

  Parents legally separated or divorced and remarried:

  - The plan covering the parent with custody will pay first.
  - The plan covering the stepparent with custody pays second.
  - The plan covering the parent without custody pays last.

- If none of the above establishes the plan that pays first, the plan that has covered the Person for the longer period of time pays first.

The Plan coordinates benefits with Medicare when legally possible. If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

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

Coordination of Benefits with Medicare

General Medicare Information for Retirees

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

If you retire, are eligible for retiree benefits under the Fund, elect one of the Fund-sponsored Medicare Advantage Plans, you will have coverage for Medicare Parts A, B, and D.

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

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

Coordination with Medicare for Active Participants

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

Fund's Right of Subrogation and Reimbursement

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

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

Definitions

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.

Allowable Charge:

- 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.
- With respect to an out-of-network provider, the Allowable Charge means the amount as determined by the Board of Trustees for a particular service or supply. 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 does not need to be part of a Hospital, but it must be permanently equipped and operated primarily to provide surgical services. A Physician's office may be considered an Ambulatory Surgical Facility for certain minor operations.

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

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

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

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

1. It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or

2. Where licensing is not required, it meets all of the following requirements: has at least one Physician on staff or on call **and** provides skilled nursing care by licensed Nurses under the direction of a full-time Registered Nurse (RN) **and** prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

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

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

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

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

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

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

Custodial Care (long-term care): Care rendered to a patient who:

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

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

Dependent: Any one of the following individuals:

- The Employee's spouse;
- An "Eligible Child" under the Plan is any one of the following individuals:
  - Any child who has not reached his/her 26th birthday (last day of the 26th birthday month), and is the employee's:
    - » Natural child;

  - » Adopted child or child placed for adoption;
  - » Foster child;
  - » Child who is named as an alternate recipient in a child support order, if the Plan determines the support order to be a Qualified Medical Child Support Order (QMCSO);
  - » Stepchild who was born to the spouse or who was legally adopted by the spouse before the marriage of the employee and that spouse;
- Any child listed above, at any age, who is unmarried, permanently and totally disabled and incapable of self-sustaining employment by reason of a medically determined physical or mental impairment that is expected to last for a continuous period of 12 or more months or result in death, and if:
  - » Such incapacity began before the child reached age 26,
  - » The child is dependent on the employee for at least 50% of his/her financial support and maintenance during the calendar year,
  - » The child maintains a principal residence with the employee during each calendar year, and
  - » The employee provides proof of such incapacity for the child when the Trustees request such proof.

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

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

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

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

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

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

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

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

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

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

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

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

Home Health Care consists of these services and supplies:

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

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

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

Hospital: Hospital means an institution that:

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

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

Injury: A bodily injury that requires treatment by a Physician and may result in loss, independently of Sickness or other causes.

Medically Necessary: A service or supply that:

- Is appropriate and consistent with the diagnosis in accord with accepted standards of community practice; and

- Could not have been omitted without adversely affecting the Person's condition or the quality of medical care.

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

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

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

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

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

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

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

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

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

Plan Year: Any calendar year (January 1 through December 31).

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

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

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

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

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

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

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

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

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.

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.

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

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;
- 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 on page ii, 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 Zenith American Solutions. 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 Zenith American Solutions
18861 90th Avenue, Suite A
Mokena, IL 60448
Toll-free: 1-866-463-9418
Email: tristate@abpa-tpa.com

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 Mr. Daniel McAnally. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon Mr. McAnally 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 abuse of discretion. 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:

MetLife
200 Park Ave
New York, NY 10166

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.