HEALTH BENEFIT PLAN

IRON WORKERS DISTRICT COUNCIL
(Philadelphia and Vicinity)

Locals 399, 401, 404, 405, 451

IRON WORKERS DISTRICT COUNCIL
(Philadelphia and Vicinity)

HEALTH BENEFIT PLAN

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TABLE OF CONTENTS

GENERAL INFORMATION 4

Name of Plan Sponsor and Fund Administration 4
Plan Amendments or Termination of Plan 5
Investments 6
Employer Contributions 6
Income and Reserves 6

ELIGIBILITY FOR BENEFITS 10

Effective Date of Coverage 10
Eligibility During Periods of Disability 11

TERMINATION OF BENEFITS 11

3000 Hour Look-back Rule 12
Reinstatement of Benefits 12

DEFINITION OF DEPENDENTS 13

Eligible Dependents 13
Continuation of Benefits for Certain Disabled Children 13

ENROLLMENT 14

How to Enroll 14
Start of Coverage Following Enrollment 15
Late Enrollment 15
Qualified Medical Child Support Orders (QMCSO) (Special Rule for Enrollment) 15

LEAVE OF ABSENCE FOR ELIGIBLE EMPLOYEES 16

CONTINUATION OF COVERAGE 18

Other Health Coverage Alternatives to COBRA 19
COBRA Eligibility (COBRA-Qualifying Events) 19
*COBRA Coverage in Cases of Social Security Disability 19
How COBRA Coverage Works 20
How to Elect COBRA Continuation Coverage 21
The COBRA Continuation Coverage that Will Be Provided 21
Paying for COBRA Coverage 21
Cost of COBRA Coverage in Cases of Social Security Disability 22

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE FOR EMPLOYEES 24

WEEKLY DISABILITY BENEFITS FOR EMPLOYEES 26

MEDICAL AND HOSPITAL BENEFITS Personal Choice PPO 27

Services that Require Pre-Authorization 28

COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE 34
Mandatory Generic Maintenance Prescription Drug (Mail Order) Program 36
Benefit Exclusions and Limitations 37
OPTICAL BENEFIT 38
DENTAL BENEFIT 39
Exclusions & Limitations 42
PENSIONER BENEFITS 43
CO-ORDINATION OF BENEFITS PROVISION 44
EXCLUSIONS 50
DEFINITIONS 51
CLAIMS AND APPEALS 53
EXTERNAL REVIEW OF CLAIMS 64
PAYMENT OF CLAIMS 69
YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) 72
HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION PLAN DOCUMENT AMENDMENT 73
RECIPROCAL AGREEMENTS FOR HEALTH AND WELFARE FUNDS 76
BRIEF EXPLANATION OF POINT OF CLAIM RECIPROCITY 76

GENERAL INFORMATION

Name of Plan Sponsor and Fund Administration

The Iron Workers District Council (Philadelphia and Vicinity) Benefit Plan is administered by a joint Board of Trustees, composed of an equal number of Union and Employer Trustees. The Board of Trustees is the Plan Sponsor and Plan Administrator. Certain day-to-day activities of the Plan (including determination of eligibility and enrollment) have been delegated to the Co-Administrators and Fund Office. The address of the Board is 2 International Plaza, Suite 120, Philadelphia, Pennsylvania 19113-1504.

Members of the Board Include:

NAME	BUSINESS ADDRESS
Kevin Boyle Local Union #401	11600 Norcom Road Philadelphia, PA 19154
Stephen Sweeney Local Union #405	2433 Reed Street Philadelphia, PA 19146
Jeffrey Hendrickson Local Union #451	203 Old DuPont Road Wilmington, DE 19804
Stephen Sweeney Local Union #404	981 Peifers Lane Harrisburg, PA 17109
Richard Sweeney Local Union #399	409 Crown Point Road Westville, NJ 08093
Adam Short c/o Steel Supplies, Inc.	PO Box 2662 Wilmington, DE 19805
Joseph N. Merlino Bayshore Rebar, Inc.	1509 S. New Road Pleasantville, NJ 08232
Jack Kocsis Building Contractors Association	Raritan Center Plaza II Fieldcrest Avenue Edison, NJ 08837-3627
Bernadette Sweeney P B A Construction Inc.	4999 Grays Avenue Philadelphia, PA 19143
Tad A. Hoffmaster Enerfab Power & Industrial, Inc.	8261 Old Derry Street Hummelstown, PA 17036

Fund Co-Administrators are Stephen E. Conley and Albert F. Frattali.

Plan Administrator is the Board of Trustees.

The Board of Trustees is the agent for service of legal process in accordance with the proposed regulations under the Employee Retirement Income Security Act of 1974.

For disputes arising under those portions of the Plan insured by Fidelio Dental Insurance Company or by Amalgamated Life Insurance Company, service of legal process may be made upon the applicable insurance company at one of their local offices or upon the official of the Insurance Department in the state in which you reside.

The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is EIN 23-1599740.

The Plan number is 501.

The fiscal year end date is September 30th.

Plan Amendments or Termination of Plan

Plan benefits for active, retired or disabled participants are not guaranteed.

The Board of Trustees reserve the right, subject to the provisions of any pertinent collective bargaining agreements, to terminate or amend the Plan or any part of it, at any time, without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan. The Board of Trustees reserves the right to amend, modify or terminate the Benefit Plan in order to maintain the financial integrity of the Benefits being provided to eligible participants as defined by the Plan. Such action will be taken at a Trustee meeting properly constituted in accordance with the provisions of the Agreement and Declaration of Trust. The decisions made and implemented by the Trustees shall be final and binding on all affected participants.

Amendments to the Plan will be made in writing and become effective on the written approval of the Board of Trustees, or on such other date as may be specified in the document amending the Plan.

Allocation and Disposition of assets upon termination

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of these Plan Rules.

The Plan may be terminated in writing by the Board of Trustees when there is no longer in effect an agreement between the Employer and the Unions requiring payment to the Fund. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Trustees and the Fund Office (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

Investments

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Fund's Assets and Reserves are invested and held in custody by Atalanta Sosnoff Capital, LLC.

Employer Contributions

The Iron Workers District Council (Philadelphia and Vicinity) Welfare Plan is maintained and receives contributions in accordance with collective bargaining agreements with various Employers in the industry and the Iron Workers Locals — 399, 401, 404, 405, and 451. These collective bargaining agreements provide that Employers contribute to the Fund on behalf of each covered employee on the basis of a fixed rate per hour, in accordance with the applicable collective bargaining agreement. A copy of any such agreement(s) may be obtained by participants and beneficiaries upon written request to the Co-Administrators and is available for examination at the Fund Office.

A complete list of employers and any applicable employee organizations sponsoring the Plan may be obtained upon written request to the Co-Administrators, and is available for examination at the Fund Office. In addition, you may receive, upon written request, information as to whether a particular employer or employee organization is a Contributing Employer and their address.

Income and Reserves

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement. Income received by the Fund from Contributing Employers is held in a Trust Fund for the purpose of providing benefits to covered Employees and defraying reasonable administrative expenses. The Fund's assets and reserves are invested by various investment advisors.

Type of Administration

The Board of Trustees of the Iron Workers District Council (Philadelphia and Vicinity) Health Benefit Plan self-funds group health plan for medical and hospital, alcohol/substance abuse, mental health, prescription drug, and optical benefits under the Plan. Claims for these benefits are administered by independent claims administrators as listed on the Summary of Benefits and Information on Contacts and Administrators Chart (on the following page).

Independent insurance companies (whose name and address are listed on the Summary of Benefits Chart, located on the following page) administer the fully insured benefits of this Plan (including Dental, Life, AD&D and Weekly Disability benefits) and provide payment of claims and determination of appeals associated with these benefits.

No Medical Examination

No medical examination is required in order to become covered under this Plan. However, in order to obtain coverage under the Plan, it is necessary to fill in a Health Benefit Enrollment Card. See page 10 for a description of the enrollment process.

Individual Certificates of Insurance/Booklets

As a Covered Member, you will receive a certificate from the Amalgamated Life Insurance Company that sets forth the terms of the Life Insurance, Accidental Death and Dismemberment (AD&D) and Weekly Disability benefits which are insured through a contract with Amalgamated. You will also receive a Certificate

from Fidelio that sets forth the terms of the Dental benefits that are insured by Fidelio. You will receive a Personal Choice PPO Booklet from Independence Blue Cross (IBC) that sets forth the hospital and medical benefits which are administered by Independence Blue Cross/QCC Insurance Company (they are considered the claims administrator for these benefits). These documents outline the particular terms and conditions of the policies issued to the Trustees. In the event of any question regarding the interpretation of a certificate or the proper payment of benefits, you may contact the applicable insurance company or claims administrator at the address and phone number listed in the Summary of Benefits Chart and Information on Contacts and Administrators starting on the next page.

> This document, together with the Certificates from Amalgamated and Fidelio as well as the Personal Choice PPO Booklet from QCC (a subsidiary of Independence Blue Cross), constitute your Plan Document/Summary Plan Description.

SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION		
FOR INFORMATION ON	**ADMINISTRATOR/ WHOM TO CONTACT**	**PLAN BENEFIT**
Eligibility, Enrollment, COBRA and General Plan Information including Privacy and Security and Claims Administrator for Mental Health/ Alcohol/ Substance Abuse Benefits	Administered by: Iron Workers District Council (Philadelphia and Vicinity) Health Benefit Plan Fund Office 2 International Plaza, Suite 120 Philadelphia, PA 19113-1504 Phone: 215-537-0900 or 1-800-473-5005 Fax: 215-537-0862 www.iwdcphila.com The Board of Trustees acts as the claims administrator/claim review fiduciary for purposes of eligibility and second level Medical (IBC PPO) appeals, Post-Service Mental Health and Alcohol/Substance Abuse Claims & Appeals, Post-Service Prescription Drug Appeals, and Post-Service Vision Appeals.	See the beginning of this SPD for information on when you will become eligible for benefits, eligible Dependents, enrollment rules, COBRA continuation coverage and other information. You may also contact the Fund Office for general information on the Plan's benefits and necessary forms.
Benefits for Members (Eligible Employees) Only		
Life Insurance and Accidental Death (AD&D) and Dismemberment Benefits	Insured and administered by: Amalgamated Life Insurance Company 333 Westchester Avenue White Plains, NY 10604 914-367-5000	Life Insurance benefit: $30,000 Accidental Death and Dismemberment benefits: $30,000 Accidental Death and Dismemberment work related: $70,000 See the Sections entitled Life Insurance Benefits beginning on page 24 and Accidental Death Dismemberment Benefits beginning on page 25.

SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION		
FOR INFORMATION ON	**ADMINISTRATOR/ WHOM TO CONTACT**	**PLAN BENEFIT**
Weekly Disability Benefit	Insured and administered by: Amalgamated Life Insurance Company 333 Westchester Avenue White Plains, NY 10604 914-367-5000	Eligible Employees are eligible for up to $150 per week. Duration based on disability for a maximum of 26 weeks. See the section entitled Weekly Disability Benefit beginning on page 26 for details.
Benefits for Members and Eligible Dependents		
HealthCare Strategies, Inc. Large case management and disease management	HealthCare Strategies 9841 Broken Land Parkway Columbia, MD 21046 1-800-582-1535 HealthCare Strategies, Inc., acts as the claims administrator for Large Case Management and Disease Management	Large Case Management Disease Management Out of Pocket maximum coordination **$1,000.00 Copay for non-compliance**
Preferred Provider Organization (PPO) Medical and Hospital Benefits Personal Choice PPO Program Pre-authorization and claims administration and out-of-pocket maximum coordination.	Administered by: Independence Blue Cross Personal Choice PPO Program Member Services 215-567-5667 Phone 1-800-358-0050 Toll-free www.ibx.com Blue Cross PPO P O Box 69352 Harrisburg, PA 17106-9352 Appeals: Member Appeals Department P.O. Box 41820 Philadelphia, PA 19101 Phone 1-888-671-5276 Fax: 1-888-671-5274 Independence Blue Cross (IBC) acts as the claims administrator/ claim review fiduciary for purposes of initial determination of claims (including pre-service claims) as well as first level appeals.	Benefits are provided under the Personal Choice PPO Program and gives you the freedom to choose your own doctors and hospitals. You can maximize your coverage by accessing your care through the Personal Choice's large network of hospitals, doctors and specialists or by accessing care through preferred providers that participate in the BlueCard PPO Program. Keep in mind that if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit claims for reimbursement. A summary of benefits begins on pages 27 and 29. For details on pre-authorization, covered benefits, exclusions, coordination of benefits, claims and appeals, and other details about your hospital and medical benefits, please refer to the PPO Personal Choice Booklet from IBC.
Medical Outpatient Laboratory, Pathology, X-ray, All Medical Imaging (MRI, CT), Cardiac stress test, EKG studies	Administered by: Health Care Solutions Corporation 14 Mystic Lane Malvern, PA 19355 1-800-655-8125 Health Care Solutions Corporation administers the Network	Benefits are payable for outpatient laboratory/x-ray, imaging (MRI, CT Scan), ERG Studies, cardiac and stress tests are paid in full (the $100 copay is waived) if you use an HCSC provider. See page 33 for details.

SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION		
FOR INFORMATION ON	**ADMINISTRATOR/ WHOM TO CONTACT**	**PLAN BENEFIT**
Mental Health/ Alcohol/ Substance Abuse Benefits Pre-Certification and claims administration	Administered by: Allied Trade Assistance Program 4170 Woodhaven Road Philadelphia, PA 19154 1-800-258-6376 Allied Trade Assistance Program acts as the claim review fiduciary for purposes of pre-service claims and appeals. Please note that post-service claims are administered by the Fund Office.	These benefits are payable in the same way as medical and surgical benefits but are administered by Allied Trade Assistance Program. However, out-of-network claims for mental health and alcohol/substance abuse benefits should be forwarded to Allied Trade Assistance Program.
Dental Benefits	Insured and Administered by: Fidelio Dental Insurance Company 2826 Mount Carmel Avenue Glenside, PA 19038 www.fideliodental.com 1-800-929-0340	Benefits are payable for dental procedures up to the Scheduled Allowance. For details, see the Dental Benefits section beginning on page 39.
Optical Benefits	Administered by: National Vision Administrators, L.L.C. (NVA) P O Box 2187 Clifton, NJ 07015 Customer Service 800-672-7723 or service@e-nva.com www.e.-nva.com NVA acts as the claims administrator/claim review fiduciary for purposes of initial determination of claims.	The Plan provides for an eye exam, a pair of lenses and a frame or contact lenses (in lieu of all other benefits) once every 2-year period (a one-year period for children) up to the Plan's allowances or at discounted prices if received through a National Vision Administrators provider. See the description of optical benefits beginning on page 38.
Prescription Drug Benefits	Administered by: EnvisionRx Options Customer Care Correspondence 2181 E. Aurora Road Suite 201 Twinsburg, OH 44087 800-361-4542 EnvisionRx Options acts as the claims administrator/claim review fiduciary for purposes of initial determination of claims (including pre-service claims) and pre-service appeals.	Benefits are payable for retail and mail order prescription drugs. See the description of Prescription Drug benefits beginning on page 35.

ELIGIBILITY FOR BENEFITS

INITIAL ELIGIBILITY FOR COVERAGE

Your eligibility for coverage is based on the number of hours for which a Contributing Employer makes contributions to the Plan on your behalf. The following rules determine your eligibility for coverage under the Plan:

- New members who are active participants in a bona fide Apprentice Training Fund for Iron Workers, and *organized members* will become eligible for all benefits on the first day of the month immediately following the month in which you are credited with at least 500 hours in Covered Employment with Contributing Employer(s) in any six consecutive calendar months. Hours are measured on a rolling basis from the first day of employment and the Fund Office reviews credited hours each month to determine if you have met the eligibility requirement. In addition, all other rules of eligibility must also be met.

  For example: You start working January 1st in a bona fide Apprentice program for a Contributing Employer and are credited with 100 hours in Covered Employment for each of the months January, February, March, April and May for a total of 500 hours. Coverage will be effective on June 1st. If you only credited with 90 hours in each of those months, you would have to work at least 50 hours in June in order to become eligible as of July 1st.

- New members other than apprentices, will become eligible for coverage on the first day of the month immediately following the month in which you work at least 1,000 hours of Covered Employment with Contributing Employers in any 12-consecutive month period. In addition, you need to work at least 250 hours in Covered Employment in the quarter or three months immediately preceding your eligibility date. Hours are measured on a rolling basis from the first day of employment and the Fund Office reviews credited hours each month to determine if you have meet the eligibility requirement.

  For example: You start working in Covered Employment on January 1st and are credited with 100 hours in Covered Employment for each of the months January through October for a total of 1,000 hours. You also worked 250 hours in each of the three months immediately preceding the date you meet the 1,000 hours. Coverage will be effective on November 1st.

- Organized members will be treated the same as apprentices for eligibility purposes.

Effective Date of Coverage

You become covered on the date you meet the eligibility requirements described above. Coverage begins on the first day of the month immediately following the month in which you work the necessary number of hours, as described above.

Continuation of Coverage

Once you become eligible for coverage, your coverage will continue for the next three (3) month period provided that you work at least 250 hours in any of the three, consecutive months immediate preceding that 3-month period, as described in the table below:

If you work at least 250 hours during the following 3-consecutive month period:	Your coverage will continue *from*:	Your coverage will continue *to*:
January/February/March February/March/April March/April/May	June 1st	September 1st
April/May/June May/June/July June/July/August	September 1st	December 1st
July/August/September August/September/October September/October/November	December 1st	March 1st
October/November/December November/December/January December/January/February	March 1st	June 1st

Eligibility During Periods of Disability

If, after you meet the eligibility requirements, you are then unable to work because of a disability for which you receive Workers' Compensation benefits or Weekly Disability benefits from the Health Benefits Plan, you will receive credit toward eligibility on the basis of 21 hours of employment for any week during which you receive such benefits up to a maximum of 26 weeks in the 12-month period commencing from the date the disability was incurred. **Such credit may be granted only once during a 12-month period.**

Periods of disability, for the same illness or injury, separated by less than 10 days of active work are considered as the same (one) period of disability. Periods of disability for different illnesses or injuries separated by one day of active work shall be considered as separate periods of disability. You will receive credit toward continued eligibility based upon those hours in accordance with the regular eligibility rules which are stated on page 10. If you receive Workers' Compensation Benefits, be sure to notify the Benefit Plan office, so that you can receive credit towards eligibility for the period you collect the Workers' Compensation Benefits.

TERMINATION OF BENEFITS

Benefits terminate on the earliest of the following:

- Your coverage will terminate on March 1st, June 1st, September 1st or December 1st if you fail to work at least 250 hours in Covered Employment with Contributing Employers during any of the 3-consecutive calendar months preceding these dates, as listed above. For example, if you fail to work 250 hours in Covered Employment during the three consecutive months of January, February and March, your coverage will *be* terminated on June 1st.
- For anyone who retires on or after October 1, 2005, all Health Benefits will terminate after 3 months of retirement. (See page 43 for benefits provided to certain type pensioners.)
- The date you enter active Military Service (subject to the continuation requirements of USERRA as described beginning on page 17).

See page 24 for information regarding the privilege of converting to an individual Life Insurance Policy at your own expense.

Your Spouse's benefits terminate when your spouse ceases to be dependent as defined on page 13 or upon termination of your benefits, whichever occurs first. Coverage for your Dependent Children terminates the end of the month in which the child ceases to be a dependent as defined on page 13 of upon termination of your benefits, whichever occurs first.

However, if your benefits are terminated solely because of your death, coverage of your dependents will be continued until the first day of the month coinciding with or next following the end of thirty months after your death or your dependent(s) for Medicare, whichever occurs sooner. If a dependent is eligible for Medicare at the time of your Spouse's death, his or her coverage will only be continued for an additional six months.

(Once you lose coverage, you may be able to continue medical benefits under the Comprehensive Omnibus Budget Reconciliation Act (COBRA). See page 19 for a description.)

3000 Hour Look-back Rule

In the event your Plan coverage is terminated, *i.e.,* you fail to work 250 hours in Covered Employment in the previous quarter, you may be granted one additional quarter (three months) of eligibility. This additional coverage will be granted if you have accumulated at least 3,000 hours of actual work in covered employment in the two prior calendar years. You should be aware that this benefit may be used only once in any calendar year. In order to become eligible for subsequent use of this provision, you must re-establish eligibility based on actual work in Covered Employment.

Reinstatement of Benefits

If you are covered for Benefits and lose eligibility, except for entrance into the military service, and this loss of eligibility is for less than twenty four (24) consecutive months, you will be reinstated for all Benefits based on the chart below: or

If you were covered for benefits and your eligibility was terminated solely because of entrance into active military service, see the section on USERRA for your rights under the Plan. If you were covered for benefits and lose eligibility, except for entrance into the military service, for 24 consecutive months or more, you will need to meet the requirements of the initial eligibility rules.

If you work at least 250 hours during the following 3-consecutive month period:	Your coverage will Reinstate on:	Your coverage will continue *to*:
January/February/March February/March/April March/April/May	June 1st	September 1st
April/May/June May/June/July June/July/August	September 1st	December 1st
July/August/September August/September/October September/October/November	December 1st	March 1st
October/November/December November/December/January December/January/February	March 1st	June 1st

See page 17 for more details on continuation of benefits during a leave for military service.

DEFINITION OF DEPENDENTS

Eligible Dependents

For the purposes of this Plan the following are the persons who will be eligible for dependent coverage provided you properly enroll them and the necessary supporting documents are forwarded to the Fund Office (see the Enrollment Section for details on how to enroll your Dependents):

- Your lawful Spouse. Your covered Spouse is no longer eligible for coverage if you and your Spouse are legally separated and/or separated and living apart for at least eighteen months including a New Jersey "divorce from bed and board."
- Each of your Dependent Children under the age of 26 provided that you properly enroll them and the necessary supporting documents are forwarded to the Fund Office (see the Enrollment section for details on how to enroll your dependents).

Eligible Children shall mean:

- Natural children (whether married or unmarried) of the Eligible Employee.
- Legally adopted children or children placed for adoption with the Eligible Employee.
- Mentally or physically disabled children who otherwise fulfill the requirement of this definition but who are over age 26, unmarried and incapable of self-sustaining employment as described below.

"Dependent Children" shall not mean step-children or foster children.

Except for Dependent Children who are incapable of self-sustaining employment, coverage will terminate for a Dependent Child the first day of the month following the child's 26th birthday.

This Plan is compliant with Newborns' and Mothers' Health Protection Act details are available on the web at www.dol.gov/ebsa.

Continuation of Benefits for Certain Disabled Children

Eligibility for benefits under this Plan can be continued for an unmarried child who is incapable of earning his own living because of a mental or physical handicap and is chiefly dependent on you for support on the date the child ceases to be eligible for coverage under this Plan benefits due to attainment of the limiting age. Coverage for such a child can be continued for the duration of the incapacity provided coverage does not terminate for any other reason including termination of the employee's coverage. Proof of incapacity must be furnished to the Fund Office within 31 days after the child attains the limiting age and must be furnished thereafter as required.

An Employee must notify the Fund Office within 31 days after the child's 26th birthday to qualify for continued dependent coverage. Evidence of disability from the attending physician must be submitted at this time.

Notice to the Plan

You, your Spouse or any of your eligible Children **must notify the Plan preferably within 31 days but no later than 60 days after the date if your:**

- Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce, legal separation, or any separation such as a New Jersey divorce from bed and board); and
- Eligible child ceases to meet the Plan's definition of Dependent (such as the eligible Child reaches the Plan's limiting age or the Child ceases to have any physical or mental disability);

Failure to give this Plan a timely notice (as noted above) may cause your eligible Spouse and/or Children to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of an eligible Child to end when it otherwise might continue because of a disability, or may cause claims to not be able

to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to the Plan if any benefits are paid to an ineligible person.

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions or premiums (including COBRA premiums) are not timely paid, or in cases of fraud or intentional misrepresentation of material fact. In cases of fraud or intentional misrepresentation of material fact, the Plan will provide you with 30-days advanced notice.

ENROLLMENT

The Fund Office will notify you when you are eligible for coverage under the Plan and send you an Enrollment Card. Please note that if you do not enroll yourself and your Dependents as described, benefits will not be payable from the Plan.

How to Enroll

You (the Eligible Employee) are automatically enrolled for benefits provided by the Plan. There is no option to decline coverage. However, you should submit a completed Enrollment Card to assure that the Fund Office has the correct information on file for you and to ensure proper enrollment in coverage.

For you and your eligible Dependents to be eligible for coverage under the Plan, you need to enroll them within 60 days of the effective date of your coverage and provide the Fund Office with the necessary proof. The Fund Office will accept a copy of any of the following documents as proof:

- **Spouse/Marriage:** copy of your certified marriage certificate (you will also need to notify the Fund Office of other coverage for your Spouse or family, if applicable).
- **Child/Birth:** copy of your child's certified birth certificate.
- **Adoption or placement for adoption:** copy of court order signed by the judge showing that employee has adopted or intends to adopt the child and a copy of the child's birth certificate
- **Disabled Dependent Child:** Current written statement from the child's physician, indicating the child's diagnoses that are the basis for the physician's assessment, that the child is incapable of self-support because of mental or physical incapacitation and proof that the child is dependent on you for support.
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by judge or National Medical Support Notice.

Special Enrollment for Dependents

If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption after your initial effective date of coverage, you may enroll your new Dependents. However, you should request enrollment 60 days after the marriage, birth, adoption, or placement for adoption and complete the proper enrollment paper work, as described above.

If you decline enrollment (or do not enroll) your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll your Dependents in this plan if your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your Dependents' other coverage). However, you should request enrollment for your dependents within 60 days and enroll for benefits as described above, after your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

To request special enrollment or obtain more information, contact the Fund Office.

Medicaid or a State Children's Health Insurance Program (CHIP)

You and your dependents may also enroll 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.

Start of Coverage Following Enrollment

Coverage for your Dependents cannot begin until the Fund Office receives a completed Enrollment Card along with the necessary documentation (e.g., copies of birth certificate, marriage certificate, adoption papers). If you have Dependents and enroll them when you are first eligible for coverage, their coverage will be effective as of the date you were first eligible.

For newly added Dependents, if the Fund Office receives a complete Enrollment Card and the necessary documentation coverage will be effective:

For newborn Children: Coverage will be effective retroactive to the date of birth.

For adopted Dependent Children: Adopted Children are covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is placed for adoption with you within 31 days of the date the child was born will be covered from birth. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

For your new Spouse: Your new Spouse's coverage is retroactive to the date of your marriage.

Late Enrollment

If the Fund Office receives the necessary enrollment material for your Dependents after 60 days but within 365 days of the event, coverage will be effective retroactive to the date of the event. If the Fund Office does not receive the documentation within 365 days, coverage will not become effective until the beginning of the month following the month in which the Fund Office receives your completed Enrollment Card and necessary proof. If you submit claims for your dependents before you enroll them, they will be denied and will need to be resubmitted once enrollment is complete but will only be paid retroactive to the effective date of coverage.

Qualified Medical Child Support Orders (QMCSO) (Special Rule for Enrollment)

According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. AQMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and thename and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Children.

Enrollment Related to a Valid QMCSO: If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions. The Plan will accept a Special Enrollment of the alternate recipient specified by the QMCSO from either the employee or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the Special Enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any limits on selection of provider and requirements for authorization of services, as permitted by applicable law.

Termination of Coverage: Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent Children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage. See also the COBRA chapter of this document.

Additional Information: For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Fund Office

LEAVE OF ABSENCE FOR ELIGIBLE EMPLOYEES

If you are an Eligible Employee, there are certain circumstances where you may be entitled to a leave of absence from Covered Employment. This section does not apply to Pensioners or eligible dependents.

Coverage Under Special Circumstances

Special circumstances may entitle you to continue your eligibility for coverage under the Plan when you are on leave from work due to either family and medical leave reasons or service in the uniformed services of the United States. Please note that in order to be eligible for continued coverage as provided below, your Employer must properly grant the leave and make the required notification and payment to the Fund Office. Please contact your Employer to determine whether you are eligible. The general rules are set forth below:

Family and/or Medical Leave (FMLA)

The Family Medical Leave Act, 29 USC §2601 et seq. provides that if you work for an employer covered by that Act you are entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own illness. You may also be entitled to unpaid leave to take care of a military service member who is your spouse, child, parent, or next-of-kin and is undergoing medical treatment or recuperating from serious illness or injuries as a result of service. In general, the employers covered by FMLA are those who employ 50 or more employees for each working day during each of twenty or more calendar weeks in the current or preceding calendar year. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain

your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer.

Leave for Military Service

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services. If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working. If the employee goes into active military service for up to 31 days, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.

USERRA allows the employee to apply accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When an employee's accumulated eligibility is exhausted, the employee may pay for USERRA coverage under the self-pay rules of this plan. If the employee does not want to use his accumulated eligibility to pay for USERRA coverage, the employee can choose to freeze his eligibility and instead proceed to pay for the USERRA coverage.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Fund Office has been notified by the employee in writing that they have been called to active duty in the uniformed services and provides a copy of the orders. The employee must notify the Fund Office as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage are the same and will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. (See the COBRA section for more details). However, unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage: If elected, USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA section for more details.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review

the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces: When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years. The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to your employer.

Reinstatement of Coverage After Leaves of Absence

If your coverage ends while you are on an approved leave of absence for family, medical or military leave, your coverage will be reinstated on the first day of the month following your return to active employment, if you return within 14 days after your leave of absence ends, subject to any limitations for Pre-Existing Conditions that existed before the start of the leave of absence, and subject to all accumulated benefit maximum that were incurred prior to the leave of absence.

Any period of any approved leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Rights Act will **not** be counted as a Break in Coverage.

CONTINUATION OF COVERAGE

The Federal Law, Consolidated Omnibus Budget Reconciliation Act (called COBRA), requires that Plans, such as this Plan, offers Eligible Employees and their eligible dependents an opportunity to elect a temporary continuation of their group health coverage which includes medical, mental health, alcohol/substance abuse, prescription drugs, dental and optical benefits, but does NOT include Life Insurance, AD&D and Weekly Disability Benefits ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law). Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

The Fund Office is the COBRA Administrator.

Under the law, a Qualified Beneficiary is any Eligible Employee or the Spouse or eligible dependent of an employee or retiree who was covered by the Plan when a Qualifying Event occurs, and who is, therefore, entitled to elect COBRA Continuation Coverage. A child who becomes an eligible child by birth, adoption or placement for adoption with the Eligible Employee or retiree during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.

Qualified Beneficiaries are entitled to the same Special Enrollment rights as Eligible Employees. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are shown in

the chart below) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan as a result of the Qualifying Event. If a covered individual has a Qualifying Event but does not lose health care coverage under this Plan, (e.g. the Employee's hours are reduced, but not enough to terminate coverage) then he or she would not be offered COBRA at this time.

Other Health Coverage Alternatives to COBRA

You may also have other options besides COBRA available to you when you lose group health coverage that can be purchased through the Health Insurance Marketplace. In addition, in the marketplace you could be eligible for a tax credit that lowers your monthly premiums for marketplace — purchased coverage. Being eligible for COBRA does not limit your eligibility for a tax-credit. To find out more about enrolling in the Marketplace, its enrollment periods and qualifying events, please call (1-800-318-2596) or visit: www.HealthCare.gov. You may also qualify for a special enrollment opportunity for another group health Plan for which you are eligible (such as a spouse's Plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

COBRA Eligibility (COBRA-Qualifying Events)

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event. The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date of the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (as described in below). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

COBRA Coverage May Continue for	Qualifying Event	Maximum Length of COBRA Coverage
You and Your Eligible Dependents	• Termination of your employment (for example, you resign) for any reason except gross misconduct • Reduction in the number of hours you work that makes you ineligible for the health coverage	18 months (29 months if you or your eligible dependents is Social Security — disabled)* *See "COBRA Coverage In Cases of Social Security Disability," below, for more details
Your Eligible Dependents Only	• You die • You are divorced • You become entitled to Medicare (and voluntarily drop Fund coverage) • Your Children no longer qualify as eligible dependents under the Plan	36 months

***COBRA Coverage in Cases of Social Security Disability**

If you, your Spouse, or any of your covered Dependent Children are entitled to COBRA coverage for an 18-month period, that period can be extended for the Qualified Beneficiary who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to 11 additional months (for a total of 29 months) if: (i) the disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage; and (ii) the disabled Covered Person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.

The Plan must be notified by you or by the disabled Covered Person or another family member that the Social Security determination was received no later than: (i) 60 days after it was received; and (ii) before the 18-Month COBRA continuation period ends. This extended period of COBRA coverage will end at the earlier of: (i) the last day of the month, 30 days after Social Security has determined that you and/or your eligible dependent(s) are no longer disabled; (ii) The end of 29 months from the date loss of coverage due to the COBRA qualifying event; or (iii) the date the disabled individual becomes entitled to Medicare.

NOTE: When you retire, you will have the option of electing COBRA in the same way as an employee who terminated employment (for any other reason except gross misconduct). If you are eligible for Pensioner benefits from the Fund upon your retirement, you will have the option of electing COBRA continuation of your active coverage (for a temporary period of time on a fully self-paid basis) or Pensioner benefits (on the terms described on page 43). Unlike Pensioner benefits, the entire cost of COBRA continuation coverage must be paid by you. If you do not timely elect COBRA continuation coverage when you retire, you will no longer have any rights to COBRA continuation coverage, even if you later lose your Pensioner benefits. However, if your spouse and/or dependent Children who receive retiree coverage lose that coverage due to a COBRA qualifying event (for example, if you die or get divorced), they will be entitled to continue the retiree coverage on a self-pay basis in accordance with COBRA for a period of up to 36 months from the date of the loss of retiree coverage.

How COBRA Coverage Works

The Fund Office is responsible for administering COBRA Continuation Coverage.

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "Dependent Child" under the Plan, you and/or a family member must inform the Plan in writing of that event no later than 60 days after the loss of coverage due to the qualifying event.

That written notice should be sent to the Fund Office at the address is listed on the chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of any affected Dependents, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Fund Office within the 60-day period, the Qualified Beneficiary will not be entitled to elect COBRA Continuation Coverage.

Officials of the employee's own employer should notify the Fund Office of an employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the Fund Office in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage

When:

- **your employer notifies the Fund** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled for health care coverage under the Plan, you died, or have become entitled to Medicare; or
- **you notify the Fund** that a Dependent Child has lost Dependent status, you are divorced or have become legally separated.

Then:

The Fund Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

How to Elect COBRA Continuation Coverage

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage. One or more eligible Dependents may elect COBRA even if the employee does not elect it. One member of the family may elect COBRA for other members of the family. COBRA Continuation Coverage may be elected for some members of the family and not others. In order to elect COBRA Continuation Coverage, the persons for whom COBRA is being elected must have been covered by the Plan on the date of the Qualifying Event. A parent or legal guardian may elect or reject COBRA Continuation Coverage on behalf of eligible Dependent Children.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. There may be other coverage options for you and your family. Under key parts of the Affordable Care Act, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Keep in mind that as long as you are covered under this Plan, you are not eligible to buy coverage through the Health Insurance Marketplace.

The COBRA Continuation Coverage that Will Be Provided

If you choose COBRA Continuation Coverage, you will be entitled to the same health (medical, prescription drug, dental, and optical) coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the sections entitled "Cost of COBRA Continuation Coverage" and "Paying for COBRA Coverage," below, for information about how much COBRA will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA Continuation Coverage.

Paying for COBRA Coverage

The amount you, your eligible Spouse, and/or your eligible Children must pay for COBRA coverage will be payable monthly. The Plan is permitted to charge the full cost of coverage for similarly situated active employees and families, plus an additional 2% (for a total charge of 102%). The COBRA Continuation Coverage charge is different in cases of extended COBRA coverage due to Social Security disability. See the section entitled "Cost of COBRA Coverage in Cases of Social Security Disability" below for further information.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect. The cost will generally change annually.

Grace Periods: There will be an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month. There will then be a grace period of 30 days to pay these monthly payments. You will get continuation coverage for each month as long as payment for that month is made before the end of the month. If payments are not made by the end of the grace period, COBRA Continuation Coverage will be canceled as of the due date. You will be responsible for any claims that were paid during the grace period. This means that you will have to reimburse the Plan for these claims. COBRA payment is considered made when it is postmarked. **If payment of the amount due is not made by the end of this grace period, your COBRA coverage will terminate.**

Cost of COBRA Coverage in Cases of Social Security Disability

If the 18-month period of COBRA Continuation Coverage is extended because of Social Security disability, the Plan will charge members and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month Social Security disability extension period. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Children have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Children are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the Fund Office to add a dependent.

Loss of Other Group Health Plan Coverage

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage your Spouse or dependent loses coverage under another group health plan, you may enroll the Spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the Spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You

must enroll the Spouse or dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Fund Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Multiple Qualifying Events While Covered by COBRA

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, divorce or legally separate, become entitled to Medicare (and you voluntarily terminate Plan coverage), or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or child is extended to up to 36 months from the date of loss of coverage due to the occurrence of your termination of employment or reduction of hours.

For example, assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your eligible dependents for COBRA coverage. Three months after your COBRA coverage begins, you divorce and your former spouse is no longer eligible for Plan coverage. Your former spouse can continue COBRA coverage for 33 months, for a total of 36 months of COBRA coverage.

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after your loss of coverage due to the termination of employment or reduction of hours. However, this extended period of COBRA Continuation Coverage is available to any Children born to, adopted by, or placed for adoption with you (the active member) during the 18-month period of COBRA Continuation Coverage.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or if you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of Social Security disability). As a result, if you experience a reduction of hours then have a termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the date of loss of coverage due to the occurrence of the initial qualifying event.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you must notify the Fund Office in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

Termination of Employment/Reduction of Weeks Following Medicare Entitlement

If you become entitled to (enrolled in) Medicare and you later have a termination of employment or reduction of hours, your Spouse and/or your eligible child would be entitled to COBRA Continuation Coverage for a period of 18 months from the date of your loss of coverage due to your termination of employment or reduction of hours or 36 months from the date you become entitled to Medicare, whichever is longer.

Notice of Unavailability of Coverage

When you or your dependents have provided notice to the Fund Office of a divorce, a beneficiary ceasing to be covered under the plan as a dependent, or a second qualifying event but are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA.

When COBRA Coverage Ends

Your COBRA coverage ends on the earliest of the date the COBRA period (18, 29, or 36 months) ends or any of the below listed events occurs.

When COBRA Coverage Will Be Cut Short

Once COBRA coverage has been elected, it will be cut short (terminates early) on the occurrence of any of the following events:

- The first day of the time period for which you do not pay the COBRA premiums within the required time period.
- The date on which the Plan is terminated.
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become covered by another group health plan and that plan does not contain any legally applicable exclusion or limitation.
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become entitled to (enrolled in) Medicare (usually age 65).
- If you and/or your family members have the 11-month extension for Social Security disability and the person is deemed no longer disabled by Social Security Administration.
- If you take actions that would result in termination of active employee coverage (for example, if you submit false claims to Independence).

Notice of Early Termination of COBRA Continuation Coverage

If continuation coverage is terminated before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable following the Fund Office's determination that continuation coverage will terminate. The Notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

COBRA Questions

If you have any questions about your COBRA rights, please contact Fund Office.

For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE FOR EMPLOYEES

Insured Through a Contract with Amalgamated Life Insurance Company

Life Insurance Coverage for Employees

The Life Insurance benefit is payable in event of your death from any cause at any time or place while you are insured. Payment will be made in a lump sum or in installments to the beneficiary designated by you. The beneficiary may be changed whenever you wish by contacting the Plan Office.

A person who, while covered under the Plan's eligibility rules, becomes totally and permanently disabled will continue to have his life insurance remain in force for the period of disability until attainment of age 62, provided satisfactory proof is furnished to the Trustees.

For purposes of Life Insurance coverage only, total and permanent disability shall mean:

(a) The employee is totally disabled as a result of bodily injury or disease and is unable to perform any work;

(b) The disability is permanent and continuous for the remainder of the employee's life;

(c) The employee is unable to engage in or secure any other employment or gainful pursuit; and

(d) The disability is not a result of a self-inflicted injury, addiction to narcotics or alcohol, or was incurred in the course of perpetrating a crime.

The disability must be incurred during a period of time the person is eligible for life insurance benefits under the Plan's rules. Application for benefits may be made at any time but should not be made at a date later than nine months after the disability was incurred.

The life insurance benefit for a person who is approved for this continued life insurance benefit due to total and permanent disability will be adjusted to the level of $3,000.00 if the Disability Pensioner has at least 15 but less than 20 Pension Credits, $4,000 if the Disability Pensioner has at least 20 but less than 25 Pension Credits and $5,000 if the Disability Pensioner has at least 25 Pension Credits. This adjusted level will also be applicable to individuals with at least 15 Pension Credits upon attainment of age 62. Those individuals with less than 15 years of Pension Credit will receive a benefit of $3,000.

If your death should occur within thirty-one days after your Life Insurance has terminated in accordance with the termination rules, the death benefit will be payable. By making application and paying the first premium to the Amalgamated Life Insurance Company, within this thirty-one day period, you may convert your Group Life Insurance to an individual Life Insurance policy on any regular Whole Life or Endowment Plan. This individual policy will be issued without medical examination at the Insurance Company's regular rates, according to occupation and attained age.

Accidental Death and Dismemberment Coverage for Employees

Accidental Death and Dismemberment Coverage provides benefits for your loss of life, limbs, or the entire and irrecoverable loss of sight including losses resulting from occupational bodily injuries. Benefits are payable if the loss is a direct result of a bodily injury caused by an accident and the loss is sustained within ninety days after the date of the accident.

The full Principal Sum to which you are entitled in accordance with the Schedule of Insurance, will be paid for the loss of:

- Life
- Both Hands
- Both Feet
- One Hand and One Foot
- One Foot and Sight of One Eye One Hand and Sight of One Eye Sight of Both Eyes
- One-half the Principal Sum will be paid for the loss of one hand, one foot or the sight of one eye. In no case will more than the full Principal Sum be paid for all losses sustained through any one accident.

Payment will be made directly to you, if living, otherwise to your Beneficiary.

Since the purpose of this coverage is to provide benefits for losses due to accidents, no benefits are paid on account of a loss caused or contributed to by:

- bodily or mental infirmity; or
- disease, ptomaine's or bacterial infections; or

- medical or surgical treatment (unless made necessary by an injury covered under the Plan; or
- suicide or intentionally self-inflicted injury; or war or any act ofwar.

The loss must occur while insurance is in force.

The Life Insurance benefit is payable in event of your death from any cause at any time or place while you are insured. Payment will be made in a lump sum or in installments to the beneficiary designated by you. The beneficiary may be changed whenever you wish by contacting the Plan Office. **If you do not designate a beneficiary, or your beneficiary(ies) do not survive you, your life insurance will be paid to your wife, if living, or to your children, or to your estate.**

Life Insurance Benefit and Accidental Death and Dismemberment (AD&D) Claims and Appeals

A Life Insurance Benefits Claim is any claim made by your beneficiary on the occasion of your death. An Accidental Death and Dismemberment (AD&D) Claim is any claim for loss as specified in Amalgamated Insurance Company Certificate.

You should file all claims and appeals requests with Amalgamated Life in accordance with the Claims filing procedures described in the Certificate of Insurance.

Please refer to page 7 for amounts.

Please refer to Amalgamated Insurance Certificate for details on your claims and appeals rights.

> This Plan also contains a number of other provisions as well as forms of payment and claims and appeals procedures and the definition of disability that are explained in the Amalgamated Life Insurance Company's Certificate of Insurance.
>
> All provisions of this benefit are subject to the contract and described in the Certificate of Insurance issued by Amalgamated Life Insurance Company. If there are any discrepancies between this Booklet and the Certificate or contract, the Certificate or contract will govern.

WEEKLY DISABILITY BENEFITS FOR EMPLOYEES

The Plan provides you with a weekly benefit of up to $150 per week while you are disabled and prevented from working as a result of a non-occupational accidental bodily injury or disease.

The weekly benefit to which you are entitled will commence on the first day of disability resulting from injury or on the eighth day of disability resulting from disease. After benefits have been payable for disease for three consecutive weeks or more, benefits are payable for the first seven days of disability. Benefits are payable for a maximum period of twenty-six weeks for any one disability.

Payment will be made for as many separate and distinct periods of disability as may occur.

If you recover from a disability and again become disabled after less than two weeks of active work on a full-time basis, both disabilities will be considered as one period of disability unless the subsequent disability is due to an injury or disease entirely unrelated to the causes of the previous disability and commences after you have returned to work and have completed **at least one day of continuous active employment.**

When benefits have been paid for the maximum period of twenty-six weeks, Weekly Disability Benefits will terminate. However, you will again be eligible for this coverage as soon as you have returned to active work and have completed one day of continuous active employment.

It is not necessary to be confined to your home to collect benefits, but no benefits are payable for any period during which you are not under the care of a legally qualified physician. The period of disability must commence while insurance is in force.

Weekly Disability Claims and Appeals

A Disability Claim is any claim that requires a finding of total disability (as defined by Amalgamated Life Insurance Company) as a condition of eligibility. You should file all claims and appeals requests with Amalgamated Life in accordance with the Claims-filing procedures described in the Certificate ofInsurance.

Amalgamated Life Insurance Company reserves the right to have a Physician examine you (at their expense) as often as is reasonable while a claim for benefits is pending.

Please refer to Amalgamated Insurance Certificate for details on your claims and appeals rights.

This Plan also contains a number of other provisions as well as forms of payment and claims and appeals procedures and the definition of disability that are explained in the Amalgamated Life Insurance Company's Certificate of Insurance. All provisions of this benefit are subject to the contract and described in the Certificate of Insurance issued by Amalgamated Life Insurance Company. If there are any discrepancies between this Booklet and the Certificate or contract, the certificate or contract will govern.

MEDICAL AND HOSPITAL BENEFITS

Personal Choice PPO

This is a brief summary of your benefits. For full details on these provisions, please see the Personal Choice PPO Booklet attached to this document.

Medical and Hospital benefits are administered by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association. Independent is considered the Claims Administrator.

Personal Choice®, Independence Blue Cross' Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing your care through Personal Choice's large network of hospitals, doctors and specialists, or by accessing care through preferred providers that participate in the BlueCard® PPO program, Of course, with Personal Choice, you have the freedom to select providers who do not participate in the Personal Choice network or BlueCard® PPO program. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

Designation of Primary Care Provider

Under the Plan, there is no requirement to designate a primary care provider. However, should you wish to choose a primary care provider, you have the right to designate any primary care provider who participates in the Plan's Network and who is available to accept you or your family members. This includes the right to designate a participating pediatrician as your child's primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact IBC.

Direct Access to Obstetrical and Gynecological Care

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Fund Office.

With Personal Choice...

- You do not need to enroll with a primary care physician

- You never need a referral
- Certain services require Pre-Authorization

For full details on these provisions, please see the Personal Choice PPO Booklet attached to this document. Information in that booklet includes a description of:

- covered benefits;
- limitations;
- exclusions;
- cost-sharing provisions;
- preventive services;
- medical tests, devices and procedures;
- provisions governing the use of network providers and out of area services;
- limits on the selection of primary care providers or the providers of specialty medical care;
- limits applicable to emergency care;
- coordination of benefits;
- provisions regarding pre-authorization or utilization review requirements;
- provisions regarding claims and appeals of benefits.

There are rights and benefits you have with respect to medical benefits provided by the Plan, which are described below.

Women's Health and Cancer Rights

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with you and your attending physician, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. For more information on WHCRA benefits, the amount of coverage available to you, and co-payment, deductible and maximum amounts, please refer to the Schedule of Benefits and Schedule of Covered Services in the attached Independence Blue Cross booklet. You may also contact Independence Blue Cross Member Services at the toll-free number located on your I.D. card.

Newborns' and Mothers' Health Protection

This Plan complies with the protections afforded under the Newborns' and Mothers' Health Protection Act of 1996, which prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's and newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier. In any case, the Plan and Independence Blue Cross may not, under Federal law, require that a provider obtain authorization from the Plan or Independence Blue Cross for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Services that Require Pre-Authorization

Personal Choice network providers will obtain pre-authorization for you, if it is required for the service provided. You are not required to obtain pre-authorization when you are treated in a Personal Choice network hospital or facility, or by a Personal Choice network doctor. Members are not responsible for financial penalties because a Personal Choice network provider does not obtain prior approval.

If you use an out-of-network provider, you must obtain pre-authorization if required for the service or supply being provided. You may be subject to financial penalties if you do not obtain pre-authorization.

- Call Independence Blue Cross at the pre-authorization telephone number listed on the back of your identification card to initiate pre-authorization for all claims except for Mental Health and Alcohol/Substance Abuse Benefits administered by Allied Trade Assistance Program.
- Call the Allied Trade Assistance Program at 1-800-258-6376 to initiate pre-authorization for Inpatient Mental Health and Alcohol/Substance Abuse claims.

You may be responsible for financial penalties if you do not pre-authorize services when you use an out-of-network provider. There is a $1,000 penalty for failure to pre-authorize inpatient services or treatment, and a 20% reduction in benefits for failure to pre-authorize outpatient services or treatment.

Pre-authorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, *i.e.,* actively enrolled in the health benefits plan when the pre-authorization is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

Services that Require Pre-Authorization	**In-Network** (Personal Choice network provider or BlueCard PPO provider)*	**Out-of-Network Provider**
ALL NON-EMERGENCY INPATIENT ADMISSIONS (EXCEPT MATERNITY ADMISSIONS)	Required	Required
INPATIENT NON-EMERGENCY INPATIENT ADMISSIONS FOR MENTAL HEALTH OR ALCOHOL/SUBSTANCE ABUSE (CALL ALLIED TRADE ASSISTANCE PROGRAM)	Required	Required
HYPERBARIC OXYGEN	Required	Required
PAIN MANAGEMENT PROCEDURES (epidural injections, transformational epidural injections, paravertebral facet, joint injections)	Required	Required
OUTPATIENT SURGICAL PROCEDURES	Required	Required
Bunionectomy	Required	Required
Cataract Surgery	Required	Required
Cochlear implant surgery	Required	Required
Laparoscopic Cholecystectomy	Required	Required
Hemorrhoidectomy	Required	Required
Hernia Repair	NOT Required	Required
Arthroscopic Knee Surgery/Diagnostic Arthroscopy	Required	Required
Obesity Surgery	Required	Required
Prostate Surgery	NOT Required	Required
Spinal/Vertebral Surgery	NOT Required	Required
Submucous Resection (nasal surgery)	Required	Required

Services that Require Pre-Authorization	**In-Network** (Personal Choice network provider or BlueCard PPO provider)*	**Out-of-Network Provider**
Tonsillectomy and/or Adenoidectomy	Required	Required
RECONSTRUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES (for a complete list of these procedures, please see Benefits that Require preauthorization available on ibx.com)	Required	Required
Surgery for varicose veins including perforators and sclerotherapy	Required	Required
Orthognathic surgery procedures, including, but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies	Required	Required
TRANSPLANTS	Not covered	Not covered
OPERATIVE AND DIAGNOSTIC ENDOSCOPIES	Required	Required
MRI/MRA	Required	Required
CT/CTA SCAN	Required	Required
PET SCAN	Required	Required
NUCLEAR CARDIAC STUDIES	Required	Required
OUTPATIENT THERAPIES Speech	Required	Required
OUTPATIENT PRIVATE DUTY NURSING	Required	Required
OTHER FACILITY SERVICES Skilled Nursing, Inpatient Hospice, Home Health, Birth Center	Required	Required
Inpatient rehabilitation facility for Mental Health or Alcohol/Substance Abuse (Call Allied Trade Assistance Program)	Required	Required
NON-EMERGENCY AMBULANCE	Required	Required
DURABLE MEDICAL EQUIPMENT Purchase items (including repairs and replacements) over $500, and ALL Rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)	Required	Required
PROSTHETICS Purchase items (including repairs and replacements) over $500 (excluding ostomy supplies)	Required	Required
INFUSION THERAPY IN A HOME SETTING	Required	Required
INFUSION THERAPY DRUGS administered in an Outpatient Facility or in a Professional Providers Office (see list included in your open enrollment packet)	Required	Required

Benefits Provided Through the Personal Choice PPO

The following chart represents only a partial listing of the benefits and exclusions of the Personal Choice program. Benefits and exclusions are defined by the medical policy. This managed care plan may not cover all of your health care expenses. If you need more information, please call 1-800-358-0050 (outside Philadelphia) or 215-567-5667 (if calling within the Philadelphia area) or visit Blue Cross' website at www.ibx.com. The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Non-Preferred or Out-of-Network Providers may bill you the differences between the Plan allowance, which is the amount paid by Personal Choice and the actual charge of the provider. This amount may be significant. Claims payments for Non-Preferred or Out-of-Network Professional Providers (physicians) are based on the lesser of the Medicare Professional Allowable Payment or the actual charge of the provider. For covered services that are not recognized or reimbursed by Medicare, the payment is based on the lesser of the Independence Blue Cross (IBC) applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, payment is 50% of the actual charge of the provider. For services rendered by hospitals and other facility providers in the local service area, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under IBC contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year, but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider. Also note that out-of-pocket maximums may change on an annual basis.

SUMMARY OF BENEFITS
PERSONAL CHOICE PPO

Benefit	**In-Network**	**Out-of-Network**
	DEDUCTIBLE	
Individual	$0	$500
Family	$0	$1,000
AFTER DEDUCTIBLE, PLAN PAYS	100%	70%
OUT-OF-POCKET MAXIMUM (includes coinsurance only)		
Individual	$6,350	$7,500
Family	$12,700	$15,000
LIFETIME MAXIMUM (includes psychiatric services)	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
• Primary Care Service	$20 Copayment	70%, after deductible
• Specialist Services	$20 Copayment	70% after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	70%, after deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	70%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP (One per calendar year for women of any age, combined in/out-of-network)	100%	70%, NO deductible
MAMMOGRAM	100%	70%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT (6 visits per year combined in/out of network)	100%	70%, NO deductible
ALLERGY INJECTIONS (Office visit copayment waived if no office visit is charged)	100%	70%, after deductible

Benefit	In-Network	Out-of-Network
MATERNITY (Excludes Dependent Children) • First OB visit	$20 Copayment	70%, after deductible
• Hospital	100%	70%, after deductible
INPATIENT HOSPITAL SERVICES	$100 copayment per day, up to a maximum of $500 per admission	70%, after deductible
• Facility Physician/Surgeon	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70 days/calendar year
OUTPATIENT SURGERY	100%	70%, after deductible
• Facility/Physician/Surgeon	100%	70%, after deductible
EMERGENCY ROOM	$150 Copayment (waived if admitted)	$150 Copayment, NO deductible (waived if admitted)
URGENT CARE CENTER	$50 Copayment (waived if sent to emergency room)	70%, after deductible
OUTPATIENT LABORATORY	100%	70%, after deductible
OUTPATIENT RADIOLOGY	$100 Copayment	70%, after deductible
THERAPY SERVICES		
• Physical, Speech and Occupational	$20 Copayment	70%, after deductible
• Cardiac Rehabilitation (36 visits per calendar year) Combined in/ out-of-network	$20 Copayment	70%, after deductible
• Pulmonary Rehabilitation (12 visits per calendar year) Combined in/ out-of-network	$20 Copayment	70%, after deductible
• Respiratory Therapy	$20 Copayment	70%, after deductible
RESTORATIVE SERVICES, including Chiropractic care • 20 Visits per calendar year • Orthoptic/Pleoptic Therapy limited to 8 sessions lifetime maximum • Combined in/out-of-network	$20 Copayment	70%, after deductible
CHEMOTHERAPY, RADIATION, DIALYSIS	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%	70%, after deductible
SKILLED NURSING CARE	100%	70%, after deductible
HEARING AID	n/c	n/c
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	100%	70%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%	Not Covered

Benefit	In-Network	Out-of-Network
OUTPATIENT X-RAY, MEDICAL IMAGING PROCEDURES (MRI, CT SCAN), EKG STUDIES, CARDIAC STRESS TEST, LABORATORY AND PATHOLOGY TESTING	100% for procedures done by and authorized by Health Care Solutions Corporation (HCSC) Contact HCSC at 1-800-655-8125 to authorize the procedure. You will be given an authorization number. Contact the provider and schedule the appointment. Benefits provided by an HCSC network provider are paid in full. The $100 copayment that applies to IBC providers is waived. For Outpatient Laboratory, you can use any Labcorp of America and Quest Diagnostic draw site for your procedures. You do not need an authorization number, just show your insurance ID cards. There are no member costs if you use a Labcorp or Quest facilities.	Covered through IBC's Out of Network Benefits at 70%, after deductible

What is not covered: This is only a partial list and the complete list of exclusions and limitations is included in the PPO Personal Choice booklet.

- Services not medically necessary
- Cosmetic services/supplies
- Routine foot care
- Supportive devices for the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes
- Dental care, including dental implants, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Vision care, except as covered by the Optical Benefit
- Military or occupational injuries or illness
- Benefits payable by the government, Medicare or through motor vehicle insurance
- Assisted fertilization techniques such as, but not limited to, in-vitro fertilization, artificial insemination, GIFT, ZIFT (except as specified in a group contract)
- Charges in excess of benefit maximums or allowable charges as set forth in the group contract
- Services or supplies which are experimental or investigative except routine costs associated with clinical trials
- Alternative Therapies/complimentary medicine
- Inpatient private duty nursing
- Maintenance of chronic conditions
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices (except as indicated in the Schedule of Benefits)
- Blood, Autologons, Blood Drawing, Storage, and Transfusion services

- Immunizations required for employment or travel
- Sterilization Reversals
- Services not billed and performed by a provider properly licensed and qualified to render the medically necessary treatment, services or supplies
- Automobile Accidents (see page 51)
- Organ Transplants

The Plan excludes expenses arising from any injury incurred as a result of operation of riding on a motorcycle.

No obstetrical benefits are provided for Dependent Children except for benefits required under the Preventive benefits as they relate to pre-natal care.

Dental or Oral Surgery

Benefits are provided for hospitalization for dental or oral surgery consisting of cutting procedures for treatment of diseases and injuries of the jaw or treatment of fractures and dislocations of the jaw; and for extraction of impacted teeth. Other extractions, and care of teeth, are included as a dental benefit (refer to "Schedule of Dental Services").

Limitations

Coverage for Infertility

Coverage for infertility treatment through drug therapy for participants and covered Spouses based on a requirement that such drugs be purchased through the Fund Office and subject to a lifetime maximum of $10,000 per covered individual. This maximum is inclusive of prescription drugs and physician fees.

COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE

Pre-authorization is required for inpatient Mental Health and Substance/Alcohol Abuse benefits. Call the Allied Trade Assistance Program at 1-800-258-6376 to initiate pre-authorization. See the Preauthorization for details on the penalties and requirements for services that must be precertified. Pre-authorization is not required for Outpatient services. However, participants should call the Allied Trade Assistance Program in order to obtain a referral to an In-Network provider. Post-Service claims are administered by the Fund Office and should be forwarded to the Fund Office for processing.

MENTAL HEALTH	In-Network	Out-of-Network
• Office visits	$20 Copayment	70%, after deductible
• Other Outpatient (including Intensive Outpatient and Partial Hospitalization)	100%	70%, after deductible
• Inpatient (including Inpatient Rehabilitation)	$100 Copayment per day, up to $500 maximum per admission	70%, after deductible
SUBSTANCE/ALCOHOL ABUSE		
• Office visits	$20 Copayment	70%, after deductible
• Other outpatient (including Intensive Outpatient and Partial Hospitalization)	100%	70%, after deductible
• Inpatient	$100 Copayment per day, up to $500 maximum per admission	70%, after deductible

PRESCRIPTION DRUG PROGRAM FOR EMPLOYEES AND DEPENDENTS

The Plan provides you and your eligible Dependents with prescription drug coverage administered by EnvisionRx Options. Benefits will be provided for Covered Drugs for out-of-hospital use (but not while a patient in a nursing home or other institution) dispensed by a legally licensed pharmacy.

How to Obtain Your Prescription Drugs

EnvisionRx Options has established a network of pharmacies through which you may fill prescriptions; these are generally referred to as participating pharmacies. If you use participating pharmacies, your out-of-pocket costs may be lower than if you use a non-participating pharmacy.

EnvisionRx Options network consists of pharmacies nationally, including chain drugstores like CVS, Rite Aid and Walgreens. You may contact EnvisionRx Options customer service or check online at ***www.envisionrx.com*** to find a participating pharmacy in your area.

You will receive an identification card when you first become eligible for Plan coverage. Your identification card can be used at any participating drug store that displays the EnvisionRx Options decal in the store window or near the pharmacy area. For service, simply present your identification card and a valid prescription at any participating pharmacy for service. The pharmacy is usually able to check eligibility online and may not ask for your ID card but bring it in case you are asked for it. The participating pharmacy will dispense a prescription in a quantity not to exceed a 30-day supply and collect the applicable copayment (as described on the next page). You will be asked to sign a signature log to verify that you picked up the medication. While a pharmacy can usually check eligibility online through EnvisionRx Options, if you purchase a prescription at a participating pharmacy without your ID card, you might need to pay for the prescription and submit the prescription drug receipt to Iron Workers Benefit Plan for direct reimbursement.

If you purchase a prescription at a non-participating pharmacy, you will have to submit a claim along with the prescription drug receipt to Iron Workers Benefit Plan for reimbursement. You must submit the receipt(s) no later than 45 days from date of purchase in order to receive reimbursement. Please note any difference in the cost of the prescription and the amount allowed by the Plan is your responsibility. It is always to your advantage to use a participating pharmacy.

See the "Claims and Appeals" chapter of this booklet for information on how to file an appeal for a prescription drug claim.

Copayments if You Use a Participating Pharmacy

	Retail Pharmacy Outlet (up to 30-day supply)	**Mail Order (up to 90-day supply)**
Generic Drugs A generic drug is defined by its official chemical name and is an equivalent to a brand name medication. All drugs, including generics, must meet the same Food and Drug Administration (FDA) standards for quality, strength, purity, effectiveness, stability, and safety.	\$10 co-pay per prescription	\$20 co-pay per prescription
Affordable Care Act (ACA) Preventive Medications Certain generic preventive medications (as outlined later in this section)	Paid at 100%	Paid at 100%

	Retail Pharmacy Outlet (up to 30-day supply)	Mail Order (up to 90-day supply)
Formulary Brand Name Drugs A formulary is a list of preferred medications. A formulary is a list of carefully selected medications that have been selected based on their clinical effectiveness and opportunity for cost savings to the Plan. Under the formulary program, the Plan requires a lower Copayment for formulary medications, and a higher Copayment for non-formulary medications. Contact EnvisionRx for commonly prescribed formulary medications and alternatives to non-formulary medications (you can reach them at the number found on your ID).	$25 co-pay per prescription	$50 co-pay per prescription
Non-Formulary Brand Name Drugs A non-formulary drug is a medication that is not listed on the formulary. These drugs have a higher co-payment then those listed on the formulary.	$50 co-pay per prescription	$100 co-pay per prescription
Specialty Drugs	2% of cost of drug, subject to regular copayment minimum (described above) and maximum of $250 per prescription	
Step Therapy is mandatory for all drugs including specialty drugs. Under this program, EnvisionRx Option will first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Step-1 and Step-2 drugs both treat a medical condition, Envision Rx Option may not cover the Step-2 drug unless you try the Step-1 drug first. If the Step-1 drug does not work, EnvisionRx Option will then cover the Step-2 drug.		

Mandatory Generic Program

If you fill a prescription for a brand name drug for which there is a generic equivalent, the pharmacy or mail order program will dispense the generic equivalent. You may still receive the brand name drug (for instance, if your physician indicates the prescription is to be "dispensed as written") but you will have to pay the difference between the brand name drug and its generic equivalent plus the applicable copayment.

Mandatory Generic Maintenance Prescription Drug (Mail Order) Program

If you or your eligible dependents are being treated for a chronic (long duration or frequently reoccurring) illness that requires a prescription drug you are now required to obtain those drugs from Envision-Pharmacies. Your physician must complete the prescription on the form supplied by the Fund Office (one prescription per form). The member must complete the section of the form as indicated. Use the prepaid postage addressed envelopes (also furnished by the Plan Office) to mail the prescription form to Envision-Pharmacies. Do not send money or checks. The prescribed drugs will be mailed to you and will be paid for by the Health Benefit Fund (Welfare Fund). If your physician requires that a prescription be taken for more than 12 months, you must have a new prescription form completed every 12 months. The Provider of the maintenance drugs for the Fund will only supply the generic equivalent of the drug unless you and/or your doctor elect to have the brand drug dispensed. In this case the Provider will bill you directly for the difference in cost. The Fund will pay the Provider only for the cost of generic equivalent. If there is no generic substitute available, you will receive the brand drug with a $50.00 or $100.00 (non-formulary) co-pay for

each 90 day supply. Effective January 1, 2009 you can use Rite Aid, Walgreens or Costco for a 90 day supply of your prescription drugs.

EnvisionPharmacies
PO Box 3094
Canton, Ohio 44799-2043
Phone #1-866-909-5170

Preventive Medications

The Affordable Care Act (ACA) makes certain preventive medications available to you at no cost. The following preventive medications are covered 100% for generic prescription drugs and brand name drugs if a generic is unavailable or medically inappropriate. This list should be used as a guide. It cannot be considered a comprehensive listing of medications available or covered without cost-sharing. Coverage of any of the listed medications (including over-the-counter (OTC) medications) requires a prescription from a licensed health care provider. This list is subject to change as ACA guidelines are updated or modified.

- Aspirin 81 mg and 325 mg.
- Fluoride Products: fluoride chewable tablets 0.25 mg and 0.5 mg; fluoride drops, 0.125, 0.25 mg and 0.5 mg; multivitamin w/fluoride chewable 0.25 mg and 0.5 mg; drops 0.25 mg and 0.5 mg suspension.
- Iron Supplements: iron (various strengths), drops, liquid, suspension, granules; multivitamin with iron, drops, liquid, suspension.
- Folic Acid products; folic acid tablet 0.4 mg and 0.8 mg; prenatal and multivitamins w/folic acid 0.4 mg and 0.8 mg.
- Smoking Cessation Products: All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider.
- Vitamin D Supplements: vitamin D 1,000 units or less per dose unit; calcium with vitamin D.
- Bowel Preps (Limit of two prescriptions per year); Bisacodyl, Magnesium Citrate, Milk of Magnesia, Peg 3350-electrolyte.
- Primary Prevention of Breast Cancer: Tamoxifen; Raloxifene; Soltamox (liquid Tamoxifen).
- Immunizations including routine vaccines recommended by the ACIP of the Centers for Diseases Control and Prevention and that meet the FDA approved indications for age and/or gender limitations.
- Contraceptive Methods including OTC contraceptive methods, oral contraceptives and contraceptive devices.

Benefit Exclusions and Limitations

Certain items are not covered by the Plan.

- Any charge for any type of vitamin, except Pre-Natal vitamins (Generic) and as noted above, even if such medication is a prescription legend drug.
- Any charge for Rogaine or any other hair growth product.
- Any charge for devices or appliances, regardless of their intended use.
- Any charge for administration of Covered Drugs.
- The charge for any prescription order refill in excess of the number specified by a doctor, or any refill dispensed after one year from the date of the original prescription order.

- The charge for any drug that has not been prescribed by a doctor of medicine, osteopathy, dental surgeon, dental medicine, or surgical chiropody.
- The charge for any medication for which the employee or dependent is entitled to receive reimbursement under any Workmen's Compensation Law or is entitled to from any municipal, State or Federal program of any sort whether contributory or not.
- The charge for medication covered under any other prescription drug, drug coverage plan or policy of insurance.

Prior Authorization is required for certain prescription. You will need to submit the diagnosis, name of medication and approximate length of treatment to the Fund Office. Prior Authorization is required for the following:

- Retin A
- Viagra/Cialis (6 pills a month subject to approval)
- All injectables other than Insulin
- Actiq
- Oxycontin (160 pills a month)
- All Step Therapy prescriptions
- Compound Medications

This list changes from time to time. EnvisionRx Options maintains the list of drugs that require prior authorization and will intervene at the point of service to support appropriate use through pre-established clinical criteria. Please contact EnvisionRx Options for the most up-to-date information on drugs needing prior authorization and for information on which drugs have a limit to the quantity payable by this Plan.

Prescription Drug Benefits for Medicare Eligible Individuals

Medicare covers prescription drug benefits under Part D. If you are enrolled in either Part A or B ofMedicare, you are eligible for Medicare Part D. For covered individuals who are Medicare-eligible, this Plan offers "Creditable Coverage." This means that this Plan's prescription drug benefits are expected to pay out, on average, as much or more as the standard Medicare prescription drug benefits will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have this Plan's prescription drug coverage as an Eligible Participant in order to avoid a late penalty under Medicare. When you lose coverage under this Plan, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare's annual enrollment period (October 7–December 7 of each year). For more information about Creditable Coverage see the Plan's Notice of Creditable Coverage that will be mailed to you from the Plan once a year. You may request another copy of this Notice by calling the Fund Office and asking for one.

OPTICAL BENEFIT

Optical Benefits under your Plan are provided through National Vision Administrators. Benefits may be provided for each Eligible Employee and dependent once in every two-year period.

Optical benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA.

Covered Dependent Children 18 years of age or younger may have an eye examination and new lenses once a year, if there is a prescription change.

Benefits are payable up to the following amounts:

- $20.00 for an eye examination
- $40.00 towards the purchase of single vision lenses
- $60.00 towards the purchase of bifocal lenses
- $100.00 towards the purchase of eyeglass frames.

A maximum benefit of $84.00 will be paid toward the purchase of prescribed contact lenses when using an out of network provider.

Contact the Fund Office for the required forms and submit the completed form along with an itemized bill to National Vision Administrators.

The Fund Office also has a contract with National Vision Associates which will enable you to have eye examination, lenses and eyeglass frames provided at discount prices. Please contact the Fund Office for proper forms and a list of participating doctors.

National Vision Administrators website is ***www.e-nva.com***, our sponsor # is 14860001.

DENTAL BENEFIT

Your Dental Benefits are insured and administered by Fidelio Dental Insurance Company. Fidelio has an extensive network of preferred providers. Their website is www.fideliodental.com telephone # 1-800-929-0340.

Dental benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA.

Employees and their eligible dependents are covered for dental benefits. The Plan pays you a benefit for a dental service as shown in the schedule of Dental Services.

Fidelio Participating Providers

Fidelio Participating Providers have agreed to accept the Fidelio's schedule as payment in full for services. Therefore, if you use a Participating Provider, you generally will have no or very little out-of-pocket expenses. You or your dependents may select any dentist of your choice through the Fidelio network. You make your dental appointment for a time that is convenient for both you and your dentist. You are not limited to certain dentists. You may change dentists at your convenience without endangering your benefits. However, in the event an Eligible Employee or dependent transfer from the care of one dentist to that of another dentist during the course of treatment or have more than one dentist perform services for one dental procedure, the Dental Plan shall be liable for not more than the amount it would have been liable for had one dentist performed the service.

Benefits for Non-Participating Providers

If you use a Non-Participating Provider, the Dental Plan will pay a benefit up to the maximum allowance as shown in the Schedule of Maximum Allowance (refer to Dental Benefits) or the dentist's actual charges, whichever is less. If two or more dental services are rendered, payment will be made for each dental service unless the Schedule of Maximum Allowances specifies a maximum amount for a particular combination of dental services.

Pre-authorization for dental treatment must be submitted when dentist charges are estimated to be $250 or more.

DENTAL BENEFIT PROGRAM SCHEDULE OF MAXIMUM ALLOWANCES FOR NON- PARTICIPATING PROVIDERS EFFECTIVE MAY 1, 2008

		Maximum Allowance
GENERAL		
110	Initial Exam	$32.00
120	Oral Exam & Diagnosis	$30.00
111	Prophy	$48.00
120	Stannous Fluoride Treatment	$22.00
130	Emergency Treatment of Dental Pain	$20.00
DENTAL X-RAY		
270	Bitewing X-Rays, each film	$12.00
220	Periapical X-Ray, each film	$12.00
230	Periapical additional film	$10.00
210	Maximum Periapical & Bitewing X-Ray	$65.00
330	Panoramic Film	$60.00
EXTRACTION OF TEETH		
7110	Extraction with local anesthesia	$65.00
7120	Extraction each additional tooth	$65.00
INLAYS AND FILLINGS		
2140	Amalgam involving one tooth surface	$50.00
1351	Occlusal Pitt & Groove Sealer	$30.00
2150	Amalgam involving two tooth surfaces	$65.00
2160	Amalgam three or more tooth surfaces	$80.00
2334	Amalgam Pin	$15.00
2950	Silicate build up	$98.00
2380	Silicate filling each tooth	$68.00
2410	Gold Foil, one tooth	$275.00
2420	Gold Foil, two tooth surfaces	$315.00
2430	Gold Foil, three or more tooth surfaces	$360.00
2510	Gold Inlay, one tooth surface	$275.00
2520	Gold Inlay, two tooth surfaces	$315.00
2530	Gold Inlay, three or more tooth surfaces	$360.00
2610	Porcelain Inlay, each	$275.00
CROWNS, PERMANENT, EACH		
2740	Porcelain crown	$475.00
2750	High noble porcelain crown	$525.00
2810	Three quarter gold crown	$320.00
2830	Stainless steel crown	$150.00
2790	Cast gold crown	$435.00
PONTICS		
6240	Porcelain or acrylic pontic	$425.00
6242	Gold acrylic pontic	$400.00

		Maximum Allowance
ENDODONTICS		
3410	Apicoectomy	$345.00
3310	One root canal	$340.00
2891	Gold core and post	$140.00
3320	Two root canals	$415.00
3330	Three root canals	$525.00
3230	Therapeutic pulpotomy	$115.00
3220	Vital pulpotomy	$80.00
3110	Pulp capping	$18.00
SPACE MAINTAINERS		
1510	Space maintainers, acrylic	$190.00
1515	Space maintainers, metal	$300.00
REMOVABLE DENTURES		
5110	Full dentures, either jaw each	$575.00
5130	Full denture immediate and permanent	$450.00/$575.00
5213	Partial maxillary	$645.00
5214	Partial mandibular	$645.00
5711	Rebasing with slow cure acrylic	$185.00
REPAIRS AND ADDITIONS TO DENTURES		
5620	Repair of broken denture	$100.00
5520	Broken teeth on denture replace	$42.00
5630	Reattaching undamaged clasp	$65.00
5660	Replacing broken clasp on denture	$65.00
PERIODONTICS		
4330	Occlusal adjustments-complete	$125.00
4345	Root scaling initial treatment	$90.00
4910	Root scaling subsequent treatments	$90.00
REPAIRS TO INLAYS, CROWNS AND BRIDGES		
2910	Recementing inlay	$25.00
2920	Recementing crown	$40.00
6930	Recementing bridge	$65.00
ORTHODONTICS		
8050	Phase I Ortho treatment Initial	$400.00
8060	*Phase I monthly active Ortho Treatments Maximum of 12 visits x $50.00 (amount paid towards Phase I will be deducted from Orthodontic lifetime maximum*	
8070	*Initial Ortho Treatment (Banding)*	$400.00
8460	Active Orthodontic treatment — 24 months x $100.00	$2,400.00

- ***Orthodontic lifetime maximum = $2,800.00 per individual***
- ***If Phase I is required any funds applied will be deducted when entering Phase II***

Please call the Fidelio Office for the fee schedule for any procedures not listed.

Exclusions & Limitations

1. Any service unless rendered by a duly licensed dentist.
2. Any procedure or the supplying or fitting of any appliance unless required in accordance with accepted standards of dental practice.
3. Replacing any lost appliance.
4. Any service for which the patient incurs no dentist's charge.
5. Plastic surgery or dental work solely for cosmetic purposes.
6. Injuries, diseases or conditions, the treatment of which is available without cost to the person treated under laws enacted by the legislature of any State or the Congress of the United States (such as Workmen's Compensation, Veterans Compensation, etc.).
7. Any service received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or other similar person or group.
8. Any prosthetic appliance, fixed or removable, made as an adjunct to periodontal care, unless it replaces a missing tooth.
9. The replacement of any full or partial permanent denture by another permanent denture unless a period of two years has elapsed from the installation of the original appliance.
10. In connection with dentures, crowns or fixed bridgework:
    (a) Expenses for replacement of crowns, as restoration and/or abutment or pontics more often than once every five years.
    (b) Expenses for replacement of fixed bridge replacing same teeth originally provided under dental plan more often than once every five years.
    (c) Expenses for crowns or pontics originally placed if included in second placement more often than once every five years.
    (d) Replacement of fixed bridgework or splint by a denture or dentures unless a period of five years has elapsed from installation of original appliance.
    (e) If work in making a crown, denture or bridge started prior to effective date of coverage of the individual.
11. Maximum allowance for prosthetic or crowns for restoration or splints which includes crown and bridge, crown for abutment teeth and any associated charges will be $5,000 per year, with a maximum amount of $10,000 extended in two consecutive years if two separate arches are treated. A maximum of $5,000 per arch will be paid in any consecutive 60 month period.
12. A $5,000 yearly maximum Fund Allowance will be applied to all crowns, crown and bridge, pontics post and core, and precision attachments.
13. There will be no allowances for second arch crowns, crown and bridge pontics, post and core precision attachments until 12 months after the date of insertion of the last procedure in a series of treatment which caused the maximum to be applied.
14. All claims must be filed within one year of the Dental Procedure.

This Plan also contains a number of other provisions as well as forms of payment and claims and appeals procedures that are explained in the Fidelio Certificate of Insurance.

All provisions of this benefit are subject to the contract and described in the Certificate of Insurance issued by Fidelio Dental Insurance Company. If there are any discrepancies between this Booklet and the Certificate or contract, the Certificate or contract will govern.

PENSIONER BENEFITS

Pensioners with effective Date of Pension on and after January 1, 1993

The benefits and rules and regulations of the Iron Workers District Council (Philadelphia and Vicinity) Pension Plan are outlined in a separate section of this binder.

In addition to monthly cash pensions payable by the Pension Plan upon retirement, the Iron Workers District Council (Philadelphia and Vicinity) Benefit Plan will continue to provide certain benefits, as described below, to eligible pensioners and their eligible dependents.

Eligibility

You are eligible for Pensioner Benefits if you meet the following requirements:

- Retire as a Regular Retirement Pensioner or Early Retirement Pension on or after January 1, 1993;
- Have 25 years or more of Pension Credit in the Pension Plan of which at least 2 full years of pension credit were earned under the Pension Plan in 4 calendar years prior to retirement; and
- Are age 62 or more at the time of retirement. Effective January 1, 2002, those Pensioners who retire on or after January 1, 1993 on an Early Retirement Pension are covered for the benefits described above between the ages of 62 and 65 if they retire prior to age 62, return to work in covered employment for at least 3 years and again leave covered employment on or after age 62 with 25 years or more Pension Credit in the Pension Plan and pay the required co-payment. All Pensioners who retire on or after January 1, 1993 who are eligible for Pensioners Benefits at the time of retirement are eligible for a $5,000 death benefit.

Effective Date of Pensioner Benefits

Benefits for Eligible Retirees become effective on the first day of the month after coverage as an Eligible Employee ends, provided you enroll for such coverage and pay the applicable premiums.

Monthly Contribution/Premiums for Retiree Benefits

Pensioners (and eligible dependents) who are currently eligible for and are covered under the Plan for Pensioner benefits are required to pay a monthly contribution (an assessment) of $100 per month. This contribution is the same for single coverage as for family coverage, and is subject to change. This contribution applies to any Eligible Employee who retires on and after July 1, 1993 and enrolls for Pensioner benefits (if eligible).

Pensioner Benefits

If you are eligible for and properly enroll for Pensioner benefits and make the required contributions, you will be entitled to the following benefits under the Plan. ***Please note that you are eligible for different benefits depending on whether or not you are eligible for Medicare.***

Dental, Optical and Prescription Drug Benefits for All Eligible Pensioners and Eligible Dependents of Eligible Pensioners

Prescription Drug, Dental and Optical Benefits for all eligible Pensioners and their eligible Dependents are the same as those for Eligible Employees.

Medical Benefits for Non-Medicare-Eligible Pensioners and/or Their Non-Medicare-Eligible Dependents

Medical and hospital benefits, for eligible Pensioners or eligible Dependents of eligible Pensioners who are under age 65 and not otherwise eligible for Medicare Part A or B (due to disability or ESRD), are the same as those for Eligible Employees.

Medicare Supplemental Benefits — Medical Benefits for Medicare-Eligible Pensioners and Dependents

For eligible Pensioners or eligible Dependents of eligible Pensioners who are age 65 or over (or younger than age 65 and otherwise eligible for Medicare (due to disability or ESRD), this Plan supplements Medicare benefits. That means that this Plan coordinates with Medicare and pays on a secondary basis after Medicare has made its payments. For details on how this Plan coordinates with Medicare, see the section, "Coordination with Medicare" beginning on page 48.

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period. It is your responsibility to apply for Medicare Part A and Part B. If you are eligible for Medicare and want information about enrollment, contact your local Social Security Office three months before your 65th birthday.

Traditional Medicare has two parts, A and B. In general, Part A covers hospital services, skilled nursing facilities, hospice, and some home health care services. Part B covers medical services such as physician visits, physical and occupational therapy and diagnostic testing. In general, your Pensioner Benefits through this Plan supplements Part A and covers the Part A deductible and coinsurance amounts. This Plan also supplements Part B coverage and covers the Part B deductible and coinsurance amounts. Part D (which covers prescription drugs) — only if purchased — covers outpatient prescription drugs. **Please note that if you enroll in a Part D Plan (a Medicare prescription drug plan), you will not be eligible for prescription drug coverage under this Plan.**

Coordination with Other Group Plan Coverage

If a Pensioner, who is eligible for Pensioner benefits under this Plan is also covered under any other group plan by his current employer (regardless of whether or not the Pensioner or any eligible Dependents are eligible for Medicare), this Plan will coordinate with the other Plan subject to the COB provisions of the Plan. In effect, this Plan will pay benefits on a secondary coverage to any Plan you are covered under as an active employee. This means the other employer Group Health Plan must pay benefits first, then this Plan will pay on the balance of covered expenses in accordance with Plan COB provisions.

Plan benefits for active, retired or disabled participants are not guaranteed.

The Trustees reserve the right to change or discontinue (1) the types and amount of benefits under this Plan, and (2) the eligibility rules, including those that apply to retired employees (pensioners) up to an including terminating all eligibility for benefits, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated.

CO-ORDINATION OF BENEFITS PROVISION

Members of a family can be covered under more than one plan of employee benefits (if, for instance, both spouses are working and have coverage). Realizing there have been many instances of duplication of benefits — two plans paying benefits for the same dollar of medical expense — a "co-ordination of benefits" provision has been included in our plan for all covered benefits excluding life insurance, accidental death and dismemberment insurance, weekly accident and sickness benefits. These are the rules of coordinating generally that apply to all benefits under the prescription drug and mental health/substance use disorder

benefits. **Please note that the specific provisions pertaining to COB for the Personal Choice PPO benefits and insured Dental benefits are described in detail in the applicable booklets.**

The amount of benefits payable under this Plan will be coordinated with any coverage you or an eligible Dependent has under other health care plans. Other plans include benefits or services provided by:

- Group, blanket or franchise insurance coverage;
- Service plan contract, group practice, individual practice and other prepayment coverage;
- Any labor-management Trusteed plans, Union welfare plans, Employer organization plans or Employee benefit organization plans; and
- Any coverage under governmental programs, including any coverage required or provided by any statute.

This Fund will always pay either its regular benefits in full, or a reduced amount that, when added to the benefits payable on your behalf by other plans, will equal the total regular benefits in full. However, no more than the maximum benefits payable under this Plan will be paid.

When the Fund pays secondary pursuant to the rules set forth in this subsection, it pays as if the PPO negotiated discounts have been applied regardless of whether, in fact, they have been. Likewise, the Fund applies its coinsurance requirements, rather than paying up to 100%. (In other words, if the Fund has higher coinsurance requirements than the primary plan, there may be no secondary coverage at all.)

Order of Payment

If you or your eligible Dependent is covered under more than one plan, the primary plan pays first. The secondary plan will adjust its benefit payment so that the total benefits payable does not exceed 100% of covered expenses incurred or what it would normally pay if no other plan were available (see also note above regarding the application of PPO negotiated discounts and Coinsurance). Please note that where this Plan pays secondary to another plan, this Plan will exclude from coverage payment of any claims denied under your primary coverage due to your failure to obtain a required pre-certification, pre-authorization, or referral from your primary care provider.

When both you and your spouse are covered under different group health plans as Employees and someone in your family has a claim, both you and your spouse should file the claim with your own plan. The claim departments will decide which plan has primary and secondary responsibility.

If you or your Dependents are eligible under another plan(s) the following rules apply:

1. If the other group plan does not have a coordination of benefits provision that is consistent with industry standards, that plan will always pay first.
2. When the other plan has a coordination of benefits provision, the plan covering the person as an Employee, member, subscriber, policy holder, or Pensioner will pay first, and the plan covering the person as a spouse or dependent will pay second. However, if the dependent person is a Medicare beneficiary, and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired Employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, member, subscriber, policy holder, or Pensioner is the secondary plan and the other plan is the primary plan.
3. If the parents of an eligible Dependent Child are married, the plan of the parent whose birthday is earlier in the calendar year will pay first. If both parents' birthdays are on the same day, the plan covering the parent for the longer period will pay first.

4. If the parents of an eligible Dependent Child are divorced or legally separated, then the following rules apply:
   - if a court decree or ruling or order of an administrative tribunal with appropriate jurisdiction establishes financial responsibility for medical/health care for a child, the plan covering the parent with that responsibility will pay first and the plan covering the other parent will pay second;
   - if a court decree or ruling or order of an administrative tribunal with appropriate jurisdiction, states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of the birthday rule above will determine the order of benefits;
   - if a court decree or ruling or order of an administrative tribunal with appropriate jurisdiction states that both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of the birthday rule above will determine the order of benefits; or
   - if there is no court decree or ruling or order of an administrative tribunal with appropriate jurisdiction allocating responsibility for the Dependent Child's health care expenses or health care coverage benefits on a claim will be payable as follows:
     - the plan covering the parent who has custody will pay first;
     - the plan covering the spouse of the parent who has custody (the step-parent of the child) will pay second; the plan covering the parent without custody will pay third; and
     - the plan covering the spouse of the parent without custody will pay last.
5. The plan that covers an individual as an active employee (an employee who is not terminated, laid-off, or retired) is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, policy holder, or Pensioner is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
7. The plan that covers the person as a full-time employee or as a dependent of a full-time employee is the primary plan and the plan that provides coverage due to part-time employment is the secondary plan.

   If an Employee's Dependent works for an employer that tries to avoid paying the Dependent's claims under its health plan by excluding or reducing benefits for those Dependents that are covered under this Plan, the Plan will exclude the Dependent from coverage entirely. The Dependent's employer's plan(s) will be responsible for the claims incurred. This exclusion applies only if a Dependent's employer's plan(s) attempts to limit the amount of benefits it has to pay on behalf of the Dependent's employer's employees because of coverage under the Plan. If the Dependent's employer's plan pays benefits for the Dependent in the same manner and in the same amount as it does for all of its other employees without regard to any other coverage that an individual may have, then this rule will not affect the Dependent's coverage under the Plan.

Sometimes the above rules do not clearly show which plan should pay first; in such cases, the plan that has covered the person for the longest period will pay first. The plan that has covered the person for the next longest period will pay second, and the plan that has covered the person for the shortest period will pay third, etc. In addition, where part of the plan coordinates benefits and a part does not, each part will be treated like a separate plan.

If the preceding rules do not determine the order of benefits, the benefits payable will be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

If you file a claim for benefits, you are required to authorize any Physician, Hospital, Employer, etc., to release to the Fund Office any information that is required for proper processing of your claim. For purposes of coordination of benefits, the Fund Office has the right to:

- Receive and Release any necessary claim information without notice to you. Any person claiming benefits under this Plan must give the Fund Office any information that may be necessary to process the claim.
- Recover the amounts paid from the other plan or from a person if the other plan has already made its payment to a person; and
- Directly pay another plan the benefits the Plan should have paid if another plan has paid benefits on a claim first when this Plan should have paid first.

How Much this Plan Pays When It Is Secondary

Secondary Liability of this Plan: When this Plan pays second, it will pay, 100% of "Allowable Expenses" **less** whatever payments were actually made by the Plan (or plans) that paid first. It will reduce its benefits so that the total benefits paid or provided by all coordinating plans is not more than 100% of total allowable expenses and in no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, which is covered in full or in part by any of the Plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is determined (by the Plan Administrator it is designee) to be Medically Necessary.
- If the coordinating plans determine benefits on the basis of an Allowed charge amount, any amount in excess of the highest Allowed Charge is not an allowable expense.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If one coordinating plan determines benefits on the basis of an Allowed charge amount and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.
- When benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.]

Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Administration of COB

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

This plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided Plan's Allowed charge.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Coordination of Benefits and Medicaid

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.

The Plan honors any Medicaid assignment of rights made on behalf of a participant. The Plan also honors any reimbursement or subrogation rights that a state may have by virtue of payment of Medicaid benefits for expenses covered by the Plan. In addition, the Plan will not consider Medicaid eligibility or medical assistance provided by Medicaid in determining Plan benefits or eligibility. To the extent the Plan is required by law to pay primary to Medicaid and Medicaid has paid benefits already, the Plan shall make benefit payments in accordance with any state law that affords the state rights to such payment.

Coordination of Benefits with Medicare

Generally, anyone aged 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage after a waiting period.

How Medicare Works with Plan Benefits for Active Employees

If you, your covered spouse, or dependent child are covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this Plan. If you, your spouse, or your dependent child are covered by this Plan and by Medicare, and you retain your coverage under this Plan, as long as you remain actively employed, your health care coverage will remain the same, and this Plan pays first and Medicare pays second.

If you cancel your coverage under this Plan, coverage of your spouse, and your dependent child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. Refer to the section on COBRA Continuation Coverage, for further information. The choice of retaining or canceling coverage under this Plan of a Medicare participant is the responsibility of the employee. Neither this Plan nor the employee's

employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

If an Eligible Employee under this Plan becomes totally disabled and entitled to Medicare because of that disability, the Eligible Employee will no longer be considered to remain actively employed. As a result, once the employee becomes entitled to Medicare because of that disability, Medicare pays first and this Plan pays second. Generally, if an eligible Dependent of an Eligible Employee under this Plan becomes disabled and entitled to Medicare because of that disability, this Plan pays first for that dependent and Medicare pays second (as long as the Dependent remains eligible under the terms of the Plan).

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of:

- The month in which Medicare ESRD coverage begins; or
- The first month in which the individual receives a kidney transplant.

Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Benefits for Pensioners and Dependents Who Are Medicare Eligible

Those enrolled in any Part of Medicare may either retain or cancel coverage under this Plan. If a Pensioner under this Plan is covered by Medicare and cancels coverage under this Plan, coverage for his/her dependents will terminate (but they may be entitled to COBRA Continuation Coverage). Refer to the section on COBRA Continuation Coverage for further information.

Medicare has three parts: Part A, Part B, and Part D. In general:

- Part A covers hospital services, skilled nursing facilities and Hospice.
- Part B covers medical services such as physician visits, physical and occupational therapy and diagnostic testing.
- Part D covers prescription drug expenses.

How Much this Plan Pays When It Is secondary to Medicare

If you are retired and covered by Medicare Parts A and B, as well as this Plan, Medicare pays first and this Plan pays second. In such cases, you pay the Part A and Part B deductibles and any coinsurance amounts and this Plan pays the amounts you paid for deductibles and coinsurance. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the billed charges of the Health Care Provider.

Please be aware that when Medicare is primary, you must follow Medicare guidelines. Secondary coverage under the Fund is limited to Medicare approved charges only.

Once retired, you and your eligible dependents that are eligible or become eligible for Medicare due to age or disability must enroll in Medicare Part B and pay the Medicare premiums and deductibles. This Plan pays benefits secondary to Medicare and **WILL NOT** duplicate hospital and medical benefits available under Medicare for Pensioners and dependents who are eligible for Medicare. **If you do not enroll in Part B, the Plan will coordinate as if you were enrolled in Medicare.**

When You Are Not Covered by Medicare Parts A and B

You should understand that not enrolling in Medicare Parts A and B will have significant impact on the expenses for which you will be responsible. This is because if you and/or your eligible dependent(s) are eligible for Medicare (e.g., because you are age 65), but choose not to enroll in Medicare Parts A and B, this Plan pays benefits as if it were coordinating with Medicare Parts A and B. Therefore, you will only receive

the benefits the Plan would have paid had Medicare Part A or Part B paid benefits first (generally any applicable deductible and/or the 20% Medicare coinsurance for a particular service or supply).

This provision does not apply for Medicare Prescription Drug Benefits (Medicare Part D). You will receive prescription drug benefits from this Fund only if you **DO NOT** enroll in the Medicare Part D Prescription Drug Plan.

Prescription Drug Benefits and Medicare

You and your spouse or spousal equivalent are eligible for retiree prescription drug coverage under this Plan that is the same as the coverage you were eligible to receive when you retired. If you are Medicare-eligible and if you or your spouse enroll in the Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Plan with prescription drugs (MA-PD), your (or your spouse's/spousal equivalent's) prescription drug coverage under this Plan **will end.** Any Pensioner or dependent enrolled in Medicare Part D **WILL NOT** be eligible to receive benefits for any prescription drugs under the Plan.

The Medicare Advantage Program (Formerly Called Medicare + Choice or Part C) Without Prescription Drug Benefits

If an individual is covered by both this Plan and a Medicare Advantage program, and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services in-network when the Medicare Advantage program requires it, this Plan will reimburse all applicable co-payments, deductibles and/or coinsurance. However, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification/preauthorization, case management or utilization of in-network provider requirements, this Plan will **NOT** provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.

Medicare Private Contracts

Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain health care practitioners with whom he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare participant enters into such a contract, this Plan will pay benefits for health care services and/or supplies the Medicare participant receives pursuant to it, but only up to the amount it would have paid if the provider did participate with Medicare. Therefore, the Plan will pay up to the amount Medicare would have allowed **less** the amounts that would have been paid by Medicare had the provider been eligible to submit the claim to Medicare Part A or B. The difference is the patient'sresponsibility.

EXCLUSIONS

No benefits are payable under this Plan for the charges listed below, and the amount of any such charges will be deducted from the individual's expenses before the benefits of this plan are determined.

1. Charges that would not have been made if no Benefit Plan existed or charges that neither you nor any of your dependents are required to pay.
2. Charges for services or supplies which 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. Charges for services or supplies which 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.

4. Charges for services and supplies which are not necessary for treatment of the injury or disease or are not recommended and approved by the attending physician or charges to the extent that they are unreasonable.
5. Charges for services rendered or supplies provided before the patient became covered under the Plan; or after the date the patient's coverage ends, except under those conditions described in the COBRA section of this document.
6. Hypnosis (including diet, obesity and smoking sessions).
7. All diet control programs and related drugs, except as required under the ACA preventive benefits.
8. Infertility testing except as noted under "Limitations."
9. Bio-Feedback therapy.
10. Organ Transplants.

Charges for services that are payable by any insurance policy for which the premiums were paid by the member participant or his spouse or his dependents.

Automobile Accidents

No benefits are payable under the Benefit Plan for claims arising out of a Participant's or Dependents' involvement in any type of motor vehicle accident including accidents involving motorcycles. The Plan excludes expenses arising from injury as a result of operating or riding on a *motor*cycle.

However, should you or your spouse or any of your covered Dependent Children be injured in an automobile accident and the medical bills exceed the maximum insurance coverage offered by your automobile insurance company or, if applicable, the maximum insurance protection permitted under the law of your state of residence, this Plan will cover any additional medical bills up to the limit of this Plan's coverage.

In order to take advantage of this benefit, you must submit proof that you have paid all the required deductibles and that your medical bills exceed the maximum coverage offered by your automobile insurance company or, if applicable, the maximum permitted in state of residence.

DEFINITIONS

To be recognized as a hospital for benefit purposes, an institution must keep patients regularly overnight, have full diagnostic, surgical and therapeutic facilities under the supervision of a staff of physicians who are doctors of medicine and regularly provide 24 hour nursing service by registered graduate nurses. Unless they fully meet this definition, institutions such as clinics, nursing homes, and places for rest, the aged, drug addicts or alcoholics do not qualify as hospitals.

To be covered by this Plan, the services or supplies must be for the treatment of a non-occupational bodily injury or disease. Thus, elective services such as routine physical are not covered, nor are expenses in connection with occupational accidental bodily injuries or disease.

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Please note that the IBC PPO Booklet contains important definitions.

Active Participant means an Eligible Employee or eligible Apprentice.

Calendar Year means the 12-month period beginning January 1 and ending December 31.

Coinsurance means the portion of Eligible Covered Expenses, generally expressed as a percentage, that are paid by the Covered Person in accordance with the provisions of the Plan. Coinsurance amounts are listed

in the Medical Summary of Benefits, the Coverage for Mental Health and Alcohol/Substance Abuse Section and the Prescription Drug Section.

Covered Employment means employment covered by a collective bargaining agreement between a Contributing Employer and the Union for which contributions are required to be made on Active Participant's behalf.

Covered Person means any Eligible Employee, eligible Apprentice, eligible Pensioner or eligible Dependent who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan. A covered person is also referred to as a Plan Participant.

Eligible Apprentice means an Apprentice who has met the eligibility requirements detailed in the Eligibility section of this booklet and is enrolled for coverage under this Plan.

Eligible Dependents means your spouse (unless you and your spouse are living separate and apart) and your children who meet the requirements of an eligible Child as described on page 13 and are properly enrolled in the Plan. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility chapter, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Eligible Employee means an Employee who has met the eligibility requirements detailed in the Eligibility section of this booklet and is enrolled for coverage under this Plan. Once an Eligible Employee is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility chapter, and that person is a covered Employee, and remains a covered Employee until his or her coverage ends in accordance with the terms and provisions of the Plan.

Eligible Participant means an Eligible Employee, Eligible Apprentice or Eligible Pensioner. Unless specifically indicated otherwise, when used in this document, Eligible Participant refers to a person employed under a Collective Bargaining Agreement between the Employer and the Union and on whose account the Employer is obligated to make, and is making, required contributions to this Plan. Eligible Participant can also mean a nonbargaining unit employee of a corporate employer who has signed a nonbargaining unit participation agreement with the Plan. See the Eligibility provisions in the Eligibility chapter of this document.

Employer or Contributing Employer means an entity that has entered into a collective bargaining agreement with the Union or a Participation Agreement requiring contributions to be made into the Health Fund.

Fund means the Iron Workers District Council of Philadelphia and Vicinity Health Benefits Fund.

Illness means any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy is treated in the same manner as an Illness under the Plan for you or your eligible spouse only for the purpose of coverage under this Plan. Prenatal and postnatal visits for a pregnant dependent child will be an illness that is covered by this Plan, but not ultrasounds and other pregnancy-related services of the pregnant dependent child, the delivery and/or newborn expenses.

Injury means physical damage to you or your Dependent's body part resulting from trauma from an external source. Only injuries which are not employment-related are considered for benefits under this Plan, except under Accidental Death and Dismemberment Benefits.

Medicare means the Health Insurance for the Aged and Disabled provisions in Title XVIII of the Social Security Act as it is now amended and as it may be amended in the future.

Plan means the group health plan sponsored by the Board of Trustees.

Pensioner or Eligible Pensioner means a former Eligible Employee who meets this Plan's Pensioner Eligibility rules and is enrolled for Pensioner Benefits under this Plan.

Union means Iron Workers Locals — 399, 401, 404, 405, and 451.

There are other terms applicable to this Plan that are defined throughout this booklet and in the attached Independence Blue Cross Personal Choice PPO booklet, the Amalgamated Life Insurance Certificates of Insurance (for Life, AD&D and Weekly Disability Insurance).

Whenever a pronoun is used in the masculine, it also includes the feminine, unless the context clearly indicates otherwise.

CLAIMS AND APPEALS

Internal Claims and Appeal Procedures

This section describes the procedures followed by the Iron Workers District Council (Philadelphia and Vicinity) Health Benefit Plan in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health and alcohol/substance abuse, dental, optical, prescription drug, weekly disability, death, and accidental death and dismemberment benefits. Please note that specific procedures as they relate to insured dental, weekly disability and death and accidental death and dismemberment are outlined in the applicable Certificate of Insurance/Coverage.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted. Please note that dental and optical benefits are considered "excepted benefits" and therefore there are no external review rights for these benefits.

General Information

Claims Administrator(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations (see the contact information in the Summary of Benefits and Information or Contacts and Administration for contact information):

Appropriate Claims Administrator	Types of Claims Processed
Independence Blue Cross (IBC) Personal Choice PPO	• Urgent, Concurrent and Pre-service Medical Claims • Medical Post-Service Claims
HealthCare Strategies, Inc.	• Disease Management and Large Case Management
Allied Trade Assistance Program (ATAP)	• Mental Health and Alcohol/Substance Abuse Urgent, Concurrent and Pre-Service Claims
Iron Workers District Council (Philadelphia and Vicinity) Health Benefit Plan Fund Office	• Post-Service Mental Health and Alcohol/Substance Abuse Claims
Envision Rx Options	• Pre-service drug claims • Post-Service Claims for out–of-network retail drugs

Appropriate Claims Administrator	Types of Claims Processed
Fidelio Dental Insurance Company	• Pre-Service Claims • Dental Post-Service Claims
National Vision Administrators	• Pre-Service Claims Post-Service Claims
Amalgamated Life Insurance Company Life Insurance Dependent Life	• Life Insurance coverage for employees • Accidental Death and Dismemberment Claims coverage for employees • Weekly Disability Claims • Note: submit initial claim to Fund Office to verify eligibility

Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

Discretionary Authority Of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law. All notices relating to external review sent will contain a notice about the availability of Spanish language services. Assistance with filing a claim for external review in Spanish is available by calling the number on the back of your identification card. Notices relating to external review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al número de servicio de atención al cliente que aparece detrás de su tarjeta de identificación.

Definition of a Claim

A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, mental health and alcohol/substance abuse, dental, optical, and prescription drug benefits. There are four categories of health claims as described below:

- ***Pre-Service Claims*** **(applicable to medical, mental health and alcohol/substance abuse and prescription drug benefits)** — A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for certain medical, mental health and alcohol/substance abuse and prescription drug benefits as outlined in those sections.
- ***Urgent Care Claims*** **(applicable to medical, mental health and alcohol/substance abuse and prescription drug benefits)** — An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.
- ***Concurrent Claims*** **(applicable to medical, mental health and alcohol/substance abuse, dental, and prescription drug benefits)** — A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.
- ***Post-Service Claims*** **(applicable to medical, mental health and alcohol/substance abuse, dental, optical, hearing, and prescription drug benefits)** — A Post-Service Claim is a request for benefits under the Plan 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 claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Weekly Disability Benefit Claims

A Weekly Disability claim is a request for benefits during a period of disability. Weekly Disability claims are filed after a participant suffers a disability and benefits are paid if the Claims Administrator determines that the participant has suffered a disability as defined by the terms of the Plan.

Life Insurance/Accidental Death and Dismemberment Insurance Claims

A Life Insurance/Accidental Death and Dismemberment Insurance Claim is a request by a designated beneficiary for benefit payment following the death of the participant. A claim for Accidental Death and Dismemberment Benefits may also be filed by a participant after he or she has provided the Plan with proof of a bodily loss.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the appropriate Claims Administrator;
- Name a specific individual participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;

- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) 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;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network optical provider(s). After the denial by the optical service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline

Claims should be filed within twelve (12) months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than eighteen (18) months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

Health Care Claims — Decision Timeframes

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be

provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- **Pre-Service Claims**

  Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if a applicable) notification before the expiration of the initial fifteen (15) day determination period.

  If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

- **Urgent Care Claims**

  In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

  The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you and your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

  If you improperly file an Urgent Care Claim, the Claims Administrator will notify you and your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you and your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied

(i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you and your health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

- **Concurrent Claims**

  If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

  A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

  A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

  If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

  If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

- **Post-Service Claims**

  Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

  The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

  If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Weekly Disability Claims — Decision Timeframes

Generally, claims for Weekly Disability benefits will be decided no later than 45 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part). See the Amalgamated Life Insurance Company's Certificate of Insurance booklet for details on appeals procedures.

If your initial disability claim is denied and you disagree with the decision you or your authorized representative may request an appeal you have 180 days to do so.

Life Insurance and Accidental Death and Dismemberment Insurance — Decision Timeframe

Generally, you will receive written (or electronic, as applicable) notice of a decision on your initial claim within 90 days of receipt of your claim by the Claims Administrator. If additional time or information is required to make a determination on your claim (for reasons beyond the control of the Claims Administrator, you will be notified in writing (or electronically, as applicable) within the initial 90-day determination period. The 90-day period may be extended up to an additional 90 days.

You should refer to the Certificate from Amalgamated Life Insurance Company for complete details on Weekly Disability, Life Insurance and Accidental Death and Dismemberment Insurance claims.

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such a request is not considered to be a request for an internal appeal or external review);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide an explanation of the Plan's internal appeal and external review processes along with time limits and information about how to initiate an appeal and an external review;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;
- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;
- For Urgent Care Claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and
- Provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, you will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you and your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

Health Care Claims (applicable to medical, mental health and alcohol/substance abuse, optical, and prescription drug benefits) and Weekly Disability Claims

If an initial health care claim or weekly disability claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances for health care claims, explained in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

Life Insurance/Accidental Death and Dismemberment Insurance Benefits

If an initial life insurance or accidental death and dismemberment/death benefit claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an appeal. You have 60 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an appeal. The Plan will not accept appeal requests filed after this 60-day period.

You should refer to the Certificates from Amalgamated Life Insurance Company for information on appeals for Weekly Disability, Life Insurance and Accidental death and Disability Insurance.

Internal Appeals Process

Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan as follows:

For Personal Choice Claims

For Personal Choice PPO benefits, the Plan maintains a one level appeals procedure for Pre-Service, Urgent and Concurrent claims. The Plan maintains a two-level process for Post-Service claims.

Pre-Service, Urgent, Concurrent and 1st Level Post-Service PPO Personal Choice Claims should be submitted to:

Independence Blue Cross
Member Appeals Department
P.O. Box 41820
Philadelphia, PA 19103
Telephone: 1-888-671-5274
Toll Free: 1-888-671-5274_
www.ibx.com

If you are dissatisfied with your 1st level appeal, you may submit a 2nd level appeal to the Board of Trustees. Second level appeals must be submitted within 90 days of receipt of the 1st level appeal determination.

2nd Level PPO Personal Choice Post-Service Claims should be submitted to:

The Board of Trustees
Iron Workers District Council (Philadelphia and Vicinity) Health Benefit Plan Fund Office
2 International Plaza, Suite 120
Philadelphia, PA 19113-1504
Telephone: 1-215-537-0900
Toll Free: 1-800-473-5005
www.iwdcphila.com

The Plan maintains a one-level internal appeal process for Mental Health and Alcohol/Substance Abuse benefits, medical laboratory, pathology, x-ray, medical imaging, cardiac stress test and EKG studies provided by Health Care Solutions Corporation (HCSC), prescription drugs, hearing aids and optical benefits.

To file an internal appeal, you must submit a written statement to the Plan as follows:

Pre-Service (including Urgent and Concurrent Claims) Prescription Drug Claims should be submitted to:

EnvisionRx Options
2181 E. Aurora Road
Suite 201
Twinsburg, OH 44087
Telephone: 1-800-361-4542

Pre-Service Mental Health and Alcohol/Substance Abuse Claims should be submitted to:

Allied Trade Assistance Program
4170 Woodhaven Road
Philadelphia, PA 19154
Telephone: 1-800-258-6376

Appeal requests involving Urgent Care Claims may be made orally by calling the appropriate Claims Administrator at the telephone number listed above.

Post-Service Prescription Drug, HCSC Services, Mental Health and Alcohol/Substance Abuse, Hearing Aid or Optical Claims should be submitted to:

The Board of Trustees
Iron Workers District Council (Philadelphia and Vicinity) Health Benefit Plan Fund Office
2 International Plaza, Suite 120
Philadelphia, PA 19113-1504
Telephone: 1-215-537-0900
Toll Free: 1-800-473-5005
www.iwdcphila.com

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;
- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;
- A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

- The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:
    - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and
    - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
    - The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

Pre-Service Claims (applicable to Personal Choice PPO, mental health and alcohol/substance abuse, and prescription drug benefits).

- ***Urgent Care Claims (applicable to Personal Choice PPO, mental health and alcohol/substance abuse, and prescription drug benefits).*** This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).
- ***Concurrent Claims (applicable to Personal Choice PPO, mental health and alcohol/substance abuse, dental and prescription drug benefits).*** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the applicable Claims Administrator. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.
- ***Post-Service Claims (applicable to Personal Choice PPO, mental health and alcohol/substance abuse, HCSC benefits, optical, and prescription drug benefits).*** **One-level appeals process.**

  The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination

will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The [Plan Administrator/Board of Trustees] will notify you in writing (or electronically, as applicable) of the benefit determination no later than five (5) calendar days after the benefit determination is made.

- ***Two-level appeal process (applicable to Personal Choice PPO benefits).*** Under the Plan's two (2) level appeal process, the Plan routes the first level of review to the appropriate Claims Administrator who will make the first level determination on the appeal of your initial Post-Service Claim no later than 30 calendar days from the Plan's receipt of the appeal request. There is no extension permitted in the two (2) level appeal process. Within this 30-day period, you will be sent a written (or electronic, as appropriate) notice of the appeal determination. If the first level appeal determination results in an adverse benefit determination, you will have 90 calendar days from the date of your receipt of a notice of adverse benefit determination to request a second level appeal review by writing to the Board of Trustees. The Board of Trustees will then make a second level determination no later than 30 calendar days from its receipt of the second level appeal. You will then be provided with a written (or electronic, as applicable) notification of the second-level appeal determination no later than 30 days after the Plan's receipt of your request for a second level appeal.

Notice of Adverse Benefit Determination Upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review;
- If the denial was based on an internal rule, guideline, protocol or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;
- If the denial was based on a medical judgment (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request; and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

This concludes the appeal process under this Plan. The Plan does not offer a voluntary appeal process.

Authorized Representative

The Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan An authorized representative under the Plan also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A health care provider with knowl-

edge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a claimant) along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the appropriate Claims Administrator/Plan Administrator).

If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.* notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the your legal spouse, parent, grandparent, or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative rather than to you. The Plan will honor the designated authorized representative for one (1) year before requiring a new authorization/until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the appropriate Claims Administrator/Plan Administrator.

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

Limitation on When a Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly. For post-service claims, notice that the issue will be decided at the second quarterly Board meeting, or if the Plan received the appeal within 30 days of a Board meeting, the third meeting from receipt.

In addition, you are not required to exhaust external review before seeking judicial remedy.

No lawsuit may be started more than three years after the end of the year in which services were provided, [or, if the claim is for disability benefits, more than three years after the start of the disability].

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

EXTERNAL REVIEW OF CLAIMS

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

All notices relating to external review sent will contain a notice about the availability of Spanish language services. Assistance with filing a claim for external review in Spanish is available by calling 1-215-537-0900. Notices relating to external review will be provided in Spanish upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-215-537-0900.

Claims Eligible for the External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible for the External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that you or your dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than health care benefits (such as disability benefits, death benefits, and dental/vision benefits that are considered excepted benefits).
- Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

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

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

- If the Plan waives the requirement that you complete its internal claims and appeals process first.
- In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

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

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, do the following:

Stephen E. Conley
Iron Workers District Council (Philadelphia & Vicinity) Benefit Plan
2 International Plaza, Suite 120
Philadelphia, PA 19113
215-537-0900
sconley@iwdcphila.com

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

Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).
- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

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

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

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

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.
- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial.
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.
- A statement that judicial review may be available to you.
- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review of an Urgent Care Claim

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

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, do the following:

Stephen E. Conley
Iron Workers District Council (Philadelphia & Vicinity) Benefit Plan
2 International Plaza, Suite 120
Philadelphia, PA 19113
215-537-0900
sconley@iwdcphila.com

Preliminary Review of an Urgent Care Claim by the Plan

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

Review of an Urgent Care Claim by the IRO

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

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

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

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

What Happens After the IRO Decision Is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.
- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

PAYMENT OF CLAIMS

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate(s), other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Facility of Payment

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, claim administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

Erroneous Payments

Notwithstanding any other provision of the Plan to the contrary, any person who receives a benefit (including a payment) from the Plan shall be required to repay to the Plan: (1) any erroneous payment made to or on behalf of such person, including the value of any benefit erroneously provided, without regard to the reason for such erroneous payment; (2) appropriate interest; and (3) in the case of fraud or misrepresentation or in the event repayment is contested, any and all costs of collection (including attorney's fees). In addition, the Board of Trustees may take any reasonable action to recoup such erroneous payment or benefit, together with interest, and where applicable, costs, and including, without limitation, by offsetting future benefits and/or payments.

Fund's Right to Repayment from Recovery in Third-Party Actions

If any Claim is made against any entity for medical benefits payable under any applicable Workers' Compensation statute or other similar statute providing for payment of medical expenses, or if any legal action is brought against any third party to recover damages for injuries or illness, or if the right to make such a Claim or bring such an action exists and arises out of an event which gave rise to charges, costs, expenses or fees which make up all or part of a benefit under the Plan, the Covered Person (which term for purposes of this Section shall mean Covered Person, his Dependents and any other person or entity who may be entitled to, or receives, benefits under the Fund) shall notify the Fund of such action and the Fund shall be entitled to

reimbursement from any payment made as a result of such action or Claim to the full extent of the benefits paid out by the Fund without any deduction for attorney fees.

At the time of application for benefits under the Plan, the Covered Person and/or any Dependent on whose behalf benefits are payable shall execute a Repayment Agreement which fully implements the intent of the provisions below.

1. In the event that a Covered Person and/or Dependent on whose behalf benefits are payable fails or refuses to execute the required Repayment Agreement, such failure or refusal shall constitute a basis for denial of any benefit payments to such Covered Person and/or Dependent unless and until the Repayment Agreement is duly executed and delivered in a timely manner so as not to prejudice the Fund's rights. In the event that the Covered Person fails to notify the Funds Office of the existence of an action as to which he or one of his Dependent recovered or could recover damages from which the Fund would have been repaid had the Fund known of such action or fails to remit or otherwise deliver to the Fund Office any monies to which the Fund is entitled, irrespective of the existence of a Repayment Agreement, then upon becoming aware of such recovery, the Fund shall inform the Covered Person that he is obligated to return to the Fund the portion of such recovery which should have been paid over to the Fund, and the Fund shall make no benefit payment on any account to such Covered Person until the amount due the Fund from such recovery is returned or offset against amount which should otherwise have been paid to such Covered Person.
2. When notifying the Fund, the Covered Person shall provide the name and address of the Covered Person's attorney, provide the attorney with a copy of these provisions and any Repayment Agreement and require that the attorney comply with these provisions and of any such Agreement.
3. Keep the Fund informed, in writing, of the progress and/or settlement of his/her Third-Party Claim.
4. Specifically grant the Fund a first right of reimbursement and reimburse the Fund that portion of the Available Funds (defined below) which is due to the Fund for benefits paid to or on behalf of the Covered Person as well as for any premiums and other payments paid on behalf of the Covered Person to continue health insurance. The right of reimbursement granted to the Fund by the Covered Person includes the right of the Fund to seek reimbursement from any person or entity that holds the Available Funds, including but not limited to, a legal guardian, representative, trustee, parent or dependent.
5. Specifically grant to the Fund subrogation and all rights of recovery and causes of action that the Covered Person may have against the third-party, whether by suit, settlement or otherwise, that may be liable for the Covered Person's Illness or Injury (defined below) for which the Fund has paid or is obligated to pay benefits on the Covered Person's behalf.
6. Hold in trust for the Fund's benefit that portion of the total recovery from any source that is due for payments made or to be made. The Covered Person shall reimburse the Fund immediately upon recovery.
7. Do nothing to impair, release, discharge or prejudice the Fund's rights to subrogation and/or reimbursement. The Covered Person shall assist and cooperate with representatives the Fund designates. The Covered Person shall do everything necessary to enable the Fund to enforce its subrogation and reimbursement rights.
8. Require and authorize Covered Person's attorney, if any, to withhold from Available Funds any monies due the Fund pursuant to this provision and/or the Repayment Agreement and to forward them to the Fund as required by this provision and/or the Repayment Agreement. In case of any dispute over what monies are due the Fund, Available Funds shall be escrowed pending resolution of such dispute.
9. Available Funds shall be considered plan assets under ERISA (without regard to how, or with respect to whom, such Available Funds are held or titled). Further, the Covered Person and/or his Dependent who recovers, and any other person who holds (or who has any title to), such Available Funds shall be considered an ERISA fiduciary with respect thereto and may not assign, transfer, pledge, encumber, alienate, spend, or dispose of, the Available Funds.

10. Counsel Fees. The Fund shall have no obligation to pay any attorney's fees to any attorney retained by the Covered Person to pursue Third-Party Claims or to have any attorney's fees or costs withheld from amounts due to the Fund. The Fund shall not be bound by any agreement to the contrary made by the Covered Person. The Covered Person shall be solely responsible for paying all legal fees and expenses in connection with any recovery and the Fund's recovery shall not be reduced by such legal fees or expenses unless the Board of Trustees agree in writing to discount the Fund's claim.

11. Right to set-off. The Covered Person agrees that in the event that the Covered Person fails or refuses to comply with these provisions and/or the Repayment Agreement, then the Fund, in addition to any other rights to which the Fund or the Board of Trustees thereof might have, shall have the right to withhold from any payments due or which become due to the Covered Person or to third parties on behalf of the Covered Person any amounts necessary until the Fund is fully reimbursed as described in this provision and/or the Repayment Agreement.

12. Recording or use. The Covered Person hereby authorizes the Fund to record and/or use these provisions and/or the Repayment Agreement in any proceedings involving the Covered Person including using these provisions and/or the repayment Agreement in any Third-Party Claims that the Covered Person may have.

13. Authorization to pay. The Covered Person hereby authorizes any person or entity paying Available Funds to or on behalf of this Covered Person to pay over to the Fund such monies as the Fund is entitled to under these provisions and/or the Repayment Agreement and these provisions and/or the Repayment Agreement shall constitute their warrant to do so. In case of any dispute over what monies are due the Fund, Available Funds shall be escrowed pending resolution of such dispute.

14. Minors. Any Covered Person making a Claim on behalf of any minor child under the Fund's plan of benefits shall make the Repayment Agreement on behalf said minor child and agrees that he/she is authorized to make the Repayment Agreement on behalf of said minor child.

15. Other Insurance. It is agreed that any payment received by a Covered Person from any insurance carrier or from any like or similar plan for which the Covered Person has paid the full premium in order to secure individual, as distinguished from group coverage, shall be excluded from the requirements of these provisions and/or the Repayment Agreement.

16. Rejection of make-whole doctrine. The application of the make-whole doctrine is specifically disavowed by the Fund and by the Covered Person. The Covered Person agrees that the Fund's right to reimbursement, as set forth above, takes first priority on a first-dollar basis over any other Claims, regardless of whether or not Covered Person has been fully compensated for all Claims for damages or whether the Available Funds include payment for medical or non-medical expenses or are so characterized.

17. Equitable Lien/Constructive Trust. By making payments on behalf of the Covered Person, the Fund is granted an equitable lien by agreement and constructive trust over the Available Funds, to which the Covered Person consents.

18. Rejection of Common Fund doctrine. Covered Person agrees to the Fund's express rejection of Common Fund doctrine. The Fund's reimbursement and subrogation rights apply to any recovery by a Covered Person without regard to legal fees and expenses of the Covered Person.

For purposes of this Section, the following terms shall be defined as follows:

The term "Illness or Injury" shall mean any illness or injury of whatever kind or description, whether arising out of a work-related cause or whether unrelated to work of the Covered Person.

The term "Available Funds" shall mean monies recovered from third parties through a lawsuit, settlement or otherwise (whether called pain and suffering, weekly indemnity, workers compensation, damages, restitution, wage loss, medical reimbursement, out of pocket expenses or any other term) as a result of the injury or illness.

The terms "Claim" or "Third-Party Claim" shall mean any claim for monetary or non-monetary compensation of whatsoever kind or description whether made by petition (e.g. workers' compensation petition), court complaint, insurance claim or whether merely by written or oral demand.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As an Eligible Participant and/or Eligible Dependent enrolled in the Iron Workers District Council (Philadelphia and Vicinity) Health Benefit Plan, you are entitled to certain rights and protections under Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

- Receive information about your Plan and benefits. Examine, without charge, at the Fund Office and other specified locations such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the public disclosure room of the 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 and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Eligible Participant with a copy of the summary annual report.
- Continue health coverage for yourself, Spouse, and Eligible 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 summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Eligible Participants, ERISAimposes 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 ofyou and other Eligible Participants and beneficiaries. NO one, including your Employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Pan 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, which 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 medical child support order, you may file suit in a 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 period 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 area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication s hotline of the Employee Benefits Security Administration.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION PLAN DOCUMENT AMENDMENT

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the Iron Workers District Council Philadelphia and Vicinity Health Benefits Fund (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by an employer in its role as an employer, including but not limited to health information on disability, work-related illness/ injury, sick leave, Family and Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which is available from the Fund Office. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Trustees), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.**

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

   - **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

- **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

  a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

  b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;

  c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

  b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

  c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

  d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

  e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

  f. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

B. **When an Authorization Form Is Needed:** Generally the Plan will require that you sign a valid authorization form (available from the Fund Office or from the Appropriate Claims Administrator) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

   1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,

2. Ensure that any agents 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. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
3. Not use or disclose the information for employment-related actions and decisions,
4. 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 or disclosed in the Plan's Notice of Privacy Practices).
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
8. Make available the information required to provide an accounting of PHI disclosures,
9. 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 the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor 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 of the PHI infeasible.
11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Plan Administrator,
2. Assistant Plan Manager/Controller, Assistant Controller, Administrative Assistant, Receptionist, Claims Clerk, Claims Clerk/Secretary,
3. Staff designated by the Fund Administrator based on their job title and function.
4. Business Associates under contract to the Plan including but not limited to the medical claims administrator/preferred provider organization network, mental health and alcohol/substance abuse EAP/claims administrator, prescription drug program, and optical claims administrator.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Summary of Benefits and Information on Contacts and Administrations chart in the front of this document.

F. In compliance with **HIPAA Security** regulations, the Plan Sponsor:

1. Has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

2. Will ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Will report to the Plan any security incident of which it becomes aware concerning electronic PHI.

RECIPROCAL AGREEMENTS FOR HEALTH AND WELFARE FUNDS

BRIEF EXPLANATION OF POINT OF CLAIM RECIPROCITY

Point of Claim Reciprocity is an arrangement under the Iron Workers International Reciprocal Health and Welfare Agreement whereby an employee can maintain his eligibility for benefits under this Plan even though he is working in the jurisdiction of another health fund. The other health fund (a Cooperating Fund, in whose jurisdiction the employee is working, agrees under certain circumstances to transfer employer contributions it has received on the employee's behalf to this Fund (the Home Fund). Therefore, hours of service with a Cooperating Fund(s) will be considered service with the Home Fund for the purpose of maintaining the employee's eligibility for benefits with the Home Fund, regardless of the dollar amount of the contributions transferred.

For this Fund to be an employee's Home Fund, he must either be (1) a member of the local union(s) which participates in this Plan and have established his eligibility to be a Plan participant, or (2) have had the largest amount of employer contributions made on his behalf in the preceding 12-month period paid to this Fund. If an employee changes his membership to another local union which does not participate in this Plan, this Fund will no longer be the employee's Home Fund. The health fund in which his new local union participates would then become the employee's Home Fund.

Employees should follow the procedures listed below when filing claims for benefits:

1. File claims for benefits with your Home Fund as long as your service with the Home Fund is enough to meet its eligibility requirements (refer to the eligibility requirements of this Plan), even though you may be working in the jurisdiction of a Cooperating Fund when you file your claim.
2. File claims for benefits with a Cooperating Fund if you have lost your eligibility status with your Home Fund but have been working in the jurisdiction of the Cooperating Fund for a period long enough to meet its eligibility requirements.
3. Where you do not meet the eligibility requirements of either your Home Fund or a Cooperating Fund, you should file claims for benefits with your Home Fund. In this instance, Point of Claim Reciprocity becomes effective. Your service with a Cooperating Fund will be used towards meeting the eligibility requirements of your Home Fund. You will not be entitled to benefits from any of the Funds if your service, including service with Cooperating Funds, is not enough to reestablish eligibility with your Home Fund.

In filing claims for benefits with your Home Fund, indicate all Cooperating Funds in whose jurisdiction you have worked. Contact the Fund Office to determine if a welfare fund is a Cooperating Fund with your Home Fund.

This Plan is signatory to Exhibit "A" of the Iron Workers International Reciprocal Health and Welfare Agreement. A copy of the text of the Agreement follows.

Some Plans have also executed Exhibit "B" of the International Agreement which requires the transfer of contributions to the employee's Home Fund.

If you have worked outside the Jurisdiction of this Fund and have or expect to have a medical claim, you should contact the Fund Offices of the other Fund to determine as to what type of reciprocity you are entitled.

EXHIBIT "A"

Article Point-of-Claim Reciprocity

Section 1. Purpose — Eligibility is continued for health, welfare and insurance benefits under this Agreement for Employees who would otherwise lose eligibility for health, welfare and insurance benefits because their employment is divided between Local Union jurisdictions and in some cases such Employees may not have sufficient hours of contributions in one Fund to be eligible for benefits because of the division of hours and contributions among such Funds.

Section 2. Definitions

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

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

c. "Cooperating Fund" shall mean any Health, Welfare or Insurance Fund which by resolution of the Board of Trustees, has approved participation in and executed the

   - Iron Workers International Health and Welfare Reciprocal
   - Agreement.

d. "Home Fund" — each Employee who has Employer contributions made on his behalf to one or more of the Cooperating Funds shall have a determined Home Fund. In the absence of evidence substantiating a claim to the contrary, the following rules shall be used in determining an Employee's Home Fund:

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

Section 3. Transfer of Contributions

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

b. Transfer of Contributions to Home Fund

   1. upon a request by a Home Fund to another Cooperating Fund in whose jurisdiction an Employee has worked, the Cooperating Fund shall, subject to the conditions of Section 3(a) of this Article transfer all Employer contributions made on Employee's behalf back to his Home Fund. The

amount of contributions transferred shall be based on all of the Employee's hours of work up to and including the month in which the claim was incurred during the eligibility period set forth in the Home Fund's Plan. Such hours shall be multiplied by the contribution rate of the transferring Cooperating Fund. Upon transfer of hours and contributions, such hours transferred shall not be used for determining future eligibility for the Employee under the Cooperating Fund's rules.

2. Hours and contributions shall first be transferred from the Cooperating Fund in whose jurisdiction the Employee was working when the claim was incurred. If those hours and contributions do not result in establishing the Employee's eligibility on the basis of hours, then contributions shall be transferred from all other Cooperating Funds in reverse order of employment until such eligibility is established within the Home Fund's eligibility period.

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

Section 4. Designation of New Home Fund — If an Employee changes his membership from one Local Union to another Local Union his Home Fund shall be the Health, Welfare or Insurance Fund in the jurisdiction of his new Local Union. Claims incurred by such an Employee shall be filed with his new Home Fund if he is eligible under the new Home Fund. If he is not eligible in his new Home Fund, but is eligible in his prior Home Fund, such claims shall be filed with his prior Home Fund. If he is not eligible in either his new Home Fund or the prior Home Fund, but would be eligible in the new Home Fund if contributions were transferred from his prior Home Funds, the contributions shall be transferred in accordance with Section 5 to the new Home Fund as designated.

Section 5. Transfer of Contributions to New Home Fund — Upon a request from a new Home Fund to a prior Home Fund, the prior Home Fund shall transfer employer contributions made on the Employee's behalf to the new Home Fund. The amount of contributions transferred shall be based on the Employee's actual hours of work during the period that will establish his eligibility in the new Home Fund for the claim he incurred. However, such hours shall be limited to those worked after the date on which such Employee lost eligibility in his prior Home Fund. In any event, such hours shall not include hours which an Employee may have to his credit in any "hours bank" arrangement. Such hours shall be multiplied by the contribution rate to be transferred.

Section 6. Information to Be Transferred — The transfer of hours and contributions specified in Sections 3 or 5 shall be made within thirty (30) days of the date requested by the Home Fund or the new Home Fund.

Section 7. Effective Date — This Article and the point-of-claim reciprocity between Cooperating Funds, shall be effective no earlier than 1-1-1983 for purposes of contribution transfer.

Fund's Right to Repayment from Recovery in Third-Party Actions

If any claim is made against any entity for medical benefits payable under any applicable Workers' Compensation statute or other similar statute providing for payment of medical expenses, or if any legal action is brought against any third party to recover damages for injuries or illness, or if the right to make such a claim or bring such an action exists and arises out of an event which gave rise to charges, costs, expenses or fees which make up all or part of a benefit under the Plan, the Covered Person (which term for purposes of this Section shall mean "Covered Parson and/or his Dependents") shall notify the Fund of such action and the Fund shall be entitled to reimbursement from any payment made as a result of such action or claim to the full extent of the benefits paid out by the Fund without any deduction for attorney fees.

At the time of application for benefits under the Plan, the Covered Person and/or any Dependent on whose behalf benefits are payable shall execute a Repayment Agreement which fully implements the intent of (1) above.

1. In the event that a Covered Person and/or Dependent on whose behalf benefits are payable fails or refuses to execute the required Repayment Agreement, such failure or refusal shall constitute a basis for denial of any benefit payments to such Covered Person and/or Dependent unless and until the Repayment Agreement is duly executed and delivered in a timely manner so as not to prejudice the Fund's rights. In the event that the Covered Person fails to notify the Funds Office of the existence of an action as to which he or one of his Dependent recovered or could recover damages from which the Fund would have been repaid had the Fund known of such action or fails to remit or otherwise deliver to the Fund Office any monies to which the Fund is entitled, irrespective of the existence of a Repayment Agreement, then upon becoming aware of such recovery, the Fund shall inform the Covered Person that he is obligated to return to the Fund the portion of such recovery which should have been paid over to the Fund, and the Fund shall make no benefit payment on any account to such Covered Person until the amount due the Fund from such recovery is returned or offset against amount which should otherwise have been paid to such Covered Person.

IRON WORKERS DISTRICT COUNCIL
(Philadelphia and Vicinity)

LONG TERM DISABILITY

2 International Plaza, Suite 120
Philadelphia, Pennsylvania 19113-1504
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Fax (215) 537-0862
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CO-ADMINISTRATORS
Stephen E. Conley
Albert F. Frattali

LEGAL COUNSEL
Joseph T. Cleary, Esq.

CONSULTANTS
The Segal Company

ACCOUNTANTS
Fischer Dorwart, P.C.

When am I eligible for long-term disability benefits?

An employee may be eligible for Long-Term Disability Benefits if he meets the following requirements:

a) on the date disability was incurred, he has at least three but less than fifteen consecutive years of eligibility under the Iron Workers District Council (Philadelphia and Vicinity) Health Benefits Fund *and*

b) he is totally disabled — which means he cannot perform work as an ironworker during the first 24 months of disability. Thereafter, in order to remain eligible, he must be on Federal Social Security Disability.

How much is the benefit?

The Long-Term Disability Benefit shall be a monthly amount of $100.00 (for eligible employees who have a minimum period of three years of coverage under the Health Benefits Fund) *plus* an additional $12.50 a month for each year of continuous coverage in excess of three years under the Health Benefits Fund, up to a maximum of $247.00 per month.

For example, an employee who has 13 years of continuous coverage under the Health Benefits Fund would be eligible for Long-Term Disability Benefits of $225.00 per month. ($100 plus 10 years x $12.50.)

Proportionate benefits for each quarter year of coverage, in excess of three years, under the Health Benefits Fund.

When do benefits begin?

Long-Term Disability Benefits commence on the first day of the month following a continuous six-month period from the date total disability commenced or on the first day of the month following a continuous period of six months during which Weekly Accident and Sickness benefits were paid from the Health Benefits Fund or a State Fund, whichever is later.

When do benefits stop?

Generally, benefits stop when one of the following conditions arise:

a) Your death;

b) The date disability, as defined, ceases;

c) The date you become eligible to receive pension benefits under the provisions of the Iron Workers District Council (Philadelphia and Vicinity) Pension Fund as described in Section I of this plan;

d) Your 65th birthday if disability commenced prior to your 60th birthday and, upon attainment of age 65, if you are not entitled to a benefit under the provisions of the Iron Workers District Council (Philadelphia and Vicinity) Pension Fund, except that benefits will continue if the number of years you have been receiving LTD benefits plus the number of years of pension credit you have earned total 15 or more;

e) After the 60th month of receiving benefits if your disability commenced on or after your 60th birthday;

f) The date satisfactory information is received which would make you ineligible under the Rules and Regulations.

What happens then?

An employee who has been receiving Long-Term Disability Benefits and who continues to accumulate pension credit under the Pension Plan and who at some point of time subsequent to the date of disability becomes eligible for a Pension by virtue of attaining the required age and/or service requirements shall at that time be granted a pension under the Pension Plan if these benefits would be in a higher amount.

For all others, no other benefits are available.

OTHER INFORMATION

DEFINITION OF TOTAL DISABILITY

An employee will be considered totally disabled if, as a result of illness or injury, he is unable to perform work in Covered Employment during the first 24-month period of his disability. For periods subsequent to this 24-month period of time, an employee shall be "totally disabled" if, as a result of illness or injury, he is unable to perform work in any type of occupation and he must be on Federal Social Security Disability. Individuals who are eligible for **Long-Term Disability Benefits** effective July 1, 1993 or later **will be covered for Health Fund Benefits** up to a **maximum period of 12 consecutive months** from the date of coverage termination.

MEDICAL PROOF

To be considered as an applicant for Long-Term Disability Benefits, an employee must provide the Trustees with medical proof of his disability certified by a qualified physician. The Trustees may require that an employee submit to a medical examination by a qualified medical doctor for determination of his disability or for determination of continued disability. When such a request is made by the Trustees for an employee to have a physical examination by a doctor other than his own personal physician, the cost of such examination will be paid for by the Plan.

CLAIM PROCEDURE

Contact the Fund Office for all necessary forms for application for Long-Term Disability Benefits.

APPEAL PROCEDURE

You (or your authorized representative) may simply file a written appeal with the Fund Office no later than 180 days after you received the notice of denial.

A claimant who has not received a decision on a claim for benefits within 60 days may request a review of his claim. Also, you have a right to review pertinent documents, and to submit comments in writing.

The Board of Trustees or a designated committee will decide the appeal within 60 days after it was filed. The decision will be in writing and will include the specific basis for the decision and specific references to plan provisions on which the decision was based. The decision of the Board or its designated committee will be final and binding on all concerned.

* * * *

A joint Board of Trustees, consisting of Union representatives and Employer representatives is the administrator of the Plan. The Board of Trustees has been designated as the agent for the service of legal process. Process may be served at the Fund Office.

All contributions to the Plan are made by Employers in accordance with their collective bargaining agreements with the Union. The collective bargaining agreements require contributions to the Plan at fixed rates per hour paid.

The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of employees working under the union contract.

Benefits are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreement and the trust agreement and held in a trust fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

This Plan was established as the result of collective bargaining agreements and its purpose is to improve the security and well being of the employees and their beneficiaries. The Trustees, the employers, and the Union want you as a participant in the Plan to enjoy its benefits. This booklet describes the Plan and tells you and your beneficiary how to get more information. The description of the claims and the appeals procedure tells you how to apply for benefits and how to follow up, if necessary.

However, in addition to what the Trustees, the employers and the Union have done to see that the Plan's obligations are fulfilled, federal regulations require the following summary of rights and protections to which every participant in the Plan is entitled under the law (ERISA).

ERISA provides that you, as a Plan participant, shall be entitled to:

Examine, without charge, at the Plan administrator's office and other specified locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan administrator. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a benefit and, if so, what your benefits would be. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge. The Plan will provide this information to the extent it is able to be based on available records.

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 pension benefit or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Long-Term Disability Plan General Information

Board of Trustees employer identification number: 23-1599740.

Plan number: 501

Fiscal year end date: September 30th

This has been no more than a brief and very general explanation of the most important provision of the Long Term Disability Plan. No general explanation such as this can adequately explain all the details of the Plan. Nothing in this statement is meant to interpret, extend or change in any way the rules or regulations expressed in the Plan itself.

Accordingly, your rights, if you are covered by this Plan can only be determined by consulting the Plan itself. Further information, if necessary, may be secured by inquiring at the Fund Office or a Union Office. For your convenience, a complete copy of the Plan is printed in the next section of this booklet.

IRON WORKERS DISTRICT COUNCIL
(Philadelphia and Vicinity)
Rules and Regulations

LONG-TERM DISABILITY PLAN

By Resolution dated September 26, 1973, the Trustees of the Iron Workers District Council (Philadelphia and Vicinity) Welfare Fund adopted the following Rules and Regulations of a Long-Term Disability Plan effective October 1, 1973 and as further amended from time to time.

Section 1. Eligibility. An Employee shall be eligible for benefits if

a) He becomes totally disabled as defined in Section 6 of this Plan, and

b) On the date his disability commenced, he has at least three but less than fifteen consecutive years of eligibility in the Iron Workers District Council (Philadelphia and Vicinity) Health Benefits Fund and had at least three consecutive years of such eligibility immediately prior to the date the disability commenced.

An Employee shall not be entitled to receive benefits under this Plan at the time he is receiving benefits under the Iron Workers District Council (Philadelphia and Vicinity) Pension Plan. However, if an Employee who is receiving benefits under this Plan continues to accumulate Pension Credit under the applicable provisions of the Rules and Regulations of the Pension Plan and becomes eligible for a Pension under the Rules and Regulations of the Pension Plan, his benefit under this Plan shall be terminated and he shall begin receiving a pension benefit from the Iron Workers District Council (Philadelphia and Vicinity) Pension Fund.

Section 2. Benefit Amount. The Long-Term Disability Benefit shall be a calculated amount, payable monthly, as follows:

a) For employees who have at least three continuous years of coverage under the Health Benefits Fund — $100.00 *plus*

b) $12.50 per month for each full year of coverage under the Health Benefits Fund in excess of three years up to a maximum benefit of $247.00 per month.

A proportional benefit for partial years of coverage, in excess of three, under the Health Benefits Fund shall be payable based upon calendar quarter years of such coverage.

Section 3. Termination of Benefits. Benefits under this Plan shall terminate and cease upon the occurrence of any one of the following conditions on the first day of the month following:

a) The Employee's death.

b) The date disability, as defined, ceases.

c) The date the Employee becomes eligible to receive pension benefits under the provisions of the Iron Workers District Council (Philadelphia and Vicinity) Pension Fund as described in Section 1 of this Plan.

d) An Employee's 65th birthday if disability commenced prior to his 60th birthday and, upon attainment of age 65, if he is not entitled to a benefit under the provisions of the Iron Workers District Council (Philadelphia and Vicinity) Pension Fund.

   An employee who has been receiving Long-Term Disability Benefits shall upon the attainment of age 65 continue to receive benefits only if the number of years during which he received Long-Term Disability Benefits and the number of years that he has credited service under the Pension Fund (at the time his disability commenced) total 15 or more.

e) After the 60th month of receiving benefits if the Employee's disability commenced on or after his 60th birthday.

f) The date satisfactory information is received which would make the Employee ineligible under the Rules and Regulations.

Retroactive adjustments may be made on any and all benefit payments taking into consideration all information available to the Trustees but such adjustment shall not include information pertaining to a retroactive period beyond eighteen months of the date of adjustment.

Section 4. Commencement of Benefits. Benefits shall commence on the first day of the month following a continuous six-month period from the date disability commenced or the date maximum benefits under the Weekly Accident and Sickness provisions of the Health Benefits Fund or of any State Fund have been paid, whichever is later. Benefits due but not paid to a deceased Employee shall be paid to the Employee's designated beneficiary as noted in the Welfare Fund Records.

However, an Employee who is disabled for a period of at least four consecutive months and who returns to Covered Employment for a period of less than six consecutive months and who is subsequently disabled for a period of at least two consecutive months shall be entitled to benefits on the first day of the month following the last month of disability.

An Employee who receives benefits under this Plan and who subsequently returns to Covered Employment shall, if he again becomes disabled, be entitled to benefits without being subject to a waiting period provided his return to Covered Employment was for a period of less than six consecutive months.

Section 5. Information Required. Applications must be made in a form and manner prescribed by the Trustees. Each Employee shall furnish to the Trustees any information or proof requested and reasonably required to administer this Plan.

Section 6. Definitions. The term "total disability" as used herein shall mean that an Employee will be considered totally disabled if, as a result of illness or injury, **he is unable to perform work in Covered Employment (as an ironworker) during the first 24 months of disability;** that is, commencing on the date the disability was incurred and provided the Employee was eligible under the Plan rules on the date the disability was incurred.

Thereafter, for subsequent periods of time, the Employee shall be considered disabled if he is permanently prevented (due to the illness or injury) **from performing any work in any occupation which he may be trained for, educated for or experienced.**

Individuals who are eligible for **Long-Term Disability Benefits effective July 1, 1993 or later will be covered for Health Fund Benefits up to a maximum period of 12 consecutive months** from the date of coverage termination.

The term "Employee" as used herein shall mean an individual who performs work in "Covered Employment."

The term "Covered Employment" as used herein shall mean employment with an employer who is required to make contributions, on behalf of the Employee, to the "Health Benefits Fund" in accordance with a negotiated collective bargaining agreement.

The term "Health Benefits Fund," as used herein shall mean the Iron Workers District Council (Philadelphia and Vicinity) Health Benefits Fund.

The term(s) "Pension Plan" and/or "Pension Fund" as used herein shall mean the Iron Workers District Council (Philadelphia and Vicinity) Pension Fund.

Section 7. Exclusions. Disabilities resulting from one or more of the following causes shall not be considered in the determination of "total disability."

1. war (whether declared or not), insurrection, rebellion or participation in a riot or civil commotion; or
2. commission of or attempt to commit assault, battery or felony; or
3. intentional self-inflicted injuries.

Section 8. Medical Examination. An Employee who is receiving benefits or who has applied for benefits under this Plan shall, at the sole discretion of the Trustees, be examined by a qualified medical doctor for determination of "total disability" and/or for determination of continued "total disability." The Trustees may, at their sole discretion, request such examination be performed by a physician other than the Employee's normal physician and in which event the cost of such examination shall be paid by the Plan.

Section 9. Right of Appeal. A Participant whose application for benefits under this Plan has been denied, in whole or in part, is to be provided with adequate notice in writing setting forth the specific reasons for such denial, and shall have the right to appeal the decision, by written request filed with the Trustees within 180 days after receipt of such notice. The appeal shall be considered by a person or committee designated by the Trustees.

Section 10. Amendment and Discontinuance. The Trustees reserve the right, at their sole discretion, to amend the Rules and Regulations of this Plan at any time and to discontinue any or all provisions of the Plan.

Section 11. Determination of Eligibility and Interpretation of the Plan. The Board of Trustees of the Plan has the sole discretionary authority to determine eligibility for benefits provided by the Plan and to construe and interpret the provisions of the Plan.