

WELFARE BENEFITS PLAN
SPONSORED BY THE
STRUCTURAL IRON WORKERS LOCAL #1
WELFARE FUND

SUMMARY PLAN DESCRIPTION

JANUARY 1, 2011

STRUCTURAL IRON WORKERS LOCAL #1 WELFARE FUND

FOREST PARK, ILLINOIS

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STRUCTURAL IRON WORKERS LOCAL #1 WELFARE FUND

Forest Park, Illinois

Dear Participant:

The Board of Trustees of the Structural Iron Workers Local #1 Welfare Fund (the “Fund”) is pleased to present this revised booklet which describes the Welfare Benefits Plan Sponsored by the Structural Iron Workers Local #1 Welfare Fund as amended and restated effective September 1, 2007 (the “Plan”). The Plan offers major medical health care coverage to help you and your Dependents stay healthy. This coverage can help provide financial protection against catastrophic health care bills. The Plan offers other welfare benefits as well. Specifically, the Plan provides:

- Comprehensive major medical benefits;
- Routine physical exam benefits;
- Voluntary sterilization benefits;
- Prescription drug benefits;
- Dental benefits;
- Vision care benefits;
- Hearing aid benefits;
- Life Insurance benefits;
- Accidental Death and Dismemberment benefits;
- Short-Term Disability benefits, and
- Employee Assistance Program benefits.

The Plan was set up and is administered under a written Plan Document and Trust Agreement. This booklet replaces any prior summary plan description booklets and related summaries of material modification. It summarizes the benefits provided under the Plan. The booklet was written to help you understand the Plan Document and Trust Agreement and the rules governing the Welfare Plan.

However, this booklet does not replace the Plan Document. If there are any inconsistencies between this booklet and the Plan Document, the Plan Document will govern. If you wish, you may read the actual Plan Document and Trust Agreement at the Fund Office during regular business hours. You also may request copies of Plan Documents if you make your request in writing. The Fund Office may charge you a reasonable fee for the cost of the copies.

Please note that coverage under the Plan is in no way a guarantee of continued employment with your employer.

Most capitalized terms are defined in the Definitions section at the end of this booklet. Alternatively, capitalized terms may be defined as they appear and are used.

Sincerely,

The Board of Trustees

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ELIGIBILITY

Employees, Retirees, and their Dependents may be eligible for coverage under the Plan if they meet the eligibility requirements set forth below.

If you make a deliberate misrepresentation with respect to eligibility or with respect to any other Plan matter or fail to notify the Fund of any changes in eligibility, you and your Dependents may lose your eligibility for coverage under the Plan.

Initial Eligibility

You will receive a minimum of three months of Plan coverage beginning on the first day of the month after you complete at least 500 credited hours during 6 consecutive months or less. If you do not complete at least 500 credited hours during your first 6 months, your coverage begins on the first day of the month after you complete at least 500 hours during any continuous 6-month period.

A credited hour means any hour you work for a Contributing Employer for which contributions have been made pursuant to the applicable Collective Bargaining Agreement or participation agreement or otherwise under applicable law. However, credited hours do not include hours with respect to which the Plan remits the related contribution to another health and welfare trust fund that provides benefits to you pursuant to a reciprocal agreement between the Union and another Local of the Union or some other agreement that provides for such transfer of contributions.

Deferred Effective Date for Insured Life and AD&D Insurance

If you are not “actively at work” (as defined in the life insurance and AD&D policy and/or booklet-certificate) due to a physical or mental condition on the date that you become eligible for Plan coverage, your coverage with respect to the insured Life Insurance and AD&D Insurance benefit will not start until the first day that you return to active work for one full day.

Continuing Eligibility

If after becoming initially eligible, you work at least 1,000 credited hours in any 12-month period, you will remain covered for the next 12 months beginning on the first of the month in which you worked the first of your 1,000 credit hours. Hours credited for work prior to the date you received coverage under the initial eligibility rule are not credited toward the 1,000 hours. However, if these hours are used to satisfy reinstatement, then they are applied to the 1,000 hours.

You are also able to continue coverage in smaller time periods. If you work at least 250 credited hours during a 3-month period you will remain covered for the next 3 months. If you do not work at least 250 credited hours during 3 consecutive months or at least 1,000 credited hours during 12 consecutive months, you will no longer be eligible for coverage.

Owner-In-Fact Contribution Requirements

Your employer may be required to contribute at least 1,952 hours per year (or a prorated amount for partial years) on your behalf if you control the Contributing Employer or have the power to control the employer through stock ownership, relationship, marriage or any other way. This holds true no matter how many credited hours you actually work. You should contact the Fund Office if this situation applies to you. Nonetheless, you will be eligible for coverage only if you meet the requirements set forth above for initial and continuing eligibility regardless of whether contributions have been or are required to be made under this “Owner in Fact” contribution requirement.

Reinstatement

Coverage is reinstated the first day of the month following the month in which you complete at least 250 credited hours during 3 consecutive months or less. In the event you do not meet this requirement within 2 calendar years after returning to work, you must meet the requirements for Initial Eligibility.

If your coverage ends due to active service in the uniformed services, your coverage will be reinstated the day you return to work with a Contributing Employer so long as you return to work within 90 days after discharge from service, in accordance with the terms of the Uniformed Services Employment and Reemployment Rights Act (USERRA). If you return to work later than 90 days after discharge, your coverage will be reinstated the day after you complete at least 250 credited hours during 3 consecutive months or less.

ELIGIBILITY EXAMPLE

Initial Eligibility

John worked for the first time under the jurisdiction of a Collective Bargaining Agreement in January 2000 and receives credited hours that apply towards eligibility as shown below.

John reaches 500 hours in March 2000 and is eligible for benefits the first of the next month. This means that even if he stops working at this point, he is eligible for three months of coverage during April, May, and June 2000.

Chart 1 Initial Eligibility

		Credited Hours		Initial Eligibility	
Dec-99					
Jan-00		200			
Feb-00		200			
Mar-00		200			
Apr-00					
May-00					
Jun-00					
Jul-00					

Continuing Eligibility

After meeting the initial eligibility rule, an employee can continue coverage under either the three or twelve month coverage rules. John continues working as shown below.

Chart 2 Continuing Employment after Initial Eligibility

		Credited Hours		Initial Eligibility		Coverage Under 3 Month Rule		Coverage Under 12 Month Rule	
Dec-99									
Jan-00		200							
Feb-00		200							
Mar-00		200							
Apr-00		200							
May-00		200							
Jun-00		200							
Jul-00		200							
Aug-00		200							
Sep-00									
Oct-00									
Nov-00									
Dec-00									
Jan-01									
Feb-01									
Mar-01									
Apr-01									

Continuing Eligibility after Break in Coverage of less than Two Calendar Years

John does not return to work until January 2002 and has the following work history:

Chart 3 Continuing Eligibility

		Credited Hours		Coverage Under 3 Month Rule		Coverage Under 12 Month Rule	
Dec-01							
Jan-02		200					
Feb-02		200					
Mar-02		200					
Apr-02		200					
May-02		200					
Jun-02		10					
Jul-02							
Aug-02							

		Credited Hours		Coverage Under 3 Month Rule		Coverage Under 12 Month Rule	
Sep-02							
Oct-02							
Nov-02							
Dec-02							
Jan-03							

He has at least 250 credited hours for the three month work period, December, January, and February, and receives coverage for the three-month benefit period, March, April, and May 2002.

John works regularly during this period with his final hours in June 2002. Based on the three-month coverage rule, he has enough credited hours to continue coverage through September 2002. This is because he works at least 250 hours for the three-month work period April, May, and June 2002. As a result, he is covered for the following three-month benefit period, July, August, and September 2002.

When John finished his work in June 2002, he had 1010 credited hours, enough to qualify for the 12-month coverage rule. Coverage is extended for a 12-month period beginning on the first of the month in which the employee worked the first of the 1000 credited hours. The first month that John worked the 1000 credited hours is January 2002. His coverage is extended for the 12-month period January through December 2002. This means he receives coverage retroactively for January and February, which is two months prior to the March 1, 2002 coverage date under the three-month coverage rule. The twelve-month rule also extends his coverage through December 2002, three months longer than under the three-month coverage rule.

Eligibility after a Two-Calendar Year Break In Coverage

John does not return to work until January 2005 and has incurred a two-calendar year break since his coverage terminated on December 31, 2002. John’s hours of work are shown below.

Chart 4 Reinstatement of Eligibility

		Credited Hours		Coverage Under 3 Month Rule		Coverage Under 12 Month Rule	
Dec-04							
Jan-05		200					
Feb-05		200					
Mar-05		200					
Apr-05		200					
May-05		200					
Jun-05		10					
Jul-05							
Aug-05							
Sep-05							

		Credited Hours		Coverage Under 3 Month Rule		Coverage Under 12 Month Rule	
Oct-05							
Nov-05							
Dec-05							
Jan-06							

Because two calendar years have elapsed since his coverage terminated, John must meet the initial eligibility rule. He would have been able to use the 3-month continuing eligibility rule if he had regained coverage before the end of calendar year 2004. With a two-calendar year break he must meet the initial eligibility rule with one modification compared to a new employee. In applying the initial eligibility rule after a two-calendar year break in coverage, the hours credited prior to the date of reinstated coverage can also be applied to the 1000 hour 12-month rule.

Under the initial eligibility rule, the employee must complete at least 500 credited hours during a period of six consecutive months or less. The first day of the next month, the employee receives coverage for a three month benefit period. John reaches 500 hours in March 2005 and the first day of the next month is eligible for three benefit months during April, May and June 2005.

When John finished his work in June 2005, he had 1010 credited hours, enough to qualify for the 12-month coverage rule. Coverage is extended for a 12-month period beginning on the first of the month in which the employee worked the first of the 1000 credited hours. The first month that John worked the 1000 credited hours is January 2005. His coverage is extended for the 12-month period January through December 2005. This means he receives coverage retroactively for January, February, and March, which is three months prior to the April 1, 2005 coverage date under the initial eligibility rule. The twelve-month rule also extends his coverage through December 2005, three months longer than under the three-month coverage rule.

Reciprocity

If you have been eligible under this Plan and later work in a different Iron Workers union jurisdiction, you can request that the hours you work in that jurisdiction be transferred back to this Fund. This will prevent an interruption in your coverage under this Fund, provided you have enough total credited hours to receive coverage. Hours transferred from another jurisdiction will be adjusted for any difference in the contribution rate.

Conversely, if you previously became eligible for coverage under another multi-employer health and welfare trust fund, and then work in the jurisdiction of the Union, hours that you work in the Union's jurisdiction may be transferred back to the other fund pursuant to a reciprocal agreement between the Union and another union or some other agreement that provides for such transfer.

Eligibility During Periods of Disability

- ***Work-Related Disabilities***

If you become eligible for workers' compensation benefits after meeting the Plan's eligibility requirements by virtue of an on-the-job injury that occurred while working for

a Contributing Employer, credited hours will not be subtracted from your Accumulated Reserve Account until your absence from work lasts more than 12 consecutive months. An absence (up to 12 months) will not be included as part of the 3-month or 12-month period used to determine continuing coverage. After a 12-month absence, the continuing eligibility requirements apply.

- ***Disabilities Not Related to Work***

If you become eligible for Short-Term Disability Benefits after meeting the Plan's eligibility requirements, credited hours will not be subtracted from your Accumulated Reserve Account until your absence from work lasts more than 6 consecutive months. An absence (up to 6 months during which Short-Term Disability Benefits are being paid) will not be included as part of the 3-month or 12-month period used to determine continuing coverage. After a 6-month absence during which Short-Term Disability Benefits are being paid, continuing eligibility requirements apply.

If you are receiving workers' compensation that will be considered evidence that you are unavailable for work as an ironworker and that you are disabled.

You will not be considered to be an active employee eligible for benefits while you are receiving benefits from the Pension Plan.

Accumulated Reserve Account

In the event you become unable to work the number of credited hours required for eligibility or otherwise become ineligible for coverage, you may be able to continue coverage for yourself and your covered Dependents if you have hours accumulated in your Accumulated Reserve Account (ARA).

Whether you have any hours in your ARA is determined at the end of each month, based on your credited hours during the previous five calendar year period. You will have hours in your ARA if you average more than 1680 hours per year during the previous five calendar year period ($1680 \text{ hrs/yr} \times 5 \text{ yrs} = 8400 \text{ hour threshold}$) or if you work in excess of 8400 hours during a period shorter than five years. (In other words, to accumulate hours in your ARA, you need not have worked in covered service for a full five calendar years – you may begin to accrue ARA hours as soon as you have exceeded 8400 hours even if you do so within a period shorter than five years.)

The previous five-year period generally is determined based upon full calendar years ending immediately preceding the date on which the determination is made. When making a determination as to ARA hours effective as of May 1, 2008, for example, the Plan looks at the hours worked during the five preceding calendar years, i.e. January 1, 2003 – December 31, 2007. With respect to retirees, the five-year period is the five calendar year period immediately preceding the calendar year in which the date of retirement occurs. With respect to Employees who become eligible for Family and Medical Leave Act leave, workers' compensation benefits, or Short-Term Disability Benefits after meeting the Plan's eligibility requirements, the five-year period is the five calendar year period immediately preceding the calendar year in which you first are absent from work. If you return to work following an absence during which you

received either workers' compensation or Short-Term Disability Benefits, and then subsequently retire or otherwise become entitled to utilize your ARA for purposes of continuing coverage, the five-year period does not include calendar years during which you were out on such a leave; in such case, the year(s) in which a leave occurred will not be counted in the five-year period. So, for example, if you are out on leave and receiving workers' compensation benefits for the period from July 1, 2007, through June 30, 2008, and then retire on January 1, 2010, the five-year period will be the 2003, 2004, 2005, 2006, and 2009 calendar years; the 2007 and 2008 calendar years will not be included in the five calendar years. However, if you return from a leave during which you received workers' compensation or Short-Term Disability Benefits, subsequently retire, return to work and then retire again, the year(s) including the period of leave will be included in the five calendar years.

Following a five year period of high employment, you may have hours accumulated in your ARA. If you subsequently have a five year period of low employment, there may not be any hours accumulated in your ARA.

Your ARA includes only credited hours.

Eligibility may be extended for three month eligibility periods called ARA Benefit Quarters. You will be eligible for an ARA Benefit Quarter if you have at least 420 hours accumulated in your ARA. Eligibility will be extended on a quarterly basis provided you have at least 420 hours in your ARA up to a lifetime maximum of 12 ARA Benefit Quarters.

The calculation of the ARA is determined as follows:

Accumulated Reserve Account = A-B-C

A = The total number of hours worked for a Contributing Employer over the past five years.

B = The number of ARA Benefit Quarters used in the past five years x 420 hours per quarter = Benefit Hours

C = 8,400 hour threshold

If you are using the Accumulated Reserve Account to continue coverage, that coverage will end if you become eligible for coverage under the Reinstatement rules described above. Short-term disability benefits will not be continued under this Section.

The calculation and use of the ARA is shown in the following example.

If you are Medicare eligible, please see also the subsequent section entitled "Enrollment in Medicare/Coordination of Benefits with Medicare."

EXAMPLE 1:

John works 205 hours per month for 60 months during the five year period January 1, 2006, through December 31, 2010, at which time John stops working and retires. John receives seven

months of active coverage under the 12-month rule through July 31, 2011. John can then extend eligibility if he has at least 420 hours accumulated in his ARA.

As of July 31, 2011 the accumulated hours in John's ARA are calculated based on the hours worked during the preceding five calendar year period, January 1, 2006, through December 31, 2010. Because John has not used any ARA Benefit Quarters, there are no Benefit Hours included in the calculation.

John's ARA as of July 31, 2011 is calculated as follows:

Accumulated Reserve Account = A-B-C

A = 205 hours per month x 60 months = 12,300 hours worked

B = Number of ARA Benefit Quarters (0) x 420 hours per quarter = 0 Benefit Hours

C = 8,400 hour threshold

A-B-C = 12,300 hours worked - 0 Benefit Hours - 8,400 hour threshold = 3,900 ARA hours

John continues to receive extended eligibility through his ARA until his balance is exhausted. At the end of each Benefit Quarter the Fund recalculates his ARA based on the ARA Benefit Quarters that he has received times 420 hours per quarter.

EXAMPLE 2: As of October 31, 2013, John has received 9 Benefit Quarters of eligibility by using his ARA. As of October 31, 2013, John's ARA is calculated as follows:

Accumulated Reserve Account = A-B-C

A = 205 hours per month x 60 months = 12,300 hours worked

B = 9 ARA Benefit Quarters x 420 hours per quarter = 3,780 Benefit Hours used

C = 8,400 hour threshold

A-B-C = 12,300 hours worked - 3,780 Benefit Hours - 8,400 hour threshold = 120 ARA hours

John does not qualify for an additional ARA Benefit Quarter because he does not have at least 420 hours accumulated in his ARA.

After his final ARA Benefit Quarter, John may be eligible for the Retiree Program according to the Retiree Program Eligibility Rules as described below.

Dependent Eligibility

Generally, your Dependents will become eligible on the same day you become eligible. In the event you do not have Dependents on the date your eligibility begins, your Dependents will become eligible on the date you acquire them provided you remain eligible at that time.

Delayed Dependent Eligibility for Life Insurance Benefit

For Dependent Life Insurance, newborns automatically are covered from the 14th day until the 31st day after birth. To continue coverage after 31 days, you will need to complete a change form and return it to the Fund within the 31-day enrollment period.

Dependent Defined

A Dependent is defined as:

- Your spouse.
- Your child from birth until such child attains age 26.
- Your child who is incapable of self-sustaining employment by reason of mental or physical impairment, provided:
 - such incapacity began before the limiting age (age 26),
 - the child was covered under this Plan at the time the child reached the limiting age or at the time of commencement of disability,
 - if after reaching the limiting age (age 26), such child is primarily dependent upon you for financial support and maintenance; and
 - you provide the Trustees with proof of such incapacity upon reasonable request.

Your “child” is defined as a child who is born to you, adopted by you, placed with you for adoption, or for whom you are legal guardian or your stepchild or foster child.

Documentation for Dependents

Spouse

You must provide a marriage certificate as proof of marriage, and periodically certify as to your marital status, as requested by the Fund.

Children

Generally: Proof of Relationship to the child's other parent. You must be able to establish that the child is your legal dependent. Any outside documents that exist, such as a divorce decree or other guardianship papers that name another person as responsible for the child's health insurance, must be presented. Specifically, if you previously were married to the child's other parent, the Fund must be provided with a certified copy of the divorce decree including the portion of the divorce decree that deals with the financial arrangements for the child.

Natural Children. You must provide a certified copy of the child's birth certificate which proves your relationship to the child. A certified copy of the birth certificate must have been issued by a municipality, county or state. It must contain parental information and the birth registration number. If a child is born while you are covered by the Fund or within the 90-day period preceding your initial eligibility, the Fund will accept hospital footprints as a temporary replacement until an original or a certified copy of the birth certificate is provided. This evidence will not be valid after 90 days from the date of birth.

Adopted Children. If a child is adopted and the birth certificate has not been amended to name you as the child's parents, you should provide the Fund a copy of the letter issued by the agency placing the child in your home for adoption.

Legal Guardianship. If you are appointed as the legal guardian of a child, you must provide a notarized statement that you claim the child as your dependent on your federal income tax return and an authorization for the Fund to obtain a copy of your latest federal tax return directly from the federal government. With regard to a new guardianship with respect to which tax returns claiming the child as a dependent have not yet been filed, you must submit instead an affidavit attesting to your belief that the child will qualify as a tax dependent and that you intend to claim the child as such with respect to the current year. The child also must not exceed the age limitations otherwise applicable to children under the Plan. A form of affidavit for this purpose may be available from the Plan Administrator. You also must provide a copy of the guardianship appointment certified by the clerk of court in which the appointment occurred. In the event that any child support orders exist regarding the child, you also must supply copies of any such order(s) to the Fund.

Stepchildren. You must provide the Fund with a copy of the child's birth certificate, which should name your spouse. Additionally, if your spouse is divorced from the child's other parent, you must provide a certified copy of a divorce decree indicating your spouse's responsibility for health insurance or, if your spouse is a widow or widower, a certified copy of the death certificate of the former spouse. If the divorce decree does not say who is responsible for providing health insurance and there is no other support order, you and your spouse must complete a notarized affidavit stating that no child support order has been entered into the court. If neither the divorce decree nor child support order designate who was responsible for health insurance, then the child can be covered by the Fund. If the child is claimed as a dependent for federal income tax purposes, you and your spouse must submit 1) a notarized statement that the child is claimed as a dependent on the your federal income tax statement, and 2) an authorization to obtain a copy of his latest federal income tax statement directly from the federal government.

Dependent children who are physically or mentally incapacitated. In addition to a birth certificate and proof of dependency (if the child is 26 years old or older), you must provide a completed statement of total disability, including proof of incapacitation prior to the limiting age. You are not eligible to enroll an adult child if the dependent is beyond the limiting age as of the date the you first become eligible for coverage.

HIPAA Special Enrollment Rights

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you are entitled to enroll your new Dependents. To enroll a new Dependent, please contact the Fund Office promptly following the marriage, birth or adoption.

Loss of Other Coverage. Under HIPAA (the Health Insurance Portability and Accountability Act of 1996), if you were to decline enrollment under the Plan for yourself or for an eligible Dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you might be entitled to enroll yourself and your Dependents in the Plan at a later time if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, because all eligible individuals (employees and Dependents) automatically are enrolled in the Plan (regardless of whether such individuals have other coverage through another plan), this special enrollment right has no application to the Plan.

Children's Health Insurance Program Reauthorization Act Special Enrollment Rights. Effective April 1, 2009, under HIPAA, if you or your Dependent experience (1) a loss of eligibility for Medicaid or a state children's health insurance program, or (2) become eligible to participate in a premium assistance program under Medicaid or a state children's health insurance program, you and/or your Dependent will be entitled to receive coverage under the Plan. As described above, however, because all eligible individuals and their Dependents are already enrolled in the Plan, this special enrollment right has no application.

Qualified Medical Child Support Order

This Plan recognizes and will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO). A QMCSO is an official court order that provides benefits for a Dependent child or children in the event of a divorce or other family law action.

Upon receipt of a QMCSO, the Fund Administrator will promptly notify you and the person affected by the QMCSO, of the receipt of such Order and the Plan's procedures for determining whether the Order is a QMCSO. The Fund Administrator will then determine whether the Order is a QMCSO pursuant to the Plan's procedures and notify you and each affected person of the determination.

Any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by the Dependent's custodial parent or legal guardian will be made to the Dependent or the Dependent's parent or legal custodian.

Employee's Termination of Eligibility

Your eligibility will terminate upon the first of the following events:

- Termination of the Plan,

- The date determined by the Fund due to an act of fraud or a material misrepresentation by you or your Dependent with respect to the Plan,
- Entrance into the Armed Forces, subject to USERRA, or
- Your failure to satisfy the continuing eligibility requirements as set forth under “Continuing Eligibility” above (determined on a month-by-month basis).

However, your eligibility will terminate earlier under the following circumstances, as applicable:

- Non-bargaining Unit Employees
 - In addition to the normal termination of eligibility rules described above, eligibility for non-bargaining unit Employees will terminate the first day of the third month after the Employee is no longer working for a Contributing Employer. This early termination of eligibility provision shall not apply if prior to termination of eligibility either (A) the Employee becomes available for work as an Iron Worker within the trade and territorial jurisdiction of the Union, or (B) the Employee receives a pension from the Structural Iron Workers Local No. 1 Pension Plan.
- Employees with Option to Reciprocate Contributions for Periods of New Employment on or after September 1, 2003.
 - In addition to the normal termination of eligibility rules described above, for Employees who have the option to require the Plan to remit contributions to another health and welfare plan pursuant to any reciprocal agreement approved by the Trustees, Plan eligibility will terminate the first day of the month after the Employee is no longer working for a Contributing Employer within the jurisdiction of the Union. Also, as of the date of termination of eligibility, the ARA balance is reduced automatically to zero.

Dependent’s Termination of Eligibility

Your Dependent’s eligibility will terminate upon the first of the following events:

- Termination of the Plan,
- The date determined by the Fund due to an act of fraud or a material misrepresentation by you or your Dependent with respect to the Plan,
- The last day of the month in which the Dependent ceases to meet the definition of a Dependent, or
- The termination of your eligibility.

Retired Employee With Active Member Benefits

When you retire, you will receive the Active Plan of Benefits until your eligibility ends.

You may choose to extend your eligibility in the Active Plan of Benefits by using the hours in your Accumulated Reserve Account. If you are eligible, you are required to enroll in Medicare Part A and Part B, which will be primary to the Active Plan for retirees, regardless of whether you are continuing to participate in the Active Plan as a result of ARA hours. When your Accumulated Reserve Account is exhausted, you and your Dependents will receive the benefits of the Retiree Health Program if you are eligible.

Also, you may extend coverage under the Active Plan of Benefits by electing COBRA continuation coverage. Once you have exhausted COBRA coverage, you may enroll in the Retiree Health Program if you are eligible.

If you are eligible for and fail to enroll in the Retiree Health Program following discontinuation of your participation in the Active Plan (i.e. after you are no longer eligible, or, if later, after the exhaustion of your ARA and/or COBRA), you may not later enroll in the Retiree Health Program; no gap in coverage is permitted.

Retiree Health Program Eligibility Rules.

You will be eligible for the Retiree Health Program if you meet each of the following conditions:

- You are credited with 10,000 hours of contributions to the Fund in any ten consecutive calendar year period before applying for the Retiree Health Program (not applicable to those persons receiving Retiree Health Program coverage as a result of entitlement to a Disability Pension as set forth below). For this purpose, “calendar year” is determined on a January 1 to December 31 basis.
- You are receiving one of the following types of pensions from the Structural Iron Workers Local No. 1 Pension Plan (the “Local No. 1 Pension Plan”):
 - an Early Retirement Pension, with at least 15 Pension Credits under the Local No. 1 Pension Plan, excluding any credits from a related plan under the Partial Pension Provision of the Local No. 1 Pension Plan;
 - a Regular Pension with at least 35 Pension Credits;
 - a Disability Pension, provided you meet the additional conditions for Disability Pensioner Eligibility set forth below.
- With respect only to retirees whose pensions begin/began on or after July 1, 2004, you were eligible for health coverage under the Fund for at least 30 out of the 60 months prior to your pension effective date under the Local #1 Pension Plan.
- You make the applicable retiree self contribution.

- You enroll in Medicare Parts A and B as soon as you are eligible.

If you should die after becoming covered by the Retiree Health Program, your surviving spouse and any children who are covered Dependents at the time shall continue to be covered by the Retiree Health Program until, with respect to the surviving spouse, the surviving spouse becomes eligible for Medicare, or, if later, the date that your Accumulated Reserve Account is exhausted, and with respect to the children, the date the child otherwise no longer meets the requirements to be an eligible “dependent” as defined in the Plan.

In addition, if you are a Retiree who is eligible for the Retiree Health Program and die after termination of your employment and while you are covered by the Active Plan of Benefits as the result of utilizing your Accumulated Reserve Account, your surviving spouse and children who are covered Dependents at the time may enroll in the Retiree Health Program and continue in the Program until, with respect to the surviving spouse, he or she becomes eligible for Medicare (or, if later, the date that the remaining credits in the ARA are exhausted) and with respect to the children, the date the child otherwise no longer meets the requirements to be an eligible “dependent” as defined in the Plan. In order for your surviving spouse and children to enroll in the Retiree Health Program, they must submit a completed election form together with the applicable premium payment (or an election to have such payments withheld from any survivor benefits that he or she is receiving from the Local No. 1 Pension Plan) to the Fund Office within the election period afforded under COBRA (in other words, within 60 days of the later of the loss of coverage or the date the COBRA election/Retiree Health Program notice is issued). Enrollment in the Retiree Health Program will be effective as of the first day of the month next following the month in which you die.

Disability Pensioner Eligibility Rules.

If you meet the above Retiree Program Eligibility Rules as a Disability Pensioner, you must also:

- Submit proof of your application for Social Security disability benefits, and
- At the time your application for a Disability Pension is submitted, enroll and make arrangements for Self-Contributions for the Retiree Health Program to be withheld from your pension check.

Termination of Coverage for Retiree.

A Retiree will terminate coverage under the Retiree Health Program when one of the following occurs:

- You fail to make timely payment of the applicable Self-Contribution,
- You instruct the Plan to cancel your coverage,
- You die,
- You or one of your Dependents commits an act of fraud or a material misrepresentation with respect to the Plan,

- You are eligible for and fail to enroll in Medicare Parts A and B, or
- You attain age 65 or, if later, the date your Accumulated Reserve Account is exhausted.

Retiree Health Program coverage may be cancelled by the Retiree voluntarily only at the end of the month for which a Self-Contribution last has been received. Coverage may be terminated mid-month with a pro-rata refund of the Self-Contribution only in the event of the Retiree's death.

Termination of Coverage for Dependent of Retiree.

A Dependent of a Retiree will terminate coverage under the Retiree Health Program when one of the following occurs:

- The Dependent fails to make timely payment of the applicable Self-Contribution,
- The Dependent instructs the Plan to cancel coverage,
- The Dependent dies,
- The date determined by the Fund due to an act of fraud or a material misrepresentation by the Retiree or his Dependent with respect to the Plan,
- The Dependent is eligible for Medicare Parts A and B due to disability and fails to enroll,
- The Dependent (except in the case of a Retiree's death with respect to a surviving spouse) no longer meets the definition of Dependent, or
- The Dependent attains age 65 or, if later, the date the Employee's Accumulated Reserve is exhausted.

Retiree Health Program coverage may be cancelled by the Dependent voluntarily only at the end of the month for which a Self-Contribution last has been received. Coverage may be terminated mid-month with a pro-rata refund of the Self-Contribution only in the event of the Dependent's death.

Retiree Self-Contribution Amount.

The Board of Trustees will determine the applicable Self-Contribution Amount from time to time and will notify retirees. Until further notice, the Self-Contribution Amount is based on the following:

- If you are otherwise eligible for the Retiree Health Program and have attained age 52 and earned at least 15 Pension Credits in Covered Employment within the jurisdiction of the Pension Plan of Structural Iron Workers Local Union No. 1 Pension Trust Fund, the following Self-Contribution Amounts apply:

Retiree and/or Dependent Coverage

Single.....\$215 per month

Family.....\$320 per month

Note, "Single" means coverage for one family member only (regardless of whether you, in fact, are married). "Family" means coverage for the Retiree plus one or more of his/her family members. If you wish to cover your spouse or an eligible child in addition to yourself, you must pay the "Family" amount. If you are married, but do not wish to cover your spouse or any eligible dependents, you should pay the "Single" amount. Likewise, if you are married, and either you or your spouse is over age 65 and thus no longer eligible for the Retiree Health Program, and you have no eligible children whom you wish to cover, you should pay the "Single" amount for spouse-only or Retiree-only coverage.

- If you are otherwise eligible for the Retiree Health Program, but have not met the above requirements, the following Self-Contribution Amounts apply (unless you subsequently meet the above requirements, in which case your rate will drop down to the lower amount):

Retiree and/or Dependent Coverage \$390 per month

Note: the higher rate listed above will apply only to disabled retirees; all other retirees qualify for the reduced rate listed in the preceding paragraph (by virtue of the already applicable Retiree Health Program eligibility rules).

Retrospective Rescission of Coverage.

The Plan will not rescind coverage on a retroactive basis with respect to medical, dental, pharmacy and vision benefits. However, the Plan will retroactively terminate coverage of either active employees or retirees and their dependents if benefits were provided due to fraud or intentional misrepresentation of material fact. You will receive 30 days advance notice if your coverage will be retroactively terminated. Neither termination of coverage due to the failure to pay a premium nor termination of coverage due to fraud or misrepresentation is considered a rescission.

COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** COBRA (and the description of COBRA continuation coverage contained here) applies only to the group health benefits offered under the Plan and not to any other benefits that may be offered under the Plan or another plan in which you participate (such as life insurance, disability benefits, or accidental death or dismemberment benefits).

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It also can become available to your spouse and dependent children who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office. The Plan provides no greater COBRA rights than what COBRA itself requires, and nothing in this notice is intended to expand your rights beyond COBRA’s requirements.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event occurs and any required notice of that event properly is provided to the Plan Administrator in care of the Fund Office, COBRA continuation coverage must be offered to each person losing coverage who is a “qualified beneficiary.” You and your Dependents could become qualified beneficiaries and be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under qualified medical child support orders also may be qualified beneficiaries with the same rights as all other qualified beneficiaries.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay the entire cost of the COBRA continuation coverage plus an administrative fee.

COBRA continuation coverage is the same coverage that the Plan gives to other similarly situated persons under the Plan who are not receiving continuation coverage. This means, for example, that if the Plan changes benefits for active employees or their family members, your COBRA coverage will change accordingly. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other persons covered under the Plan.

Who Is Entitled to Elect COBRA?

If you are an employee of a Contributing Employer, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee of a Contributing Employer, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- Your spouse’s hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse dies;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. (Also, if the employee reduces or eliminates a spouse's group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation occurs, the divorce or legal separation may be considered a qualifying event for the employee's spouse though the coverage was reduced or eliminated before the divorce or separation.)

Your children who are Dependents (as defined by the Plan) will be entitled to elect COBRA if they lose group health coverage under the Plan because any of the following qualifying events happens:

- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee dies;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both) (applicable only to retiree coverage);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "Dependent" as defined by the Plan.

You do not have to show that you are insurable to elect COBRA continuation coverage. However, COBRA coverage is provided subject to your eligibility for such coverage. In particular, you must have been both eligible for coverage and actually covered by the Plan on the day prior to the date of the qualifying event. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to have been ineligible.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both; applicable only to retiree coverage), the Employer must notify the Plan Administrator in care of the Fund Office of the qualifying event. However, because Employers contributing to multi-employer

funds may not be aware of all qualifying events, the Fund Office also may rely on its records for determining whether eligibility is lost under certain circumstances.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you will not be entitled to COBRA unless you notify the Plan Administrator in care of the Fund Office in writing within 60 days after the later of (i) the date of the qualifying event, and (ii) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as result of the qualifying event.

The notice must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. If mailed, the notice must be postmarked no later than the deadline. If hand-delivered, the notice must be received no later than the deadline. Notice sent via facsimile is also acceptable but notice that is sent via e-mail is not. The notice may be provided by the covered employee, another qualified beneficiary who would lose coverage as a result of the event, or a representative acting on behalf of either one.

The notice must contain the Plan name, the name of the Contributing Employer, the employee's name, address, birth date, and social security (or other identification) number, the name and address of any impacted spouse or dependent child, a description of the qualifying event, the date of the event, and adequate documentation of the event (such as divorce decree or decree of legal separation, a copy of the dependent child's birth certificate, or a transcript showing the last date of the dependent child's enrollment in an educational institution, as applicable). A form for providing this notice may be available from the Fund Office, but need not be used so long as all the relevant information is included in the written notice.

If you provide a written notice that does not contain all of the information and documentation required, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified;
- the notice is provided by the deadline;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (the divorce, legal separation, or child's loss of Dependent status), and the date on which the qualifying event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements within 15 business days

after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for this notice).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan Administrator will treat the notice as having been provided on the date that the Plan Administrator receives all of the required information and documentation but will accept the notice as timely.

Electing COBRA Continuation Coverage

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees (and the spouse if a qualified beneficiary) may elect COBRA continuation coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA continuation coverage on behalf of their children.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period described in the Plan's COBRA Election Notice will lose his or her right to elect COBRA continuation coverage.

You may elect COBRA continuation coverage even if you are enrolled in Medicare or in another group health plan on or *before* the date on which COBRA is elected. However, as discussed below, your COBRA continuation coverage will terminate if you first become enrolled in Medicare or another group health plan (but only after you have exhausted or satisfied any applicable preexisting conditions exclusions under that other group health plan) *after* the date on which you elect COBRA.

Your election must be provided to the COBRA Administrator via hand-delivery, U.S. Mail, some form of express mail delivery, or facsimile.

Newborns and Adopted Children

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), if a child is born to the covered employee or placed for adoption with the covered employee during a period of COBRA coverage, that child will be eligible for COBRA coverage. In accordance with the terms of the Plan and the requirements of federal law, the newborn or child placed for adoption can be added to COBRA coverage and become a qualified beneficiary under COBRA upon proper notification to the Plan Administrator in care of the Fund Office within 30 days of the birth or adoption or during open enrollment (if the Plan offers open enrollment) and payment of any required additional premium. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Special considerations in deciding whether to elect COBRA

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by

other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you to avoid such a gap. Second, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the qualifying event indicated in this notice. You also will have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Special second election period under the Trade Act for certain eligible employees who did not elect COBRA

Under the Trade Act of 2002, special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). The process for determining individual eligibility for trade adjustment assistance begins when employees (or their representatives) petition the Department of Labor to recognize their Employer as being adversely affected by trade. Generally, an Employer may be found to be adversely affected by trade if the Employer meets the following criteria:

- employees have been totally or partially laid off (a partial layoff means a reduction of hours and wages to 80% or less per week),
- Sales or production have declined due to trade, and
- Increased imports have contributed to employee layoffs.

Eligible individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, please contact the Plan Administrator in care of the Fund Office. **Contact the Plan Administrator promptly after qualifying for TAA or ATAA or you will lose the right to elect COBRA during a special second election period.**

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, as discussed below, 150 percent) of the cost to the group health plan (including both Employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (“PBGC”) (“eligible individuals”). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you think these new tax provisions may apply to you or if you have questions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for COBRA continuation coverage be made?

All COBRA premiums must be paid by personal check or money order.

First payment for COBRA continuation coverage

If you elect COBRA continuation coverage, you do not have to send any payment with your election. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date your election is post-marked, if mailed, or the date your election is received by the Plan Administrator in care of the Fund Office, if hand-delivered.) **If you do not make your first payment for COBRA continuation coverage in full within 45 days of the date of your election, you will lose all continuation coverage rights under the Plan.**

Your first premium payment must include payment for the period from the date that you lost (or otherwise would have lost) coverage until the date of your election, and each regularly scheduled monthly premium that became due during the period between your election and the first payment.

Example Sara’s health coverage terminated on September 30. She elects continuation coverage on November 15 and makes her initial premium payment on December 15 (15 days before the December 30 deadline for doing so (45 days after the date of the COBRA election)). Sara’s minimum required initial payment is the premium amount for coverage for October and November. Her December premium is due December 1, so, in fact, it too should be included, but because of the grace period (discussed below), she has until January 15 to pay the December premium.

You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator in care of the Fund Office to confirm the correct amount of your first payment.

Claims for reimbursement may not be processed and paid until you have elected COBRA and made the first payment.

Monthly payments for COBRA continuation coverage

After you make your first payment for COBRA continuation coverage, you will be required to make monthly payments for each subsequent month of coverage. Under the Plan, each of these monthly payments for continuation coverage is due on the first of the month for that month's COBRA continuation coverage. If you make a monthly payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that coverage period without any break. If you do not make a monthly payment on or before the first day of the month, your coverage may be suspended pending payment. The Plan is not required to send monthly notices of payments due for these coverage periods. It is your responsibility to pay your COBRA premiums on time, regardless of whether you receive a monthly bill.

Grace periods for monthly payments

Although monthly payments are due on the first day of each month of COBRA continuation coverage, you will be given a grace period of 30 days to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both; applicable only to retiree coverage), the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event may last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA continuation coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally may last for only up to a total of 18 months.

The COBRA continuation coverage periods described above are maximum coverage periods (subject to extension as discussed below).

COBRA continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan (but only after any applicable preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied),
- a covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both; applicable only to retiree coverage) after electing COBRA (does not apply to retirees and their family members entitled to COBRA due to a bankruptcy), or
- during a disability extension period (as explained below), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

COBRA continuation coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

You must notify the Plan Administrator in care of the Fund Office in writing within 30 days if, after electing COBRA continuation coverage, you or one of your family members enrolls in another group health plan or becomes entitled to Medicare (Part A, Part B, or both). This notice should include the name and address of the covered or former covered employee, the type and date of the initial qualifying event, the name and address of the qualified beneficiary who has become covered by Medicare or another group health plan and the date that Medicare or other coverage began. Documentation of the date of Medicare entitlement or other group health coverage should be included (for example, a copy of the Medicare card or health insurance card). The notice may be provided by the covered or former covered employee, a qualified beneficiary, or a representative acting on behalf of either, and such notice will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries. (A form for providing this notice may be available from the Fund Office.) The Plan reserves the right to terminate your COBRA continuation coverage retroactively and to require reimbursement of all benefits paid after the date of commencement of the other health coverage or Medicare, regardless of whether or when notice is provided.

There are two ways in which the 18-month period of COBRA continuation coverage resulting from a termination of employment or a reduction of hours may be extended, as explained below.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration (“SSA”) to be disabled and you notify the Plan Administrator in care of the Fund Office in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA continuation coverage because of a covered employee’s termination or reduction of hours. The disability must have

started at some time before the 61st day after the covered employee's termination or reduction of hours and must last at least until the end of the period of COBRA continuation coverage that would be available without the disability extension (generally 18 months, as described above). The disability extension is available only if you (i) apply for the determination and (ii) give written notice to the Plan Administrator in care of the Fund Office of such application prior to the start of or within the 18-month period. Further, your notice to the Plan Administrator must be provided within 60 days of the date of your application to the Social Security Administration, unless you applied prior to the commencement of continuation coverage, in which case, notice must be provided within the first 60 days of the 18-month period. Finally, once you receive the actual determination from the SSA, a copy must be provided to the Plan Administrator. If you receive this determination more than 60 days prior to the expiration of the 18-month period, you must provide a copy to the Plan Administrator within 60 days. If you receive the determination less than 60 days prior to the expiration of the 18-month period, you must provide a copy to the Plan Administrator by the later of 30 days after receipt or the expiration of the 18-month period. If the SSA determines that you in fact are not entitled to Social Security disability benefits, your continuation coverage will end by the later of the expiration of the 18 months or the last day of the month next following the month containing the date on which you received the determination.

The notices described in the paragraph above must be mailed or hand-delivered; oral notice, including notice by telephone, is not acceptable. If mailed, the notice must be postmarked no later than the deadline. If hand-delivered, the notice must be received no later than the deadline. Notice sent via facsimile also is acceptable, but notice that is sent via e-mail is not. The notification must include the Plan name, the name of the employee and any other covered Dependents that have elected COBRA continuation coverage, the employee's social security (or other identification) number, the date of the employee's termination or reduction in hours, the date that the disabled qualified beneficiary became disabled (according to the SSA determination), and, as applicable, a copy of your application for an SSA determination, or, when available, the SSA determination. The notice may be provided by the covered employee (i.e., the employee or former employee who is or was covered under the Plan), another qualified beneficiary who lost coverage to the covered employee's termination or reduction in hours and is still receiving COBRA coverage, or a representative acting on behalf of either one. A form for providing this notice may be available from the Fund Office, but need not be used so long as all the relevant information is included in the written notice. **There will be no disability extension of COBRA continuation coverage unless notice is properly provided.**

If you provide a written notice to the Plan Administrator that does not contain all of the information and documentation required, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified;
- the notice is provided by the deadline;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan and a qualified beneficiary's disability;

- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), and the date on which the covered employee's termination of employment or reduction of hours occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for this notice).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan Administrator will treat the notice as having been provided on the date that the Plan Administrator receives all of the required information and documentation but will accept the notice as timely.

If the disabled person is determined by SSA to no longer be disabled, you must notify the Plan in writing of that fact within 30 days after SSA's determination. This notice should include the name and address of the covered or former covered employee, the type and date of the initial qualifying event, the name and address of the qualified beneficiary whose disability has ended, the date that the disability ended, and the date of the SSA determination regarding cessation of disability. A copy of the SSA determination regarding cessation of disability should be included. The notice may be provided by the covered or former covered employee, a qualified beneficiary, or a representative acting on behalf of either, and such notice will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries. Provided that the original 18-month period already has elapsed, COBRA coverage for all qualified beneficiaries will terminate (retroactively, if applicable) as of the first day of the month that is more than 30 days after a final determination that the qualified beneficiary no longer is disabled, regardless of whether or when the notice is provided. The Plan will require repayment of all benefits paid after the termination date.

Second qualifying event extension of COBRA continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage due to the covered employee's termination of employment or reduction of hours (including COBRA continuation coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

You must notify the Plan Administrator in care of the Fund Office in writing within 60 days after a second qualifying event occurs if you want to extend your continuation coverage. The notice must be mailed or hand-delivered; oral notice, including notice by telephone, is not acceptable.

If mailed, the notice must be postmarked no later than the deadline. If hand-delivered, the notice must be received no later than the deadline. Notice sent by facsimile also is acceptable, but notice that is sent via e-mail is not. This notice must include the Plan name, the employee's name, address, birth date, and social security (or other identification) number, the name and address of any impacted spouse or dependent, a description of the qualifying event, the date of the initial qualifying event (the termination of employment or reduction in hours) and the date of the second qualifying event, and adequate documentation of the event (such as a death certificate or published obituary, divorce or legal separation decree, a copy of the employee's Medicare card, a copy of the dependent's birth certificate, or a transcript showing the last date of the dependent child's enrollment in an educational institution, as applicable). The notice may be provided by the covered employee (i.e., the employee or former employee who is or was covered under the Plan), another qualified beneficiary who lost coverage to the covered employee's termination or reduction in hours and is still receiving COBRA coverage, or a representative acting on behalf of either one. **There will be no extension of COBRA continuation coverage unless notice is properly provided.**

If you provide a written notice to the Plan Administrator that does not contain all of the information and documentation required, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified;
- the notice is provided by the deadline;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for this notice).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan Administrator will treat the notice as having been provided on the date that the Plan Administrator receives all of the required information and documentation but will accept the notice as timely.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator in care of the Fund Office at the telephone number and

address indicated in the section entitled “Administrative Information About the Plan” towards the end of this SPD.

For more information about your rights under ERISA, including 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep Your Plan Informed of Address Changes/Keep Copies of Notices

In order to protect your family’s rights, you should keep the Plan Administrator and COBRA Administrator informed of any changes in your address and the addresses of family members. You also should keep a copy, for your records, of any notices you send to the Plan Administrator.

Change of Eligibility Rules

The Trustees in their discretion are empowered to change or amend the Eligibility Rules of the Plan at any time.

Fraud Regarding Eligibility Rules

It is a fraudulent act to provide false documentation to establish eligibility of a person who is not eligible for Plan benefits. You must notify the Plan immediately of any changes in eligibility. In the event that a claim is filed on behalf of a formerly eligible person and you receive an explanation of benefits indicating that that person was covered, you must notify the Fund Office that that individual is no longer eligible. Acts of fraud will be grounds for termination of eligibility for you and your entire family. The Fund Office also may notify the Employer of the fraud, and it may be grounds for discipline up to and including termination of employment. You will be held responsible for any claims paid on behalf of an ineligible person.

Family and Medical Leave Act (FMLA)

Under certain circumstances, you may be able to take unpaid leave from your employment under the Family and Medical Leave Act (FMLA). Your entitlement to such leave is determined by your Contributing Employer. During your leave, you will maintain all coverage offered through the Fund for up to a maximum of six months, depending on the circumstances. You will remain eligible until the end of the leave, provided your Contributing Employer properly grants the leave under the federal law, and your Employer makes the required notification and payment to the Fund. An absence due to FMLA leave will not be included as part of the period used to calculate continuing eligibility. Nor will you be required to use ARA hours in order to maintain coverage during FMLA leave, and your FMLA leave will not otherwise impact the calculation of your ARA balance at any time.

Contact your Employer for more information regarding such a leave and whether you are eligible. Your Employer will decide your eligibility for FMLA leave and is required to notify the

Fund of any such leave. If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Fund will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

Uniformed Services Employment and Reemployment Rights (USERRA)

The Plan provides benefits as described below that comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The benefits offered during a military leave under this section do not include short-term disability, life, or accidental death and dismemberment insurance benefits.

Although USERRA allows the allocation of certain costs to the last employer, the Plan has decided to absorb these costs and to provide the benefits as described below.

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA also will be an election under USERRA, and COBRA and USERRA both will apply with respect to the continuation coverage elected. If COBRA and USERRA afford the Employee (or the Employee's Dependents) different rights or protections, the law that provides the greater benefit will apply.

If you take a leave of absence to enter active uniformed service, please contact the Fund Office for more information as to your rights to continuation coverage.

If you enter active service, your coverage under the Plan will not be affected during the initial 31-day period. Your coverage under the Plan will be suspended at the end of this initial 31-day period under Option 1 below (the default option), unless you elect otherwise.

In order to exercise your options, you must notify the Fund Office when you are called to active service. You will have three options regarding your Plan benefits as follows:

- Option 1: Suspend coverage under the Plan and rely on military coverage for you and your Dependents. This is the **DEFAULT OPTION**.
- Option 2: Suspend active coverage and elect COBRA/USERRA continuation coverage for up to 24 months.
- Option 3: Continue active coverage for as long as the Plan's eligibility rules permit, and then elect COBRA/USERRA continuation coverage for up to 24 months.

If your failure to provide advance notice when called to active service is excused under USERRA because of military necessity, then you can make a retroactive election to continue coverage, provided you pay any unpaid amounts that are due.

Option 1

If you elect Option 1 (suspend eligibility and rely on military coverage), your eligibility and credited hours will be frozen until you are discharged from military service. In order to reinstate active eligibility, you must provide the Fund Office with a copy of your discharge papers within the time periods provided under USERRA as described in the following chart.

Length of Military Service	Reemployment/Reinstatement Deadline
Less than 31 days	1 day after discharge (allowing 8 hours for travel)
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

Once you provide the Fund Office with your discharge papers, your credited hours, as of the end of the initial 31 day period, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Plan. Your eligibility for subsequent periods will be determined under the Plan's eligibility rules.

Option 2

If you elect Option 2 (suspend active coverage and elect COBRA/USERRA continuation coverage), your eligibility and credited hours will be frozen until you are discharged from military service. Under this Option, you and your Dependents can pay the monthly COBRA/USERRA premium for up to 24 months of COBRA/USERRA continuation coverage. The standard election and payment deadlines that would apply under COBRA apply here.

In order to reinstate active eligibility upon discharge, you must provide the Fund Office with a copy of your discharge papers within time periods provided under USERRA as described in the above chart.

Once you provide the Fund Office with your discharge papers, your credited hours, as of the end of the initial 31 day period, will be reinstated effective as of your date of discharge, or a later date as agreed to by the Plan. Your eligibility for subsequent periods will be determined under the Plan's eligibility rules.

Option 3

If you elect Option 3 (continue active coverage), you and your Dependents will receive active coverage for as long as your credited hours permit. (In other words, you can use your ARA to continue coverage.) Thereafter you will be offered COBRA/USERRA continuation coverage for up to 24 months. The standard election and payment deadlines that would apply under COBRA apply here.

Under USERRA, you must provide the Fund Office with a copy of your discharge papers within time periods provided as described in the above chart.

If active eligibility has been exhausted under Option 3, then upon discharge you will not qualify for active eligibility until you satisfy the requirements set forth under "Reinstatement" in the Eligibility section above. If you do not meet this requirement within 2 years of discharge, you must meet the requirements for Initial Eligibility.

In the meantime, you will have the opportunity to pay for continuation coverage as of the date of discharge, or a later date as agreed to by the Plan. Upon discharge, you can pay for continuation

coverage until the later of 1) the end of six months of payments, or 2) the end of the original 24 month period.

Contact the Fund Office at (708) 366-1188 in order to obtain the USERRA Military Service Election Form, or for more information.

Certificate of Creditable Coverage

When your coverage (or the coverage of your Dependent(s)) under this Plan ends, the Fund will provide you and/or your eligible Dependents with a Certificate of Creditable Coverage that indicates the period of time that you and/or your Dependents were covered under the Plan and certain additional information that is required by federal law. The Fund Office (or its delegate) will send you the certificate by first class mail within 44 days after coverage under this Plan ends. If you or your Dependents elect COBRA Continuation Coverage or coverage under USERRA, another certificate will be provided within a reasonable period of time after the COBRA Continuation Coverage or USERRA coverage ends.

In addition, you (or your new group health plan, if authorized by you) may request a certificate in writing. A certificate will be provided by the earliest day that the Fund Office, acting in a reasonable and prompt fashion, can provide it, so as long as your written request is received within two years after the later of the date active coverage under this Plan ended or the date COBRA continuation coverage or USERRA coverage ended.

SCHEDULE OF BENEFITS

Unless indicated otherwise the following Schedule applies to all eligible classes of Employees and Dependents.

Classes of Employees:

- I. All active eligible employees;
- II. All employees who are eligible in accordance with their Accumulated Reserve Account;
- III. Retirees prior to December 1, 1969; and
- IV. Retirees on and after December 1, 1969.

Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total that may be split between Network and Non-Network Providers.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
ANNUAL MAXIMUM FOR ESSENTIAL HEALTH BENEFITS (effective January 1, 2011)		
ACTIVE	\$1,500,000.00	
RETIREE	\$1,500,000.00	
<i>Note: Benefits determined to be non-essential health benefits will not count toward the \$1,500,000 annual limit.</i>		
ANNUAL MAXIMUM FOR ESSENTIAL HEALTH BENEFITS (effective January 1, 2014)		None

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Per Covered Person	\$500	\$1,000
Per Family Unit	\$1,000	\$2,000
<i>Note: Amounts that apply to the deductible for PPO Network Providers apply towards the deductible for Non-Network Providers and vice versa. Percentages of coverage indicated below apply only after the deductible has been met.</i>		

MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR		
<i>(Including deductible prior to 10/1/09; thereafter, excluding deductible)</i>		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Per Covered Person	\$1,500	\$3,000
Per Family Unit	\$3,000	\$6,000
<i>The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.</i>		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%:		
<ul style="list-style-type: none"> • Cost containment penalties • Drug Card Co-payments • Charges above Usual & Customary 		
COVERED CHARGES		
HOSPITAL SERVICES		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• Pre-Admission Testing Services	90%	80%
• Emergency Room	90%	90%
• Outpatient Services <i>Not including Emergency Room Care</i>	90%	80%

• Inpatient Room and Board	90%	80%
	the semiprivate room rate	the semiprivate room rate
• Intensive Care Unit	90%	80%
	Hospital's ICU charge	Hospital's ICU charge
• Skilled Nursing Facility	90%	80%
• Pregnancy	90%	80%
• Organ Transplants	90%	80%
PHYSICIAN SERVICES		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• Second Surgical Opinion	90%	80%
• Inpatient Visits	90%	80%
• Office Visits	90%	80%
• Office Visit - Laboratory/X-Ray Services	90%	80%
• Allergy Shots	90%	80%
• Surgery - Inpatient	90%	80%
• Surgery - Outpatient	90%	80%
• Emergency Room	90%	90%
• Assistant Surgeon <i>Benefits available only where an Assistant Surgeon is Medically Necessary.</i>	90%	80%
• Chemotherapy/Radiation Therapy	90%	80%
• Anesthesia	90%	80%

• Laboratory/X-Ray Services	90%	80%
• Infertility	90%	80%
	<i>Limited to Covered Charges Incurred to diagnose this condition.</i>	
• Hearing Aid and Exam	90%	80%
	Limited to: \$50.00 Per Fitting	
	One per ear per 48 consecutive months up to \$3,000.00 (\$4,000 if two years)	
• Home Health Care	90%	80%
• Outpatient Private Duty Nursing	90%	80%
• Hospice Care	90%	80%
• Bereavement Counseling (as part of Hospice Care)	90%	80%
	Limited to 6 Visits Per Occurrence	
• Ambulance Service	90%	80%
• Jaw Joint/TMJ	Covered under Dental Only	Covered under Dental Only
• Lasik/RK/ALK/Surgery	90%	80%
	Lifetime Maximum: \$875.00 Per Eye	
• Wig After Chemotherapy	90%	80%
• Occupational Therapy <i>Covered when there is underlying medical condition only</i>	90%	80%
• Speech Therapy <i>Covered when there is underlying medical condition only</i>	90%	80%
• Physical Therapy <i>Covered when there is underlying medical condition only</i>	90%	80%
• Developmental Delays and Learning Disorders <i>Covered when there is</i>	90%	80%

<i>underlying medical condition only</i>		
• Durable Medical Equipment	90%	80%
• Prosthetics	90%	80%
• Podiatric Services	90%	80%
• Custom Molded Orthotics <i>(only after an open-cutting operation or when used in lieu of such operation)</i>	90%	80%
• Smoking Cessation	90%	80%
• Sterilization <i>(Vasectomy/tubal ligation) Reversal is not covered.</i>	90%	80%
• Chiropractic Services <i>This includes all services rendered and/or recommended by a chiropractor (such as, but not limited to, acupuncture).</i>	90%	80%
	After services totaling \$2,000.00 per calendar year have been rendered, a complete medical review to determine whether Necessary Treatment is required before additional benefits will be approved.	
MENTAL DISORDERS		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• Inpatient	90%	80%
• Outpatient	90%	80%
SUBSTANCE ABUSE/CHEMICAL DEPENDENCY/ALCOHOL		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• Inpatient - Alcohol	90%	80%
• Inpatient - Substance Abuse/Chemical Dependency	90%	80%
• Outpatient - Alcohol	90%	80%

• Outpatient - Substance Abuse/Chemical Dependency	90%	80%
PREVENTIVE CARE		
	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
• Preventive Care and Routine Physical Services Covered by the Plan	100%	100%
<i>Preventive Care includes office visits, immunizations, pap smears, mammograms, prostate screenings, gynecological exams, routine physical examinations, x-rays, and laboratory blood tests.</i>		
<i>The Plan will cover 100% of the costs for the preventive care services identified in the section entitled Preventive Care/Routine Physical Exam Benefit.</i>		
PRESCRIPTION DRUG CARD BENEFIT		
Pharmacy Option		
Generic Copay		\$7.00
Brand Name Copay when equivalent Generic not available		\$25.00
Brand Name Copay when equivalent Generic is available		\$25 + cost difference between brand and generic
Copay for insulin, injectable diabetic medications, and diabetic supplies		\$5
Mail Order Prescription Drug Option		
Co-payment, per Prescription		
Generic Copay		\$15.00
Brand Name Copay when equivalent Generic not Available		\$50.00
Brand Name Copay when equivalent Generic is available		\$50 + cost difference between brand and generic
Copay for insulin, injectable diabetic medications, and diabetic supplies		\$10
Brand Copay When An Equivalent Generic Is Available:		
If you choose a brand name prescription when an equivalent generic drug is available, the copay is equal to the applicable brand name copay plus the difference in cost between the brand name drug and the generic alternative that is available.		

EXCEPTION: This higher copay for brand name drugs when a generic is available does not apply when a Physician indicates that a brand name prescription (for which a generic alternative exists) is to be dispensed as written and provides a written explanation satisfactory to the Plan as to why a generic is not effective. The higher copay will be charged initially, with a refund to be issued upon receipt of such explanation and authorization by the Plan.

EXAMPLE: John makes a retail purchase for a brand name drug with a cost of \$100.00 when a generic drug with a cost of \$15.00 is available. His copay is equal to \$25.00 plus the difference (\$100.00 - \$15.00 = \$85.00) for a total of \$110. The Physician subsequently explains in writing why the generic is not effective, and the Plan approves a higher reimbursement. John then will be reimbursed \$85.00, but still will have to pay the \$25.00 brand name copay.

If you go to a pharmacy that is not in the network, you must pay the cash price for your prescription. You may then submit a paper (direct) claim to the Claims Administrator as identified in the section entitled “Administrative Information About the Plan.” The paper (direct) claim will be processed at the discounted price, less the copay.

VISION CARE

Benefits Payable at 100% up to the Listed Maximum Per Calendar Year:

Screening	1 per calendar year up to \$60.00
Frames	1 per calendar year up to \$90.00
Lenses:	
Single Vision	1 per calendar year up to \$100.00
Bifocals	\$120.00
Trifocals	\$140.00
Contacts, each pair	\$150.00
Total Maximum Annual Benefit (Excluding Lasik/RK/ALK Surgery):	\$290.00
Lasik/RK/ALK Surgery –	\$875 per eye per lifetime

The listed maximum benefit payable for screening, frames, single vision, bifocals, trifocals, and contacts only applies to individuals age 19 and over.

DENTAL BENEFITS

Dental Percentage Payable

Class A Services - Diagnostic/Preventive	100%
Class B Services - Basic	70%
Class C Services - Major (TMJ/Jaw Joint Included)	70%
Class D Services - Orthodontia	70%

Maximum Benefit Amount:

For Class A, B and C (combined), per Covered Person per Calendar Year:\$3,000.00

For Class D - Orthodontia, Lifetime maximum per Covered Person\$4,000.00

For treatment of a severe dental condition, up to an additional \$10,000 per lifetime per condition payable at 70% as a medical benefit.

The Maximum Benefit Amounts for Class A, B and C and for severe dental conditions only applies to individuals age 19 and over.

MEDICARE PREMIUM SUPPLEMENT

Supplement for Retirees	\$162.00 each January 1 received from the Fund Office for Retiree only
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LIFE, AD&D, AND DISABILITY BENEFITS

Life Insurance (based on Employee Class as defined at the beginning of this Schedule of Benefits):

Class I Employee	\$50,000
Class II Employee	\$50,000
Class III Employee	\$1,000
Class IV Employee	\$2,500

Accelerated Benefit if Terminally Ill/Under age 60	up to \$37,500, \$5,000 min.
Spouse	\$5,000
Dependent Child of Class I and II Employee	\$2,500
Accidental Death and Dismemberment Insurance:	
Class I Employee Principal Sum:	\$45,000
Passenger Restraint Benefit Amount	\$10,000
Air Bag Benefit Amount	\$5,000
Rehabilitation Training Benefit	\$2,250
Medical Coverage Funding Benefit	\$300 per month (up to a maximum of \$3,600 per 12 months for up to 36 months)
Monthly Hospital Benefit	\$2,500 per month (for a maximum of 12 months up to \$30,000)
Adoptive Home and Vehicle Benefit	Up to \$10,000 (one-time, expense incurred benefit)
Coma Benefit	5% of Principal Sum per month payable for up to 11 months in a row; 45% of Principal Sum if still comatose in month 12
Third Degree Burn Benefit:	
75% or more of your body	100% of Principal Sum
50%-74% of your body	50% of Principal Sum
Total Disability Death Benefit	100% of Principal Sum

Short Term Disability Benefit (Class I Employee Only)

Maximum Weekly Amount\$400

Waiting Period

Accident 0 Days

Sickness..... 7 Days

Maximum Benefit Period26 Weeks

EMPLOYEE ASSISTANCE PROGRAM

Up to 8 counseling sessions per year are offered.

KEEPING COSTS UNDER CONTROL FOR YOU AND THE PLAN

Deductible Amount

The deductible amount is the amount of covered expenses you pay each calendar year (January 1 through December 31) before the Plan pays benefits. The deductible amount is listed in the Schedule of Benefits.

A family will not be required to meet a deductible greater than the family deductible amount listed in the Schedule of Benefits for all covered family members during a calendar year. When the family deductible amount is reached during a calendar year, no further deductible will be required from any covered family members for the rest of the calendar year.

If two or more Covered Individuals of the same family are injured in the same accident, only one deductible must be satisfied. The single deductible will apply to covered expenses incurred by those family members as a result of the common accident during the current and following calendar year.

Annual Maximum on Essential Health Benefits

The Plan pays up to the annual maximum amount (listed in the **Schedule of Benefits** section) per person per year for benefits deemed to be Essential Health Benefits. The Board of Trustees has the sole discretion and responsibility to determine whether a benefit is deemed to be an “Essential Health Benefit.”

Benefits determined to be non-essential will not count toward the annual maximum for Essential Health Benefits. Non-essential health benefits may be subject to a separate annual maximum as set forth in the Schedule of Benefits.

Preferred Provider Organization (PPO)

The Fund has entered into an agreement with a Preferred Provider Organization (PPO) to reduce Plan costs. The identity of and contact information for the PPO is provided below in the section entitled “Administrative Information About the Plan.” You and your Dependents may choose health care, dental services and prescription drug benefits available through providers that have negotiated service agreements and discounts with the PPO. These providers are considered to be “Network Providers.” Such agreements may be renegotiated from time to time. The Fund Office will furnish you with a list of preferred providers, free of charge, at your request or you may visit the PPO’s website or call the PPO to locate a provider in your area. Because of the negotiated discounts arranged by the PPO, services received from Network Providers tend to be significantly less expensive than services received from Non-Network Providers.

You also may choose providers that are not part of the PPO; these providers are considered to be “Non-Network Providers.” Different levels of benefits may apply to services provided through Network and Non-Network Providers, as described in the Schedule of Benefits, and the services received from Non-Network Providers are likely to be more expensive (meaning that your personal payment responsibility will tend to be higher).

Services rendered by Non-Network Providers will be subject to the same level of benefits as Network Providers if the Plan's utilization review provider determines in advance of treatment that no Network provider located within the Chicago metropolitan area (defined as Cook, Lake, DuPage, McHenry, Will and Kane counties) is able to provide the service. If the utilization review provider is not able to make a determination in advance due to emergency circumstances, the advance determination requirement may be waived.

The fact that certain providers or facilities are "Network" Providers should not be construed as a recommendation, referral or any other statement as to the ability or quality of such providers or facilities, and neither the Plan nor the Plan Administrator bears any liability for any act or omission of such providers or facilities. Conversely, the fact that certain providers or facilities are "Non-Network" should not be construed as a statement, negative or positive, as to the skill or quality of such provider or facility.

Notwithstanding the above, emergency room services and emergency room physician visits will be provided under the Plan on the same cost sharing basis. Additionally, the agreements entered into between the Fund and providers of emergency room benefits allow the Fund to pay the highest reasonable amount in order to lower your out-of-pocket costs.

Under the Plan, you still will not be required to designate a primary care provider and you are free to see any Physician you wish, including pediatricians. Also, as a reminder, you do not need prior authorization from the Preferred Provider Organization, the Claims Administrator, or any other person or entity (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with the Plan's Utilization Review or Alternative Care procedures (set forth below).

Pre-Admission Tests

If you are scheduled for Hospital confinement, the Hospital may require routine tests and/or X-rays as part of its admission policy. The Plan will pay the Usual and Customary Charge for such tests and/or x-rays if:

- They are performed on an out-patient basis;
- They are performed within 10 days before a covered Hospital confinement;
- They are performed in connection with a covered Hospital confinement;
- The confinement is deemed required by a Physician before the tests are taken; and
- The tests would have been covered if done on an in-patient basis.

Additional Surgical Opinion

If your Physician recommends an operation to treat a Sickness or Injury, you may obtain up to two additional opinions as to its need before it is performed. The Plan will pay the Specialist's Usual and Customary Charge for the opinion if it is obtained from a Board Certified Specialist

who practices in the surgical or medical specialty for which surgery is proposed and who has examined you in person.

This benefit will:

- Be based on a written report from the Specialist;
- Not be paid if the Specialist giving the opinion also performs the surgical procedure; and
- Include charges for diagnostic procedures performed or ordered by the Specialist to verify the need for surgery.

Utilization Review

Pre-Certification Review – Non-Emergency Situations

You are requested to pre-certify any non-emergency, elective Hospital admission whenever your Physician recommends hospitalization for treatment of an Injury or Sickness. Pre-certification is strongly recommended so that you can avoid unnecessary treatment and procedures. In order to pre-certify, you should notify the Utilization Review Provider identified in the “Administrative Information About the Plan” section below or as listed on your Welfare Plan I.D. card at least 48 hours in advance of admission (or 24 hours in advance where you yourself have less than 48 hours notice of the need for admission) by calling the number provided.

An elective admission is when you have been notified of the need for inpatient hospital admission at least 24 hours in advance of the admission.

Pre-Certification Review – Emergency Situations

You should notify the Plan by calling the Utilization Review Provider identified in the “Administrative Information About the Plan” section below in emergency situations within 48 hours of the first business day after the admission.

An emergency admission is defined as one in which you have less than 24 hours notice regarding the admission.

Within 5 working days of receipt of the notice, the Plan’s Utilization Review Provider will provide written notice to your Physician, you and the Hospital of the number of days of Hospital confinement that are authorized for the treatment of the Injury or Sickness. That number of days will not be less than the number required by any applicable law.

Continued Hospital Confinements – Concurrent Review

The Utilization Review Provider may re-evaluate and extend the number of authorized days of Hospital confinement at any time during your Hospital confinement. The decision will be based upon peer review or other professional medical opinion and individual case considerations. You or your attending Physician may, at any time, initiate a request for re-evaluation or extension. If

your attending Physician determines that medically Necessary Treatment requires a longer stay, the Physician should request the additional days no later than 24 hours before the end of the original pre-certified number of days.

Dental Benefits

See the *Pre-Determination of Dental Benefits* subsection in the “Dental Benefits” section below for an explanation of procedures for pre-certification of dental benefits that are expected to equal or exceed \$300.

Case Management

The Plan offers case management services when a catastrophic condition (such as a spinal cord injury, cancer, AIDS, or premature birth) occurs. Case management is a program whereby a case manager from the Plan’s Utilization Review Provider (as identified in the “Administrative Information About the Plan” section below) monitors your condition and explores, discusses, and recommends coordinated and/or alternative types of appropriate Necessary Treatment. The case manager consults with you, your family members, and the attending Physician. Once agreement has been reached amongst these parties as to the most appropriate treatment plan, the Plan will reimburse all Necessary Treatment set forth in the treatment plan even if such expenses otherwise would not be covered. Participation in case management is voluntary.

Alternative Care

Sometimes specialized care or adaptations to the home are required, but are not typically covered under the Plan. The Large Case Management program has been established to address those situations in which there otherwise would be a large cash outlay for non-Covered Charges for catastrophic conditions. If the Plan Administrator, attending Physician, patient, and patient's family all agree to an alternative treatment plan, the Plan Administrator will direct the Plan to reimburse for expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. To learn more, contact the Claims Administrator.

Your Medical Records

The Plan has secured the services of a Medical Records Provider as an added voluntary benefit to enhance the safety of Plan participants. If you use its services, the Medical Records Provider will keep a record of your medical history on file for transmission to your medical provider in case of an emergency. The medical information kept by the Medical Records Provider includes your medical history, allergies, current medications, acute medical conditions, emergency contacts, health insurance information and your personal Physician. The program benefits you by:

- Reducing the possibility of medical error;
- Speeding up your admission for faster emergency care;
- Reducing the chance of your adverse reaction to drugs;
- Informing emergency personnel of your emergency contacts;

- Reducing medical costs from unnecessary testing.

You can activate these services by calling the Medical Records Provider at the number indicated in the section below entitled “Administrative Information About Your Plan.”

COMPREHENSIVE MAJOR MEDICAL BENEFITS

If you incur covered charges as a result of a non-occupational Injury or Sickness, the Plan will pay benefits subject to the deductibles, at the percentages stated and up to the maximum amounts shown in the Schedule of Benefits and according to the provisions that follow explaining covered expenses. You must pay your deductible and any coinsurance indicated in the Schedule of Benefits.

Covered Major Medical Expenses

Covered expenses are the covered charges you incur for Necessary Treatment for the following types of medical services and supplies, which are performed or prescribed by your Physician. Covered expenses are subject to the General Exclusions and Limitations as set forth in the section bearing that title.

1. Hospital room, board and general nursing services up to:
 - a. For ward and semi-private accommodations: up to the Usual and Customary Charge that is charged by a similar institution in the same geographic area;
 - b. For private accommodations: the average semi-private room rate charged by the Hospital in which you are confined, unless the Hospital only has private rooms, in which case, the private room rate charged.
2. Care in the Hospital's Intensive Care Unit, up to three times the Hospital's daily semi-private rate, or if the Hospital does not have semi-private rooms, then up to three times the private room rate;
3. Charges made by a Hospital for medical services and supplies;
4. Charges for pregnancy-related Hospital confinements;

Benefits will be provided for a hospital stay in connection with childbirth for the mother and newborn child of at least 48 hours following a normal vaginal delivery and at least 96 hours following a caesarian section. No authorization from the Plan is required for prescribing a length of stay up to these lengths of time. However, the attending Physician, in consultation with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

5. Operating and recovery room charges;
6. Charges made by a Physician for medical care and treatment and for performing a surgical procedure;
7. Charges for medical and surgical benefits in connection with a mastectomy and certain reconstructive surgery. If you elect breast reconstruction in connection

with a mastectomy (where the mastectomy itself is considered Necessary Treatment) in a manner determined in consultation with your attending Physician, covered charges include:

- a. Reconstruction of the breast on which the mastectomy was performed;
 - b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
8. Charges made for diagnostic tests;
 9. Charges made for radiation and chemotherapy treatment;
 10. Charges made for the cost and administration of an anesthetic;
 11. Charges for private duty nursing in your home by an R.N. or L.P.N;
 12. Charges for rental of durable medical equipment used in your home (however, the Plan reserves the right to purchase (if permitted by the vendor) the equipment instead of paying for rental, if purchase would cost less than the rental amount allowed);
 13. Charges for artificial limbs, eyes and other prosthetic devices (including replacement due to growth, necessary refitting, or deterioration);
 14. Charges for casts, splints, trusses, crutches and braces (except dental braces);
 15. Charges for oxygen and rental of equipment for the giving of oxygen;
 16. Charges for physical therapy, but only if given by a licensed physical therapist;
 17. Charges for smoking cessation programs or related services performed or prescribed by a state licensed professional;
 18. Charges for licensed ambulance service to and from a local Hospital in an emergency where transportation via some other, slower means reasonably could be expected to adversely impact the outcome;
 19. Charges for blood and blood plasma, except when replaced;
 20. Mammography and diagnostic screening procedures once per calendar year;
 21. Emergency treatment for an Injury or Sickness;
 22. Pre-admission testing;

23. Emergency room visits;
24. Outpatient services;
25. Hospital room and board;
26. Routine well newborn care;
27. Skilled nursing facility services;
28. Pregnancy;
29. Organ transplants;
30. Office visits, including any laboratory or radiology services;
31. Allergy shots;
32. Assistant surgeons;
33. Anesthesia;
34. Outpatient laboratory and radiology services;
35. Home health care;
36. Hospice care;
37. Bereavement counseling, up to six visits, when part of hospice care;
38. Wig after chemotherapy;
39. Occupational and speech therapy;
40. Podiatric services;
41. Sterilizations;
42. Alternative medicine services, but only in those states where alternative medicine providers are licensed;
43. Pap smear once per year;
44. PSA test once per year;
45. Charges for a licensed rehabilitation facility, provided that inpatient services are covered only to the extent that such services cannot be provided on an outpatient basis,

46. Charges related to substance abuse, chemical dependency and alcoholism, and
47. Charges related to mental disorders.

Major Medical Exclusions and Limitations

No benefits will be payable for anything excluded under the General Exclusions and Limitations as set forth below.

PREVENTIVE CARE/ROUTINE PHYSICAL EXAM BENEFIT

If you incur expenses for a routine physical performed by a Physician or other routine preventive care, the Plan will pay 100% of covered charges up to the annual maximum for Essential Health Benefits set forth in the Schedule of Benefits.

Preventive Care/Routine Physical Exam Covered Expenses

Covered physical examination expenses include the following expenses that you incur:

1. Complete physical examination;
2. Complete medical history;
3. Complete blood count;
4. Urinalysis;
5. Complete blood chemistry including sugar, nitrogen and protein;
6. Electrocardiogram;
7. Electroencephalogram;
8. Chest x-rays;
9. Immunizations (including but not limited to immunizations against the HPV virus and/or cervical cancer); and
10. Colonoscopy.

Covered preventive care and physical examination expenses also include the following services as set forth on the governmental website www.healthcare.gov:

Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin use for men and women of certain ages
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk

- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Tetanus, Diphtheria, Pertussis
 - Varicella
- Obesity screening and counseling for all adults
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users
- Syphilis screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breast Feeding interventions to support and promote breast feeding
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Folic Acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Syphilis screening for all pregnant women or other women at increased risk

Covered Preventive Services for Children

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders

- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns
- Height, Weight and Body Mass Index measurements for children
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - Diphtheria, Tetanus, Pertussis
 - Haemophilus influenzae type b
 - Hepatitis A
 - Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for all children

Physical Exam Exclusions and Limitations

The Plan will not pay benefits under the Routine Physical Exam Benefit for any:

1. Eye examinations for the purpose of prescribing corrective lenses; or
2. Any dental examination.

VOLUNTARY STERILIZATION BENEFIT

The Plan pays up to the amounts shown in the Schedule of Benefits above with respect to Physician's charges, and in-patient and out-patient hospital charges and other medical expenses in connection with voluntary sterilization (i.e., vasectomy and tubal ligation).

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Plan provides an Employee Assistance Program (EAP) that is available at no cost to you or your Dependents. The EAP offers confidential services for help with stress, anxiety, depression, marital, relationship, or family difficulties, parenting concerns, child and elder care, alcohol or drug dependency, compulsive gambling, and legal or financial problems. The number of counseling sessions available per year is set forth in the Schedule of Benefits.

You can receive your initial consultation over the telephone. If face-to-face counseling is required, you can be referred to a location near your home or work. The counselors will also be able to provide information on community resources for elder and child care, self-help groups such as Alcoholics Anonymous or Gamblers Anonymous, and community financial and legal services for debt management.

The Plan has contracted with an EAP Provider (identified below in the “Administrative Information About the Plan” section) to provide EAP services. The Fund Office will not have access to your records, which will remain strictly confidential under the terms of the EAP contract.

Professional counselors are available 24 hours a day by calling the EAP Provider. The EAP Provider also can be reached at its online website. See the “Administrative Information About the Plan” section below for the EAP Provider’s contact information. For more information about the EAP, see also the brochure provided by the EAP Provider.

GENERAL EXCLUSIONS AND LIMITATIONS

The Plan will not pay benefits for any of the following:

1. Injury or Sickness that arises out of or in the course of your employment or for which you receive compensation under any workers' compensation or occupational disease act or law (but the Plan may pay benefits for claims for which you may eventually receive workers' compensation provided that you sign a subrogation and reimbursement agreement and otherwise comply with the subrogation requirements set forth in the Subrogation section below);
2. Expenses that are caused by declared or undeclared war or act of war (but expenses which are caused by a terrorist act are covered);
3. Expenses that are not approved by a Physician;
4. Expenses that do not relate to Necessary Treatment;
5. Charges above the Usual and Customary Charge;
6. Experimental or Investigative treatment, procedures or medications;
7. Cosmetic surgery, except that the following are covered by the Plan:
 - a. Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other disease of the involved part;
 - b. Reconstructive surgery in connection with a mastectomy (as described above under "Covered Major Medical Expenses"); or
 - c. Reconstructive surgery to correct a congenital disease or anomaly;
8. Eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses, except as provided under the Plan's Vision benefits;
9. Glasses, hearing aids, or contact lenses except contact lenses when required because of surgery or as provided under the Plan's Vision benefits;
10. Charges made by a health care provider who is related to or living with the person requiring treatment;
11. Any period of Custodial Care confinement in a Hospital or skilled nursing facility;
12. Treatment of infertility, i.e., in vitro, GIFT, etc., or expenses incurred as the result of artificial insemination or similar fertilization methods;

13. Dental work, Temporomandibular Joint (TMJ) Disorder, orthognathic treatment, or oral surgery, except as otherwise specified or except surgery for:
 - a. Excision of completely unerupted impacted teeth;
 - b. Extraction of teeth root without extraction of entire tooth;
 - c. Closed or open reductions of fractures or dislocations of the jaw;
 - d. Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction of teeth; and
 - e. Treatment of a “severe dental condition” as described below under “Dental Benefits.”.

For the purposes of oral surgery, the term Physician will be deemed to include a Dentist.

14. Reproductive enhancement;
15. Genetic manipulation including genetic testing (except that testing shall be covered to extent it is considered Necessary Treatment for purposes of diagnosing disease or determining the course of treatment);
16. Home births;
17. Reversals of sterilizations;
18. Abortion charges, except (a) with respect to medical treatment for post procedure complications, or (b) when the life of the mother would be endangered;
19. Treatment for obesity (except screening and counseling as specified in the Preventative Care benefit), including charges related to gastric bypass, lap band, or other weight-loss surgery, or the complications thereof;
20. Charges incurred for or in connection with treatment of a Preexisting Condition with respect to any individual age 19 or older for the first twelve consecutive calendar months that the Employee works for a Contributing Employer, except to the extent that the twelve-month period is reduced by the number of days of prior creditable coverage as described in the section below entitled Preexisting Conditions Exclusion;
21. Treatment for Injuries that are intentionally self-inflicted unless arising out of a medical condition (such as, but not limited to, depression) regardless of whether the medical condition was diagnosed prior to the Injury;
22. Treatment for Injuries incurred in the course of committing a crime that (i) involves an intent to physically harm others, (ii) leads to a criminal charge or

indictment, and (iii) ultimately results in a criminal conviction (following a criminal charge or indictment, the Plan will deny claims, but if the criminal charges later are dismissed or you are not convicted, you may request that the claims be reconsidered); and

23. Charges that would not have been made if no coverage existed, or charges that you are not legally obligated to pay.
24. Charges with respect to an otherwise eligible Dependent in the event that the amount of benefits s/he is eligible to receive under any other plan(s) which covers him/her as an employee differs from the level of benefits provided to any other participant in that plan who does not have dependent health insurance coverage under another plan (such as this Plan) (applies only if Dependent's employer's plan attempts to limit amount of benefits it pays because of coverage under the Plan; if 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, this exclusion will not apply).

PREEXISTING CONDITIONS EXCLUSION

The Plan imposes a Preexisting Condition exclusion. That means that if you or a Dependent has a medical condition before joining the Plan, you or your Dependent might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to Preexisting Conditions, defined as conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the previous 6-month period. Generally, this 6-month period ends the day before the first day that you begin work for a Contributing Employer. Genetic information will not be considered a Preexisting Condition. In addition, for the purpose of this definition, medical advice, diagnosis, care or treatment is taken into account only if it is recommended by or received from an individual licensed or similarly authorized to provide such services under the applicable state law and who is operating within the scope of practice authorized by such state law.

The Preexisting Condition exclusion does not apply to pregnancy or to any individual under age 19. The exclusion also does not apply to any other Dependent who becomes your Dependent after you become covered under the Plan.

This exclusion may last up to 12 months from the first day of your employment with a Covered Employer. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.

To reduce the 12-month exclusion period by your creditable coverage, you should give the Plan a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a HIPAA Certificate, but you do have prior health coverage, the Fund Office will help you obtain a HIPAA Certificate from your prior plan or issuer. There are also other ways that you can show that you have creditable coverage. Please contact the Fund Office if you need help demonstrating creditable coverage.

Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator to determine its authenticity. In reviewing the HIPAA Certificate, the Plan Administrator may consult the prior plan administrator or insurer. Submission of a fraudulent HIPAA Certificate may be considered a federal health care crime under HIPAA and be punishable by fine and/or imprisonment.

If it is determined that the Plan's Preexisting Condition exclusion will apply to you or a Dependent, the Fund Office will notify the individual in writing within a reasonable time following the receipt of the HIPAA Certificate or other evidence of coverage that the Plan's Preexisting Condition exclusion will apply and the length of time the exclusion period will be imposed.

The Preexisting Condition exclusion described here applies only to you and your Dependents when you become covered for the first time under the Plan. If you lose and regain eligibility under the Plan, the Preexisting Condition exclusion will not apply.

PRESCRIPTION DRUG BENEFIT

If you incur an expense for covered prescription drugs, the Plan will pay benefits as shown in the Schedule of Benefits. Prescription Drug benefits currently are provided through a contract with the Plan's Prescription Benefit Manager, as identified in the "Administrative Information About the Plan" section below. You may contact the Prescription Benefit Manager for a listing of participating pharmacies, which will be provided to you free of charge by calling the phone number listed in the "Administrative Information" section at the end of this document. You may also request mail order envelopes from the Fund Office. Additional information about your benefits is also available at the Prescription Benefit Manager's website as listed in the "Administrative Information" section.

Retail Pharmacy Program

In order to receive retail pharmacy benefits from the Plan you must:

- Use a pharmacy that is part of the Prescription Benefit Manager's network;
- Present your Prescription Drug identification card when you go to the pharmacy to fill your prescription; and
- Pay your copayment for your prescription.

If you use a pharmacy that is not in the network, you must pay the cash price for your prescription. You may then submit a direct paper claim to the Claims Administrator at the address and phone number provided in the "Administrative Information" section below. Your claim will be processed as though you paid the discounted price, minus your copayment.

Mail Order Pharmacy Program

If you are taking maintenance medications on a long-term basis, you may use the Prescription Benefit Manager's mail order program in order to reduce your costs. To use the mail order program, you should contact the Fund Office to request a mail order envelope. When your Physician prescribes a prescription for maintenance medication, you should complete the mail order form and send it along with your prescription and copayment as instructed on the mail order envelope.

It may take up to two weeks for the Prescription Benefit Manager's mail order program to fill your mail order prescription. If you need to start taking your medication right away, ask your Physician for two prescriptions – one for a short-term supply that you can fill immediately at a Prescription Benefit Manager's network pharmacy and one for a long-term supply that you can order through the Prescription Benefit Manager's mail order program.

Covered Prescription Drug Expenses

The Plan covers prescription drugs that are approved by the Food and Drug Administration (including Federal legend drugs) that your doctor prescribes as a medically Necessary Treatment of an Illness or Injury.

Prescription Drug Exclusions and Limitations

In addition to the General Exclusions and Limitations set forth above, prescription drug benefits are not provided for any of the following:

- Over-the-counter medications and items lawfully obtainable without prescription.
- All non-sedating antihistamines including but not limited to Allegra, Allegra-D, Zyrtec, Zyrtec-D, and Clarinex and any other prescription drugs that are therapeutically equivalent to over the counter Claritin.
- All proton pump inhibitors (PPIs), including Prilosec, Omeprazole, Nexium and Prevacid and any other prescription drugs that are therapeutically equivalent to over the counter Prilosec shall only be covered for 90 days, unless preauthorized by the Fund's Prescription Benefit Manager. Use of a PPI will be authorized if the patient's condition is effectively treated by such PPI and similar results are not obtained from the use of OTC Prilosec.
- Any charge where the Usual and Customary Charge is less than your copayment.
- Any charge above the lowest of the Usual and Customary, advertised, or posted charge.
- Any charge for the administration of a drug or insulin.
- Any unauthorized refills.
- Prescriptions covered without charge under federal, state or local programs, including workers' compensation.
- Medication while you are confined to a rest home, nursing home, sanitarium, extended care facility, Hospital or similar entity.
- Experimental or Investigative drugs, including medicines that:
 - Have not been recognized as an acceptable medication because their effectiveness has not yet been proven,
 - Are still in a trial use primarily in a research setting,
 - Have not received required governmental approval as treatment for the prescribed purpose, or

- Are not appropriate, based on the advanced stage of the patient's condition.

DENTAL BENEFIT

The Plan covers your expenses for dental services when they are performed or prescribed by a licensed Dentist and are Necessary Treatment and customary as determined by the standards of generally accepted dental practice. The Plan will pay up to the maximum amounts shown in the Schedule of Benefits in accordance with the provisions of this section.

Covered Dental Benefits

For purposes of determining whether an expense is incurred during a period of eligibility, Covered Charges for dental expenses will be considered to be incurred on the date noted below.

1. For appliances or a modification of appliances, on the date the master impression is made;
2. For a crown, a bridge or inlay or onlay restoration, on the date the tooth or teeth are prepared;
3. For root canal therapy, on the date the pulp chamber is opened;
4. For all other charges, on the date service is rendered or a supply furnished.

Schedule of Dental Procedures

The following is a representative list of dental procedures covered under the Dental Benefit. For covered procedures not listed, the amount allowable will be determined on the basis of comparative similarity with the listed procedures. See the section entitled "Schedule of Benefits" for more information regarding amount of coverage and applicable limits.

Class A Services - Preventive

• Routine oral examinations, two per calendar year	• Cleaning (prophylaxis), two per calendar year
• Emergency oral examinations	• Emergency pain relief
• Bitewing x-rays, two per calendar year	• Space maintainers for children to age 16
• Full-mouth x-rays, once every 36 months	• Fluoride, topical for children to age 18
• Other diagnostic x-rays	• Harmful Habit Appliance for children to age 16
• Sealants for children to age 14	• Diagnostic Casts
• Consultations	• Biopsy and examination of tissue

Class B Services – Basic/Minor Restorative

• Fillings(amalgam, resin, etc.), other than gold	• Injectable antibiotics
• Pins, posts and buildups for fillings	• Oral Surgery
• Simple extractions of erupted non-impacted teeth	• General Anesthesia, as medically necessary
• Recementing/repair of crowns, onlays & inlays	• Endodontics, including root canal treatment
• Denture relining and rebasing	• Periodontics
• Tissue conditioning	• Surgical extractions of erupted teeth
• Occlusal adjustments	• Extractions of tissue or partially impacted teeth
• Occlusal and Bruxism appliances	

Class C - Major Restorative

• Gold fillings, onlays or inlays	• Precision attachments to dentures
• Crowns, including posts and buildups	• Dentures, full or partial (removable and fixed)
• Bridges (removable and fixed)	• Recementing and repair of prosthodontics
• Addition of tooth to a bridge or denture	• TMJ treatment

Class D - Orthodontia

• Orthodontia	
• Dental (tooth) implants	

Dental Exclusions and Limitations

In addition to the General Exclusions and Limitations set forth above, the Plan will not pay benefits for any of the following:

1. An Injury or Sickness that arises out of or in the course of your employment for which you receive compensation under any workers’ compensation or occupational disease act or law (but the Plan may pay benefits for claims for which you may eventually receive workers’ compensation provided that you sign a subrogation and reimbursement agreement and otherwise comply with the subrogation requirements set forth in the Subrogation section below);
2. Any charges caused by declared or undeclared war or act of war;
3. Any charges for any dental services and supplies that are included as covered medical expenses under any other provisions of this Plan or under any comprehensive medical or major medical expense benefits plan carried or

sponsored by the Employer or the Welfare Fund, whether benefits are payable for all or only part of such charges;

4. Any charges for prosthetic devices (including bridges and crowns) and the fitting thereof that were ordered before you were covered under the Plan or that were ordered while you were covered under the Plan, but are finally installed or delivered more than 90 days after your coverage terminates;
5. Any charges for treatment other than by a Dentist, except for cleaning or scaling of teeth, which may be performed by a licensed dental hygienist if such treatment is rendered under the supervision and direction of the Dentist.
6. Any charges for replacement of an existing partial or full removable denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, unless evidence satisfactory to the Fund is presented that:
 - a. The placement or addition of teeth is required to replace one or more additional natural teeth extracted after the existing denture or bridgework was installed; or
 - b. The existing denture or bridgework was installed at least 5 years before its replacement and the existing denture or bridgework cannot be made serviceable; or
 - c. The existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within 12 months from the date of installation of the immediate denture;
7. Any charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures; or
8. Any charges for the replacement of a lost or stolen prosthetic device;
9. Any charges for any services or supplies that are for orthodontic treatment (including correction of malocclusion), except as specifically provided for in the Schedule of Dental Procedures; and
10. Any charges for items excluded in the section regarding General Exclusions and Limitations

Severe Dental Conditions

Dental services described in Classes A, B, and C generally are subject to an annual maximum as set forth in the Schedule of Benefits. However, if you can show that you have a dental condition that is so severe that it is leading to medical deterioration, the Plan will pay an additional benefit up to a lifetime maximum as set forth in the Schedule of Benefits for expenses related to this condition for one course of Necessary Treatment in order to permit expeditious completion of

major dental treatment necessary to restore your overall health. You will be responsible for paying the balance of charges to treat your condition. Such severe medical deterioration generally results from developmental abnormalities, severe generalized attrition and/or abrasion or severe alveolar ridge resorption. The lifetime maximum for severe dental conditions does not apply to individuals under the age of 19; instead these charges are subject to the Plan's overall annual maximum applicable to Essential Health Benefits.

This benefit is subject to all other Plan exclusions, limitations and coinsurance, as well as other dental plan provisions. This benefit is in addition to the annual calendar year maximum benefit (which is imposed only on adults age 19 and over) that is provided under the Plan's dental expense program.

To receive these benefits, you must meet the following conditions:

1. You must submit the proposed treatment to the Claims Administrator for predetermination of benefits before you receive the services, including pretreatment x-rays, tests and other materials and reports needed for the Fund's dental consultant to evaluate your condition;
2. Treatment must meet generally accepted standards of dental care and be listed in the American Dental Association CDT-3 (or higher) code of dental procedures and nomenclature;
3. The following must be substantiated, in the opinion of the Fund's dental consultant:
 - a. The proposed treatment cannot be reasonably performed over multiple benefit years;
 - b. The treatment is not experimental in nature and is reasonably expected to maintain and be functional for a minimum period of five years; and
 - c. There is a high probability that irreversible medical deterioration could result to you if the proposed treatment is not completed within a reasonable period of time.
4. The Plan reserves the right to review all pertinent records and to have you examined by an independent dentist chosen by the Plan; and
5. The Fund's dental consultant will have the right to adjust benefits based on the cost of an alternative treatment that meets generally accepted standards of dental care. This cost information will be used solely to determine benefits that may be applied toward the cost of any other treatment that meets generally accepted standards of care agreed to by you and your dentist.

Pre-Determination of Dental Benefits

If you and your Dentist reasonably expect your course of treatment to involve Covered Charges of \$300 or more, you or your Dentist should file a description of the procedures to be performed and an estimate of the Dentist's charges with the Claims Administrator before treatment begins. The Plan will pay an amount equal to that applicable for the generally accepted treatment method that, in its sole judgment, will provide you with adequate dental care at the lowest cost to you. In determining the amount of benefits, the Claims Administrator will be guided by nationally established standards of the dental profession.

The Claims Administrator will notify you and/or your Dentist of the benefits that it certifies as payable based upon the course of treatment, subject, however, to any limitation on the payment of benefits if coverage should terminate. In determining the amount of benefits payable, the Claims Administrator will consider alternate procedures, services, materials, or courses of treatment that may be performed for the dental condition involved in order to accomplish a satisfactory result.

Alternate Courses of Dental Treatment

Due to the element of choice involved in the utilization of many dental services, situations frequently arise where there are two or more alternate methods of treatment for a particular dental condition.

If an alternate service is used to treat a dental condition, Covered Dental Charges will be limited to the charges for that service that:

1. Is customarily employed nationwide in the treatment of the condition; and
2. Is recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice, taking into account your total current oral condition.

The purpose of this Plan provision is to define the level of dental care upon which benefits are based when alternative methods of treatment may be used.

VISION CARE

The Plan will pay benefits when you incur expenses for vision care up to the maximum amounts listed in the Schedule of Benefits (except that the maximum amount does not apply to coverage for individuals under the age of 19 instead; these charges are subject to the Plan's overall annual maximum applicable to Essential Health Benefits) and according to the provisions of this section. Discounts may be available for coverage received from Network providers.

Covered Vision Care Charges

Covered Charges for Vision Care include:

1. Charges for Vision Screening and Analysis, limited to one per calendar year. "Vision Screening and Analysis" consists of any one or more of the following:
 - a. Checking the principal vision functions;
 - b. Determining the ability and condition of vision;
 - c. Completing a case history;
 - d. Refraction;
 - e. Measuring and recording of visual acuity, corrected and uncorrected; and
 - f. Determining the prescription (if needed);
2. Charges for frames or a replacement, if prescribed; and
3. Charges for prescription lens/lenses (including sunglasses), if prescribed.

Any exam must be performed and covered supplies must be prescribed by a duly licensed optometrist or ophthalmologist, acting within the scope of his or her license.

Vision Care Exclusions and Limitations

In addition to the General Exclusions and Limitations listed previously, the Vision Care benefit does not include benefits for any of the following:

1. Surgical care (except for Lasik surgery) or medical care for treatment of eye disease and/or Injury;
2. Treatment related to an Injury or Sickness that arises out of or in the course of your employment for which you are compensated under Worker's Compensation or Occupational Disease Act or Law;
3. Treatment related to an Injury or Sickness that arises out of or in the course of a declared or undeclared war or act of war;

4. Vision Care services or supplies received from a medical department maintained by:
 - a. a mutual benefit association;
 - b. the union or another labor organization;
 - c. a Trustee;
 - d. an Employer; or
 - e. a similar group;
5. Orthoptics, vision training or aniseikonia;
6. Expenses incurred for cosmetic or fashion reasons (i.e., tinting of glasses, extra thin lenses, etc.)

Any exam must be performed and covered supplies must be prescribed by a duly licensed Optometrist or Ophthalmologist, acting within the scope of his or her license.

The Plan will not pay benefits for any expenses you incur after the date your coverage terminates. However, benefits will be paid for lenses and/or frames if:

1. Prescribed before termination of coverage; and
2. Received by you within 60 days after termination of coverage.

HEALTH REIMBURSEMENT ACCOUNT BENEFIT

The Plan has established a Health Reimbursement Account to reimburse you for certain out-of-pocket “Qualifying Health Care Expenses” (defined below).

Crediting of Your Health Reimbursement Account

Effective June 1, 2010, an amount equal to \$.50 for each hour you work on or after June 1, 2010, shall be credited to your Health Reimbursement Account. Credits will be issued regardless of whether you are eligible for any other benefits offered by the Fund. However, credits will not be issued until contributions with respect to those hours have been made by the Contributing Employer and received by the Fund. (Credits to the accounts of those individuals receiving reciprocity credit for service in a different Iron Workers union jurisdiction will be adjusted to reflect any difference in the contribution rate.) The amount credited shall be available to reimburse Qualifying Health Care Expenses incurred on or after January 1, 2011. A debit card will not be issued until your account balance equals or exceeds \$50. You will not be entitled to any earnings (such as interest) on the money credited to the Health Reimbursement Account, nor will you be subject to losses.

The Health Reimbursement Account also may be credited as a result of hours transferred to the Fund from another jurisdiction. However, the allocation to the Health Reimbursement Account with respect to reciprocity credit will be adjusted on a pro rata basis to reflect any difference in the contribution rate. For example, if the contribution rate in another Iron Workers union jurisdiction is 80% of the rate paid under the collective bargaining agreement with the Structural Iron Workers Local # 1, then you will receive hours credit at the rate of 80% (meaning every hour worked is counted as .8) and 80% of fifty cents (in other words, forty cents) would be allocated to the Health Reimbursement Account per hour worked.

Eligible Expenses: Qualifying Health Care Expenses

Only those expenses which are “Qualifying Health Care Expenses” are eligible for reimbursement. “Qualifying Health Care Expense” means certain medical expenses incurred and paid by you or your covered spouse or dependent children on or after January 1, 2011, for medical care as defined in section 213(d) of the Internal Revenue Code (including amounts paid for health plan deductibles, co-payments, hospital bills, doctor and dental bills, and drugs, and amounts exceeding health plan maximums for certain types of expenses), but only to the extent that you are not otherwise reimbursed or entitled to reimbursement for the expense from the Fund, another health plan, insurance policy, or otherwise.

Additionally, “Qualifying Health Care Expenses” include expenses incurred for:

- Over-the-counter drugs and products such as antacids, allergy medicines, pain relievers and cold medicines, *provided that you or your covered spouse or dependent has a prescription for such over-the-counter drugs and medicines* (except that no prescription is required for insulin), and, with respect to the payment of such expenses by use of the debit card, subject to the retailer having an approved merchant code and inventory control system.

- Long-term care insurance premiums,
- COBRA premiums, and
- Premiums paid to participate in the Retiree Health Program.

"Qualifying Health Care Expense" does not include any expense incurred for qualified long-term care services, charges for failure to pre-certify hospital admissions or other services as required, or the emergency room deductible applied if not admitted to the Hospital.

Claims for Reimbursement

Once your Health Reimbursement Account balance equals or exceeds \$50, for the first time, you may access funds in the Health Reimbursement Account on or after January 1, 2011, by paying for covered expenses utilizing a debit card. Debit cards began to be issued starting in December of 2010. A second debit card has been or will be provided if you have covered dependents. Your debit card(s) will remain active until your Health Reimbursement Account balance reaches zero and has remained at a zero balance for six months. Thereafter, a new card(s) will be issued if and when your Health Reimbursement Account balance once again reaches \$50. Please contact the Fund Office immediately if your debit card is lost or stolen.

If your debit card is not active or is rejected or if you are seeking reimbursement for claims incurred at a time when you had insufficient funds available through your debit card, you may apply in writing to the Claims Administrator for reimbursement of Qualifying Health Care Expenses provided that your Health Reimbursement Account balance has reached \$50 (even if it no longer equals this amount). Written claim statements must be in such form as the Plan Administrator may prescribe, and should set forth:

1. the amount, date and nature of each expense with respect to which a benefit is requested;
2. the name of the person, organization or entity to which the expense was paid and evidence of such payment, such as a receipt;
3. the name of the person for whom the expense was incurred and paid, and, if such person is not you, the relationship of such person to you;
4. the amount recovered from the Fund or from any other health plan or insurance arrangement, with respect to the expense; and
5. a statement that the claimed expense has been paid by you or your covered spouse or dependent child and has not been reimbursed and is not reimbursable under any other health plan or insurance.

You must include with any claims a written receipt or other documentation showing that the expense has been incurred and paid, the date(s) of such treatment and the amount of the expense, and/or such other documents that the Claims Administrator or the Fund Office may request. With respect to any claim paid directly by means of the debit card, you must maintain records of

all of the above information and be prepared to submit it, together with supporting documentation, to the Claims Administrator or the Fund Office for verification upon request.

In the event of your death, your spouse (or, if none, your estate's executor or administrator) may apply on your behalf for reimbursements.

In most cases, any fees associated with the debit card will be borne by the Fund. However, you will be obligated to pay a \$3.00 monthly maintenance fee (subject to adjustment as determined by the Plan Administrator) beginning six months after you lose eligibility for the other group health benefits offered by the Fund.

To the extent that you have sufficient funds in your Health Reimbursement Account, the Fund shall start issuing reimbursements on January 1, 2011, for Qualifying Health Care Expenses provided you submit your claim as set forth above.

Rollover of Health Reimbursement Account Balance

If any balance remains in your Health Reimbursement Account for a calendar year, such balance shall be carried over to reimburse you for Qualifying Health Care Expenses incurred during subsequent calendar years. Conversely, amounts credited to your Health Reimbursement Account during a subsequent calendar year may be used to reimburse expenses incurred during the prior calendar year, provided that the expense was incurred on or after the date that you first were credited with an hour of work.

Termination and Continuation of Coverage

You may continue to be reimbursed for Qualifying Health Care Expenses from the Health Reimbursement Account for so long as there is money in the Health Reimbursement Account even after your eligibility to receive other benefits offered by the Fund otherwise terminates. Additionally, if you die with a positive account balance, your spouse may continue to submit claims with respect to you, him/herself and any dependent children for up to six months following your death. If you are not married at the time of death, the remaining balance in the Health Reimbursement Account (if any, after expenses that were incurred prior to your death have been paid) will be split between any dependent children, and they may continue to submit claims for up to six months following your death. If you have no surviving spouse or dependent children, or if your survivors do not use up the available funds, the remaining balance is forfeited and reverts back to the Plan to be used to fund other Plan benefits.

If you have terminated employment or retired, the debit card(s) will be deactivated six months after termination of employment if (1) there is a zero balance, or (2) there have been no new contributions into the Health Reimbursement Account for a six-month period after loss of other Fund coverage. Active participants who do not accrue hours for six months and whose debit card(s) is deactivated, will not have the debit card(s) reactivated until the Health Reimbursement Account balance once again reaches \$50. Participants that continue to have amounts credited to their Health Reimbursement Account will continue to be able to use their debit card.

A participant whose debit card has been deactivated will be able to file paper claims with the Claims Administrator.

Amendment or Termination of Health Reimbursement Account Benefits

As is the case with any other Fund benefit, the Health Reimbursement Account is not a vested benefit and the Board of Trustees reserves the right to modify or terminate the benefits provided under the Health Reimbursement Account at any time for any reason. Any portion of your Health Reimbursement Account that is not used prior to such modification or termination of benefits will remain available to reimburse Qualifying Health Care Expense indefinitely.

For More Information

If you have questions about the Health Reimbursement Account, please contact the Claims Administrator.

HEARING AID BENEFIT (FOR ACTIVE EMPLOYEE AND DEPENDENTS ONLY)

The Plan will pay expenses for a hearing examination or a hearing aid instrument that you incur up to the maximum amount shown in the Schedule of Benefits and in accordance with this section.

Covered Hearing Care Expenses

The following are covered hearing care expenses:

1. Examinations performed by a licensed otologist (M.D.) or licensed otolaryngologist (M.D.);
2. Audiometric testing by such licensed Physician or an audiologist who possesses a master's degree from an accredited university providing training in this field;
3. A hearing device (non-aural or bi-aural) prescribed by such licensed Physician.

Hearing Care Exclusions and Limitations

In addition to the General Exclusions and Limitations listed in this SPD, the Plan will not pay benefits for any of the following:

1. Hearing aids, examination and evaluation in excess of one per each ear per person during any 48-consecutive-month period;
2. Replacement of a hearing aid, except if the replacement involves a hearing aid that has been in use for 48 consecutive months and is replaced upon the written recommendation of a Physician certified as an otolaryngologist;
3. Charges for any services or supplies that are included as Covered Charges under the Major Medical Expense Benefit (as described above), whether payable as to all or only part of such charges;
4. Audiometric examinations and evaluations by an audiologist that are not ordered by an otologist or an otolaryngologist;
5. Medical or surgical treatment;
6. Drugs or other medications;
7. Audiometric examinations, hearing aid evaluation tests and hearing aids provided under any applicable workers' compensation law;
8. Audiometric examinations and hearing aid evaluation tests performed and hearing aids ordered:
 - a. Before you became eligible for coverage; or

- b. After your coverage terminated;
- 9. Hearing aids ordered while you were covered under the Plan, but delivered more than 60 days after termination of your coverage;
- 10. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids for which you are not charged or for which no charge would be made in the absence of this Hearing Aid Benefit coverage;
- 11. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids that are not Necessary Treatment, or which are not recommended or approved by the otologist or otolaryngologist;
- 12. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids received as a result of ear disease, defect or Injury due to an act of war, declared or undeclared;
- 13. Charges for audiometric examinations, hearing aid evaluation tests and hearing aids provided by any governmental agency that are obtained by you without cost by compliance with laws or regulations enacted by any federal, state, municipal or other governmental body;
- 14. Charges for any audiometric examinations, hearing aid evaluation tests and hearing aids to the extent benefits are payable for them under any health care program supported in whole or in part by funds of the federal government or any state or political sub-division thereof;
- 15. Charges for the completion of any forms;
- 16. Replacement parts for and repairs of hearing aids;
- 17. Eye-glass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one hearing aid.

LIFE INSURANCE

The Plan will pay Life Insurance benefits as shown in the Schedule of Benefits when the Fund Office receives written proof of your death or the death of your eligible Dependent. Proof must include a certified copy of the deceased individual's death certificate.

For purposes of this section only, all boldface terms will be defined as set forth in the life insurance and AD&D policy and/or booklet-certificate issued by the Life and AD&D Insurance Provider.

Funding for Life Insurance Benefits

The Life Insurance benefits provided by the Fund are insured through a group insurance contract with an insurance company, as identified below in the section entitled "Administrative Information About the Plan," (the "the Life and AD&D Insurance Provider"). The terms of this benefit are governed by the insurance policy and the booklet-certificate issued by the insurance company, and to the extent that there is any conflict between this SPD and those documents, the policy and/or the booklet-certificate control. (A copy of either the policy or the booklet-certificate will be provided to you.)

Life Insurance Beneficiary

You may designate a beneficiary to receive the life insurance benefit upon your death. Contact the Fund Office for the proper form. Each designation will revoke all prior designations. Your designation is effective as of the date of execution of the form, whether or not the covered individual is living at the time such form is filed, provided that the form is filed with the Fund prior to your death. The Trustees (and the Life Insurance Provider) are entitled to rely upon the designation of beneficiary form that is in the Fund's possession at the time that distribution is made. If you do not designate a beneficiary, or if your beneficiary dies before you, benefits will be paid to your estate, except that the Life Insurance Provider has the right instead to pay benefits at its option to your estate or to the first of the following to survive you:

- Your spouse,
- Your children in equal shares, or
- Your father or mother or to both parents if both survive you.
- Your siblings in equal shares, or
- The executor or administrator of your estate

Accelerated Benefit for the Terminally Ill

The Plan's Accelerated Death Benefit feature allows you to receive a partial life insurance benefit if you are:

- Diagnosed with a terminal illness and not expected to survive more than 24 months, or
- Diagnosed with one of the following medical conditions:
 - End state heart, kidney, liver and/or pancreatic organ failure and you are not a transplant candidate, or
 - A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a hospital or skilled nursing facility.

Important Reminder – You cannot request an Accelerated Death Benefit payment if you have assigned your life insurance benefits.

You can request up to the Accelerated Death Benefit percentage (75%) of the life insurance that is currently in effect for you. The amount you request cannot be less than \$5,000.

You may request and receive an Accelerated Death Benefit under this Plan only *once* on your own behalf.

To request the Accelerated Death Benefit, you must complete and submit to the Life and AD&D Insurance Provider a request form. The request form must include:

- The amount requested, and
- A **physician's** statement verifying that you are suffering from a non-correctable **terminal illness**, or, are suffering from one of the listed medical conditions that is expected to result in a drastically limited life span. The statement also must provide the following information:
 - All medical test results,
 - Laboratory reports, and
 - All supporting documentation and information on which the **physician's** statement is based.

Submit the form to the Life and AD&D Insurance Provider. The Life and AD&D Insurance Provider may, at its own expense, require you to submit to an independent medical exam by a **physician** it chooses. The Life and AD&D Insurance Provider will not process your Accelerated Death Benefit request until the exam has been completed and the Life and AD&D Insurance Provider has received the results.

The Life and AD&D Insurance Provider may stop processing your Accelerated Death Benefit request or refuse your Accelerated Death Benefit request if:

- The group life insurance policy terminates coverage for your eligible class before the Life and AD&D Insurance Provider approves your Accelerated Death Benefit request (even if all or part of your life insurance coverage continues for any reason),
- All of your life insurance coverage terminates under the group policy for any reason before the Life and AD&D Insurance Provider approves your Accelerated Death Benefit request, or
- You die before the Life and AD&D Insurance Provider issues the Accelerated Death Benefit payment.

If your request is approved, the Life and AD&D Insurance Provider will pay you the Accelerated Death Benefit in a lump sum.

The amount of your life insurance coverage will be reduced by the amount of the Accelerated Death Benefit payment.

An Accelerated Death Benefit payment affects the amount of life insurance you are eligible to convert to an individual policy. The converted amount will be limited to the reduced amount of life insurance after the Accelerated Death Benefit payment.

Refer to the life insurance and AD&D policy and/or booklet-certificate for more information about the conversion privilege.

To the extent allowed by law:

- Your Accelerated Death Benefit payment is exempt from any legal or equitable process for your debts, and
- You are not required to request an Accelerated Death Benefit in order to satisfy claims of creditors.

You should consider the tax consequences of requesting an Accelerated Death Benefit. Consult your counsel or tax advisor before proceeding with the request.

Dependent Life Insurance

Dependent Life Insurance is available as set forth in the Schedule of Benefits.

The definition of “Dependent Children” for purposes of Dependent Life Insurance is set forth in the life insurance and AD&D policy and/or booklet-certificate provided by the Life and AD&D Insurance Provider.

Benefits are payable to you, if you survive your child. Otherwise, the Life and AD&D Insurance Provider will pay the benefits, at its option, to either your surviving spouse or your estate.

The following dependents are *not* eligible for dependent life insurance:

- Full-time, active military personnel, and
- Children less than 14 days of age.

Life Insurance Limitations

The Life Insurance Benefit is subject to the Plan's General Exclusions and Limitations as set forth above.

**ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFIT
(CLASS 1 AND CLASS II EMPLOYEES ONLY)**

The Accidental Death and Dismemberment Insurance benefit currently is provided through a group insurance contract with an insurance company (the “Life and AD&D Insurance Provider”), as identified below in the section entitled “Administrative Information About the Plan.” The terms of this benefit are governed by the insurance policy and the booklet-certificate issued by the insurance company a copy of one or both will be or has been provided to you), and, to the extent that there is any conflict between this document and the insurance policy, the terms of the policy control.

For purposes of this section only, all boldface terms will be defined as set forth in the life insurance and AD&D policy and/or booklet-certificate issued by the Life and AD&D Insurance Provider.

The Accidental Death & Dismemberment (AD&D) Benefit outlined below is paid if you die, or suffer a covered loss solely and as a direct result of a bodily **injury** within 365 days of the **accident** causing the **injury**, the Plan will pay a benefit. The benefit is expressed as a percentage of the principle sum. The principle sum is the full benefit payable by the Plan. The following table defines the benefit payable for each type of loss.

For Loss Of:	AD&D Benefit:
Life	100% of principal sum
Both hands, both feet, entire sight of both eyes, or speech and hearing in both ears	100% of principal sum
Movement of both upper and lower limbs (quadriplegia)	100% of principal sum
Movement of both lower limbs (paraplegia) or both upper and lower limbs on one side of your body (hemiplegia)	50% of principal sum
One hand, one foot or entire sight of one eye	50% of principal sum
Speech or hearing in both ears	50% of principal sum
Movement of one limb (uniplegia)	25% of principal sum
Thumb and index finger of either hand	25% of principal sum

This benefit is in addition to any other benefits you may receive from the Plan. If you die, the benefit is paid to your beneficiary. Otherwise, the benefit is paid to you. The AD&D principal benefit amount is listed in the Schedule of Benefits.

Coma Benefit

The Plan will pay a monthly benefit if you suffer a bodily injury and are in a coma solely and as a direct result of an accident, if all of the following occur while covered by the Plan:

- The bodily injury is caused by a covered accident, and
- You become comatose within 30 days after the accident, and
- The coma is the direct result of your accident, and

- You remain continually comatose for at least 30 days in a row.

Written proof that you are in a **coma** must be provided to the Life and AD&D Insurance Provider within 60 days after the date you become **comatose**.

The first monthly benefit will be payable on the first day of the month following the date you have been in a **coma** for at least 30 days.

The Plan will pay a monthly benefit equal to:

- Your principal sum, minus
- Any other accidental death and personal loss payment the Plan makes or may make for injuries resulting from the same **accident** times the **coma** benefit percentage.

Your principal sum is the maximum payable for all the losses resulting from the same accident.

The monthly **coma** benefit is payable for 11 months. After you have been continually **comatose** for 12 months, the Plan will pay the remainder of the principal sum.

If the monthly payments are less than \$20 each, the payments will be paid in one lump sum on the first day of the month following the date you, have been continually **comatose** for 12 months.

The Life and AD&D Insurance Provider has the right to require proof that the **coma** continues. The Life and AD&D Insurance Provider may, at its own expense, examine you while **comatose**. The Life and AD&D Insurance Provider will not request an exam or proof more than twice in a 12-month period.

The monthly **coma** benefit is payable as long as the **coma** continues, until the earliest of the following occurs:

- You are no longer in a **coma** because you have died or recovered, or your condition has changed, as certified by a **physician**,
- The Life and AD&D Insurance Provider requests an exam, and it is not performed, or the results are not given to the Life and AD&D Insurance Provider,
- The Life and AD&D Insurance Provider is not given proof that the **coma** continues, or
- The Plan pays your principal sum in full.

The Plan will not pay a **coma** benefit if:

- No named beneficiary survives you,
- No beneficiary has been named,
- No immediate family member (your spouse, children, parents, and brothers and sisters) to whom the benefit may be paid, at the Life and AD&D Insurance Provider's discretion, survives you, and

- No guardian of the estate or conservator of the estate has been appointed.

Covered Loss	Percentage of the Principal Sum Paid By the Plan
Coma	5% of your principal sum per month payable for up to 11 months in a row
	45% of your principal sum if still comatose in month 12

Third Degree Burn Benefit

The Plan will pay a third degree burn benefit if:

- You suffer third degree burns solely and as a direct result of an **accident** covered by this Plan; and
- The **accident** occurs while you are covered by the Plan.

The benefit payable is based on the principal sum and the extent of the burns.

If the Third Degree Burn Covers:	the benefit payable is:
75% or more of your body	100% of your principal sum
50%-74% of your body	50% of your principal sum

Proof of the nature and extent of the burns must be submitted to the Life and AD&D Insurance Provider.

The principal sum is the maximum payable for all losses occurring to one person as the result of the same **accident**.

If you later die as the result of the same **accident**, the accidental death and personal loss Plan death benefit will be:

- Your principal sum, *minus*
- Any amount already paid by the Plan for the same **accident**.

Total Disability Death Benefit

The Plan will pay a benefit equal to the principal sum if:

- You become totally disabled solely and as a direct result of a bodily **injury**,
- You remain continuously disabled from the date of the **accident** until your death, and

- You die while you are covered by the Plan.

For purposes of this benefit provision, you are totally disabled if:

- You are not able to work at your own job;
- You are not able to work at any other job for pay or profit; and
- You are under age 60 at the time of the **accident**.

The Life and AD&D Insurance Provider must be notified of your death within 12 months of the date of your death. The payment will be issued to your beneficiary. The amount of the payment will be reduced by any other AD&D Insurance Benefit the Plan makes for the same **accident**.

Additional Benefits Under the AD&D Insurance Benefit

This section describes additional losses that may be covered by the AD&D Insurance Benefit if the losses are solely and as a direct result of an **accident**. You must be covered by the Plan at the time of the accident that causes the loss and the loss must occur within 365 days of the **accident**.

Passenger Restraint and Airbag Benefit

The Plan will pay a **passenger restraint** benefit if:

- You are the driver of, or a passenger in, a **motor vehicle**, and
- The **motor vehicle** is involved in an **accident**, and
- You die as a direct result of the **motor vehicle accident**, and
- Death occurs within 365 days of the **accident**, and
- You were properly using a **passenger restraint** at the time of the **accident**, and
- The driver of the **motor vehicle** in which you were traveling had a valid **motor vehicle** license at the time of the **accident**.

The Plan will also pay an **airbag** benefit if:

- An **airbag** is activated as the result of the same **motor vehicle accident**, and
- The **airbag** system does not save the life of the person it was designed to protect.

The Plan will pay the **airbag** benefit only if you are properly using a **passenger restraint** at the time of the **accident**.

The benefit payable depends on whether you were using a **passenger restraint** properly at the time of the **accident** and whether the **airbag** deployed:

At the time of the accident, if	...and the Airbag	...the Plan will pay:
--	--------------------------	------------------------------

you:		
Used the passenger restraint properly,	Deployed,	Passenger restraint benefit; and Airbag benefit.
Used the passenger restraint properly,	Did not deploy,	Passenger restraint benefit.
Did not use the passenger restraint properly,	Deployed,	No benefit.
Did not use the passenger restraint properly,	Did not deploy	No benefit.

The Life and AD&D Insurance Provider must receive verification that:

- You were using the **passenger restraint** system at the time of the **accident**, and
- For the **airbag** benefit, the **airbag** system was activated by the **accident**.

The verification must be part of the official **accident** report or certified, in writing, by the investigating officer(s).

Refer to the *Schedule of Benefits* for the benefit payable.

Monthly Hospital Benefit

The Plan will pay a monthly hospital benefit if:

- You suffer a loss (other than loss of life) solely as a direct result of an **accident** covered by this Plan,
- You are confined in a hospital or **convalescent facility** for at least 30 days in a row as a result of the **accident**, and
- You are covered by the Plan at the time the **hospital** or **convalescent facility** stay begins.

The monthly hospital benefit is outlined in the Schedule of Benefits.

The first payment will be made after you have been hospitalized for 30 successive days. The Life and AD&D Insurance Provider must receive written proof of the confinement,

Subsequently monthly benefit payments will be calculated by multiplying:

- The number of days you are in the **hospital**, times
- 1/30th of the monthly benefit.

A person may be discharged from the **hospital** or **convalescent facility** after the treatment for a covered loss, then readmitted for the same cause. If this happens, the person's benefits will

depend on the amount of time that elapses between discharge and readmission, as shown in the following chart:

If readmitted to the hospital or convalescent facility for the same condition resulting from the same accident:	...the Plan will:	...benefits will:
Within 14 days of discharge,	Treat the second stay as the same period of confinement and	Continue as though there had not been a break in your stay.
More than 14 days after discharge,	Treat the second stay as a new period of confinement.	Not be paid until you have been confined in the hospital or convalescent facility for 30 days in a row.

You must give the Life and AD&D Insurance Provider proof that you or your covered dependent have been confined for 30 days in a row. If you are unable to submit the claim, another person may act on your behalf. After the first month, you or your representative must give the Life and AD&D Insurance Provider proof within 30 days of each successive 30 day period of **hospital** confinement. The deadline for filing a claim is 90 days after you or your covered dependent are discharged from the **hospital** or **convalescent facility**. If you cannot meet the claim filing deadline through no fault of your own, the Life and AD&D Insurance Provider will accept your claim if you file it as soon as possible. The Life and AD&D Insurance Provider will not accept a claim more than one year from the claim filing deadline, unless you are legally incapacitated.

The Plan will continue to pay benefits until the earliest of the following occurs:

- The date you are discharged from the **hospital**,
- The date 12 monthly payments have been made, or
- The date the group policy terminates.

Medical Coverage Funding Benefit

The Plan will pay a medical coverage funding benefit to your dependents if:

- You die solely and as a direct result of an **accident** covered by the Plan, and
- The **accident** occurs while you are covered by the Plan, and
- Your death occurs within 365 days of the **accident**, and
- Your dependent continues medical coverage under the Plan, in accordance with:
 - The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) or state law, and

- Makes an out-of-pocket contribution toward the cost of such medical coverage.

Refer to the *Schedule of Benefits* for the Medical Coverage Funding Benefit Payable.

Proof of the out-of-pocket expenses for the medical coverage must be submitted to the Life and AD&D Insurance Provider.

If the total value of the medical coverage funding benefit is less than \$250, the Life and AD&D Insurance Provider may make a lump sum payment.

The Life and AD&D Insurance Provider will issue payment to your surviving spouse. If your spouse does not survive you the Life and AD&D Insurance Provider will issue the payment to your surviving child or children. If a dependent child is a minor, the Life and AD&D Insurance Provider will issue payment to:

- The guardian of the estate of the minor,
- The custodian under the Uniform Transfer to Minors Act, or
- The adult caretaker/legal guardian, as permitted under state law.

The Plan will continue to pay benefits until the earliest of the following occurs:

- Three years from the date of your death,
- The date your last surviving dependent dies, or
- The date the group policy terminates.

Rehabilitation Training Benefit

The Plan will pay a benefit if:

- You suffer a loss (except loss of life) solely and as a direct result of an **accident** covered by the Plan, and
- The **accident** occurs while you are covered by the Plan, and
- You enter a rehabilitation training program within 90 days after the loss.

The rehabilitation training program is designed to help you return to work at your occupation with your policy holder.

You must complete the program before payments are made.

The benefit payable is expressed as the expenses you incur for the program.

Refer to the Schedule of Benefits for the benefit payable.

You must complete the rehabilitation training program within 2 years following the **accident** that caused the loss.

The Life and AD&D Insurance Provider will issue the rehabilitation training program benefit after you provide satisfactory:

- Proof that you have completed the program, and
- Documentation of your out-of-pocket expenses.

Adaptive Home and Vehicle Benefit

The Plan will pay a one-time adaptive home and vehicle benefit if:

- You suffer a loss (except loss of life) solely and as a direct result of an **accident** covered by this Plan, and
- The loss occurs within 365 days of the **accident**, and
- You are covered by the Plan at the time of the **accident**, and
- As a result of the loss, you alter your principal home and/or your personal **motor vehicle** to make them more accessible and easier to use.

The modifications to your principal residence and/or your personal motor vehicle must be performed by a person who is authorized to make such changes.

The Life and AD&D Insurance Provider will issue the payment for expenses you incur within one year from the later of:

- The date of the loss, or
- The date you are discharged from a **hospital** or **skilled nursing facility**.

The benefit payable is based on your principal sum and the expenses you incur for the modifications.

Refer to the Schedule of Benefits for the benefit payable.

You must give the Life and AD&D Insurance Provider proof of your out-of-pocket expenses for the modifications to your personal residence and/or your personal **motor vehicle**.

The Plan will not pay for the following:

- Charges that you are not legally obligated to pay,
- Charges that are covered under any other Plan covering you,

- Charges that are not necessary to make a home accessible or a vehicle usable as determined by the Life and AD&D Insurance Provider, and
- Charges that are made only because there is a benefit.

Exclusions That Apply to Accidental Death and Personal Loss

Not all events which may be ruled accidental are covered by this Plan. No benefits are payable for a loss caused or contributed to by:

- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo.)
- Bodily or mental infirmity.*
- Commission of or attempting to commit a felony.
- Illness, ptomaine or bacterial infection.*
- Voluntary inhalation of poisonous gases.
- Ligature strangulation resulting from auto-erotic asphyxiation.
- Intentionally self-inflicted **injury**.
- Medical or surgical treatment.*
- 3rd degree burns resulting from sunburn.
- Use of alcohol.
- Use of drugs, except as prescribed by a physician.
- Use of intoxicants.
- Use of alcohol or intoxicants or drugs while operating any form of a **motor vehicle** whether or not registered for land, air or water use. A **motor vehicle accident** will be deemed to be caused by the use of alcohol, intoxicants or drugs if it is determined that at the time of the accident you or your covered dependent were:
 - Operating the **motor vehicle** while under the influence of alcohol at a level which meets or exceeds the level at which intoxication would be presumed under the laws of the state where the **accident** occurred. If the **accident** occurs outside of the United states, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter, or
 - Operating the **motor vehicle** while under the influence of an intoxicant or illegal drug, or

- Operating the **motor vehicle** while under the influence of a **prescription drug** in excess of the amount prescribed by the **physician**, or
- Operating the **motor vehicle** while under the influence of an over the counter medication taken in an amount above the dosage instructions.
- Suicide or attempted suicide (while sane or insane).
- War or any act of war (declared or not declared).

*These exclusions do not apply if the loss is caused by:

- An infection which results directly from the **injury**.
- Surgery needed because of the **injury**.

The **injury** must not be one which is excluded by the terms of this section.

Accidental Death Benefit Beneficiary

If you are covered under the Plan for an AD&D Insurance Benefit you may designate a beneficiary to receive your AD&D Insurance Benefit in the event that you die.

A beneficiary is the person you designate to receive benefits if you should die while you are covered and entitled to receive an AD&D Insurance Benefit. You may name anyone you wish as your beneficiary. You may name more than one beneficiary. You will need to complete a beneficiary designation form, which is available from the Fund Office.

If you name more than one primary beneficiary, the life insurance benefits will be paid out equally unless you stipulate otherwise on the form. If you name more than one primary beneficiary and the amount or percentage of the payment to your primary beneficiaries does not equal 100% of your life insurance amount, the difference will be paid equally to your named primary beneficiaries.

You may change your beneficiary choice at any time by completing a new beneficiary designation form. Send the completed form to the Fund Office. The beneficiary change will be effective on the date you sign a new beneficiary designation form.

Prior to your death, you are the only person who can name or change your beneficiary. No other person may change your beneficiary on your behalf, including, but not limited to, any agent under power of attorney, whether durable or non-durable, or other power of appointment.

The Life and AD&D Insurance Provider pays life insurance benefits in accordance with the beneficiary designation it has on record. Any payment made before the Life and AD&D Insurance Provider receives your request for a beneficiary change will be made to your previously designated beneficiary. The Life and AD&D Insurance Provider will be fully discharged of its duties as to any payment made, if the payment is made before the Life and AD&D Insurance Provider receives notification of a change in beneficiary.

If Your Beneficiary Dies Before You:

If one of your named primary beneficiaries dies before you, his or her share will be payable in equal shares to any other named primary beneficiaries who survive you. If you have named a contingent beneficiary, your contingent beneficiary will only be paid if all primary beneficiaries die before you.

If you have not named a primary or contingent beneficiary, or if the person you have named dies before you, payment will be made as follows to those who survive you:

- Your spouse, if any.
- If there is no spouse, in equal shares to your children.
- If there is no spouse, or you have no children, to your parents, equally or to the survivor.
- If there is no spouse, or you have no children, or parents, in equal shares to your brothers and sisters.
- If none of the above survives, to your executors or administrators.

If Your Beneficiary Is A Minor:

The method of payment will differ if your beneficiary is:

- A minor, or
- Legally unable to give a valid release for payment of any benefit.

In this case, the Life and AD&D Insurance Provider will issue (as permitted by applicable state law) the life insurance payment to:

- The guardian of your beneficiary's estate, or
- The custodian of the beneficiary's estate under the Uniform Transfer to Minors Act, or
- An adult caretaker/legal guardian.

SHORT-TERM DISABILITY BENEFIT (ACTIVE EMPLOYEE, CLASS I AND II, ONLY)

The Plan will pay you a weekly Short-Term Disability Benefit if you incur a Total Disability as the result of a non-occupational Injury or Illness that occurs while you are employed by a Contributing Employer and you require the regular care of a Physician. You must submit written proof to the Fund Office of your Total Disability.

Your weekly benefit will be paid in the amount listed in the Schedule of Benefits and will begin on the first day of your Total Disability due to Injury and on the eighth day of Total Disability due to Illness. The weekly benefit is made up of seven daily segments. A period of less than a full week will be calculated on a daily basis. You are limited to a maximum benefit of twenty-six weeks during any one period of Total Disability.

Successive Disabilities

If you are Totally Disabled at different times while you are covered by the Plan, for the same or a different condition, your disabilities will be treated as one continuous period of Total Disability (eligible for a maximum of 26 weeks of benefits) unless between disabilities you return to active work for at least 1 full day (eight hours). If you do return to work for at least one full day in between disabilities, then the second period of Total Disability will be considered a new period, subject to a new 26-week maximum.

Exclusions and Limitations on Short-Term Disability Benefits

The Short-Term Disability Benefit must replace actual wages lost as a result of your inability to perform ironwork. Short-Term Disability Benefits will not be paid if:

1. You are receiving workers' compensation or unemployment compensation;
2. You are receiving a pension from the Structural Iron Workers Local #1 Pension Fund; or
3. Your employer is paying you wages.

Short-Term Disability Benefits are limited based on a rolling sixty-month period.

Three Period Maximum During Any Rolling Sixty Month Period

During any rolling sixty-month period, participants are not entitled to receive disability benefits for more than three periods of disability, measured as of the end of the first period of disability, regardless of when disability actually commenced.

Example: John is disabled due to an accident on Thursday, January 5, 2006, and receives Weekly Accident and Sickness Disability Benefits for three weeks through Wednesday, January 25, 2006. He suffers a second period of disability and receives two weeks of benefits during the period Monday, February 13, 2006 through Friday, February 25, 2006. He then incurs a third

period of disability and receives four weeks of disability during the period Monday April 3, 2006 through Friday April 29, 2006.

Because he has received benefits for three periods of disability, he will not be eligible for disability benefits again until sixty months after the end of his first period of disability. This sixty-month period will end January 25, 2011. If he otherwise qualifies, he will be eligible for disability benefits if he commences a period of disability on or after January 26, 2011.

Fifty-Two Week Maximum During Any Rolling Sixty-Month Period.

During any rolling sixty-month period (measured from the first day of the first period of disability), participants are not entitled to receive disability benefits for more than fifty-two weeks, regardless of when the disability actually commenced.

Example: Tom is disabled due to an accident on Thursday, January 5, 2006, and receives Weekly Accident and Sickness Disability Benefits for twenty-six weeks through Wednesday, July 5, 2006. He suffers a second period of disability and receives twenty-six weeks of benefits during the period Monday, August 7, 2006, through Friday, February 2, 2007. He then incurs a third period of disability on Monday, December 6, 2010, and remains disabled for 50 weeks.

Because Tom has received fifty-two weeks of disability, he will not be eligible for disability benefits again until he has less than fifty-two weeks of disability during a sixty-month period. The period during which he is ineligible ends sixty months after the first day of his fifty-two weeks of disability -- in other words, as of midnight on Tuesday, January 4, 2011. Tom will then have less than fifty-two weeks during a sixty-month period beginning Wednesday, January 5, 2011.

With regard to his third period of disability, he will not be eligible for disability benefits while disabled during the period December 6, 2010, through the end of the rolling sixty-month period, January 4, 2011. He will then be entitled to disability benefits, if he otherwise qualifies, beginning January 5, 2011 for up to the twenty-six-week maximum allowed during one period of disability.

BENEFIT CLAIMS AND APPEALS

This section describes the procedures for filing claims for benefits from the Plan. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Accidental Death and Dismemberment Insurance Benefit and Life Insurance Benefit Claims

Accidental death and dismemberment insurance benefits and life insurance benefits are provided through contracts with insurance companies. The claims and appeal procedures for such benefits are governed by the applicable insurance contracts (see the life insurance and AD&D policy and/or booklet-certificate provided to you under separate cover by the Life and AD&D Insurance Provider). You may contact the Fund Office for more information on how to file a claim for these benefits.

Employee Assistance Program ("EAP") Claims

Claims for services under the EAP will be handled by the EAP Provider (as identified in the "Administrative Information About the Plan" section). As a general matter, there is no need to file a written claim for benefits under the EAP; rather, you can obtain benefits simply by contacting the EAP Provider by telephone. For further information on how to receive EAP services, please refer to the brochure provided to you by the EAP Provider. How to File a Claim for Other Benefits (Medical, Dental, Prescription Drug, Vision, Hearing, Short Term Disability).

All Other Claims

A claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures. In order to file a claim for benefits offered under this Plan (other than life insurance, AD&D insurance, and EAP benefits), you must submit a completed claim form. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as claims for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

You may obtain a claim form from the Claims Administrator (as identified in the "Administrative Information About the Plan" section). If you use the services of a Network Provider, the provider generally will file your health claims for you, and there will be no need for you to submit a claim form.

The following information must be provided by you or your physician in order for your request for benefits to be a claim, and for the Claims Administrator to be able to decide your claim.

- Participant name;
- Patient name;
- Patient Date of Birth;

- Social Security Number of participant or retiree;
- Date of Service (if applicable);
- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association; if applicable);
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services; if applicable);
- Billed charge (if applicable);
- Number of Units (if applicable, i.e., for anesthesia and certain other claims);
- Federal taxpayer identification number (TIN) of the provider (if applicable);
- Billing name and address of the provider (if applicable); and
- If treatment is due to accident, accident details.

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

When Claims Must Be Filed

You must file your claim for benefits within 12 months following the date you incurred the charges. If you fail to file your claim within the time required, it will not invalidate or reduce your claim if it was not reasonably possible for you to file the claim within a reasonable time. However, in that case, you must submit your claim as soon as reasonably possible and in no event later than 18 months from the date you incurred the charges. The Board of Trustees will determine whether you have proved good cause for filing a late claim.

Where Claims Must Be Filed

Your claim is considered filed as soon as it is received at the Claim Administrator’s Office. You should file your claims (including prescription drug benefit claims) with the Claim Administrator at the address listed in the “Administrative Information About the Plan” section; the envelope and the claim itself should reference the Structural Iron Workers Local #1 Welfare Fund

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you have designated the individual to act on your behalf (for example, if you are unable to complete the form yourself). You can obtain a form from the Fund Office to designate an authorized

representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the authorization form.

Assignment of Benefits

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

Neither you nor your beneficiary may transfer or assign any life insurance benefit payments in anticipation of receiving them.

Benefit Payment to an Incompetent Person

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

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

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

PROCEDURES APPLICABLE TO CLAIM DENIALS AND APPEALS

1. INTRODUCTION

Introduction

Under regulations issued by the Department of Labor (the “DOL”), as amended by the Patient Protection and Affordable Care Act of 2010, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described in this section are intended to comply with DOL regulations by providing reasonable procedures governing the notification of benefit decisions and the internal and external appeal of adverse benefit decisions.

Accidental death and dismemberment insurance benefits and life insurance benefits under the Plan are insured. Accordingly, the claims and appeal procedures with respect to such benefits are determined by the insurance carrier, and, to the extent that there is any conflict between this document and the insurance policy and other documents issued by the carrier, the carrier’s documents control.

2. DEFINITIONS

Adverse Benefit Determination

A decision is "adverse" if it is (i) a denial, reduction, or termination of, or (ii) a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on :

- A determination of a claimant’s eligibility to participate in the Plan;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is Experimental and/or Investigative, or not Necessary Treatment.

Authorized Representative

An authorized representative may act on behalf of a claimant with respect to a benefit claim or appeal under these procedures, provided that the claimant has designated the person to so act.

An assignment for purposes of payment (e.g., to a health care professional) does not constitute appointment of an authorized representative under these claims procedures.

Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding decisions, unless the claimant provides specific written direction otherwise.

Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant appointed in compliance with the above procedures.

Claim A claim is any request for a Plan benefit or benefits made in accordance with the Plan's claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim. Simple inquiries about the plan's provisions that are unrelated to any specific benefit claim also will not be treated as claims for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

Claimant You become a claimant when you make a request for a Plan benefit or benefits in accordance with the Plan's claims procedures. Your authorized representative also may be considered a claimant for purposes of these procedures.

Day When used in these claims procedures, the term day means a calendar day.

Final Internal Adverse benefit determination A decision on appeal is a "final internal adverse benefit determination" if it is a: (a) decision that upheld in whole or part an adverse benefit determination at the conclusion of the Plan's internal claims appeals process, or (b) an adverse benefit determination with respect to which the internal claims appeals process has been deemed exhausted.

3. FOUR TYPES OF HEALTH CARE CLAIMS; DISABILITY CLAIMS; OTHER CLAIMS

Different Rules Apply There are four different categories of health care claims, as well as disability benefit claims and all other benefit claims, each with somewhat different claim and appeal rules. The DOL regulations impose different requirements based on the type of claim involved. The primary difference is the timeframe within which claims and appeals must be determined.

Health Care Claims: General Health care claims include all claims for medical, physical exam, voluntary sterilization, prescription drug, dental, vision, and hearing aid benefits. General health care claims also include actions taken by the Fund to rescind coverage retroactively with respect to any kind of health benefits (except in cases where a benefit premium payment was past due).

Health Care A claim is a pre-service claim if this document specifically conditions

Claims: Pre-Service Claim

receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care -- unless the claim involves urgent care, as defined below. Benefits under this Plan that require approval in advance are specifically noted as being subject to pre-approval or authorization.

Health Care Claims: Urgent Care Claim

An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function, or would, in the opinion of a Physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

On receipt of a pre-service claim, the Plan will make a determination of whether it involves urgent care, provided that, if a Physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

Health Care Claims: Post-Service Claim

A post-service claim is any claim for a benefit under this Plan that is not a pre-service claim or an urgent care claim.

Health Care Claims: Concurrent Care Claim

A concurrent care decision occurs when the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) claims where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (b) claims where an extension is requested beyond the initially-approved period of time or number of treatments

Change in Health Care Claim Type

The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim initially may be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim.

Questions About Health Care Claim Type

It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding what type of claim and/or what claims procedure to follow, contact the Fund Office.

4. HOW TO FILE A CLAIM FOR BENEFITS

General Filing Rules

Except for urgent care claims, discussed below, a claim for benefits is made when a claimant (or authorized representative) submits a claim as

described above under “How to File a Claim for Other Benefits,” and the subsequent discussions of when and where to file.

Urgent Care Claims

In light of the expedited timeframes for decisions regarding urgent care claims, an urgent care claim for benefits may be submitted to the Fund Office by telephone or by fax. The claim should include at least the following information:

- the identity of the claimant
- a specific medical condition or symptom a specific treatment, service or product for which approval or payment is requested

Pre-Service Claims

If you fail to follow the Plan’s procedures for filing pre-service claims, the Plan will notify you of this failure and of the proper procedure as soon as appropriate, but not later than 5 days (24 hours in the case of a claim involving urgent care) following the failure. Such notification may be provided orally unless you request a written notice.

5. TIMEFRAME FOR DECIDING INITIAL BENEFIT CLAIMS

Pre-Service Claims

The Plan shall decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Urgent Care Claims

The Plan shall decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 24 hours after receipt of the claim.

Concurrent Care Extension Request

If a claim is a request to extend a concurrent care decision (defined above) involving urgent care and if the claim is made at least 24 hours prior to the end of the initially-approved period of time or number of treatments, the claim shall be decided within no more than 24 hours after receipt of the claim. Any other request to extend a concurrent care decision shall be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Concurrent Care Early Termination

A decision by the Plan to reduce or terminate an initially-approved course of treatment is an adverse benefit determination that may be appealed by the claimant under these procedures, as explained below. Notification to the claimant of a decision by the Plan to reduce or terminate an initially-approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse benefit determination and receive a decision on review under these procedures prior to the reduction or termination.

Post-Service Claim

The Plan shall decide an initial post-service claim within a reasonable time but no later than 30 days after receipt of the claim.

Disability Claim Claims for Short-Term Disability Benefits shall be decided with a reasonable period of time and not later than 45 days after the Plan's receipt of the claim.

Insured Life and AD&D Claims Life insurance and AD&D claims shall be decided by the insurance carrier within a reasonable period of time and not later than 15 business days after receipt of the claim.

When Extensions of Time Are Permitted

Despite the specified timeframes, nothing prevents the claimant from voluntarily agreeing to extend the above timeframes. In addition, if the Plan is not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. Likewise, if the Plan is not able to decide a Short-Term Disability claim within the above timeframes, due to matters beyond its control, one 30-day extension of the applicable timeframe is permitted, provided that the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. Finally, if, due to special circumstances, the insurer is not able to decide a life or AD&D insurance claim within the initial 15 business day period, one 45-day extension of the applicable timeframe is permitted, provided that Life and AD&D Insurance Provider notifies the covered person within the first 30-days after the claim is made. The extension notice shall include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

Incomplete Claims

If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

How Incomplete Urgent Care Claims Are Treated

If an urgent care claim is incomplete, the Plan shall notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally to the claimant, unless the claimant requests written notice, and it shall describe the information necessary to complete the claim and shall specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Plan shall decide the claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

How Other Incomplete Claims Are Treated

If any other type of claim is incomplete, the Plan may deny the claim or may take an extension of time, as described above. If the Plan takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe of no less than 45 days in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that

information.

6. NOTIFICATION OF INITIAL BENEFIT DECISION BY PLAN

Pre-Service and Urgent Care

Written notification of the Plan's decision on a pre-service or urgent care claim shall be provided to the claimant whether or not the decision is adverse. Notification of the Plan's adverse benefit determination on an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

Notification of Adverse Benefit Determination

Written notification shall be provided to the claimant of the Plan's adverse benefit determination with respect to a claim and shall include the following, in a manner calculated to be understood by the claimant:

- information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement of the specific reason(s) for the adverse benefit determination; including, but not limited to the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim.
- reference(s) to the specific Plan provision(s) on which the decision is based;
- a description of any additional material or information necessary to perfect the claim and why such information is necessary;
- a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- a description of the Plan procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request);
- if the decision involves a claim for benefits relating to treatment of a mental disorder or a substance abuse disorder, an explanation as to the criteria for medical necessity determinations;
- if the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
- in the case of an urgent care claim, an explanation of the expedited review methods available for such claims; and
- the contact information for the relevant office of health insurance consumer assistance or ombudsman (if available).

7. YOUR RIGHT TO APPEAL/HOW TO APPEAL AN ADVERSE BENEFIT DETERMINATION

A claimant has a right to appeal an adverse benefit determination under these claims procedures.

How to File Your Appeal

An appeal of an adverse benefit decision other than with respect to the insured life and ADD insurance benefits must be made in writing by the claimant (or authorized representative) to the Fund Office.

An appeal of an adverse benefit decision with respect to the insured life or ADD insurance benefits must be made to the respective insurance carrier, and an appeal with respect to Employee Assistance Program benefits must be made to the EAP Provider, all as identified in the “Administrative Information About the Plan” section below.

An appeal will be treated as received by the Plan (a) on the date it is hand-delivered to the specified address; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

The Fund maintains a two-step appeal process with respect to Health Care Claims. The first appeal is decided by the Claims Administrator, and the second appeal is decided by the Board of Trustees of the Fund. Both the first and the second appeal should be submitted to the Fund Office.

Submission of Comments, Testimony and Evidence

A claimant has the right to present testimony and submit other evidence including but not limited to documents, written comments, or other information in support of an appeal.

Important Appeal Deadlines

The appeal of an adverse benefit decision with respect to life or AD&D insurance benefits must be filed within 60 days following the claimant’s receipt of the notification of the adverse benefit decision. The appeal of an adverse benefit decision with respect to health care benefits, EAP benefits, and disability benefits must be filed within 180 days following the claimant’s receipt of the notification of the adverse benefit decision, except that the appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment (see the definition of concurrent care claim) must be filed within 30 days of the claimant’s receipt of the notification of the Plan’s decision to reduce or terminate. Failure to comply with this important deadline may cause the claimant to forfeit any right to further review of an adverse benefit determination under these

procedures or in a court of law.

If a Health Care Claim is denied upon appeal, it may be appealed a second time to the Fund's Board of Trustees by filing a written appeal within 60 days of the date of the initial decision upon appeal.

Urgent Care Appeals

In light of the expedited timeframes for decisions regarding urgent care health care claims, an urgent care appeal may be submitted by telephone or fax to the Fund Office. The appeal should include at least the following information:

- the identity of the claimant;
- a specific medical condition or symptom;
- a specific treatment, service or product for which approval or payment is requested; and
- any reasons why the appeal should be processed on a more expedited basis

8. HOW YOUR APPEAL WILL BE DECIDED

The appeal of an adverse benefit decision with respect to EAP claims will be decided by the EAP provider, and insured life and ADD insurance claims will be decided by the respective insurance carrier.

The first appeal of an adverse benefit decision with respect to Health Care and the appeal with respect to Short Term Disability Claims will be reviewed and decided by the Claim Administrator.

The second appeal of an adverse benefit decision with respect to Health Care will be reviewed and decided by the Fund's Board of Trustees.

The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision. No deference will be given to the initial benefit decision.

The following procedures will be observed when deciding any appeal.

Consideration of Comments

The review will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision.

Consultation With Expert

In the case of a claim denied on the grounds of a medical judgment, a health professional with appropriate training and experience will be consulted. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.

Access to Relevant Information

A claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. If the advice of a medical or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the Plan. Additionally, a claimant shall be given reasonable access to, and copies of any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage. Such claimant also will be afforded a reasonable opportunity to respond to such new evidence or rationale.

Expedited Methods for Urgent Care

All necessary information in connection with an urgent care appeal shall be transmitted between the Plan and the claimant by telephone or facsimile.

9. TIMEFRAMES FOR DECISIONS ON BENEFITS APPEALS

Pre-Service Claims

The first appeal of a pre-service claim shall be decided by the Claim Administrator within a reasonable time appropriate to the medical circumstances but no later than 15 days after receipt by the Plan of the request for review. If the Claim Administrator denies the appeal, you may appeal again to the Trustees, and they shall render a decision within 15 days of your second appeal.

Urgent Care Appeals

The appeal of an urgent care claim shall be decided as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt by the Plan of the request for review.

Post-Service Health Care and Disability Appeals

The first appeal of a post-service health care claim and the appeal of a disability claim shall be decided by the Claim Administrator within 30 days of the request for review.

The second appeal of a post-service health care claim shall be decided at the Trustee's next quarterly meeting if the appeal is received more than 7 days before the meeting. If instead the appeal is received within 7 days of the next meeting, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, such as the need to hold a hearing, a benefit determination shall be rendered not later than the third meeting of the Trustees following the Plan's receipt of the written request for an appeal. Notice of the Trustee's determination shall be given within 5 calendar days of

the Trustee's meeting at which it was decided.

Concurrent Care Appeals

If the appeal is filed sufficiently in advance, the appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment (see the definition of concurrent care claim) shall be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend concurrent care decision shall be decided in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

Life and AD&D Appeals

The insurance carrier shall make a determination regarding an insured life or AD&D insurance claim appeal within a reasonable period of time and not later than 60 days after receipt of the claimant's request for review, unless, due to special circumstances, an extension of time is required, in which case a 60-day extension may be taken provided that the claimant is notified of the need for the extension prior to the expiration of the initial 60-day period.

10. NOTIFICATION OF FINAL DECISION ON APPEAL

Written Notice

Written notification of the decision on appeal shall be provided to the claimant whether or not the decision is adverse.

Rationale for a Final Internal Adverse benefit determination

As soon as administratively possible before the issuance of the final internal adverse benefit determination, the claimant will receive the rationale from the Plan for the final internal adverse benefit determination if such decision is based on new or additional information.

Notification of Final Internal Adverse Appeal Decision

Written notification of a final internal adverse benefit determination on appeal shall include the following information (if applicable), written in a manner calculated to be understood by the claimant:

- information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- the specific reason(s) for the final internal adverse determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim and a discussion of the decision;
- a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- a reference to the specific Plan provision(s) on which the decision is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse benefit

determination (or a statement that such information will be provided free of charge upon request);

- a statement of the right to sue in federal court;
- a statement indicating entitlement to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination;
- if the decision involves the treatment of a mental health or substance abuse disorder, an explanation of the criteria for determining whether treatment was Medically Necessary;
- if the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request; and
- the contact information for the relevant office of health insurance consumer assistance or ombudsman (if available).

Notification of a final internal adverse benefit determination on appeal of an urgent care claim may be provided orally, but written notification shall be furnished not later than three days after the oral notice.

If the Plan should fail to strictly adhere to the above claims appeal procedures, a claimant will be deemed to have exhausted the Plan's internal claims appeal process and may initiate any available external review process (described below) or other available legal remedies under ERISA or state law. Coverage under the Plan will continue for the claimant pending the outcome of the appeal.

If you have questions about these claims procedures, contact, the Fund Office.

11. EXTERNAL CLAIM REVIEW: STANDARD PROCEDURES

Eligibility for a Standard External Claim Review

A claimant may file a request for an external review of a claim if:

- the claimant received an adverse benefit determination on appeal, or
- if the Plan failed to strictly adhere to the Plan's internal claims and appeals process.

Request for External Review

A claimant may file a request for an external review with the Plan through the Fund Office, provided such request is filed by the first day of the fifth month following the receipt of the notice of an adverse benefit determination or final adverse benefit determination. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Preliminary Review

Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether external review is available. Specifically, the Plan will consider whether:

- The claimant is or was covered under the Plan at the time the health care item or service was requested;
- The adverse benefit determination relates to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (eligibility determinations are not entitled to external review);
- The claimant has exhausted the Plan's internal appeal process (unless the claimant is not required to exhaust the internal appeals process under the interim final regulations due to the Plan's failure to strictly adhere to the claims appeal procedures); and
- The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant (or the claimant's authorized representative) advising as to whether external review is available.

If the request is complete but the claim is not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete, and the claimant will have the right to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

Independent Review Organization Process

An independent review organization ("IRO") will conduct the external review. The IRO review process shall consist of the following:

- The IRO will provide the claimant timely notice of its acceptance of the claim for external review. Within ten business days of the receipt of this notice, the claimant may submit additional written evidence, which the IRO *must* consider. The IRO *may* consider evidence submitted after ten business days.
- Within five business days after the assignment of the IRO, the Plan will provide the IRO the documents and information that had been considered in making the adverse benefit determination. The IRO may reverse the adverse benefit determination if the Plan

fails to provide these materials.

- Within one business day of receipt of information from the claimant, the IRO must forward this information to the Plan, which may reconsider its adverse benefit determination.
- **The IRO will use legal experts to make any determinations pertaining to coverage issues.**

IRO's Decision

The IRO must provide to the claimant and the Plan written notice of its decision within 45 days after the IRO receives the request for the external review. The IRO's decision shall contain:

- the reason for the decision, including specific information about the claim and the IRO's involvement with the claim;
- the rationale and the evidence-based standards relied on by the IRO;
- a statement that the decision is binding, but that there may be other state or federal remedies, which may include judicial review; and
- **the contact number for the relevant office of health insurance consumer assistance or ombudsman (if available).**

External Review Record Retention

After a final external review decision, the IRO will maintain for six years the records of all claims and notices associated with the external review process. Such records will be available for examination, upon request by the claimant, the Plan, or a state or federal oversight agency (unless such disclosure would violate state or federal privacy laws).

Reversal of Plan's decision

Upon receipt of a final external review decision reversing the adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

11. EXTERNAL CLAIM REVIEW: EXPEDITED PROCEDURES

Eligibility for an Expedited External Claim Review

A claimant may request an expedited external review from the Fund Office at the time the claimant receives an adverse benefit determination, if

- a) the adverse benefit determination involves a medical condition with respect to which the time frame for completion of an expedited internal appeal would seriously jeopardize the claimant's life or health or ability to regain maximum function, and
- b) the claimant has filed a request for an expedited internal appeal.

Preliminary Review of the Expedited External Claim Review

A preliminary review (as provided above with respect to a standard external review) will be conducted immediately upon receipt of the request for expedited external review. Immediately following a preliminary review of the request for an expedited external review, the Plan will issue a notification in writing to the claimant (or the claimant's authorized representative) as to whether an expedited external review is available.

If the request is complete but the claim is not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is complete and the claim is eligible for a standard external review, but not an expedited review, the procedures for a standard external review (described above) shall apply. If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the claimant will have the right to perfect the request.

Assignment to IRO

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO under the procedures for a standard external review (described above). The Plan will provide the IRO electronically, by telephone or facsimile, or by any other available expeditious method, all necessary documents and information considered in making the adverse benefit determination.

IRO's Expedited External Review

The review of the IRO shall consist of providing a notice of the final external review decision, in accordance with the requirements for a standard external review and resulting decision (described above), as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of the decision is not initially provided in writing, then within 48 hours after the date of providing the notice, the IRO must provide written confirmation of the decision to the claimant and the Plan.

External Review Record Retention

After a final external review decision, the IRO will maintain for six years the records of all claims and notices associated with the external review process. Such records will be available for examination, upon request by the claimant, the Plan, or a state or federal oversight agency (unless such disclosure would violate state or federal privacy laws).

Reversal of Plan's Decision Upon receipt of a final external review decision reversing the adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Physical and Dental Examination and Autopsy

The Trustees have the right, at the Fund's expense, to have a Physician or Dentist they designate examine you or your Dependent regarding your claim for Plan benefits as often as is reasonable while your claim for health care or disability is pending. The Trustees have the right to require an autopsy in case of death, where it is not forbidden by law.

Plan Interpretation and Authority of Trustees

The Trustees or the person or committee to whom the Trustees have delegated responsibility will be the sole judges of the standard of proof required in any case and the application and interpretation of this Plan and entitlement to benefits under the Plan. No benefits will be paid unless the Trustees (or their delegate) in their sole discretion determine that the Claimant is entitled to them. The decisions of the Trustees or their delegates will be final and binding (subject to the external review process described above).

You are required to submit to the Trustees or their delegates all questions or controversies in connection with this Plan or its operation regarding:

- Any claim for benefits;
- The construction of Plan language;
- Any rules and regulations adopted by the Trustees; or
- Any writing, decision, instrument, or account in connection with the operation of the Plan.

The decision on review will be binding on all persons dealing with the Plan or claiming any benefit hereunder (subject to the external review process described above). If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the Plan that such decision is to be upheld unless it is determined to be arbitrary and capricious. Notwithstanding the preceding, it is understood that an IRO following the external review process described above may conduct a *de novo* review of adverse benefit determinations. In other words, the IRO may not defer to the Trustee's decision but will conduct an independent assessment of the application of the Plan's terms to the particular facts and circumstances.

All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement to change them. The Trustees have the authority to increase, decrease or change the eligibility rules or other provisions of the Plan of Benefits as they may determine to be in the best interest of Plan participants and beneficiaries.

Exhaustion of Administrative Remedies

If your claim for benefits has been denied, you may not bring a lawsuit or other action against the Fund or its Trustees until you have exhausted the internal claims review procedures mandated by the Employee Retirement Income Security Act of 1974 (ERISA) that are outlined in this section. Once such internal claims review procedures have been exhausted, you may either request an external claim review or file a lawsuit or other action against the Fund or its Trustees. Notwithstanding the preceding, you may initiate an external claim review (as described above) or a lawsuit if the Plan failed to strictly adhere to the internal claims and appeals procedures set forth above.

Right to Make Payment and Settle Claims

The Trustees have the right to pay benefits to any other organization or person as needed to properly carry out the provisions of the Plan.

The Trustees may pay for or provide services or equipment that they deem to be Medically Necessary, but not otherwise covered by the Plan if, in their sole discretion, they conclude that paying for or providing such services or equipment would be financially beneficial to the Plan. No such payment or providing of services or equipment will be deemed to be an amendment to the Plan or establish a precedent, nor will it obligate such payments or providing of services or equipment in the case of any subsequent claim. The Trustees may, but will not be required to, delegate to the Fund Administrator the authority to authorize such payments pursuant to written rules of uniform application that they may adopt from time to time.

The Trustees also have the general right, in their sole discretion, to settle claims and waive Plan terms.

Right to Recovery

Whenever the Trustees determine that payments have been made in excess of the amount required by the Plan (for whatever reason, whether it be due to mistake, fraud, or some other cause), the Trustees will have the right to recover such payments or to set them off against further obligations, to the extent of the excess, from among one or more of the following:

1. Any persons to or for whom such payments were made;
2. Future obligations of the Plan to the affected person or the Employee to whom such person's coverage is attributable
3. Any insurance companies;
4. Any service providers; or
5. Any other organizations.

Additionally, if you submit fraudulent claims on behalf of yourself or your Dependents to the Plan, you and your Dependents may lose eligibility for coverage under the Plan.

Workers' Compensation Not Affected

The Plan benefits are not provided in place of and do not affect any requirements for coverage under any applicable workers' compensation laws of any state.

Limitation on Lawsuits

No lawsuit may be started more than six months after the final decision on review (or the expiration of the period in which the final decision is to be issued). Also, if you fail to include any theories or facts in your written appeal, they will be deemed waived. In other words, you will lose the right to raise factual arguments and theories that support your claim if you fail to include them in your written appeal.

COORDINATION OF BENEFITS

Under the Health and Welfare Plan, your benefits may be coordinated if another group plan or source is obligated to make benefit payments for you or your Dependents.

“Other Plan” means any plan that provides benefits or services for Covered Charges under this Plan, including plans providing coverage by:

1. Group insurance coverage;
2. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employer-sponsored plans, employee benefits organization plans or any other arrangement of benefits for individuals of a group; or
3. Any coverage under governmental programs, and any coverage required or provided by any statute.

Order of Benefit Payment

To coordinate benefits between the Other Plans and the Plan, the first provision that applies in the order of coordination of benefits rules will be used to determine the amount of benefits this Plan pays and the amounts to be paid by any Other Plans:

1. A plan without a coordination of benefits provision will pay its benefits before a plan that contains a coordination of benefits provision.
2. A plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.
 - a. There is one exception to the rule in 2. above. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:
 - i. secondary to the plan covering the person as a dependent; and
 - ii. primary to a plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.
3. A plan that covers a person other than as a Dependent will pay benefits before a plan that covers the person as a Dependent.

4. For claims on behalf of Dependent children who are covered under both parents' plans and the parents are not separated or divorced:
 - a. The plan that covers the parent whose birthday falls earlier in the calendar year will pay first;
 - b. If both parents have the same birthday, the plan covering the parent for the longer period of time will pay first;
 - c. if one plan uses the male/female rules and the other plan coordinates using the rule based on the parents' birthdays, the plan using the male/female rule shall determine the order of benefits.

5. For a claim on behalf of Dependent children who are covered under both parents' plans and the parents are separated or divorced;
 - a. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the Dependent children of the parent who has legal responsibility will be primary;
 - b. If there is no court decree, the plan that covers the parent with custody will be primary;
 - c. If there is no court decree and the parent with custody has remarried, the order of benefit coordination will be:
 - i. The plan of the parent with custody;
 - ii. The plan of the step-parent with custody;
 - iii. The plan of the parent without custody.

Notwithstanding anything in this Rule to the contrary, benefits will be coordinated for alternate recipients in accordance with a Qualified Medical Support Order (QMCSO) once such QMCSO has been reviewed by the Plan. Absent language in the QMCSO to the contrary, the plan under which coverage is required by the QMCSO will determine its benefits first.

6. A Plan that covers a person as an active Employee or a Dependent of an active Employee will pay its benefits before a plan that covers the person (or his or her Dependents) as a retired or laid-off Employee or as a COBRA qualified beneficiary or as a result of some other coverage extension (such as a coverage extension resulting from use of the Accumulated Reserve Account or comparable hours bank).

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

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the plan that covers the person as a dependent of an active employee will pay first.

7. 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.
8. If none of the above rules establishes the primary plan, the plan that has covered the person for the longer period of time determines its benefit before the plan that has covered the person for a shorter period of time.

Subject to any change in applicable law or Plan amendment adopted by the Trustees, this Plan will coordinate benefits with Medicare as outlined in the next section. Right to Receive and Release Necessary Information

The Trustees have the right to obtain or provide information needed to coordinate benefit payments with Other Plans. This information may be obtained from or provided to any insurance company, organization, or person without notice to you and without your consent. Anyone claiming benefits under this Plan must provide any information necessary to implement the Plan provisions or to determine their applicability.

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.

ENROLLMENT IN MEDICARE/COORDINATION OF BENEFITS WITH MEDICARE

Medicare consists of four parts. The first part is officially called “Hospital Insurance Benefits for the Aged and Disabled,” and is commonly referred to as Part A of Medicare. The second part is officially called “Supplementary Medical Insurance Benefits for the Aged and Disabled,” and is commonly referred to as Part B of Medicare. The third is “Medicare + Choice” and is commonly referred to as Part C. The fourth is the “Voluntary Prescription Drug Benefit Program” and is commonly referred to as Part D of Medicare. Part A of Medicare primarily covers hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers Physician’s services, although it, too, covers a number of other items and services. Part C is the managed care program under Medicare. Part D covers prescription drug costs.

Typically, you become eligible for Medicare upon reaching age 65. You may become eligible for Medicare before age 65 if you are a disabled worker, dependent widow, or have chronic end-stage renal disease (ESRD). You should be aware that even if you do not choose to retire or do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for Parts A, B, and D of Medicare. Since Part A of Medicare is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Parts B and D of Medicare.

If you do not apply for Medicare Parts B and D when you first become eligible, the amount you pay for Medicare Parts B and D if you enroll later may be higher, and you also may have to wait until the annual open enrollment period to enroll. Whether or not this is the case depends on whether you had other coverage as an active employee (Part B) or creditable prescription drug coverage under another group health plan such as this Plan (Part D). Regarding Medicare Part D, more information is provided to you every year in the Plan’s annual Medicare Part D Disclosure Notice.

To the extent permitted by the Medicare Secondary Payer Rules, the Plan coordinates benefits with Medicare. The benefits that this Plan pays to you will be reduced to the extent necessary so that the sum of the benefits paid under this Plan and the amounts paid under Medicare Parts A, B (or Part C in the geographic areas where Medicare HMO offerings are available), or D will not exceed the total of your “Allowable Expenses.”

“Allowable Expenses” means any necessary Usual and Customary Charges for Necessary Treatment that is covered by either this Plan or Medicare.

If you or your spouse is not in active employment covered by a group health plan, you should enroll in Medicare Parts A and B as soon as you are eligible for coverage. If you are eligible for Medicare, but you are not enrolled in Part A or Part B (the voluntary portion of Medicare), the benefits provided to you under this Plan will be paid as if you had enrolled in both Medicare Parts A and B (or Medicare Part C, if applicable).

Order of Benefit Payment

1. This Plan will have primary responsibility for expenses you or your Dependents incur if you are an eligible Active Employee who is:

- a. Eligible for Medicare Part A due to having attained age 65; and
- b. With respect to the Employee only, actively employed by an employer that (i) employs 20 or more Employees in each working day for at least 20 weeks in either the current or preceding calendar year and (ii) pays all or part of the required contributions for your eligibility.

The Plan will have secondary responsibility for you and your Dependents if you are not actively employed by an employer described in paragraph (b) above, provided that the Plan has requested and received a “small employer” exemption from the Centers for Medicare & Medicaid Services (CMS) with respect to those Employees in current employment status with an employer that employs fewer than 20 Employees as described above.

2. The Plan will have primary responsibility for the first thirty (30) months for your claims if you are eligible for Medicare benefits because of end-stage renal disease and Medicare will have secondary responsibility.
3. The Plan will have secondary responsibility for claims after thirty (30) months for expenses you incur if you are eligible for Medicare benefits because of end-stage renal disease and Medicare will have primary responsibility.
4. If you are an Active Employee, as defined under the Social Security Act and the regulations thereunder, and you are entitled to Medicare benefits because of disability, the Plan will have primary responsibility for claims incurred by you or your dependents.

“Medicare Benefits” means benefits for services and supplies that you receive or are entitled to receive under Medicare Part A, Part B, or Part D (or Part C where applicable).

COORDINATION WITH MEDICAID

A person's Medicaid eligibility will not be taken into account by the Plan in determining the person's eligibility to participate in the Plan or entitlement to benefits under the Plan. Notwithstanding anything herein to the contrary, the Plan shall pay benefits in accordance with any assignment of rights made by or on behalf of a Covered Individual as required by a state Medicaid plan. To the extent that 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 provides that the state has acquired the rights with respect to a Covered Individual to such payment.

SUBROGATION

This Plan shall be fully subrogated to any and all rights of recovery and causes of action that you, the Covered Individual, may have against any and all parties responsible for causing the injuries or illness for which benefit payments are made under this Plan. This Plan will exercise a specific and first right of reimbursement out of the proceeds of any settlement, judgment or other payment by a third party tortfeasor to you. The subrogation or reimbursement rules stated here apply if the Plan pays any benefits which arise out of an incident (accident or illness) that results in a claim against a third-party, including any person or entity liable for or indemnifying the Covered Individual. Under these circumstances, the Plan is entitled to reimbursement of its expenditures from all third party recoveries.

Third parties include, but are not limited to:

- any person or entity legally responsible for an injury;
- other benefit plans;
- insurance companies (including uninsured/underinsured carriers);
- workers' compensation; or
- any other third party which is obligated to make payments which the Plan would otherwise be obligated to make.

The Plan may maintain an action against the third party in your name and shall be entitled to recover the amount of benefit payments made and the expenses, costs and fees entailed in obtaining the recovery and any amount recovered which exceeds the foregoing shall be payable to you. The right to reimbursement of the Plan comes first even if you are not paid for all of your claims for damages or if the payment you receive is for damages other than medical expenses. You may not assign any rights or cause of action that you may have against a third party tortfeasor to recover medical expenses without the express written consent of the Plan.

Your Responsibilities

You immediately must notify the Claims Administrator whenever a claim against a third-party is made (including workers' compensation claims) regarding any loss for which benefits are received from the Plan. You must cooperate with the Plan by providing, among other things, information requested by the Plan concerning subrogation or reimbursement. Specifically, you must provide the Claims Administrator with:

- a signed subrogation and reimbursement agreement in a form acceptable to the Plan Administrator;
- the names and addresses of all potential third-parties and their insurer, adjusters and claim numbers;

- accident reports; and
- any other information the Plan requests.

The Plan Administrator may withhold future benefit payments until the Covered Individual complies with these requirements.

If You Are Reimbursed By A Third Party

If you receive payment from any party responsible for causing the injuries or illness for benefits paid by the Plan, you or the responsible party must notify the Fund Office and reimburse the Plan. This Plan, once benefits are paid, is granted a lien on the proceeds of any payment, settlement, judgment, or other remuneration, received by the Covered Individual. By virtue of your participation in the Plan, you are deemed to have consented to this lien and to have agreed to cooperate with the Plan to affect the Plan's subrogation rights.

The proceeds from the settlement, judgment, or any other payment must be divided as follows:

1. First, a sum sufficient to fully reimburse the Fund Office for all benefits advanced will be paid to the Fund. No reduction or deductions are allowed for attorneys' fees. The Covered Individual specifically is prohibited from incurring any expenses, costs, or fees on behalf of the Plan in pursuit of his or her rights of recovery against a third-party or the Plan's subrogation rights as set forth herein. No court costs, expert's fees, filing fees or other costs or expenses related to litigation nature may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
2. Then, any remainder will be paid to you. You are responsible for the fees of your attorney.

No Covered Individual may assign any rights or causes of action that he or she might have against a third-party, person or entity, which would grant the Covered Individual the right to recover medical expenses or other damages, without the express, prior written consent of the Plan. The Plan's subrogation and reimbursement rights apply even if the Covered Individual has died as a result of his or her injuries or illness and the Covered Individual's estate is asserting a wrongful death or survivor claim against the third-party under the laws of any state. The Plan's right to recover by subrogation thus shall apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent, or disabled person.

The Plan's right of subrogation and reimbursement will not be affected, reduced or eliminated by the make whole, comparative fault or common fund doctrine under applicable state or federal law. Furthermore, it is prohibited for a Covered Individual or his or her beneficiaries to settle a claim against a third-party for certain elements of damages, while not including damages related to medical expenses incurred. The proceeds of any claim against a third party must be divided as stated above even if the Employee and/or dependent are not fully compensated for the loss. However, the Plan is not entitled to receive reimbursement in excess of the amount the Employee and/or Dependent(s) receive from all third parties.

You shall be responsible for compliance with these provisions and the provisions of any subrogation and reimbursement agreement. The Employee will be responsible for compliance by the Employee's Dependents or by any agents and attorneys of the Employee or the Dependent.

If you receive payment from a third party and do not reimburse the Fund as stated above, the Plan may take any legal or equitable action to recover the benefits paid. Such actions include, but are not limited to:

- Initiating a claim in equity to compel compliance with these terms or the terms of the subrogation and reimbursement agreement;
- withholding your future benefit payments until you comply; or
- initiating such other equitable or legal action it deems appropriate.

ADMINISTRATIVE INFORMATION ABOUT THE PLAN

Plan Name

This Plan is called the Welfare Benefits Plan Sponsored by the Structural Iron Workers Local #1 Welfare Fund.

Plan Sponsor and Plan Administrator/Fund Office

The Plan is sponsored and administered by the Fund's Board of Trustees, which is the named fiduciary of the Plan. The Board of Trustees holds all assets in trust and is responsible for the operation of this Plan. The Board of Trustees has the discretion to delegate its fiduciary and other duties as it sees fit. The Board of Trustees consists of Employer representatives appointed by the Associated Steel Erectors of Chicago and Union representatives. You may contact the Board of Trustees by using the address and phone numbers listed below or in care of the Fund Office at the following address:

Board of Trustees
Structural Iron Workers Local #1 Welfare Fund
7700 West Industrial Drive
Forest Park, Illinois 60130
Telephone: (708) 366-1188
Fax: (708) 366-4809

Rules about Plan Interpretation

Only the Board of Trustees is authorized and has the full discretion to:

- Interpret the Plan, Plan Document, rules and procedures;
- Decide all questions about the Plan, including questions about your eligibility for benefits and the amount of benefits payable to you;
- Determine the facts of any claim you make for Plan benefits; and
- Change the eligibility rules and other Plan terms so as to amend, increase, decrease or eliminate benefits or terminate the Plan, partially or totally.

If a decision of the Trustees is challenged in court, it is the intent of the Fund and the Trustees that the decision will be upheld unless the court finds that it is arbitrary and capricious.

No Trustee, Employer, or Union, or any representative of any Employer or Union, is authorized to interpret the Plan nor can any such person act as an agent of the Board of Trustees. You may rely only on information regarding the Plan that is communicated to you in writing and signed on behalf of the full Board of Trustees either by the Trustees, or, if authorized by the Trustees, signed by a representative of the Fund.

You and your eligible Dependents do not acquire any vested right to Plan benefits either before or after your retirement.

Right to Amend or Terminate the Plan

The Trustees intend to continue the Plan indefinitely for your benefit and the benefit of all the Plan participants. However, the Trustees have been given the power to amend or terminate the Plan, in whole or in part, at any time, as they deem necessary. The Plan may be amended or terminated by the Board of Trustees pursuant to the terms of the Trust Agreement and the Plan Document. If this occurs, the Fund Office will send you a written notice explaining the change. Please be sure to read all Plan communications and keep them with your booklet. Such changes may include (but are not limited to) adding, changing or eliminating any type of benefit provided herein, changing participation terms and conditions or utilizing insurance providers or third parties to provide or administer benefit payments under the Plan and changing insurance providers of third party administrators. Amendments to the Plan must be reflected in writing. No oral modifications to the Plan are permitted.

No vested rights of any nature are provided under the Plan.

If the Plan is terminated, any remaining assets of the Plan shall be used to provide benefits under the Plan or to pay administrative expenses, subject to applicable law. If the Plan or a benefit thereunder is terminated, payment of claims shall be limited to those claims incurred on or prior to the date the Plan or the benefit is terminated. Neither the Plan nor the Board of Trustees shall have any liability for claims incurred after the effective date of termination of the Plan.

Board of Trustees

The Trustees of this Plan as of January 1, 2011 are:

<i>Union Trustees</i>	<i>Employer Trustees</i>
Mr. Robert R. Boskovich Structural Iron Workers Local #1 7720 West Industrial Drive Forest Park, Illinois 60130	Mr. Patrick Clark Cannon Steel Erection Co., Inc. 16770 Chicago Avenue Lansing, Illinois 60438
John F. Gardiner 7720 West Industrial Drive Forest Park, Illinois 60130	Ms. Theresa Kern M. A. Steel Erectors Box 490 Worth, Illinois 60482
Mr. Craig Satalic Structural Iron Workers Local #1 7720 West Industrial Drive Forest Park, Illinois 60130	Mr. John Zahorik c/o Midwest Steel 633 Skokie Blvd., #200 Northbrook, Illinois 60062

Collective Bargaining Agreement

The Plan is maintained through Collective Bargaining Agreements between Employers and Structural Iron Workers Local #1. The Collective Bargaining Agreements specify the amount of

contributions, due date of Employer contributions, type of work for which contributions are payable and the geographic area covered by these labor agreements.

If you request it in writing, you and your Dependents may obtain:

- Information about whether an Employer is required to pay contributions to the Plan;
- The address of a particular Contributing Employer;
- A complete list of Contributing Employers; and
- Copies of the Collective Bargaining Agreement under which you work.

You or your Dependents may also examine these documents and information at the Fund Office during regular business hours.

Plan Identification Numbers

The Plan serial number assigned to this Fund by the Board of Trustees pursuant to instructions by the Internal Revenue Service is 501. The identification number assigned to the Board of Trustees by the Internal Revenue Service is 36-2196735.

Plan Contributions and Funding

Employer contributions finance the benefits described in this booklet. All Employer contributions are paid to the Trust Fund subject to provisions in the Collective Bargaining Agreements between the Union and Associations and between the Union and those Employers that are not members of, or represented by, such Associations but that enter into an individual Collective Bargaining Agreement with the Union.

Benefits and administrative expenses are paid from the Fund unless insured. The Life Insurance Provider identified herein insures the Life Insurance and Accidental Death and Dismemberment benefits provided by the Plan. The medical, voluntary sterilization, physical exam, prescription drug, dental, vision, hearing, employee assistance program, and short-term disability Benefits are self-insured, meaning that they are provided directly from the Trust Fund. All Plan benefits are administered by the Fund Office.

Plan Year

The accounting records of the Plan are kept on a Plan Year basis beginning each January 1 and ending the following December 31.

Type of Plan and Plan Purpose

This Plan is a welfare benefits plan that is maintained for the purpose of providing medical, voluntary sterilization, physical exam, prescription drug, dental, vision, hearing, employee assistance program, and life insurance benefits for you and your Dependents who meet the

eligibility requirements described in this booklet and accidental death and dismemberment and short-term disability benefits for you when you meet the eligibility requirements.

Preferred Provider Organization

The Fund has entered into an agreement with the following medical Preferred Provider Organization (PPO):

Blue Cross Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112
www.bcbsil.com
1-800-571-1043.

The Fund has entered into an agreement with the following Dental Preferred Provider Organization (PPO):

The Guardian Life Insurance Company
P.O. Box 26095
Lehigh Valley, PA 18002
1-888-600-9200

Claims Administrator and COBRA Administrator

The Board of Trustees has delegated certain administrative functions (including processing of claims for medical, Health Reimbursement Account, voluntary sterilization, physical exam, dental, vision, hearing, and short term disability benefits and COBRA administrator) to the following Claims Administrator/COBRA Administrator:

Group Administrators, Ltd.
915 National Parkway, Suite F
Schaumburg, Illinois 60173
www.groupadministrators.com
Tel: (800) 323-1683
Fax: (847) 519-1979

(All correspondence should reference the Structural Iron Workers Local #1 Welfare Fund.)

Utilization Review Provider

MedCare Management
P.O. Box 20564
West Palm Beach, FL 33416
888-276-6622

Medical Records Provider

Global MED-NET
800-650-7283

EAP (Employee Assistance Program) Provider

Bensinger, DuPont & Associates
20 North Wacker Drive, Suite 920
Chicago, Illinois 60606
800-227-8620
www.bdaeap.com

Prescription Benefit Manager

Sav-Rx
224 North Park Avenue
Fremont, NE 68025
1-800-228-2181
1-800-228-3108
www.savrx.com

AD&D Insurance Provider and Life Insurance Provider

Aetna
One South Wacker Drive
Suite 1200
Chicago, Illinois.60606
312-928-3031 or 860-952-8223.
Fax: 860-262-7622
www.aetna.com

Fund Counsel

Laner, Muchin, Dombrow, Becker, Levin and Tominberg, Ltd.
515 N. State Street, Suite 2800
Chicago, Illinois 60654
Attention: James F. Vanek

Whitfield, McGann & Ketterman
111 East Wacker Drive - Suite 2600
Chicago, Illinois 60601
Attention: Collins Whitfield

Inspection of the Plan

A written Plan Document and Trust Agreement govern the Plan. If you wish, you may inspect these documents at the Fund Office, or you may request copies of documents relating to this Plan. You will be charged a reasonable fee to cover the cost of copying any document you request. To make your request, you should contact the Administrative Manager:

Structural Iron Workers Local #1 Welfare Fund
7700 West Industrial Drive
Forest Park, Illinois 60130
Telephone: (708) 366-1188
Fax: (708) 366-4809

Agent for Service of Legal Process

For disputes arising under the Plan, service of legal process may be made on the Board of Trustees or upon any Trustee at the address of the Fund Office.

For disputes arising under those portions of the Plan which are insured, service of legal process may be made upon an official of the insurance company at one of its local offices, or upon the supervisory official of the Insurance Department in the state where you live.

Gender and Person

Except as the context or benefits may specifically require otherwise, use of the masculine gender will be understood to include both masculine and feminine genders and use of the term “you” will be understood to include both you as the active employee and your covered Dependents if they are eligible for the particular benefits.

YOUR RIGHTS UNDER THE FEDERAL LAW: ERISA

As a participant in the Structural Iron Workers Local #1 Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information About Your Plan And Benefits

You have the right to:

- Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include 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 Benefit Security Administration.
- Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Upon written request to the Fund Administrator, a complete list of the Contributing Employers and employee organizations sponsoring the Plan may be obtained by participants and beneficiaries, and is available for examination.
- Upon written request to the Fund Administrator, receive information as to whether a particular Contributing Employer or employee organization is a sponsor of the Plan, including the address if such Contributing Employer or employee organization is a sponsor.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when:
 - You lose coverage under the Plan;
 - You become entitled to elect COBRA continuation coverage; or
 - Your COBRA continuation coverage ceases.

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

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund 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 Fund.

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 federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefit Security Administration
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 publications hotline of the Employee Benefit Security Administration. For single copies of publications, contact the Employee Benefit Security Administration Brochure Request Line at 800-998-7542 or contact the EBSA field office nearest you. You may also find answers to your Plan questions at the website of the EBSA at <http://www.dol.gov/dol/ebsa/>.

PRIVACY POLICY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations. The Plan will distribute its Privacy Notice or a reminder of its availability periodically, as required by the rules and when changes are made in policies and procedures.

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

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

Your rights under HIPAA with respect to your protected health information include the right to:

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

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

DEFINITIONS

Capitalized terms that are not defined as they arise in this document are defined below.

Collective Bargaining Agreement means a formal agreement regarding wages, hours and conditions of employment entered into between an employer or group of employers and the union representing employees of the employers which requires contributions to the Fund.

Contributing Employer means an employer that is required to contribute to the Plan under the terms of a Collective Bargaining Agreement or a participation agreement.

Covered Charge means charges eligible for reimbursement pursuant to the terms of the Plan, including its benefit limitations and exclusions.

Covered Individual means you (as an employee or retiree) or your Dependent who satisfies the requirements for coverage under the Plan and who continues to meet such requirements.

Custodial Care means care that is designed to help a person in the activities of daily living. Continuous attention by trained medical or paramedical personnel is not necessary. Such care may involve:

- Preparation of special diets;
- Supervision over medication that can be self-administered; and
- Assisting the person in getting in or out of bed, walking, bathing, dressing, eating and using the toilet.

Dentist means a duly licensed dentist acting within the scope of his or her license. It includes a Physician furnishing covered dental services which he or she is licensed to perform. A Dentist does not include you or a member of your immediate family. Immediate family means your spouse, children, brothers, sisters or parents. A Dentist is considered a health care provider.

Employee means employees of

- a member of the Associated Steel Erectors of Chicago, Illinois (the “Association”) and any other employer not a member of the Association, which employs employees within the geographical area of the International Association of Bridge, Structural and Ornamental Iron Workers, AFL CIO, (the “Union”); which acknowledges the Union as the collective bargaining representative of the employees and abides by the terms of the collective bargaining agreement between the Union and the Association;
- the Union;
- the Apprentice and Journeymen Retraining Fund;
- the Structural Iron Workers Local #1 Welfare Fund;

- the Structural Iron Workers Local #1 Pension Trust Fund;
- the Structural Iron Workers Local #1 Annuity Fund,
- the National Iron Workers Training Program for American Indians; or
- any other entity for which there is a written participation agreement requiring employer contributions to be made to the Fund.

“Employee” does not include any self-employed person, independent contractor, owner employee, sole proprietor, partner of a business organization which is a Contributing Employer, independent contractor, or any other person who in the opinion of the Trustees jeopardizes the tax exempt status of the Trust.

Essential Health Benefits means items and services covered within the following general categories: ambulatory patient services, Emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (meaning services provided to individuals under age 19), including oral and vision care.

Experimental and/or Investigative means services, supplies, care and treatment which are not within the range of appropriate, accepted medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of whether the use of specific technologies would be Experimental. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment.

In making its determination, the Plan Administrator will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, the drug or device will be considered Experimental;
2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval, the drug, device, medical treatment or procedure will be considered Investigational;
3. If “Reliable Evidence” shows that the drug, device, medical treatment or procedure is (i) the subject of on-going phase I or phase II clinical trials, (ii) the subject of the research, experimental study or investigational arm of on-going

phase III clinical trials, or (iii) otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, the drug, device, medical treatment or procedure will be considered Experimental; and

4. If “Reliable Evidence” shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trails are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, the drug, device, medical treatment or procedure will be considered Experimental.

“Reliable Evidence” for purposes of (3) and (4) above shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Hospital means an establishment that:

- Holds a license as a Hospital (if required by the state in which it operates);
- Operates primarily for the reception, care and treatment of sick or injured persons as in-patients;
- Provides around the clock nursing service;
- Has a staff of one or more Physicians available at all times;
- Provides organized facilities for diagnosis and surgery (mental Hospitals and behavioral health facilities do not need to have these facilities); and
- Is not primarily a clinic, nursing, rest or convalescent home or a Skilled Nursing Facility or a similar establishment.

The nursing service must be by registered or graduate nurses on duty or call. The surgical facilities may be either at the Hospital or at a facility with which it has a formal arrangement.

Confinement in a special unit of a Hospital used primarily as a nursing, rest or convalescent home or Skilled Nursing Facility will not be deemed to be a confinement in a Hospital.

“Hospital” also includes a licensed ambulatory surgical center. The center must have permanent facilities and be equipped and operated primarily for the purpose of performing surgical procedures. The type of procedures performed must permit discharge from the center in the same “working day.” The center will not qualify as a “Hospital” if:

- It is maintained as an office by a Physician for the practice of medicine; or

- It is maintained as an office for the practice of Dentistry.

“Hospital” also includes a treatment center for alcoholism and drug abuse duly licensed in the jurisdiction in which treatment is provided.

Injury means a physical or mental condition that is the direct or indirect result of an accident (other than an occupational accident) or an assault sustained by a Covered Person while covered under this Plan.

Intensive Care Unit means a section within a Hospital that is operated exclusively for critically ill patients. It must provide special supplies, equipment and constant observation and care by registered nurses or other highly trained Hospital personnel. It does not include any Hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Medicare means benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Necessary Treatment means medical or dental treatment that is consistent with current professionally accepted medical or dental standards of practice. Any confinement, operation, treatment or service that is ***not*** a valid course of treatment recognized by an established medical society in the United States is not considered “Necessary Treatment.” No treatment or service, or expense in connection therewith, which is deemed Experimental or Investigational in nature by an appropriate technological assessment body established by any state or federal government is considered “Necessary Treatment.”

The Fund may use peer review organizations or other professional medical opinion to determine if health care services are:

- Medically necessary; and
- Consistent with professionally recognized standards of care with respect to quality, frequency and duration

Expenses related to those services will not be deemed “Necessary Treatment” if services are not considered to be:

- Medically necessary; or
- Consistent with professionally recognized standards of care with respect to quality, frequency or duration.

The determination of whether expenses relate to “Necessary Treatment” is merely a decision as to the payment of benefits under the Plan; decisions as to the appropriate treatment and care must be made by you in consultation with your Physician or other provider.

Nurse Midwife means a licensed Registered Nurse who is certified as a Nurse Midwife by the American College of Nurse-Midwives and is authorized to practice as a Nurse Midwife under state regulations.

Orthodontic Procedures means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

Physician means a licensed practitioner of the healing arts acting within the scope of his or her license. A Physician does not include you or a member of your immediate family. Immediate family means your spouse, children, brothers, sisters or parents.

“Physician” includes a duly Certified Nurse Midwife with respect to treatment, service or care rendered by such Nurse Midwife within the lawful scope of practice of a duly Certified Nurse Midwife.

Sickness or Illness means a sickness or disease (including mental disorders, substance abuse disorders, chemical dependency disorders and alcoholism) that requires treatment by a Physician is sustained by a Covered Person while covered under this Plan and includes pregnancy and any complications thereof.

Total Disability means, for an employee, the substantial inability to perform the material duties of your regular or customary occupation or employment. The inability must be as a result of Injury or Sickness.

For a retired person and for a Dependent spouse, “Total Disability” means the substantial inability to engage in the normal activities of a person of like age and sex. The inability must be as a result of Injury or Sickness.

For a child, “Total Disability” means confinement to the house or to a Hospital. The confinement must be as a result of Injury or Sickness.

Trustee means a representative of the Union or of the group of employers that participate in the Fund who act in the capacity of trust as a fiduciary and to whom Employer contributions have been conveyed for the benefit of the Plan participants. The Trustees have the duty of managing and preserving the Fund for the benefit of the Fund participants.

Union means the Structural Iron Workers Local No. 1.

Usual and Customary Charge means a charge that does not exceed the general level of charges being made by providers of similar training and experience when furnishing similar services or supplies. The locality where the charge is incurred also will be considered. The term “locality” means a county or such greater area as is necessary to establish a representative cross section of providers regularly furnishing the type of treatment, services or supplies for which the charge was made. Notwithstanding the preceding, with respect to PPO provider charges, the contracted PPO charge is presumed to be the Usual and Customary Charge.