SHOP IRONWORKERS
LOCAL 790
WELFARE PLAN

SUMMARY PLAN DESCRIPTION AND
PLAN RULES AND REGULATIONS
FOR
ACTIVE & RETIRED
PLAN PARTICIPANTS
AND
THEIR ELIGIBLE DEPENDENTS

June 1, 2019

ADMINISTRATIVE OFFICE

Ironworker Employees' Benefit Corporation
131 North El Molino Avenue, Suite 330
Pasadena, CA 91101
(866) 339-7467
(626) 792-7335

EMPLOYER TRUSTEES

Rich Barbour
Michael Newington
Greg McClelland

UNION TRUSTEES

Jacob Jameson
Mike Kilby

LEGAL COUNSEL

Saltzman & Johnson Law Corporation

CONSULTANT

Rael & Letson

SHOP IRONWORKERS LOCAL 790
WELFARE PLAN

131 North El Molino Avenue, Suite 330
Pasadena, CA 91101
(866) 339-7467

TO ALL PARTICIPANTS:

This Summary Plan Description booklet has been prepared to explain to you how your SELF-FUNDED COMPREHENSIVE MEDICAL PLAN available through the Shop Ironworkers Local 790 Welfare Plan works. Also summarized in this Summary Plan Description booklet are the *Eligibility Requirements* that you must satisfy to qualify for benefits, information about the administration of the program, and your rights under the law. The Welfare Plan directly self-funds the *Medical, Prescription Drug Hearing Aid, Mental Health and Substance Abuse and Weekly Accident & Sickness* benefits and those benefits are described in this booklet, along with the procedures for filing claims and appealing denials of claims for these benefits.

Life Insurance and *Accidental Death & Dismemberment* benefits are provided under an insurance policy between the Shop Ironworkers Local 790 Welfare Plan and ReliaStar Life Insurance Company. Benefits are summarized in this booklet. You may request a copy of the *Certificate of Coverage* from the Administrative Office.

Mental Health Network (MHN) provides a *Member Assistance Program (MAP)* for assistance with certain family, job and relationship stress situations. These benefits are summarized in this booklet. You may request a copy of the *Evidence of Coverage* from the Administrative Office.

Vision Care Benefits are provided under an insurance contract with Vision Services Plan. Benefits are summarized in this booklet. You may request a copy of the *Certificate of Coverage* from the Administrative Office.

If you enroll in either the CIGNA PPO Plan or one of the Pre-Paid dental HMO options, *CIGNA* or *United HealthCare Dental,* you will receive a separate *Evidence of Coverage*, which describes your required copayments and information on how to obtain services, as well as the procedures for appealing a denial of a claim.

The Board of Trustees has the right to amend, change, or discontinue the types and amounts of benefits under this Plan, and the rules determining who is eligible for benefits. The Board of Trustees are granted the sole discretionary authority to make any and all determinations under the Plan, including who is eligible for benefits, the amount of benefits payable (if any) under any of the benefits funded directly by the Trust Fund, and the meaning and applicability of Plan provisions. Any such determinations shall be conclusive and binding on all parties having dealings with the Plan. No employer, trustee, or any representative of any employer or union is authorized to interpret this Plan on behalf of the Board of Trustees.

These are not vested or guaranteed lifetime benefits.

We encourage you to read this Summary Plan Description booklet carefully prior to utilizing your Plan benefits. If you have questions about Plan benefits, please contact the Administrative Office.

Sincerely,

BOARD OF TRUSTEES

PRIVACY OF YOUR HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the privacy of your personal health information be protected.

The Plan's notice of privacy practices explains what information is considered "Protected Health Information." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**
Effective Date of Notice: June 1, 2019.

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You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
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OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page. 5
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Psychotherapy notes

OUR USES AND DISCLOSURES

1. How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information as your health plan sponsor for plan administration.

Example: The Plan sponsor contracts with a health provider, and they provide certain statistics to explain the premiums they charge.

Other Uses and Disclosures

Any other use or disclosure not described in the Notice will only be made with your authorization.

Revocation of Prior Authorization.

You may revoke a prior authorization granted for psychotherapy notes, marketing, sales or any other authorized use and disclosure.

2. How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Officer, specified below, at the Administrative Office:

Shop Ironworkers Local 790 Welfare Trust
556 South Fair Oaks Avenue, Suite 30
Pasadena, CA 91105
(866) 339-7467
(626) 792-7335 Fax

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

AVAILABILITY OF PLAN RESOURCES

Benefits provided by the Plan can be paid only to the extent that there are available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide benefits beyond the obligation to make contributions as stipulated in the Collective Bargaining Agreements. In the event that at any time the Plan does not have sufficient assets to permit continued payments, nothing in the Plan shall be construed as obligating any Contributing Employer to make payments in order to provide Plan benefits.

There is no liability on the Trustees, individually or collectively, or upon any Employer, the Union, signatory association or other person or entity to provide benefits if the Plan does not have sufficient assets to make benefit payments.

QUICK REFERENCE CHART

WHERE TO CALL FOR INFORMATION

INFORMATION NEEDED	WHERE TO CALL
Eligibility Information **Claims Information:** Medical Claims Life Insurance and AD&D Hearing Aid Benefit Weekly Accident & Sickness Benefit	**ADMINISTRATIVE OFFICE** Shop Ironworkers Local 790 Welfare Plan C/o Ironworkers Employees' Benefit Corporation 131 N El Molino Ave, Suite 330 Pasadena, CA 91101 (866) 339-7467 **Mailing address for claims:** 556 S Fair Oaks Ave, Suite 30 Pasadena, CA 91105
PPO Provider Network Blue Cross Prudent Buyer	(800) 274-7767 www.bluecrossca.com
Utilization Review Organization Prior to all hospital admissions call Blue Cross**:**	(800) 274-7767
Prescription Drug Benefits WellDyneRx	(888) 479-2000 www.welldynerx.com
Substance Abuse Benefits and Member Assistance Program (MAP)	Mental Health Network (MHN) (800) 624-6864 www.MHN.com
Vision Care Benefit	Vision Service Plan (VSP) (800) 877-7195 www.vsp.com
Dental Care Benefit: PPO and Prepaid Dental Programs	Cigna (PPO Plan) (800) CIGNA-24 Cigna (Prepaid Plan) (800) CIGNA-24 United HealthCare Dental (Prepaid Plan) (800) 999-3367

OPTIONS FOR SELECTION OF PLAN BENEFITS

SUMMARY TABLE

BENEFIT	ACTIVE IRONWORKER	RETIRED IRONWORKER	SUBSCRIBER EMPLOYEE
Life Insurance and AD&D Benefit	Yes	No	Yes
Weekly Accident & Sickness Benefit	Yes	No	No
Medical & Prescription Drug Program	Yes	Yes	Yes
Vision Care Benefit	Yes	No	Yes*
Hearing Aid Benefit	Yes	Yes	Yes
Substance Abuse Benefits	Yes	No	Yes
Member Assistance Program (MAP)	Yes	Yes	Yes
Dental Care Benefit	Yes	No	Yes*

* Vision and Dental Care Benefits are not available to a Subscriber Employee whose Contributing Employer does not enroll for Vision and Dental Care Benefits.

ENROLLMENT PROCEDURE

It is important that the Administrative Office has a completed *Enrollment Form and Beneficiary Card* for you in its files. By working and by having Contributions made on your behalf, you become covered based on the *Eligibility Rules*; however, it is necessary that you complete an *Enrollment Form and Beneficiary Card* before any claims can be processed. The *Enrollment Form and Beneficiary Card* is the means by which you inform the Administrative Office of your Dependents who are eligible for benefits, select a dental plan, and designate your beneficiary for your Life Insurance and Accidental Death & Dismemberment benefits.

If you have not completed an *Enrollment Form and Beneficiary Card,* or if an additional card is needed, you may obtain one from the Administrative Office. It is important that you notify the Administrative Office in the event that:

- You change your home address.
- You wish to change your beneficiary.
- You become disabled.
- There is a change in your family status, *e.g.*, marriage, birth of a child, adoption, death, divorce, etc.

The Plan requires that the name and Social Security Number of all Participants, including Dependents, be reported. Participants must also submit a marriage certificate in order to enroll a spouse. A birth certificate is required to enroll children, stepchildren or foster children. Additional documentation may also be required. The Administrative Office will provide the *Enrollment Form and Beneficiary Card* so that you may enroll new eligible family members or delete those no longer eligible.

IMPORTANT: You can be held liable for benefit payments issued based on any incorrect information about your family members, such as failing to notify the Administrative Office in case of divorce, if your child reaches age 26, or if an adoption is rescinded. In addition, you may be liable for other costs incurred by the Plan as a result of the incorrect information. These costs include, but are not limited to, attorney's fees, administrative costs, and reasonable interest.

SHOP IRONWORKERS LOCAL 790 WELFARE PLAN

SUMMARY OF ACTIVE MEDICAL PLAN BENEFITS – BARGAINED

BLUE CROSS PRUDENT BUYER

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Choice of Providers	In order to receive the highest benefits and lowest out-of-pocket expenses, participants should go to Blue Cross Prudent Buyer PPO contracted doctors, hospitals and other healthcare providers.	Participants may go to doctors, hospitals, and other healthcare providers who are NOT contracted with Blue Cross Prudent Buyer; however, out-of-pocket expenses will be higher. Some benefits are not covered.
Calendar Year Deductible	Individual: $250 Family: $750 The calendar year deductible does not apply to all services.	Individual: $500 Family: $1,500 The calendar year deductible always applies.
Accident Deductible	If 2 or more family members are injured in the same accident, only 1 deductible will apply for Covered Expenses related to that accident.	
Annual Maximum	No annual maximum for Essential Health Benefits	
Lifetime Maximum	Unlimited	
Annual Out-of-Pocket Calendar Year Maximum	Individual: $3,000 after Deductible; $9,000 Family Maximum.	Individual: $5,000 after Deductible; $15,000 Family Maximum.
Inpatient Hospital Room & Board, ICU, Ancillary Charges	80% of contract rate (1) Calendar Year Deductible Applies.	60% of Covered Expenses (1) after a $500 deductible per hospital admission * Calendar Year Deductible also Applies.
Pre-certification of Hospital Admission *You must call Blue Cross (800) 274-7767*	If pre-certification is not obtained for any hospital admission other than for the birth of a child, benefits usually payable will be *reduced by 10%.* For the birth of a child, a mother's hospital stay expected to be longer than 48-hours for a normal delivery or 96-hours for a caesarian delivery requires pre-certification for the extended period. If you are admitted on an emergency basis, Blue Cross must be notified within *24 hours*.	

NOTE: Blue Cross has negotiated fixed amounts that they will pay to providers for various services, referred to as the "contract rate". These negotiated amounts are often far less than normal billed charges. When you use a Prudent Buyer provider, you will not be responsible for the difference between the provider's billed charges and the negotiated amount. *Admission to a non-contracted hospital in a life-threatening emergency will be covered at 80% of Covered Expenses and the $500 deductible per admission to a non-contracted hospital applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Anesthesia	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
EMERGENCY CARE		
Emergency Room (Facility)	80% of contract rate after you pay a $100 copayment; (Co-payment waived, if admitted)	80% of Covered Expenses; You pay a $100 co-payment; Deductible Applies (Co-payment waived, if admitted)
Emergency Room (Professional)	80% of contract rate;	80% of Covered Expenses;
Ambulance (Ground, Air or Water)	80% of contract rate; Deductible Applies.	80% of Covered Expense; Deductible Applies.
Skill Nursing Facility (SNF)	45% of contract rate; up to 55 days per disability; admission must occur after an inpatient hospital stay of at least 5 days; patient must be admitted to the SNF within 7 days of the hospital discharge; Deductible Applies.	35% of Covered Expenses; up to 55 days per disability; admission must occur after an inpatient hospital stay of at least 5 days; patient must be admitted to the SNF within 7 days of the hospital discharge; Deductible Applies.
Home Health Care	80% of contract rate, limitations apply; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
	Prior authorization is required.	
Hospice	100% of contract rate, Limitations apply; Deductible Does Not Apply.	100% of Covered Expenses, Limitations apply; Deductible Does Not Apply.
Physician Visits Office, Outpatient or Home	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Physician Charges - Other Hospital or Surgery (Professional Inpatient)	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Diagnostic X-Rays and Lab associated with office visit	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Diagnostic X-Rays Free-standing Facility or Outpatient Hospital	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Major Imaging Procedures CT Scan, PET Scan, MRI	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
OUTPATIENT SURGERY		
Facility and Professional Fee	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Ambulatory Surgical Center	80% of contract rate; Deductible Applies.	60% of Covered Expenses not to exceed $1,500 allowable per procedure; Deductible Applies.
	Prior Authorization for non-contracting Ambulatory Surgical Centers is required. If prior authorization is not obtained, payments may be denied. Please call the Administrative Office. It is your responsibility to confirm that the facility where the procedure is performed is contracted with Blue Cross Prudent Buyer. Also, certain surgeries also require prior authorization, please contact the Fund Office.	
PODIATRY		
Exam	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Orthotic Appliance	80% of contract rate, up to $200 per calendar year. Deductible Applies.	Not Covered.
Chiropractic	100% of contract rate after a $25 co-pay, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Does Not Apply.	60% of Covered Expenses, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Applies.
Acupuncture	100% of contract rate after a $25 co-pay, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Does Not Apply.	60% of Covered Expenses, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Applies.
	Up to a maximum of $2,000 per calendar year for PPO and Non-PPO charges combined for chiropractic and acupuncture.	

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
OUTPATIENT THERAPY		
Physical and Respiratory	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
SPEECH AND OCCUPATIONAL THERAPY	Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.	Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.
Speech	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Occupational	100% of contract rate after a $25 co-pay. Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Chemotherapy	80% of the contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Radiation Therapy	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
Intravenous Infusion Therapy	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
Dialysis	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
FAMILY PLANNING		
Infertility	NOT COVERED	NOT COVERED
Vasectomy	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Tubal Ligation	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
IUD	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Elective Abortions	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Routine Exams for Preventive Health	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
WELL BABY/CHILD CARE	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
	Charges for immunizations are included in well baby/childcare.	
WELL WOMAN CARE		
Examinations	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Pap Tests	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Mammogram	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
CARE FOR ALLERGIES		
Office Visit	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Testing	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Treatment and Serum	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Immunizations	Covered under routine exams and preventive health as shown previously.	Covered under routine exams and preventive health as shown previously.
Durable Medical Equipment	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies
Prosthetics, Orthopedic Braces, Other Equipment and Supplies	Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office. Compression Stockings & Mastectomy Bras – 2 Per Year. Wigs (A9282) – 1 per lifetime with a $500 lifetime maximum.	Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office. Compression Stockings & Mastectomy Bras – 2 Per Year. Wigs (A9282) – 1 per lifetime with a $500 lifetime maximum.
HEARING CARE		
Exam	Plan pays 100% of contract rate; Deductible Does Not Apply.	Plan pays 100% of Covered Expenses; Deductible Does Not Apply.
Molding	80% of contract rate – Dependent children only – Under 1 year old – once every 2 months - $100 maximum for each molding change up to a maximum of $600. 1 year old to 14 years old – once a year - $100 maximum for each molding change.	60% of Covered Expenses – Dependent children only – Under 1 year old – once every 2 months - $100 maximum for each molding change up to a maximum of $600. 1 year old to 14 years old – once a year - $100 maximum for each molding change.
Hearing Aid	Plan pays 80% up to a maximum of $1,500 for each hearing aid device (Left & Right) – including initial batteries. Plan covers one device per ear every four years. *Retirees are eligible for this benefit only until they reach age 65.*	Plan pays 80% up to a maximum of $1,500 for each hearing aid device (Left & Right) – including initial batteries. Plan covers one device per ear every four years. *Retirees are eligible for this benefit only until they reach age 65.*
TMJ	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Member Assistance Program	You may receive up to five face-to-face, telephonic, or web video consultations from MHN. You may also receive telephonic consultations for the following: legal, financial, child and elder care, identity theft prevention and recovery, and daily living issues.	
Substance Abuse	All inpatient benefits must be authorized by MHN. Call (800) 624-6864. If pre-authorization is not obtained, there will be a 10% reduction in benefits.	
Inpatient *(Includes detoxification)*	Plan pays 80% of the contract rate; Deductible Applies	Plan pays 60% of the Covered Expenses after a $500 deductible per hospital admission; Calendar Year Deductible also Applies.
Alternate Levels of Care *(Includes partial hospitalization, day treatment, and intensive outpatient)*	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of Covered Expenses; Deductible Applies.
Outpatient	100% of contract rate after a $25 co-pay; Deductible Does Not Apply	Plan pays 60% of Covered Expenses; Deductible Applies.
Maximum for all services	All benefits must be authorized by Health Management Companies/(MHN). Call (800) 526-6657.	
Annual Maximum	No annual maximum on Essential Health Benefits	
Mental Health	All inpatient services require preauthorization from MHN. Call (800) 624-6864. If pre-authorization is not obtained, there will be a 10% reduction in benefits.	
Inpatient	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of the Covered Expenses after a $500 deductible per hospital admission; Calendar Year Deductible also Applies.
Alternate Levels of Care *(Includes partial hospitalization, day treatment, and intensive outpatient)*	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of the Covered Expenses; Deductible Applies.
Outpatient	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	Plan pays 60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER | NON-CONTRACT PROVIDER
Supplemental Accident	100% of Covered Expenses incurred within 90 days of an accident; up to $300 for medical and $100 for X-ray/Lab services per accident; documentation must be provided to the Administrative Office. Deductible Does Not Apply. Charges remaining after the Supplemental Accident benefits have been paid will be subject to normal Plan provisions for Non-PPO claims – including coinsurance levels, calendar year deductible, and other applicable Plan provisions.
Prescription Drugs	All prescription Drugs must be obtained at pharmacies contracted with WellDyneRx.
All Generic Drugs	$15 Copayment – Retail – 30 days supply* $30 Copayment – Mail Order – 90 days supply*
Brand Name Drug on Formulary	$30 Copayment – Retail – 30 days supply $60 Copayment – Mail Order – 90 days supply
Brand Name Drug that is NOT on Formulary	$55 Copayment – Retail – 30 days supply $110 Copayment – Mail Order – 90 days supply

The above Summary of Benefits is only a SUMMARY of the coverage actually provided by the Comprehensive Medical Plan. Not all exclusions and limitations have been included. Please refer to the specific sections of this booklet for details. **No copayment is required for generic oral contraceptives.*

SHOP IRONWORKERS LOCAL 790 WELFARE PLAN

SUMMARY OF ACTIVE MEDICAL PLAN BENEFITS – NON-BARGAINED

BLUE CROSS PRUDENT BUYER – EFFECTIVE JUNE 1, 2019

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Choice of Providers	In order to receive the highest benefits and lowest out-of-pocket expenses, participants should go to Blue Cross Prudent Buyer PPO contracted doctors, hospitals and other healthcare providers.	Participants may go to doctors, hospitals, and other healthcare providers who are NOT contracted with Blue Cross Prudent Buyer; however, out-of-pocket expenses will be higher. Some benefits are not covered.
Calendar Year Deductible	Individual: $750 Family: $1,500 The calendar year deductible does not apply to all services.	Individual: $1,500 Family: $3,000 The calendar year deductible always applies.
Accident Deductible	If 2 or more family members are injured in the same accident, only 1 deductible will apply for Covered Expenses related to that accident.	
Annual Maximum	No annual maximum for Essential Health Benefits	
Lifetime Maximum	Unlimited	
Annual Out-of-Pocket Calendar Year Maximum	Individual: $5,000 after Deductible; $12,000 Family Maximum.	Individual: $10,000 after Deductible; $20,000 Family Maximum.
Inpatient Hospital Room & Board, ICU, Ancillary Charges	80% of contract rate; (1) Calendar Year Deductible Applies.	60% of Covered Expenses (1) after a $500 deductible per hospital admission. * Calendar Year Deductible also Applies.
Pre-certification of Hospital Admission *You must call Blue Cross (800) 274-7767*	If pre-certification is not obtained for any hospital admission other than for the birth of a child, benefits usually payable will be *reduced by 10%.* For the birth of a child, a mother's hospital stay expected to be longer than 48-hours for a normal delivery or 96-hours for a caesarian delivery requires pre-certification for the extended period. If you are admitted on an emergency basis, Blue Cross must be notified within *24 hours*.	

Note: ***Blue Cross has negotiated fixed amounts that they will pay to providers for various services, referred to as the "contract rate". These negotiated amounts are often far less than normal billed charges. When you use a Prudent Buyer provider, you will not be responsible for the difference between the provider's billed charges and the negotiated amount. *Admission to a non-contracted hospital in a life-threatening emergency will be covered at 80% of Covered Expenses and the $500 deductible per admission to a non-contracted hospital applies.***

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Anesthesia	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
EMERGENCY CARE		
Emergency Room (Facility)	80% of contract rate after you pay a $300 copayment; (Co-payment waived, if admitted)	80% of Covered Expenses; You pay a $300 co-payment; Deductible Applies (Co-payment waived, if admitted)
Emergency Room (Professional)	80% of contract rate;	80% of Covered Expenses;
Ambulance (Ground, Air or Water)	80% of contract rate; Deductible Applies.	80% of Covered Expense; Deductible Applies.
Skill Nursing Facility (SNF)	45% of contract rate; up to 55 days per disability; admission must occur after an inpatient hospital stay of at least 5 days; patient must be admitted to the SNF within 7 days of the hospital discharge; Deductible Applies.	35% of Covered Expenses; up to 55 days per disability; admission must occur after an inpatient hospital stay of at least 5 days; patient must be admitted to the SNF within 7 days of the hospital discharge; Deductible Applies.
	Additional benefits are available in the case of an accident.	
Home Health Care	80% of contract rate, limitations apply; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
	Prior authorization is required.	
Hospice	100% of contract rate, Limitations apply; Deductible Does Not Apply.	100% of Covered Expenses, Limitations apply; Deductible Does Not Apply.
Physician Visits Office, Outpatient or Home	100% of contract rate after a $35 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Physician Charges - Other Hospital or Surgery (Professional Inpatient)	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Diagnostic X-Rays and Lab associated with office visit	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Diagnostic X-Rays Free-standing Facility or Outpatient Hospital	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Major Imaging Procedures CT Scan, PET Scan, MRI	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
OUTPATIENT SURGERY		
Facility and Professional Fee	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Ambulatory Surgical Center	80% of contract rate; Deductible Applies.	60% of Covered Expenses not to exceed $1,500 allowable per procedure; Deductible Applies.
	Prior Authorization for non-contracting Ambulatory Surgical Centers is required. If prior authorization is not obtained, payments may be denied. Please call the Administrative Office. It is your responsibility to confirm that the facility where the procedure is performed is contracted with Blue Cross Prudent Buyer. Also, certain surgeries also require prior authorization, please contact the Fund Office.	
PODIATRY		
Exam	100% of contract rate after a $35 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Orthotic Appliance	80% of contract rate, up to $200 per calendar year. Deductible Applies.	Not Covered.
Chiropractic	100% of contract rate after a $35 co-pay, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Does Not Apply.	60% of Covered Expenses, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Applies.
Acupuncture	100% of contract rate after a $35 co-pay, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Does Not Apply.	60% of Covered Expenses, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Applies.
	Up to a maximum of $2,000 per calendar year for PPO and Non-PPO charges combined for chiropractic and acupuncture.	

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
OUTPATIENT THERAPY		
Physical and Respiratory	100% of contract rate after a $35 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
SPEECH AND OCCUPATIONAL THERAPY	Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.	Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.
Speech	100% of contract rate after a $35 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Occupational	100% of contract rate after a $35 co-pay. Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Chemotherapy	80% of the contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Radiation Therapy	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
Intravenous Infusion Therapy	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
Dialysis	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
FAMILY PLANNING		
Infertility	NOT COVERED	NOT COVERED
Vasectomy	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Tubal Ligation	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
IUD	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Elective Abortions	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Routine Exams for Preventive Health	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
WELL BABY/CHILD CARE	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
	Charges for immunizations are included in well baby/childcare.	
WELL WOMAN CARE		
Examinations	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Pap Tests	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.

Mammogram	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
CARE FOR ALLERGIES		
Office Visit	100% of contract rate after a $35 co-pay; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Testing	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Treatment and Serum	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Immunizations	Covered under routine exams and preventive health as shown previously.	Covered under routine exams and preventive health as shown previously.
Durable Medical Equipment	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies
Prosthetics, Orthopedic Braces, Other Equipment and Supplies	Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office. Compression Stockings & Mastectomy Bras – 2 Per Year. Wigs (A9282) – 1 per lifetime with a $500 lifetime maximum.	Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office. Compression Stockings & Mastectomy Bras – 2 Per Year. Wigs (A9282) – 1 per lifetime with a $500 lifetime maximum.
HEARING CARE		
Exam	Plan pays 100% of contract rate; Deductible Does Not Apply.	Plan pays 100% of Covered Expenses; Deductible Does Not Apply.
Molding	80% of contract rate – Dependent children only – Under 1 year old – once every 2 months - $100 maximum for each molding change up to a maximum of $600. 1 year old to 14 years old – once a year - $100 maximum for each molding change.	60% of Covered Expenses – Dependent children only – Under 1 year old – once every 2 months - $100 maximum for each molding change up to a maximum of $600. 1 year old to 14 years old – once a year - $100 maximum for each molding change.
Hearing Aid	Plan pays 80% up to a maximum of $1,500 for each hearing aid device (Left & Right) – including initial batteries. Plan covers one device per ear every four years. *Retirees are eligible for this benefit only until they reach age 65.*	Plan pays 80% up to a maximum of $1,500 for each hearing aid device (Left & Right) – including initial batteries. Plan covers one device per ear every four years. *Retirees are eligible for this benefit only until they reach age 65.*

TMJ	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Member Assistance Program	You may receive up to five face-to-face, telephonic, or web video consultations from MHN. You may also receive telephonic consultations for the following: legal, financial, child and elder care, identity theft prevention and recovery, and daily living issues.	
Substance Abuse	All inpatient benefits must be authorized by MHN. Call (800) 624-6864. If pre-authorization is not obtained, there will be a 10% reduction in benefits.	
Inpatient *(Includes detoxification)*	Plan pays 80% of the contract rate; Deductible Applies	Plan pays 60% of the Covered Expenses after a $500 deductible per hospital admission; Calendar Year Deductible also Applies.
Alternate Levels of Care *(Includes partial hospitalization, day treatment, and intensive outpatient)*	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of Covered Expenses; Deductible Applies.
Outpatient	100% of contract rate after a $35 co-pay; Deductible Does Not Apply	Plan pays 60% of Covered Expenses; Deductible Applies.
Maximum for all services	All benefits must be authorized by Health Management Companies/(MHN). Call (800) 526-6657.	
Annual Maximum	No annual maximum on Essential Health Benefits	
Mental Health	All inpatient services require preauthorization from MHN. Call (800) 624-6864. If pre-authorization is not obtained, there will be a 10% reduction in benefits.	
Inpatient	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of the Covered Expenses after a $500 deductible per hospital admission; Calendar Year Deductible also Applies.
Alternate Levels of Care *(Includes partial hospitalization, day treatment, and intensive outpatient)*	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of the Covered Expenses; Deductible Applies.
Outpatient	100% of contract rate after a $35 co-pay; Deductible Does Not Apply.	Plan pays 60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Supplemental Accident	100% of Covered Expenses incurred within 90 days of an accident; up to $300 for medical and $100 for X-ray/Lab services per accident; documentation must be provided to the Administrative Office. Deductible Does Not Apply. Charges remaining after the Supplemental Accident benefits have been paid will be subject to normal Plan provisions for Non-PPO claims – including coinsurance levels, calendar year deductible, and other applicable Plan provisions.	
Prescription Drugs	All prescription Drugs must be obtained at pharmacies contracted with WellDyneRx.	
All Generic Drugs	$25 Copayment – Retail – 30 days supply* $50 Copayment – Mail Order – 90 days supply*	
Brand Name Drug on Formulary	$45 Copayment – Retail – 30 days supply $90 Copayment – Mail Order – 90 days supply	
Brand Name Drug that is NOT on Formulary	$75 Copayment – Retail – 30 days supply $150 Copayment – Mail Order – 90 days supply	

The above Summary of Benefits is only a SUMMARY of the coverage actually provided by the Comprehensive Medical Plan. Not all exclusions and limitations have been included. Please refer to the specific sections of this booklet for details. **No copayment is required for generic oral contraceptives.*

SUMMARY OF RETIREE MEDICAL PLAN BENEFITS

BLUE CROSS PRUDENT BUYER

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Choice of Providers	In order to receive the highest benefits and lowest out-of-pocket expenses, participants should go to Blue Cross Prudent Buyer PPO contracted doctors, hospitals and other healthcare providers.	Participants may go to doctors, hospitals, and other healthcare providers who are NOT contracted with Blue Cross Prudent Buyer; however, out-of-pocket expenses will be higher. Some benefits are not covered.
Calendar Year Deductible	Individual: $250 Family: $750 The calendar year deductible does not apply to all services.	Individual: $500 Family: $1,500 The calendar year deductible always applies.
Accident Deductible	If 2 or more family members are injured in the same accident, only 1 deductible will apply for Covered Expenses related to that accident.	
Annual Maximum	No annual maximum for Essential Health Benefits	
Lifetime Maximum	Unlimited	
Annual Out-of-Pocket Calendar Year Maximum	Individual: $3,000 after Deductible; $9,000 Family Maximum.	Individual: $5,000 after Deductible; $15,000 Family Maximum.
Inpatient Hospital Room & Board, ICU, Ancillary Charges	80% of contract rate; (1) Calendar Year Deductible Applies.	60% of Covered Expenses (1) after a $500 deductible per hospital admission. * Calendar Year Deductible also Applies.
Pre-certification of Hospital Admission *You must call Blue Cross (800) 274-7767*	If pre-certification is not obtained for any hospital admission other than for the birth of a child, benefits usually payable will be *reduced by 10%.* For the birth of a child, a mother's hospital stay expected to be longer than 48-hours for a normal delivery or 96-hours for a caesarian delivery requires pre-certification for the extended period. If you are admitted on an emergency basis, Blue Cross must be notified within *24 hours*.	

(1) Blue Cross has negotiated fixed amounts that they will pay to providers for various services, referred to as the "contract rate". These negotiated amounts are often far less than normal billed charges. When you use a Prudent Buyer provider, you will not be responsible for the difference between the provider's billed charges and the negotiated amount. *Admission to a non-contracted hospital in a life-threatening emergency will be covered at 80% of Covered Expenses and the $500 deductible per admission to a non-contracted hospital applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Anesthesia	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
EMERGENCY CARE		
Emergency Room (Facility)	80% of contract rate after you pay a $100 copayment; (Co-payment waived, if admitted)	80% of Covered Expenses; You pay a $100 co-payment; Deductible Applies (Co-payment waived, if admitted)
Emergency Room (Professional)	80% of contract rate;	80% of Covered Expenses;
Ambulance (Ground, Air or Water)	80% of contract rate; Deductible Applies.	80% of Covered Expense; Deductible Applies.
Skill Nursing Facility (SNF)	45% of contract rate; up to 55 days per disability; admission must occur after an inpatient hospital stay of at least 5 days; patient must be admitted to the SNF within 7 days of the hospital discharge; Deductible Applies.	35% of Covered Expenses; up to 55 days per disability; admission must occur after an inpatient hospital stay of at least 5 days; patient must be admitted to the SNF within 7 days of the hospital discharge; Deductible Applies.
	Additional benefits are available in the case of an accident.	
Home Health Care	80% of contract rate, limitations apply; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
	Prior authorization is required.	
Hospice	100% of contract rate, Limitations apply; Deductible Does Not Apply.	100% of Covered Expenses, Limitations apply; Deductible Does Not Apply.
Physician Visits Office, Outpatient or Home	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Physician Charges - Other Hospital or Surgery (Professional Inpatient)	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Diagnostic X-Rays and Lab associated with office visit	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Diagnostic X-Rays Free-standing Facility or Outpatient Hospital	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Major Imaging Procedures CT Scan, PET Scan, MRI	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
OUTPATIENT SURGERY		
Facility and Professional Fee	80% of contract rate; Deductible Applies.	60% of Covered Expenses; Deductible Applies.
Ambulatory Surgical Center	80% of contract rate; Deductible Applies.	60% of Covered Expenses not to exceed $1,500 allowable per procedure; Deductible Applies.
	Prior Authorization for non-contracting Ambulatory Surgical Centers is required. If prior authorization is not obtained, payments may be denied. Please call the Administrative Office. It is your responsibility to confirm that the facility where the procedure is performed is contracted with Blue Cross Prudent Buyer. Also, certain surgeries also require prior authorization, please contact the Fund Office.	
PODIATRY		
Exam	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Orthotic Appliance	80% of contract rate, up to $200 per calendar year. Deductible Applies.	Not Covered.
Chiropractic	100% of contract rate after a $25 co-pay, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Does Not Apply.	60% of Covered Expenses, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Applies.
Acupuncture	100% of contract rate after a $25 co-pay, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Does Not Apply.	60% of Covered Expenses, up to a maximum of $35 per visit, up to a maximum of $2,000 per calendar year; Deductible Applies.
	Up to a maximum of $2,000 per calendar year for PPO and Non-PPO charges combined for chiropractic and acupuncture.	

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
OUTPATIENT THERAPY		
Physical and Respiratory	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
SPEECH AND OCCUPATIONAL THERAPY	Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.	Only covered if Case Manager determines that Speech and Occupational Therapy is medically necessary. Prior authorization is required.
Speech	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Occupational	100% of contract rate after a $25 co-pay. Deductible Does Not Apply.	60% of Covered Expenses; Deductible Applies.
Chemotherapy	80% of the contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Radiation Therapy	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
Intravenous Infusion Therapy	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
Dialysis	80% of contract rate; Deductible Applies	60% of the Covered Expenses; Deductible Applies
FAMILY PLANNING		
Infertility	NOT COVERED	NOT COVERED
Vasectomy	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Tubal Ligation	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
IUD	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Elective Abortions	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Routine Exams for Preventive Health	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
WELL BABY/CHILD CARE	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
	Charges for immunizations are included in well baby/childcare.	
WELL WOMAN CARE		
Examinations	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.

Pap Tests	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Mammogram	100% of contract rate; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
CARE FOR ALLERGIES		
Office Visit	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	60% of the Covered Expenses; Deductible Applies.
Testing	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Treatment and Serum	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.
Immunizations	Covered under routine exams and preventive health as shown previously.	Covered under routine exams and preventive health as shown previously.
Durable Medical Equipment	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies
Prosthetics, Orthopedic Braces, Other Equipment and Supplies	Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office. Compression Stockings & Mastectomy Bras – 2 Per Year. Wigs (A9282) – 1 per lifetime with a $500 lifetime maximum.	Prescription must state medical necessity and prior authorization is required. Please contact the Administrative Office. Compression Stockings & Mastectomy Bras – 2 Per Year. Wigs (A9282) – 1 per lifetime with a $500 lifetime maximum.
HEARING CARE		
Exam	Plan pays 100% of contract rate; Deductible Does Not Apply.	Plan pays 100% of Covered Expenses; Deductible Does Not Apply.
Molding	80% of contract rate – Dependent children only – Under 1 year old – once every 2 months - $100 maximum for each molding change up to a maximum of $600. 1 year old to 14 years old – once a year - $100 maximum for each molding change.	60% of Covered Expenses – Dependent children only – Under 1 year old – once every 2 months - $100 maximum for each molding change up to a maximum of $600. 1 year old to 14 years old – once a year - $100 maximum for each molding change.
Hearing Aid	Plan pays 80% up to a maximum of $1,500 for each hearing aid device (Left & Right) – including initial batteries. Plan covers one device per ear every four years.	Plan pays 80% up to a maximum of $1,500 for each hearing aid device (Left & Right) – including initial batteries. Plan covers one device per ear every four years.

	Retirees are eligible for this benefit only until they reach age 65.	*Retirees are eligible for this benefit only until they reach age 65.*
TMJ	80% of contract rate; Deductible Applies.	60% of the Covered Expenses; Deductible Applies.

MEDICAL BENEFIT	BLUE CROSS PROVIDER	NON-CONTRACT PROVIDER
Member Assistance Program	You may receive up to five face-to-face, telephonic, or web video consultations from MHN. You may also receive telephonic consultations for the following: legal, financial, child and elder care, identity theft prevention and recovery, and daily living issues.	
Maximum for all services	All inpatient services require preauthorization from (MHN).	
Annual Maximum	No annual maximum on Essential Health Benefits	
Mental Health	All inpatient services require preauthorization from MHN. Call (800) 624-6864. If pre-authorization is not obtained, there will be a 10% reduction in benefits.	
Inpatient	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of the Covered Expenses after a $500 deductible per hospital admission; Calendar Year Deductible also Applies.
Alternate Levels of Care *(Includes partial hospitalization, day treatment, and intensive outpatient)*	Plan pays 80% of the contract rate; Deductible Applies.	Plan pays 60% of the Covered Expenses; Deductible Applies.
Outpatient	100% of contract rate after a $25 co-pay; Deductible Does Not Apply.	Plan pays 60% of the Covered Expenses; Deductible Applies.
Supplemental Accident	100% of Covered Expenses incurred within 90 days of an accident; up to $300 for medical and $100 for X-ray/Lab services per accident; documentation must be provided to the Administrative Office. Deductible Does Not Apply. Charges remaining after the Supplemental Accident benefits have been paid will be subject to normal Plan provisions for Non-PPO claims – including coinsurance levels, calendar year deductible, and other applicable Plan provisions.	
Prescription Drugs	All prescription Drugs must be obtained at pharmacies contracted with WellDyneRx.	
All Generic Drugs	$15 Copayment – Retail – 30 days supply* $30 Copayment – Mail Order – 90 days supply*	
Brand Name Drug on Formulary	$30 Copayment – Retail – 30 days supply $60 Copayment – Mail Order – 90 days supply	
Brand Name Drug that is NOT on Formulary	$55 Copayment – Retail – 30 days supply $110 Copayment – Mail Order – 90 days supply	

The above Summary of Benefits is only a SUMMARY of the coverage actually provided by the Comprehensive Medical Plan. Not all exclusions and limitations have been included. Please refer to the specific sections of this booklet for details. **No copayment is required for generic oral contraceptives.*

LIFE EVENTS

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when different events occur.

1. YOU BECOME ELIGIBLE FOR BENEFITS

When you meet the initial eligibility requirements (refer to page 33), you and your Dependents (refer to page 44) become eligible for the benefits provided by the Shop Iron Workers Local 790 Welfare Plan. The Administrative Office will send you a packet of information, including:

- a copy of this Summary Plan Description;
- an *Enrollment Form and Beneficiary Card*; and
- a Notice of COBRA Rights.

You must complete and return the *Enrollment Form and Beneficiary Card*. In order to establish Dependent coverage, you must provide the following to the Administrative Office:

- for your spouse's coverage, a certified copy of your marriage certificate;
- for your natural or step-children, a certified copy of their birth certificates; and
- for your adopted children, a certified copy of the adoption papers.

2. DESIGNATING YOUR BENEFICIARY

You may name more than one beneficiary for your Life Insurance and AD&D Benefits and you may change your beneficiary at any time. If you name more than one beneficiary, you should indicate how your benefits should be divided. The initial designation or change of designation will take effect on the date it is received by the Administrative Office. It is important that you name a beneficiary. If you do not name a beneficiary or if your beneficiary is not living at the time of your death, your benefit will be paid to your survivors as follows:

- spouse; or if none,
- children, in equal shares; or if none,
- parent(s), in equal shares; or if none,
- brothers and sisters, in equal shares; or if none,
- estate.

3. GETTING MARRIED

When you marry, the medical, dental and vision programs will cover your spouse. To enroll your spouse for coverage, call the Administrative Office and request an *Enrollment Form and Beneficiary Card*. Complete the form and return it to the Administrative Office within 31 days of the marriage. Coverage begins on the first day of the month following your marriage if you have completed the updated *Enrollment Form and Beneficiary Card* and provided the Administrative Office with a copy of your marriage certificate.

You will also need to decide whether to name your spouse as your beneficiary for Life and AD&D benefits.

4. IF YOU HAVE A BABY OR ADOPT A CHILD

Your natural child will be eligible for coverage on the date of birth. You should request an *Enrollment Form and Beneficiary Card* from the Administrative Office within 31 days of the birth or adoption to update your Dependent information and return it to the Administrative Office as soon as possible.

If a child is placed with you for adoption, he or she will be eligible for coverage on the date of placement as long as you assumed legal responsibility for the financial support of the child and the situation meets the Plan requirements. See the *Eligibility Rules for Dependents* (refer to page 44) for the requirements for adopted children and stepchildren.

You may also be eligible to take a leave of absence under the Family and Medical Leave Act (FMLA – refer to page 37). You should discuss this with your Employer's personnel manager. FMLA is not provided by the Trust Fund.

5. IF YOU BECOME LEGALLY SEPARATED OR DIVORCED

If you and your spouse become legally separated or divorced, your spouse will no longer be eligible for coverage. However, your spouse may elect to continue coverage under COBRA for up to 36 months (see page 48). You or your spouse must notify the Administrative Office in writing within 60 days after the legal separation or divorce in order for your spouse to obtain COBRA continuation coverage.

A qualified medical child support order (QMCSO – refer to page 45) could have an effect on your benefit coverage or elections. Please notify the Administrative Office if you become aware of an order like this as part of divorce proceedings.

Review your beneficiary designations for Life and AD&D benefits and decide whether to name a different beneficiary.

6. IF YOUR CHILD LOSES HIS OR HER ELIGIBILITY

In general, your child is no longer eligible for coverage when he or she reaches age 26. You should contact the Administrative Office to remove your child from the dependent listing as soon as he or she is no longer eligible.

Your child may elect to continue coverage under COBRA for up to 36 months. You or your child must notify the Administrative Office in writing within 60 days after your child no longer meets the eligibility requirements to obtain COBRA continuation coverage.

If your child is not capable of self-supporting employment because of a physical or mental handicap you may continue coverage for that child for as long as your own coverage continues. To qualify, your child's disability must begin before his or her coverage would otherwise end (refer to page 45).

7. IF YOU BECOME DISABLED

If you become disabled (including undergoing inpatient or residential substance abuse treatment, authorized by Managed Health Network), you must obtain a *Disability Claim Form* from the Administrative Office. Have the certificate completed by your physician and return it to the Administrative Office for processing. After satisfactory proof of your disability has been received, your hour bank will credited for a limited number of hours each day during the first 26 weeks of disability (refer to page 35). If you continue to be disabled, you may make self-payments to continue your coverage (refer to page 35). If you are a Subscriber Employee, refer to page 43.

8. HAVE A SUBSTANCE USE OR ABUSE PROBLEM

If you have a substance use or abuse problem you should call Managed Health Network for prompt and confidential assistance (refer to page 74). You should also file a claim for Weekly Disability Benefits and extension of your coverage (see above).

If you are not sure if you need this level of assistance, but you or your spouse are concerned about this issue, call the Member Assistance Program (MAP) MHN can assist with other resources for managing life events.

9. IF YOU ARE CALLED INTO MILITARY SERVICE

If you are called into military service (active duty or inactive duty training) for up to 30 days, your health care coverage will continue. If you are called into military service for 31 days or more, you may continue your coverage by making self-contributions for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your coverage will continue to the earliest of the following:

- the date you or your dependents do not make the required self-contributions within 30 days of the due date;
- the date the Plan no longer provides any group health benefits;
- the date you reinstate your eligibility for coverage under the Plan;
- the end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- the last day of the month after 24 consecutive months.

It is very important that you notify the Administrative Office when you enter into military service and within 90 days after your discharge or release from military service. For more information about self-contributions under USERRA refer to page 36, or contact the Administrative Office.

10. IF YOU RETIRE FROM ACTIVE EMPLOYMENT

When you retire, you may be eligible for retiree coverage. In general, you will qualify for retiree coverage when you meet all of the Plan's requirements listed on page 38.

Retirees are eligible for medical/prescription drug benefits under the Comprehensive Medical Plan until they reach age 65. You must make self-contributions for retiree coverage. Once you reach age 65, your retiree coverage is provided under a Medicare Advantage Plan provided by Kaiser (refer to page 38).

11. IN THE EVENT OF YOUR DEATH

If you die while you are an active employee, your beneficiary will receive a life insurance benefit (and an AD&D benefit if your death is caused by an accident). See the Life Insurance AD&D Benefits sections of this booklet (page 79) for more information about these benefits.

Your surviving Dependents may continue medical and prescription drug coverage for a limited time after your death without charge (refer to page 36) or they may elect COBRA continuation coverage (refer to page 48), but not both.

ELIGIBILITY RULES FOR ACTIVE IRONWORKERS

1. INITIAL ELIGIBILITY FOR ACTIVE IRONWORKERS

You will become eligible for benefits - life insurance, accidental death & dismemberment benefits, weekly accident and sickness benefits, medical, prescription drug, MAP, vision, and dental programs - if you work the required number of hours in employment covered by a Collective Bargaining Agreement and your Employer makes the required Contribution on your behalf.

Effective January 1, 2018, you become eligible on the first day of the Eligibility Quarter immediately following a Qualifying Quarter during which you worked at least 330 hours for a Contributing Employer, which has made the required Contribution on your behalf. Please note that this change will not impact the Eligibility Quarters prior to **July 1, 2018**.

If you worked at least 330 hours during the following Qualifying Quarter:	You & your Dependents are eligible during the following eligibility quarter:
December 1 through February 28/29	April 1 through June 30
March 1 through May 31	July 1 through September 30
June 1 through August 31	October 1 through December 31
September 1 through November 30	January 1 through March 31

An Ironworker will continue to be eligible provided he continues to work at least 330 hours of covered employment for a Contributing Employer that makes the required Contribution on his behalf during any Qualifying Quarter.

Coverage for eligible Dependents begins on the same day as coverage for an Ironworker begins, or after the date the Dependent is acquired. Refer to the section of the booklet titled '*Eligibility Rules for Dependents*' for information on who qualifies as your Dependents.

2. INITIAL ELIGIBILITY FOR NEWLY ORGANIZED EMPLOYEES OF NEW CONTRIBUTING EMPLOYERS

The following rules will apply to employees of Contributing Employers who first begin contributing to the Plan due to the Union's organizing efforts. These rules will apply from the Employer's contribution effective date until the end of the fourth full calendar month thereafter.

A Newly Organized Employee who works at least 120 hours of covered employment for a Contributing Employer who:

- made contributions on his behalf no later than the 20th day of each work month, and,
- is a new Contributing Employer to the Plan, and
- has been providing Ironworkers with significant health care coverage during the three consecutive months immediately preceding the date the Employer first becomes obligated to contribute to the Plan,

will become eligible on the first day of the following month if the Employee was on the Employer's payroll on the date the Employer is first obligated to contribute to the Plan, assuming the Employee was not already eligible under the Plan and he has completed an *Enrollment Form and Beneficiary Card*.

Effective the 5th month, all hours worked in covered employment, for which contributions were paid, will count toward the establishment of regular eligibility as described above based on the *Qualifying Quarter.*

Examples. The following examples assume that contributions began on the first day of the month; all Employees were on the Employer's payroll when contributions began, the Employees were not already Plan Participants, and the Employees received significant health coverage from the Employer for the three consecutive months prior to the month in which the Employer began contributing to the Plan.

(1)

Work Month	Hours	Eligibility
January		150
February	150	March
March	120	April
April	120	May

Employee ceases to be a Newly Organized Employee on May 1, the first of the 5th full month since the contribution effective date of January 1. Because the Employee completed a Qualifying Quarter (330 hours in December-February), he will be eligible for June coverage based upon hours worked in January and February and will be eligible for July, August and September coverage based upon hours worked in March, April and May.

(2)

Work Month	Hours	Eligibility
January	150	February
February	0	No coverage in March (Employee may self-pay)
March	0	No coverage in April (Employee may self-pay)
April	165	May
May	165	No coverage in June (Employee may self-pay)

No regular eligibility established in Qualifying Quarter ended February. Ceases to be a Newly Organized Employee May 1, the first of the 5th full month since the contribution effective date of January 1. Work in Qualifying Quarter ended May provides eligibility in Eligibility Quarter beginning July 1.

3. CONTINUATION OF ELIGIBILITY FOR DISABILITY

If you, while eligible under this Plan, become unable to work for a Contributing Employer as the result of a Physician-certified disability, your time lost will be counted as time worked at the rate of 4 hours per day, up to a maximum of 20 hours per week for each week of disability, up to a maximum of 26 weeks for any one disability. Continuation of eligibility for Disability is not provided to persons on COBRA.

If your eligibility terminates as a result of disability, and you subsequently return to work for a Contributing Employer that makes the required Contribution on your behalf within one year following such termination, you become eligible on the first day of the month following your return to work and you will remain eligible for the balance of the Eligibility Quarter.

4. TERMINATION OF ELIGIBILITY FOR ACTIVE IRONWORKER

Eligibility of an Active Ironworker will terminate on the earliest of any of the following dates:

- the last day of the month next following a Qualifying Quarter during which the Active Ironworker fails to work at least 330 hours of covered employment; or
- the date of entrance into full-time active duty with the Uniformed Services, except as provided under USERRA (see page 32); or
- at the end of a calendar month, upon 30 days' notice, if your Contributing Employer is delinquent in paying contributions to the Plan; or
- the last day of the last month the Collective Bargaining Agreement between the Union and the Contributing Employer is in effect, if the Contributing Employer has negotiated to discontinue such contributions; or
- the date that you work as an ironworker for any non-contributing employer (non-Union work);
- the date you are no longer a member in good standing of the Union;
- the date the Plan terminates; or
- the last day of the last month in which your Contributing Employer's decertification took place.

5. HOW YOU CAN EXTEND COVERAGE

Loss of Eligibility Due to Reduction in Hours

If eligibility terminates because you have not worked at least 330 hours of covered employment during a Qualifying Quarter, you may extend coverage for Comprehensive Medical Plan, including prescription drug benefits, and optionally for dental and vision benefits, for up to 18 months by electing COBRA Continuation Coverage (see page 48).

In Case of Loss of Eligibility Due to Disability

In the case of disability covered by Workers' Compensation or other disability for which you provide proof satisfactory to the Board of Trustees, eligibility can be extended for six additional months at no charge for full benefits (excluding the Weekly Accident and Sickness Benefit). If you continue to be disabled after six months, you may continue your eligibility for up to an additional 12 months by paying the rate determined by the Board of Trustees. Current Trustee policy is to subsidize 50% of the cost of Disability Extension during this 12 month extension, provided that the Active Ironworker continues to provide satisfactory proof of disability. After 18 months of Disability Extension, COBRA Continuation Coverage may be available for an additional 11 months, up to a total of 29 months of combined Disability Extension and COBRA eligibility, if Social Security determines that you (or one of your Qualified Beneficiaries) are disabled. The cost of this 11 month extension will be substantially higher (see page 51).

Even if the Workers Compensation carrier is paying the maximum allowable benefit, you must still file a claim for a disability extension of coverage. Failure to provide the Administrative Office proper documentation could delay the processing of your eligibility.

In Case of Contributing Employer Delinquency

If eligibility terminates due to a Contributing Employer's delinquency, you may extend coverage for life insurance, accidental death & dismemberment, medical and prescription drug benefits, dental benefits, vision benefits and weekly accident and sickness benefits for up to twelve months by making self-payments to the Plan at the self-payment rates set by the Board of Trustees. Current Trustee policy is to subsidize 50% of the cost of this coverage for the first three months. Thereafter, coverage may be continued without subsidy for full benefits for an additional nine months. After twelve months, coverage

can be continued for an additional six months under the COBRA rules. If the Plan collects delinquent contributions, the first priority of the net amount recovered will be to reimburse you for your self-payments.

Extended Coverage for Surviving Dependents

The surviving Dependents of a deceased Active Ironworker may extend coverage for the Comprehensive Medical Plan, including prescription drug benefits by making self-payments, provided that the Active Ironworker was eligible for coverage at the time of death. Extended coverage for surviving Dependents is not permitted beyond the *earliest* of: 1) remarriage of the Active Ironworker's spouse; 2) becoming eligible for coverage under another group health plan; or 3) attaining age 65. Dependents may elect either this Extended Coverage by Self-Payment for a maximum of 12 months or COBRA Continuation Coverage up to 36 months, but not both.

6. CONTINUED COVERAGE WHILE IN UNIFORMED SERVICE

What to Do If You Are Called Up for Military Service

If you perform service in the Uniformed Services of the United States, federal law provides certain rights to continued coverage under this Plan. You may choose to freeze your eligibility status until the period of service ends, or continue coverage for up to a maximum of 24 months from the date that service commences.

The terms "Uniformed Services of the United States" and/or "Uniform Services" means the Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you (and your eligible Dependents) are eligible for benefits as of the date of your entry into service in the Uniformed Services of the United States, and your absence is due to a uniformed services leave of less than 31 days, coverage will be continued at no cost to you. You will be credited with hours necessary to keep coverage in effect as if you had worked in covered employment with a Contributing Employer during the period of service.

If you (and your eligible Dependents) are eligible for benefits as of the date of your entry into service in the Uniformed Services of the United States, and your absence is due to a uniformed services leave of 31 days or more, you or your eligible Dependent(s) may elect to continue coverage by self-payment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

The cost for continuation coverage under USERRA will be the COBRA rates established by the Plan, and will be payable in monthly installments. The maximum length of USERRA continuation coverage is the lesser of:

- 24 months beginning on the day that the uniformed service leave commences; or
- a period ending on the day after you fail to return to employment within the time allowed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you do not elect to continue coverage, your eligibility status will be frozen as of the date of entry into Uniformed Services. Eligibility for coverage for you and any eligible Dependents will terminate at the end of the month in which you entered into Uniformed Services.

Note: The Election and Notice Requirements for USERRA are generally the same as for COBRA Continuation Coverage. Please refer to the COBRA section of this booklet for a description of your rights and responsibilities. USERRA and COBRA Continuation Coverage shall run concurrently.

Reinstatement of Eligibility following Uniformed Service

If you were eligible for benefits on the date of your entry into the Uniformed Services of the United States, and upon completion of service you notify your Contributing Employer or your Local Union of your intent to return to employment as specified in USERRA, you will reinstate eligibility (eligibility will pick up as if it was the day before you entered into Uniformed Services). If you are re-employed with a Contributing Employer in accordance with USERRA provisions, you are entitled to coverage under the Plan and all rights and benefits under the Plan that you would have attained if you remained continuously employed with a Contributing Employer. If the last Contributing Employer employing you prior to the period served in Uniformed Services is no longer functional, benefits will be provided by the Plan at the Plan's own expense.

No benefits will be provided by the Plan for Illnesses or Injuries determined by the Department of Veterans Affairs to have been incurred in or aggravated during performance of duties in the Uniformed Services.

7. FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act of 1993 (FMLA) provides that in certain situations you may be entitled to take up to 12 weeks of unpaid leave during any 12-month period, and that in such situations the Contributing Employer is required to continue coverage. Determination as to whether a leave of absence is qualified shall be made by the Contributing Employer, and is subject to review by the Board of Trustees. If requested, you must submit proof acceptable to the Trust that the leave is in accordance with FMLA provisions.

In the event that both spouses are covered under the Plan as active Employees and are employed by the same Employer, the FMLA continued coverage may not exceed a combined total of 12 weeks if the purpose of the FMLA leave is the birth or adoption of a child or to care for a child or parent with a serious health condition.

If an Ironworker becomes eligible for both: (a) FMLA coverage due to the Ironworker's own disability, and (b) this Plan's *Extended Benefits for Total Disability,* continuation of eligibility will run concurrently until the FMLA leave is exhausted, then the available balance of *Extended Benefits for Total Disability* will be applied. Continuation of eligibility under FMLA is concurrent with any other continuation option except for COBRA (if applicable); an Ironworker may be eligible to elect COBRA Continuation Coverage following the day FMLA continuation is exhausted.

Continuation of coverage under FMLA ends on the earliest of:

- The day the Ironworker returns to work;
- The day the Ironworker notifies their Contributing Employer that he/she is not returning to work (if an Ironworker does not return to work at the end of the FMLA leave, the Contributing Employer may require the Ironworker to reimburse contributions made to the Plan on the Ironworkers' behalf during the leave);
- The day coverage under the Plan would otherwise end; or
- The day after coverage has been continued under FMLA for 12 weeks.

Ironworkers should contact their Contributing Employer to find out more about Family or Medical Leave and the terms on which an Ironworker may be entitled to it.

RULES FOR RETIRED IRONWORKERS

Retired Ironworkers receiving Pension from the Shop Ironworkers Local 790 Pension Trust or those previously covered by a Subscription Agreement subject to Board approval are entitled to elect medical coverage through the Comprehensive Medical Plan or through COBRA Continuation Coverage until they reach age 65 or earlier if they become eligible for Medicare due to disability. Those Retired Ironworkers who elect the Retiree Medical Plan waive any rights to COBRA Continuation Coverage under the Active Ironworker Plan.

BENEFITS PROVIDED TO RETIRED IRONWORKERS

1. IF YOU ARE UNDER AGE 65 AND NOT ELIGIBLE FOR MEDICARE

Retired Ironworkers who are not eligible to enroll in Part A and Part B of Medicare and are less than 65 years of age and who are receiving a Pension (as defined by the Shop Ironworkers Local 790 Pension Trust) or those previously covered by a Subscription Agreement subject to Board approval may continue eligibility for medical and prescription drug through the Comprehensive Medical Plan benefits by making self-payments to the Plan after eligibility as an Active Ironworker ends. A Retired Ironworker must be in good standing with the Union (dues must be current) to make monthly self-payments.

The Plan does not provide Life Insurance, Accidental Death & Dismemberment, Substance Abuse, Weekly Accident & Sickness, Vision, or Dental benefits to Retired Ironworkers and their Dependents. The Plan does provide MAP benefits for retirees and the Hearing Aid Benefit up to age 65.

When You or Your Spouse Reach Age 65 or Become Eligible for Medicare Due To Disability

Any Retiree (or their Dependent Spouse) who becomes eligible to enroll in Part A and Part B of Medicare will be required to enroll in Kaiser and assign their Medicare benefits to Kaiser. The retiree and his or her dependent spouse will receive all of their medical and prescription drugs from Kaiser. The Retiree must pay the full cost of the premium. For medical benefits provided under the Kaiser Plan see your Evidence of Coverage.

Note that when the retiree reaches age 65 and his/her spouse is under age 65 (or vice versa) the retiree and spouse will not be in the same Plan. The spouse who is not yet eligible for Medicare will continue in the Comprehensive Medical Plan and the spouse who is eligible for Medicare will be enrolled in Kaiser When both spouses become eligible for Medicare, they must both be enrolled in the same HMO. *Warning regarding Medicare Prescription Drug Plan*: Once you are enrolled in Kaiser, you should NOT enroll in any individual Medicare Part D prescription drug program. You will be automatically enrolled in the Kaiser Medicare Prescription Drug Program. If you enroll in any other program, you will risk being DIS-ENROLLED from your medical plan with Kaiser or you may be enrolled in a much more costly medical plan with your HMO.

2. ELIGIBILITY RULES FOR RETIRED IRONWORKERS

A Pensioner will become eligible as a retired Ironworker on whichever of the following dates is applicable:

For an Early or Normal Retirement Pensioner:

- who applies prior to the termination of eligibility as an Active Ironworker, eligibility begins with the month following termination of eligibility as an Active Ironworker (including COBRA coverage);

- who applies within 31 days following termination of eligibility as an Active Ironworker (including COBRA coverage), eligibility begins with the month following receipt of the application by the Administrative Office.

For a Disability Pensioner:

- who applies prior to the notification of the award of his disability pension, eligibility begins with the month following the notification, but not before the month in which the disability pension becomes effective;

- who applies within 31 days following notification of the award of his disability pension, eligibility begins with the month following receipt of the application by the Administrative Office.

A retired Ironworker or surviving spouse who is receiving a pension from the Shop Ironworkers Local 790 Pension Trust will have the required monthly payment deducted from their pension. An eligible surviving spouse who is *not* receiving a pension from the Shop Ironworkers Local 790 Pension Trust must pay the required monthly payment to the Administrative Office no later than the first of each month. Once discontinued, self-payments may not be resumed.

Temporary Active Medical Plan coverage may be available for a brief time after retirement if the Ironworker is covered for an Eligibility Quarter and retirement becomes effective before the end of that Eligibility Quarter. Retiree Medical Plan benefits will begin on the first day of the month following termination of benefits under the Active Medical Plan. Alternatively, a retired Ironworker may elect to continue active coverage by paying the COBRA premium for up to a maximum of 36 months depending on the qualifying event prior to enrolling in the retiree plan.

3. RETIRED IRONWORKER SPECIAL LATE ENROLLMENT PROVISIONS

A Retired Ironworker who declined coverage in the Retiree Medical Plan when first eligible will be allowed special late enrollment in the Plan under the following circumstances only:

a) The Retired Ironworker, after declining coverage, acquires a new spouse or Dependent child as a result of marriage, birth, adoption, or placement for adoption. The Retired Ironworker is allowed to request an enrollment of himself and his newly acquired spouse and/or Dependent child in the Plan within 31 days after the date the new Dependent is acquired.

b) The Retired Ironworker did not enroll in the Plan because he and his Dependent spouse had other health coverage under another health insurance policy or program (including COBRA Continuation Coverage, individual insurance, or a public program), and the Retired Ironworker and/or Dependent spouse ceased to be covered by that other health coverage. The Retired Ironworker is allowed to request to enroll himself and any other eligible Dependents in the Plan within 31 days after termination of the other coverage, *provided that the other coverage terminated due to:*

   - The loss of eligibility for the other coverage as a result of termination of employment or reduction in the number of hours of employment, or death or divorce, or
   - The termination of employer contributions toward the other coverage, or
   - If the other coverage was COBRA Continuation Coverage, the exhaustion of that coverage. COBRA Continuation Coverage is exhausted if it ceases for any reason other than the failure of the qualified beneficiary to pay the applicable COBRA premium on a timely basis.

4. TERMINATION OF RETIREE MEDICAL PLAN BENEFITS

Retiree Medical Plan benefits will terminate on the *earliest* of any of the following dates:

a) At the end of the month in which a timely self-payment is not received by the Administrative Office; or

b) The last day of the month preceding the month for which a pension is no longer payable from the Shop Ironworkers Local 790 Pension Trust; or

c) The last day of the month preceding the month in which he no longer is a Retired Ironworker in good standing with the Union; or

d) The date of death of the Retired Ironworker, and the end of the month of the Retired Ironworker's death for Dependents, unless eligibility continues under the surviving spouse coverage; or

e) The date on which a Retired Member returns to covered employment and becomes eligible for coverage as an Active Ironworker in this Plan; or

f) The date on which this Plan is discontinued.

5. RETURN OF RETIRED IRONWORKER TO COVERED EMPLOYMENT

A Retired Ironworker covered under the Retiree Medical Plan will be subject to the following if they return to covered employment either for, or as, a Contributing Employer:

- The Administrative Office must be notified of your return to covered employment.
- Any Retired Member who returns to work in covered employment and who gains Active Ironworker eligibility shall be allowed to return to the Retiree Medical Plan immediately following the termination of Active Ironworker eligibility.
- During a period of reemployment while the Retired Ironworker is eligible under the Active Medical Plan, the monthly self-payment toward the cost of Retiree Medical Plan benefits will be suspended. Any deductions made for the Retiree Medical Plan during a period when the Retired Ironworker is eligible under the Active Medical Plan will be adjusted at the time the Retired Ironworker returns to retired status.

6. EXTENDED COVERAGE FOR DEPENDENT SURVIVING SPOUSE BY SELF-PAYMENT

A Dependent surviving Spouse of a Retired Ironworker who loses eligibility due to the death of the Retired Ironworker may extend coverage under Retiree Medical Benefits for themselves and the Retired Ironworkers' other eligible Dependents by making self-payments to the Plan, subject to the following rules:

- The first monthly self-payment must be received by the Administrative Office prior to the month in which the Dependent's eligibility is terminated, or as soon thereafter as is reasonably possible, but no later than 31 days after the Dependent's eligibility is terminated; and
- Each subsequent monthly payment must be made in advance of the month for which coverage is desired; and
- Monthly self-payments must be continuous. Once discontinued, self-payments may not be resumed.

No self-payments are permitted and coverage will terminate on the first of any of the following events:

- remarriage of the Retired Ironworker's surviving spouse; or
- eligibility under another group health care plan; or
- attainment of age 65

ELIGIBILITY RULES FOR SUBSCRIBER EMPLOYEES

A Subscriber Employee is an employee of a Contributing Employer who is not covered under a Collective Bargaining Agreement. Subscriber Employees have their eligibility determined in accordance with the Subscriber Agreement their Contributing Employer has signed with the Trust Fund. Basic terms and conditions for Subscriber Employees are described in this section.

1. PARTICIPATION IN THE PLAN

Contributing Employers may enroll all Subscriber Employees by signing a Subscription Agreement approved by the Board of Trustees. If a Contributing Employer enrolls non-collectively bargained Employees, the Contributing Employer must enroll all full-time non-collectively bargained Employees, except for those excluded under the Subscription Agreement (such as those located out-of-state) or those who declined coverage because they had alternative coverage available, as of the first of the month after they are hired as full-time Employees. Full-time Employees are defined as persons working at least 120 hours per month for the Contributing Employer.

Contributing Employers may enroll their Subscriber Employees: 1) within 60 days of first signing a Collective Bargaining Agreement with the Union; or 2) during such open enrollment periods as the Board of Trustees may from time to time declare. Contributing Employers may make written application to the Board of Trustees at other times, but participation for Subscriber Employees will become effective only after the application has been approved by the Board of Trustees.

The Administrative Office must receive monthly contributions made on behalf of Subscriber Employees by their Contributing Employers no later than the first day of the month for which coverage is effective. Eligibility will not be extended as of the first of any month for which monthly contributions have not been received or for which any delinquent contributions are owed by a Contributing Employer as required under its Collective Bargaining Agreements.

2. PLAN BENEFITS

Subscriber Employees are eligible for Life Insurance, Accidental Death and Dismemberment and Hospital / Medical and Prescription Benefits, Substance Abuse, MAP and Hearing Aid Benefits. In addition, certain Subscriber Employees are also eligible for Vision and Dental Care Benefits.

Vision and Dental Care Benefits are not available to a Subscriber Employee whose Contributing Employer does not enroll for Vision and Dental Care Benefits. Subscriber Employees are not eligible for the Plan's Weekly Accident & Sickness Benefit or the Retiree Medical Benefit.

Subscriber Employees are eligible for Continued Coverage While in Uniformed Service and Family and Medical Leave Act provisions as stated in the *Eligibility Rules for Active Ironworkers* section of this booklet.

3. EFFECTIVE DATE OF COVERAGE

Eligibility for coverage becomes effective on the first day of the first full month of employment provided the first contribution is received by the Administrative Office on behalf of the Subscriber Employee.

4. COVERAGE CONTINUATION DURING TEMPORARY DISABILITY

A Subscriber Employee who becomes temporarily disabled due to Illness or Injury, and who is Physician certified as unable to perform the duties of his/her occupation, will continue to be eligible under the Plan for up to three months, provided that the Contributing Employer makes monthly contributions on behalf of the Subscriber Employee.

Successive periods of disability will be considered separate if:

- The successive period of disability is due to a different cause; or
- The successive period of disability is due to the same cause, but is separated from the last period of disability by at least three months of work.

5. SPECIAL LATE ENROLLMENT RULES

If a Subscriber Employee chooses not to enroll in the Plan on the date he/she first became eligible because they had other health coverage under another health insurance policy or program (including any COBRA Continuation Coverage, individual insurance or a public program such as Medicaid), and they cease to be covered by that other coverage, the Subscriber Employee and any eligible Dependents may request to enroll in this Plan within 30 days after termination of the other coverage *if the other coverage terminated due to any of the following reasons:*

a) the loss of eligibility for the other coverage is a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation;

b) the termination of employer contributions toward the other coverage; or

c) if the other coverage was COBRA coverage, the exhaustion of that coverage. COBRA coverage is "exhausted" if it ceases for any reason other than failure to pay premiums on a timely basis.

If a Subscriber Employee, after declining coverage because he/she had other coverage, acquires a new Dependent (spouse or child), the Subscriber Employee must request to enroll himself and the newly acquired Dependent(s) within 30 days after the date new Dependent(s) are acquired.

A Subscriber Employee is required to provide proof of other health coverage to the Administrative Office at the time he/she is first eligible to enroll and declines the coverage.

6. TERMINATION OF ELIGIBILITY FOR SUBSCRIBER EMPLOYEE

Eligibility of a Subscriber Employee will terminate on the *earliest* of any of the following dates:

- the first of any month for which monthly contributions have not been received or for which any delinquent contributions are owed by a Contributing Employer as required under its Collective Bargaining Agreements; or
- the date of entrance into full-time active duty with the Uniformed Services, except as provided under USERRA; or
- the last day of the last month the Collective Bargaining Agreement between the Union and the Contributing Employer is in effect, if the Contributing Employer has negotiated to discontinue such contributions; or
- the date the Plan terminates; or
- the last day of the last month in which your Contributing Employer's decertification took place; or
- the last day of the month in which the Employer does not contribute on behalf of any Bargaining Unit Employees for a period of six consecutive months, unless permitted by the Trustees.

ELIGIBILITY RULES FOR DEPENDENTS

A Dependent becomes eligible at the same time an Active Employee or Retired Ironworker becomes eligible, or the date the Dependent is acquired, if later. Newborn eligible Dependents will be considered eligible from the date of birth. However, it is very important that you request a new *Enrollment Form and Beneficiary Card* within 31 days of the birth of your baby or the date of your marriage or at any other time that you acquire a new Dependent. Benefits cannot be paid until the new *Enrollment Form and Beneficiary Card* is completed and returned to the Administrative Office. For the purposes of these Eligibility Rules for Dependents, "Employee" means an eligible Active or Subscriber Employee or Retired Ironworker.

1. ELIGIBLE DEPENDENTS DEFINED

a) The legal spouse of an Employee. Under limited circumstances a Domestic Partner will be covered as a spouse (see *Coverage for Domestic Partners* page 46)

b) The Employee's children, if they are:

- Natural children, or adopted children placed in the Employee's custody prior to attainment of age 18, who are younger than 26 years of age. Children placed for adoption will be covered as of the date the Employee first becomes legally obligated to provide full or partial support of the child; however, if the adoption does not proceed the child's coverage will cease.

- Stepchildren, foster children, or other children younger than 26 years of age for whom the Employee has been appointed legal guardian.

- Children older than 26 years of age who are prevented from earning a living because of mental or physical handicap (provided the disabled child was so handicapped and eligible as a Dependent at the time he/she reached the limiting age), and are solely dependent upon the Employee for support. Evidence of the child's dependence and incapacity must be filed with the Administrative Office within 31 days after attaining the limiting age and periodically thereafter.

- A child required to be recognized under a Qualified Medical Child Support Order under ERISA Section 609(a)(2)(A). Procedures for determining if a qualified medical child support order is "Qualified" are described below.

2. EFFECTIVE DATE FOR DEPENDENTS

Coverage for an eligible Dependent begins on the same day as coverage for an Employee begins, or after the date the Dependent is acquired, as follows:

- A new spouse and stepchildren become eligible upon marriage;
- An Employee's natural children become eligible at birth;
- An Employee's adopted children become eligible upon placement for adoption prior to age 18; and
- An Employee's foster children and other children become eligible when they meet the Dependent definition.

An updated *Enrollment Form and Beneficiary Card* must be requested from the Administrative Office within 31 days for the Dependent's claims to be eligible. Benefits cannot be paid until the new *Enrollment Form and Beneficiary Card* is completed and returned to the Administrative Office.

3. TERMINATION OF ELIGIBILITY FOR DEPENDENTS

A Dependent's eligibility will terminate on the earlier of the following dates:

- The date he or she no longer meets the Plan's definition of a Dependent; or
- The date eligibility terminates for the Employee; or
- In the event of an Active Employee's death, at the end of the Eligibility Quarter; or
- With respect to a Dependent spouse, on the date of entry of a final decree of dissolution of marriage or legal separation with respect to the spouse's marriage with the Employee; or
- The date the Plan terminates.
- The date the dependent declines coverage, in writing, on a Declination of Coverage form authorized by the Board of Trustees if all of the following requirements are met:

    a. On the date the dependent declines coverage the dependent is covered under another policy of medical insurance and provides evidence of such other coverage;

    b. Completes and signs the Declination of Coverage form; and

    c. An otherwise eligible dependent may re-enroll in coverage no earlier than twelve (12) months from the date the dependent declined coverage, unless a special open enrollment rule applies. Special Open Enrollment:

    If the dependent(s) declined coverage, they may be able to enroll in the Plan if one or more of the following events have occurred: 1) loss of eligibility for the other health coverage as a result of termination or employment or reduction in the number of hours of employment, or death, divorce or legal separation; 2) the termination of employer contributions toward the other coverage; or 3) if the other coverage was COBRA coverage, the exhaustion of that coverage (COBRA coverage is "exhausted" if it ceases for any reason other than the failure to pay premiums on a timely basis); or 4) if the Participant or a dependent acquires a new dependent spouse or child (by birth or adoption). If any of these triggering events applies, the dependent(s) must enroll in this Plan within 31 days from the date of the triggering event.

4. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Under the Omnibus Budget Reconciliation Act of 1993, the Plan must recognize any Qualified Medical Child Support Order (QMCSO) and enroll as directed by the Order any child of a Member specified by the Order. A Qualified Medical Child Support Order is any judgment, decree or order (including approval of a domestic relations settlement agreement or a properly completed National Medical Support Order) issued by a court or administrative agency under applicable state law which:

- provides the child of an Employee with child support or directs the Employee to provide the child with coverage under a health benefits plan, or
- enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act which provides in part that if the Employee parent does not enroll the child, then the non-Employee parent or State agency may enroll the child.

To be Qualified, a Medical Child Support Order must clearly specify:

- the name and last known mailing address of the Employee and the name and mailing address of each child covered by the Order,
- a description of the type of coverage to be provided by the Plan to each such child,
- the period of coverage to which the Order applies, and
- the name of each Plan to which the Order applies.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of benefits by the Plan under a Medical Child Support Order to reimburse expenses claimed by a child or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian if so required by the Medical Child Support Order.

No eligible Employee's child covered by a Qualified Medical Child Support Order will be denied enrollment on the grounds that the child is not claimed as a Dependent on the parent's Federal income tax return or does not reside with the parent.

If a proposed or final order is received, the Administrative Office will notify the Employee and each child named in the order. The order will then be reviewed to determine if it meets the definition of a "Qualified Medical Child Support Order." Within a reasonable time, the Employee and each child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party(ies) filing the order will be given an opportunity to correct the order or appeal the decision through the *Claims Review Appeals Procedures* explained in this booklet. If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire Qualified Medical Child Support Order must be received prior to enrollment. Any child(ren) enrolled pursuant to an order will be subject to all provisions applicable to Dependent coverage under the Plan.

5. ELIGIBILITY RULES FOR DOMESTIC PARTNERS

Coverage for Domestic Partners may be granted to Employees of a Contributing Employer who must comply with San Francisco Administrative Code Chapter 12B ("Nondiscrimination in Contracts") or other relevant local law. A Contributing Employer shall be eligible to provide coverage for Domestic Partners upon receipt and approval of a written application to the Board of Trustees and proof of a contractual relationship with the City of San Francisco or other governmental body requiring coverage for Domestic Partners.

If a Contributing Employer is eligible to offer Domestic Partner coverage, an Employee with an eligible Domestic Partner may contact the Administrative Office to apply for coverage and will be required to certify that he has registered a domestic partnership with a governmental body pursuant to local law. The Domestic Partner shall be eligible on the first day of the month following receipt and approval of this application and certification.

A Contributing Employer is eligible to offer Domestic Partner coverage so long as the Contributing Employer maintains a contract with the City of San Francisco or other governmental body requiring coverage for Domestic Partners. Satisfactory ongoing proof of an Employer's contractual arrangement will be required at least annually. Coverage for a Domestic Partner (and his/her Dependent child who otherwise meets the eligibility requirements) will cease on the last day of the month following the month in which the Contributing Employer does not provide the required proof of its ongoing contractual arrangement.

Benefits are Taxable Income to the Employee

The fair market value of coverage for Domestic Partners must be reported as taxable income to the Employee and included in his/her wages for employment tax purposes. An Employee who covers a Domestic Partner will be advised of the applicable taxable income amount. If the Domestic Partnership is registered with the California Secretary of State, only federal (but not California State) income tax applies. Please contact the Administrative Office for additional information.

Continuation of Coverage for Domestic Partners

Although a Domestic Partner and his/her Dependent child(ren) are not qualified beneficiaries under federal COBRA, a continuation of coverage is available for a Domestic Partner and his/her Dependent child(ren) upon the occurrence of a "qualifying event" (which would have been a qualifying event if the Domestic Partner had been the Ironworkers' lawful spouse), as long as the Contributing Employer has a contractual relationship with the City of San Francisco or other governmental body requiring coverage for Domestic Partners. A Domestic Partner and his/her Dependent child(ren) who has elected such continuation coverage will cease to be eligible for this continuation of coverage on the last day of the month in which the contractual relationship between the Contributing Employer and the City of San Francisco or other governmental body requiring coverage for Domestic Partners terminates.

Eligible Domestic Partners and eligible children of Domestic Partners who lose eligibility under the Plan may continue Plan coverage (Core or Full benefits) through self-payment when eligibility is lost due to any of the following reasons:

- The Contributing Employer reports less than minimum required hours on the Employee's behalf;
- The Employee's death;
- Termination of the Domestic Partner relationship with the Employee;
- Dependent child ceases to meet the Plan's "Dependent" definition.

Election and Notice for Domestic Partners Who Wish to Continue Coverage

Continuation coverage must be elected within 60 days after the later of:

- The date of any of the events described above; or
- The date of the notice from the Administrative Office notifying the individual of his/her right to continuation coverage.

A premium for continuation coverage will be charged to the Domestic Partner or Dependent child or both in amounts established by the Board of Trustees. The premium is payable in monthly installments.

Duration of Continuation Coverage

In the case of the Employee's reduction in hours or termination of employment, coverage may be continued on a self-payment basis for up to 18 months from the date of the event that resulted in the loss of eligibility. In all other circumstances, coverage may be continued for up to 36 months from the date of the event that resulted in the loss of eligibility. Eligibility to continue coverage will cease upon termination of the contractual arrangement between the Contributing Employer and the City of San Francisco or other governmental body requiring coverage for Domestic Partners.

Termination of Continuation Coverage

Continuation coverage will be terminated before the end of the 18 or 36 month period upon the occurrence of any of the following events:

- Failure to make the required premium payment when due;
- The maximum allowable number of consecutive months of continuation coverage is reached;
- The date the Domestic Partner or Dependent become covered under any other group health plan (as an employee or otherwise);
- The date the Domestic Partner or Dependent become entitled to Medicare benefits (unless the Medicare entitlement is due to End Stage Renal Disease);
- Upon termination of the contractual arrangement between the Contributing Employer and the City of San Francisco or other governmental body requiring coverage for Domestic Partners;
- The date the Welfare Plan no longer provides group health coverage.

COBRA CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act (known as COBRA), you and your eligible Dependent(s) may continue the Plan's health benefits past the date coverage would normally end under certain circumstances called "Qualifying Events." In order to receive COBRA Continuation Coverage, you and/or your eligible Dependents must file a timely application following the Qualifying Event and make monthly self-payments directly to the Administrative Office.

The Election and Notice requirements described in this section generally apply to Participants who terminate coverage due to service in the armed services of the United States, unless there is a specific circumstance described in USERRA regulations that provides an exception.

1. QUALIFIED BENEFICIARY

A Participant continuing coverage under COBRA is known as a "qualified beneficiary," defined as any Participant who on the day before a Qualifying Event was covered under this Welfare Plan by virtue of being on that day either an eligible Employee, the spouse of an eligible Employee or Retiree, or a Dependent child of an eligible Employee or Retiree.

If, during the period of COBRA Continuation Coverage, you marry, have a newborn child or have a child placed with you for adoption, that Spouse or Child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active Ironworkers. Enrollment must occur no later than 31 days after the marriage, birth, or placement for adoption. In addition, a child born or placed for adoption while you are on COBRA Continuation Coverage (but not a spouse you marry while you are on COBRA Continuation Coverage) becomes a Qualified Beneficiary and therefore will have all the same COBRA rights as your Dependents who were covered by the Plan before the Qualifying Event that resulted in your loss of coverage.

2. QUALIFYING EVENTS

i. Employee

If eligibility for health benefits terminates due to any of the Qualifying Events shown below, you and your eligible Dependents may elect COBRA Continuation Coverage for a maximum of 18 months (reduced by any months of coverage the plan may provide at a subsidized rate) following the date that your coverage normally would have been lost due to:

- Your layoff or reduction in work hours; or
- Termination of your employment for any reason other than gross misconduct.

If Social Security determines that you or one of your eligible Dependents are totally disabled at any time before or during the first 60 days of COBRA Continuation Coverage, the disabled person and family may extend COBRA coverage an additional 11 months, beyond the original 18, to a maximum of 29 months. In order to qualify for this disability COBRA extension, you must report the Social Security disability determination to the Administrative Office before the initial 18 months of COBRA coverage expires and within 60 days after the date of the Social Security determination.

ii. Dependents

Your spouse and eligible Dependent children may elect COBRA Continuation Coverage for a maximum of 36 months from the date of any of the following Qualifying Events:

- Death of the Employee;
- Divorce or legal separation from the Employee;
- Dependent child ceases to meet the Plan's definition of "Dependent";

If a second Qualifying Event occurs during the first 18 months of COBRA Continuation Coverage, or if the Employee becomes entitled to Medicare during that period, COBRA coverage may be extended for Dependent qualified beneficiaries for up to 36 months from the date of the first Qualifying Event.

If an Employee has a Qualifying Event because of a termination of employment or reduction in hours after they became entitled to Medicare, their Dependents will be allowed to continue their COBRA coverage until the later of:

- 18 months from the Qualifying Event, or
- 36 months from the date the Employee became entitled to Medicare.

3. HOW TO ELECT COBRA CONTINUATION COVERAGE

To preserve your COBRA (or USERRA) rights, you must meet the notification, election, and payment deadline requirements outlined below.

Once the Administrative Office is notified of a Qualifying Event (or your entrance into the armed services), or determines that a Qualifying Event has occurred, it will send information concerning your continuation rights and COBRA election forms. It is your responsibility to inform the Administrative Office in writing of a divorce or legal separation or of a child losing eligible Dependent status under the Plan. Your notice should include the Social Security Number of the Employee, the name of the Qualified Beneficiary, the date of the Qualifying Event. If the Administrative Office is not notified within 60 days of a divorce or legal separation, or of a child losing eligible Dependent status, your Dependents will lose the right to elect COBRA Continuation Coverage.

You will have 60 days from the later of the date of the Qualifying Event or the date you received the COBRA notice from the Administrative Office in which to make your election. If you do not make your election within this 60 day period, you will forfeit all rights to COBRA Continuation Coverage. Should you reject COBRA Continuation Coverage, your lawful spouse and Dependent children will be given the opportunity to elect coverage independently from you, within this same 60 day period, if they were covered under the Plan at the time of the Qualifying Event.

The Administrative Office will notify you of the cost of COBRA Continuation Coverage (USERRA continuation cost is the same) when it notifies you of your right to this coverage. You have a maximum of 45 days from the date you mail your election form to the Administrative Office in which to submit your first payment. If you wait until the end of the election period, payment for each full month passed since the date coverage terminated must be included with the first payment. Thereafter, your premium may be paid in monthly installments.

4. TYPE OF BENEFITS AVAILABLE

The Life Insurance Benefit and Accidental Death and Dismemberment (AD&D) Benefit cannot be continued under COBRA Continuation Coverage. You should immediately request an application to apply for a life insurance conversion policy from the Administrative Office.

Any person electing COBRA will have the option of electing either:

- **Core Benefits**: Comprehensive Medical Plan, including prescription drug benefits.

- **Full Benefits**: Medical and Prescription Drug Benefits, Vision Care Benefit, Dental Benefit, Hearing Aid Benefit, and Substance Abuse from MHN.

Once you have selected a level of benefits (Core or Full) that level of benefits cannot be changed while you have COBRA Continuation Coverage. If the coverage provided by the Plan is changed in any respect for active Participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued under COBRA.

5. TERMINATION OF COBRA CONTINUATION COVERAGE

Coverage under COBRA will terminate at the *earliest* of the following circumstances to occur:

- Failure to make the monthly payment on time (you will be allowed a 30 day grace period from the premium due date, which is the first day of the coverage month);
- The maximum allowable number of consecutive months of COBRA Continuation Coverage is reached;
- The date you or a Dependent first become, after the date of election of COBRA Continuation Coverage, covered under any other group health plan
- The date you or a Dependent become entitled to Medicare benefits (unless the Medicare entitlement is due to End Stage Renal Disease);
- The date of a determination by Social Security that an individual on extended disability coverage is no longer disabled; (This applies only to the 19th through 29th month of disability extended coverage);
- The date the Welfare Plan no longer provides group health coverage.

Should Federal legislation alter or modify COBRA provisions in existence at the time this Summary Plan Description is printed, Participants will be advised of any modifications as required.

6. COVERAGE OPTIONS UNDER THE AFFORDABLE CARE ACT

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through Covered California, the State's Health Benefit Exchange ("Exchange"). By enrolling in coverage though the Exchange, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Being eligible for COBRA does not limit your eligibility for a tax credit through the Exchange.

When Can I enroll in Exchange coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Exchange. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Exchange?

If you sign up for COBRA continuation coverage, you can switch to Exchange coverage during the open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth or a child through something called a "special enrollment period." Once you've exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Exchange coverage through a special enrollment period, even if the Exchange open enrollment period has ended.

If I choose Exchange coverage, can I switch back to COBRA continuation coverage?

If you sign up Exchange coverage, you cannot switch to COBRA continuation coverage under any circumstances.

7. OTHER COVERAGE OPTIONS

If you lose group health coverage, you may also qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan does not generally accept late enrollees.

8. COBRA QUICK REFERENCE CHART

An illustration of circumstances under which health benefits can be continued, and the maximum duration of COBRA Continuation Coverage are summarized in the following chart:

	Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
(1)	Reduction in eligible Employee's hours	Employee, spouse and Dependent children covered under Plan	18 months after Qualifying Event*
(2)	Termination of eligible Employee's employment except for gross misconduct	Employee, spouse and Dependent children covered under Plan	18 months after Qualifying Event (24 months if you are serving in the uniformed services)** Extension for retirees***
(3)	Death of eligible Employee covered under Plan	Spouse and Dependent children covered under Plan	36 months after Qualifying Event
(4)	Divorce or legal separation of eligible Employee	Spouse and Dependent children covered under Plan	36 months after Qualifying Event
(5)	Dependent child's loss of that status under Plan	Affected Dependent child if covered under Plan	36 months after Qualifying Event
(6)	Eligible Active Employee's entitlement to Medicare after a qualifying event described in (1) or (2).	Spouse and Dependent children covered under Plan	36 months after initial Qualifying Event
(8)	Employee's retirement, if all qualifications are met	Employee, spouse and Dependent children covered under Plan	18 months after Qualifying Event*

* If you or one of your eligible Dependents is disabled, COBRA Continuation Coverage may continue for that person and eligible family members for up to 29 months. Proof of eligibility for Social Security disability benefits is required within 60 days after the date of the Social Security determination and prior to expiration of the initial 18 months of COBRA Continuation Coverage to qualify for continuation of the additional 11 months of coverage. If the Participant entitled to the disability extension has non-disabled family members who are entitled to COBRA coverage, those non-disabled family members are also entitled to the disability extension.

If a second Qualifying Event occurs within the first 18-month period, COBRA Continuation Coverage may be extended for up to a maximum of 36 months from the date of the first Qualifying Event for Qualified Dependents.

** If the reason for termination of employment is your entry into the uniformed services of the United States, you and your Dependents may extend you Continuation Coverage for an additional six months, for a total of 24 months, if you are still serving in the armed services. Certain rights that apply during the first 18 months are not available during this additional six month permitted under USERRA regulations. For example, any dependents you add during this six-month period are not entitled to the rights of Qualified Beneficiaries, such as the right to extended coverage if a second Qualifying Event occurs.

*** Retirees have the option to pay COBRA for up to 36 months for Active Medical Coverage. They may then self-pay for retiree coverage if they qualify (see page 38).

SECTION 10. SPECIAL ENROLLMENT

Special Enrollment due to Medicaid or A State Children's Health Insurance Program (CHIP)

You or your eligible dependents may also enroll in this Plan if you or your eligible dependents have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your dependents lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or become eligible for a premium assistance program through Medicaid or CHIP. You must request enrollment in this Plan within 60 days after you (or your dependents) are determined to be eligible for such premium assistance.

Start of Coverage Following Special Enrollment

Coverage of an individual enrolling because of loss of other coverage or because of marriage or birth of a child: If you request Special Enrollment within 31 days of the date of the event that created the Special Enrollment opportunity, (except on account of Medicaid or a State Children's Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date the Plan receives the request for Special Enrollment.

If you request enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or a State Children's Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.

COMPREHENSIVE MEDICAL PLAN

How The Medical Plan Works - Your Responsibility

The Shop Ironworker Local 790 Comprehensive Medical Plan pays benefits to cover some of the costs for a wide range of services and supplies, including physician charges, diagnostic testing, hospital charges, and surgery. It is important to remember that the Medical Plan is not designed to cover every health care expense.

The Plan pays charges for eligible expenses, up to the limits and under the conditions established under the rules of the Plan. The decisions about how and when you receive medical care are up to you and your Physician — not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

Calendar Year Deductible

i. Individual Deductible

The Calendar Year Deductible is a dollar amount of Covered Expenses that you must pay before the Plan starts paying benefits in each calendar year. If you use only Blue Cross providers, you must satisfy a $250 per individual Deductible before the Plan begins to pay a portion of Covered Expenses. If you use healthcare providers who are NOT contracted with Blue Cross, you must pay an additional $250 in Covered Expenses to meet your Deductible.

ii. Family Deductible

Each family does not need to pay more than three individual Deductibles each calendar year before the Plan starts paying a portion of Covered Expenses. Once three individuals in a family unit have incurred Covered Expenses that are applied to their Deductible ($750 for Blue Cross provider services and $1,500 for all other provider services), the Plan will begin paying the Covered Expenses for all other family members at the appropriate Coinsurance level, without a Deductible.

If two or more family members are injured in the same accident, only one deductible will apply for Covered Expenses related to that accident.

iii. Calendar Year Carry Forward

Covered Expenses incurred in October, November, and December that are charged to your Calendar Year Deductible will also be used to satisfy your Deductible in the following year.

If you need to see a doctor:

If you need to find a new doctor, contact the Administrative Office for a list of Prudent Buyer providers near your home or go to the Blue Cross website: www.bluecross.com

- Call to make an appointment
- Write down any questions you may have ***before*** your appointment. This way, you will not forget to ask your physician important questions during your appointment.
- Make a list of any ***medications*** you are taking. Be sure to note how often you take the medications.
- Show your Blue Cross ID card when you go to your appointment.
- Your Blue Cross provider will file claims for you. If a non-Blue Cross Physician's office does not file the claim for you, file a claim form with the Administrative Office. It is a good idea to make a copy of the claim form and any supporting materials for your records before submitting the claim.

Hospital Deductible – Non-Blue Cross Hospitals Only

In addition to the Calendar Year Deductible, if you are admitted to a hospital that is not in the Blue Cross Prudent Buyer Network you must pay an additional Hospital Deductible of *$500. This additional Deductible will NOT be charged if the admission is for Emergency Care.*

Coinsurance

Generally, after you meet the Calendar Year Deductible, the Plan pays 80% of the contract rate for services you receive from Blue Cross Prudent Buyer doctors, hospitals and other healthcare providers. When you use the services of healthcare providers who are NOT contracted with Blue Cross, the Plan generally pays 60% of the Plan's Allowable Charges. Some expenses may be covered differently or subject to benefit maximums. See the *Summary of Medical Plan Benefits* in the front of this booklet and the specific descriptions of benefits in this section for more information. You pay any remaining charges not covered by the Plan. Please refer to the section called *Maximizing Your Benefits* for more information about using contract providers and the Plan's pre-certification and utilization review programs.

Annual Out-of-Pocket Maximum

Once an individual's coinsurance payments and office visit copayments for Covered Expenses reaches $3,000 for Blue Cross Prudent Buyer providers and $5,000 for non-contract providers, the Plan pays 100% of Covered Expenses for that individual for the rest of the calendar year. You must satisfy the Calendar Year Deductible first and the Calendar Year Deductible does not count toward the annual out-of-pocket maximum. Each family is only required to accrue three times the individual out-of-pocket maximum cost each Calendar Year. Note that when you use non-Blue Cross providers you are always responsible for charges that exceed the Plan's Allowable Charges and these charges are not counted toward the annual out-of-pocket maximum.

Lifetime Maximum

Active employees and their eligible Dependents can receive unlimited benefits for Essential Health Benefits.

Annual Maximum

Active employees and their eligible Dependents can receive unlimited benefits for Essential Health Benefits.

Allowable Charges

The Plan pays charges from non-contracted providers only to the extent that they do not exceed the Plan's Allowable Charges, which may be less than the billed charges. Please refer to the *Glossary of Defined Terms for the definition of "Allowable Charges*."

What Is Medically Necessary?

The Plan pays benefits only for services and supplies that are Medically Necessary. In general, "Medically Necessary" means they are:

- necessary to treat the illness or injury;
- ordered by a Physician;
- appropriate for the patient's circumstances; and
- consistent with the diagnosis.

You will find a complete definition in the *Glossary of Defined Terms*.

Maximizing Your Medical Benefits

The Plan has two cost management programs designed to help manage certain health care costs:

- a contract provider network; and
- a pre-certification and utilization review (UR) program.

i. Contract Provider Network

The Board of Trustees has contracted with Blue Cross Prudent Buyer to provide a network of contracted doctors, hospitals and other healthcare providers. Physicians and hospitals participating in the Blue Cross Prudent Buyer Network have agreed to negotiated fees and to meet Blue Cross's standards, referred to as the "contract rate". Contact information for Blue Cross is provided under the *Quick Reference Chart* in the front of this booklet. A directory of Preferred Providers may also be requested, free of charge, from the Administrative Office.

It is your decision whether to use a Blue Cross provider. You always have the final say about the physicians and hospitals you and your family use. However, for most covered services, your

coinsurance obligation will be lower if you use a contract provider. The plan generally pays 80% of Covered Expenses for contract providers versus 60% of Covered Expenses for non-contract providers.

If you live outside of the service area of a Blue Cross Prudent Buyer contract provider (more than 30 miles) for the type of medical treatment you require, the Plan will pay the contract provider level of benefits. However, if a Blue Cross provider that can provide the medical care you require is closer to your home than the actual provider from whom you receive services, then the lower level of coinsurance will apply.

ii. Pre-Certification and Utilization Review Program

The Board of Trustees has also contracted with Blue Cross to provide pre-certification and utilization review services. These services help ensure that you receive quality care in a way that uses our valuable health care resources as wisely as possible. To make it work, we need for you to become involved in the decisions regarding your care. Contact information for Blue Cross is provided under the *Quick Reference Chart* in the front of this booklet.

It is very important to call for pre-certification if your Physician recommends hospitalization **(however, please see page 58 for an exception to pre-certification for hospital stays in connection with childbirth).** When hospital admission is pre-certified, the Plan pays 80% of Covered Expenses from Blue Cross contracted providers and 60% of Covered Expenses from other providers. *If the hospital admission is not pre-certified, the Plan will reduce the level of benefits otherwise paid by 10%.*

The Blue Cross professional medical review staff can provide you with treatment alternatives, pre-certification, and referrals when needed. When you or your physician calls Blue Cross before a hospital admission, the representative will evaluate whether a hospital admission is needed and determine the expected length of stay. In the case of an emergency admission, Blue Cross must be notified within 24 hours after the admission.

If your physician recommends hospitalization, Blue Cross must be notified in advance. Your Blue Cross doctor will do this for you. If your doctor is not contracted with Blue Cross, it is your responsibility to call for pre-certification of your hospital stay. If your admission is pre-certified, the Plan pays its normal level of benefits. If not, the Plan will reduce its benefit payment.

If you receive emergency hospitalization, you or a family member must call for utilization review within 24 hours of your admission to the hospital.

iii. Concurrent Utilization Review

Once you are admitted to a hospital, the utilization review program monitors your hospital stay. If additional days are required because of complications or other medical reasons, your stay will be pre-certified for the appropriate number of additional days of inpatient care.

iv. Large Case Management

Case Management defined: Case management is a voluntary process, administered by Blue Cross and/or the Administrative Office. Blue Cross medical professionals work with the patient, family, caregivers, health care providers, and the Administrative Office to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential health care providers.

Working with the Case Manager: Any Plan Participant, Physician, or other Health Care Provider can request Case Management services by calling Blue Cross at the telephone number shown on the *Quick Reference Chart* in the front of this booklet. However, in most cases, Blue Cross will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Managers at Blue Cross will work directly with your physician, hospital, and/or other health care facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from health care providers as needed. From time to time, the Case Manager may confer with your physician or other health care providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your physician may call the Case Managers at Blue Cross at any time at the telephone number shown on the *Quick Reference Chart* in the front of this booklet to ask questions, make suggestions, or offer information.

Note that for certain services Case Management may also be coordinated by the Administrative Office. These services include physical and respiratory therapy, speech therapy, morbid obesity, hospice care and certain prescription drugs.

Choice of Primacy Care Provider

The comprehensive medical plan described in this document does not require the selection or designation of a Primary Care Provider (PCP). You may visit any contracted or non-contracted health care provider; however, payment by the plan may be less for the use of a non-contracted provider.

Prior-Authorization Not Required

Prior authorization from the plan or from any other person (including a Primary Care Provider) is not required in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Nondiscrimination in Health Care

in accordance with the affordable care act, to the extent an item or service is a covered benefit under the plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the plan will not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. The plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan. The plan is permitted to establish varying reimbursement rates based on quality or performance measures.

COMPREHENSIVE MEDICAL PLAN COVERED EXPENSES

The Medical Plan covers the medical services listed in this section to the extent that they are:

- Medically Necessary;
- due to illness or injury (except as specifically provided for in sections 11 through 14);
- performed or ordered by a physician;
- incurred while you and your eligible dependents are eligible under the Plan; and
- within the maximum limits specified by the Plan.

If you incur charges for a medical services or supplies that are in excess of what the Plan's Allowable Charges, you will be responsible for payment of the excess amount.

PHYSICIAN OFFICE VISIT COPAYMENT

When you receive services to diagnose or treat an illness or injury from a Blue Cross Prudent Buyer contracted doctor in his/her office (or your home), you pay only the Office Visit copayment.

OTHER PHYSICIAN SERVICES

Physicians' services provided in a hospital or other facility are subject to the Deductible and Coinsurance features of the Plan, which are higher if you use the services of a physician who is NOT in the Blue Cross Prudent Buyer Network.

HOSPITAL SERVICES AND SUPPLIES

Subject to the Deductible and Coinsurance features of the Plan, Covered Expenses include:

- Services you receive at a hospital as an inpatient:
  - room and board up to the hospital's average semiprivate room rate. In addition, care in an intensive care unit and cardiac care unit, when medically necessary, is also covered;
  - hospital services and supplies provided during admission.
- If you receive Emergency Care in a contract hospital from a non-contract Physician, the Plan will pay the Physician services at the contract level of benefits. The Plan covers services at a hospital Emergency Room only for Emergencies (refer to the ***Glossary of Defined Terms***).
- Diagnostic, surgical, or therapeutic services provided by a hospital on an outpatient basis.

Special Provision for Childbirth

By law, the *Newborns' and Mothers' Health Protection Act,* the Plan may not restrict benefits for a mother's or newborn child's hospital stay in connection with childbirth less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. In addition, the Plan may not require a provider to obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, the law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

SURGERY

Subject to the Deductible and Coinsurance features of the Plan, Covered Expenses include:

- Surgery and postoperative care rendered by a physician in a hospital, physician's office, or outpatient surgical center;
- Services rendered by an assisting surgeon when Medically Necessary;
- Anesthetics and their administration;
- Services and supplies related to the surgical procedure performed.

Limitations on Surgery performed at a Surgical Center

- Certain outpatient surgeries require pre-certification. ***Check with the Administrative Office prior to receiving any surgical services on an outpatient basis.***

- Plan allowance for outpatient surgeries performed at a free-standing surgical facility that is NOT in the Blue Cross Prudent Buyer Network (regardless of whether it is associated with a contracted or non-contracted hospital) is limited to ***$1,500*** per procedure. ***Always confirm with Blue Cross that the surgical facility that your doctor suggests for an out-patient surgical procedure is in the Prudent Buyer Network.***

Special Provision for Breast Cancer Patients

Under the *Women's Health and Cancer Rights Act of 1998*, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a Participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending physician and the patient, for:

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

These services are subject to all of the Plan provisions. If you would like more information about these benefits, please contact the Administrative Office at (866) 339-7467.

EMERGENCY TRANSPORTATION (AMBULANCE)

Subject to the applicable Deductible, the Plan will pay 80% of the contracted rate or the Plan's Allowable Charges for:

- Local professional ambulance service.
- In the event an injury or illness requires treatment that is not available in a local hospital, the Plan covers medically required ambulance service to the nearest hospital that can provide appropriate treatment.

Transportation that is solely for the participant's convenience, personal preference (including taxi, limousine, railroad, or other non-emergency vehicle) will not be covered.

DIAGNOSTIC LABORATORY AND IMAGING SERVICES

Covered Expenses include:

- Routine X-rays and diagnostic laboratory services provided by a Blue Cross contracted doctor at his/her office are paid under the Physician's Office Visit Benefit.
- Diagnostic X-rays and laboratory services provided by a free-standing facility or at a hospital out-patient department are covered subject to the Deductible and Coinsurance features of the Plan,
- All major imaging procedures are subject to the Deductible and Coinsurance features of the Plan,
- Routine screening mammograms and pap tests are paid under the Well Woman Benefit.

MEDICAL SUPPLY CHARGES

Subject to the Deductible and Coinsurance features of the Plan, Covered Expenses include:

- Casts, splints, trusses, braces, crutches, and surgical dressings.
- Blood, blood plasma, and its administration.
- Oxygen and its administration.
- Artificial limbs and eyes.
- Breast prosthesis following a mastectomy and subsequent prosthesis when ordered by a physician.
- Initial purchase of eyeglasses or contact lenses as a result of cataract surgery.

DURABLE MEDICAL EQUIPMENT

Upon approval by Blue Cross or the Administrative Office and subject to the Deductible and Coinsurance features of the Plan, Covered Expenses include rental (or purchase, if cost effective) of medically necessary durable medical equipment, such as:

- hospital bed;
- wheelchair; or
- oxygen and other durable medical equipment used solely by the eligible individual for the treatment of illness or injury.

Refer to the *Glossary of Defined Terms* for a definition of Durable Medical Equipment.

OUTPATIENT THERAPY

Physical and Respiratory Therapy

Important: Outpatient physical and respiratory therapies are subject to prior approval by case management. Call the Administrative Office prior to continuing to receive services.

When you receive services from a Blue Cross Prudent Buyer contracted licensed therapist, you pay only the Office Visit copayment.

When you receive services from a licensed therapist who is not contracted with Prudent Buyer, Covered Expenses are paid subject to the Non-Contracted Provider Deductible and Coinsurance.

Speech and Occupational Therapy

Important: Speech and Occupational therapy are covered only if prior authorization is obtained from case management and only for the number of visits approved in advance. Call the Administrative Office prior to receiving services.

When you receive services from a Blue Cross Prudent Buyer contracted licensed therapist, you pay only the Office Visit copayment.

When you receive services from a licensed therapist who is not contracted with Prudent Buyer, Covered Expenses are paid subject to the Non-Contracted Provider Deductible and Coinsurance.

WELL BABY / CHILD CARE

Well Baby/Child Care for well infants and children up to 18 years of age include the following:

- immunization recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- periodic physical examinations;
- laboratory services in connection with periodic physical examinations.

When you receive services from a Blue Cross Prudent Buyer contracted doctor, there is no copayment and the Deductible does not apply.

When you receive services from a doctor who is not contracted with Prudent Buyer, Covered Expenses are paid subject to the Non-Contracted Provider Deductible and Coinsurance.

ROUTINE EXAMINATION FOR PREVENTIVE CARE OF ADULTS

Routine Examinations for preventive screening for a Covered Person include the following:

- physical examination;
- routine laboratory tests, including PSA for adult males over age 40;
- immunization recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

When you receive services from a Blue Cross Prudent Buyer contracted doctor, there is no copayment and the Deductible does not apply.

When you receive services from a doctor who is not contracted with Prudent Buyer, Covered Expenses are paid subject to the Non-Contracted Provider Deductible and Coinsurance.

WELL WOMAN CARE

Well Woman Care benefits include the following:

- physical examination;
- Pap test;
- screening mammography.

When you receive services from Blue Cross Prudent Buyer contracted doctors, laboratories and imaging centers, there is no copayment and the Deductible does not apply.

When you receive services from doctors, laboratories and imaging centers that are not contracted with Prudent Buyer, Covered Expenses are paid subject to the Non-Contracted Provider Deductible and Coinsurance.

FAMILY PLANNING

Subject to the Deductible and Coinsurance features of the Plan, Covered Expenses include vasectomy, tubal ligation, and elective abortion for an Employee or Dependent Spouse only. Services are not covered for a Dependent Child.
Treatment of *infertility is not covered* by the Plan.

CHIROPRACTIC AND ACUPUNCTURE SERVICES

Charges for chiropractic care and acupuncture treatment are limited to a combined maximum of $2,000 per calendar year for contract and non-contract combined.

- When you receive services from a Blue Cross Prudent Buyer contracted licensed provider, you pay only the copayment.
- When you receive services from a licensed provider who is not contracted with Prudent Buyer, Covered Expenses are paid subject to the Non-Contracted Provider Deductible and Coinsurance.

PODIATRY BENEFITS

Examinations

When you receive services from a Blue Cross Prudent Buyer contracted podiatrist, you pay only the Office Visit copayment.

When you receive services from a podiatrist who is not contracted with Prudent Buyer, Covered Expenses are paid subject to the Non-Contracted Provider Deductible and Coinsurance.

Orthotic Appliances

Orthotic Appliances are available from Prudent Buyer podiatrists. Benefits are paid at 80% of contracted rates.

ALLERGY CARE

Office Visits

When you receive services from a Blue Cross Prudent Buyer contracted licensed provider, you pay only the copayment.

When you receive services from a licensed provider who is not contracted with Prudent Buyer, Covered Expenses are paid subject to the Non-Contracted Provider Deductible and Coinsurance.

Testing, Treatment and Allergy Serum

The Plan covers all testing, treatments and material for care of allergies subject to the Deductible and Coinsurance features of the Plan.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

The plan provides coverage for treatment of TMJ dysfunction / myofacial pain.

SKILLED NURSING FACILITY

Covered Expenses from a licensed Skilled Nursing Facility include charges for room and board and other services and supplies, not including fees for professional services.

- Patient must be admitted as an inpatient within 7 days of discharge from a hospital stay that lasted at least 5 days.
- Patient must be under the continuous care of a physician.
- Covered Expenses for Skilled Nursing Facility care are paid at **45% of contract rate at Blue Cross facility or 35% of Covered Expenses at Non-Contract Provider.**
- Covered Expenses and are limited to 55 days per period of disability. However, additional days may be covered if the admission is related to an Accident and the following conditions are met:

  - the confinement is separated by a return to full-time work for one full working day or by an availability for work for a period of 90 days for an Active Employee; or
  - the confinement is separated by a period of 90 days for a Dependent.

HOME HEALTH CARE BENEFITS

Subject to the Deductible and Coinsurance features of the Plan, intermittent nursing care provided by a registered nurse or licensed practical nurse under the supervision of a licensed Home Healthcare Agency. *Prior authorization by Blue Cross is required*. The patient must be under the continuous care of a physician. The provider may not be someone related to the patient by blood or marriage and may not be someone who resides in the patient's home.

HOSPICE CARE BENEFITS

The calendar year deductible does not apply. Subject to prior approval by case management, the Plan pays Covered Expenses at 100% for the following:

- Intermittent nursing care provided by a graduate registered nurse or licensed practical nurse under the supervision of a licensed Hospice Agency for a terminally ill patient. Terminally ill means an individual whose life expectancy is less than six month.
- Medical social services provided prior to death by a licensed clinical social worker.
- Bereavement counseling during the three month period following the death of the terminally ill patient.

Other covered hospice services are subject to the calendar year deductible and the coinsurance provisions of the Plan. Call the Administrative Office prior to obtaining hospice services to ensure that services will be covered.

SUPPLEMENTAL ACCIDENT BENEFIT

If you are injured in a non-work related accident and the Plan's Comprehensive Medical Benefits do not cover all your expenses, you may receive an additional benefit to help with your out-of-pocket medical expenses if you need to use non-Prudent Buyer providers. If the expenses are incurred at a contract provider, the Plan will pay normal benefits. If the expenses are incurred at a non-contract provider, the Plan will pay 100% of the first $300 for medical services and $100 for lab/x-ray expenses before regular Plan benefits apply.

Supplemental Accident Benefits include:

- medical and surgical treatment;
- hospital services;
- services provided by a registered nurse or physical therapist;
- laboratory and x-ray services related to the accident;
- injuries sustained to the natural teeth or gums related to the accident.

Exclusions and Limitations:

- Treatment beginning more than 90 days after the accident.
- Ptomaine poisoning.
- Disease or infections other than those related to the accident.
- Eye glasses.
- Hearing aids.
- Injuries sustained in an altercation, other than injuries sustained as a result of domestic violence.

EXPENSES NOT COVERED UNDER THE COMPREHENSIVE MEDICAL PLAN

Although the Comprehensive Medical Plan covers many services and supplies, it does not cover everything. Following is a list of expenses that are not covered:

a) Any services or supplies that are not Medically Necessary as determined by the Plan.

b) Dental services and supplies except treatment of an accidental injury to the jaw or natural teeth when treatment occurs within six months after the date of the accident.

c) Any treatment for mental health or nervous disorders except as approved by MHN (see page 74).

d) Accidental bodily injury or sickness arising out of, or in the course of, employment, including self-employment. This Plan does not provide benefits if the expenses are covered by workers' compensation or occupational disease law, whether or not a claim is filed. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan may pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, the individual must execute a subrogation and reimbursement agreement, which will be provided by the Administrative Office.

e) Services and supplies furnished by any person, hospital or other provider organization who or which, regardless of the patient's financial ability, do not require payment in any amount from the patient.

f) Services and supplies furnished by a hospital or facility operated by the federal government or any authorized agency thereof, or furnished at the expense of such government or agency, except to the extent that such services are reimbursable to the Veterans Administration for non-service connected conditions under 38 U.S.C. 629.

g) Cosmetic surgery or treatment, except for repair of damage caused by accidental bodily injury or as required by the Women's Health and Cancer Rights Act of 1998. Restorative surgery performed during or following mutilative surgery, which was required as a result of illness or injury or congenital anomaly, shall not be considered cosmetic.

h) Injuries or illness resulting from any form of warfare or invasion or while on active duty with the Uniformed Services of any country.

i) Treatment received from a relative by blood or marriage or a person who resides in the patient's household.

j) Charges in excess of the Plan's Allowable Charge (refer to the ***Glossary of Defined Terms***).

k) Experimental or Investigational Services (refer to the ***Glossary of Defined Terms***).

l) Services and supplies not recommended, approved, and prescribed by a physician.

m) Orthopedic shoes or other wearing apparel.

n) Vitamins, health foods, dietary supplements, consultations regarding food or nutrition, diabetic training and education.

o) Exercise equipment, whirlpools, Jacuzzis, saunas, pillows, and other non-prescription items for personal use, whether or not prescribed by a physician.

p) Eye refractions and any surgical procedure to correct refractive errors of the eye.

q) Any services or supplies for treatment of hearing loss (including cochlear implants) except as specifically provided under the Hearing Aid Benefit.

r) Custodial Care (refer to the ***Glossary of Defined Terms***).

s) Reversal of sterilization or any treatment, service or drug for infertility or any charges related to a surrogate pregnancy.

t) Charges related to the pregnancy of a dependent child or the dependent child's newborn (unless the Active or Retired Ironworker becomes the legal guardian of the newborn).

u) Charges related to the treatment of obesity, other than obesity screening and counseling, and surgical intervention for Morbid Obesity (refer to the ***Glossary of Defined Terms***). If your provider prescribes surgical intervention, prior authorization from case management at the Administrative Office is required.

v) Charges for self-inflicted injury, unless caused by an underlying mental or physical disorder.

w) Charges for medical services or supplies rendered or provided outside the United States, except for treatment for Emergency Care (refer to the ***Glossary of Defined Terms)***.

x) Conditions caused or arising out of involvement in the commission of a felony.

y) Any services or supply that is excluded under "Exclusions and General Plan Limitations" on page 91.

HOW TO FILE CLAIMS UNDER THE COMPREHENSIVE MEDICAL PLAN

HOSPITAL CLAIMS

Blue Cross contracted hospitals will automatically file claims directly with Blue Cross. Most other hospitals will file claims with the Administrative Office. However, it is your responsibility to ensure that the claim is filed (see below for instructions). If you do not receive an *Explanation of Benefits* from the Plan within 30 days of your discharge from the hospital, you should call the Administrative Office and inquire if the claim has been filed.

CLAIMS FOR MEDICAL SERVICES

To file a Claim for medical services that have already been received, the following information must be provided in order for your request for benefits to be a Claim and for the Administrative Office to be able to process your claim:

- Participant name
- Patient name
- Patient Date of Birth
- SSN of participant
- Date of Service
- CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association)
- ICD (the diagnosis code found in the International Classification of Diseases, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services)
- Number of Units (for anesthesia and certain other claims)
- Billed charges (bills must be itemized with all dates of Physician visits shown)
- Federal taxpayer identification number (TIN) **and** National Provider Identifier Number (NPI) of the provider
- Provider's billing name, address, phone number and professional degree or license
- Provider's signature
- If treatment is due to an accident, accident details (you may be required to sign a Third Party Liability Agreement to reimburse the Plan if you recover damages.)
- Information on other insurance coverage, if any, including coverage that may be available to your spouse through his or her employer

Claims should be filed with the Administrative Office at the following address:

Shop Ironworkers Local 790 Welfare Plan
c/o Ironworkers Employees' Benefit Corporation
556 South Fair Oaks Avenue, Suite 30
Pasadena, CA 91105

WHEN CLAIMS MUST BE FILED

Claims for medical and hospital services that have been received should be filed within 90 days after you receive the services or supply. If you have not received either a bill from the provider or an *Explanation of Benefits* from the Administrative Office within 90 days, you should call the provider to ensure that they have the correct billing information. Claims will not be paid if they are submitted more than one year after the date on which the services were received.

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG MANAGER

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan has contracted with the prescription drug manager listed under the *Quick Reference Chart* at the front of this booklet. The prescription drug manager contracts with a network of conveniently located participating pharmacies and also provides a mail order program. Always have your prescriptions filled at a participating pharmacy or through the mail order program. You save money for yourself and the Plan and you do not have to file any claims.
When you need a medication for a short time—an antibiotic or cold remedy, for example—it is best to have your prescription filled at a participating retail pharmacy. If you are taking a medication on a long-term basis, it is usually best to have it filled through the mail order program.

RETAIL PHARMACY PROGRAM

You will receive a prescription drug ID card. When you have a prescription filled at a participating pharmacy and show the pharmacist your ID card, your copayment requirements for *up to a 34-day supply* per prescription are as follows:

	Actives – Bargained	Retirees	Actives –Non-Bargained
All Generic Drugs*	$15	$15	$25
Brand Name Drug on Formulary	$30	$30	$45
Brand Name Drug NOT on Formulary	$55	$55	$75

When you have a prescription filled at a participating pharmacy:
- Present your ID card
- Pay your copayment

* No copayment is required for generic oral contraceptives.

MAIL ORDER PROGRAM

Use the mail order prescription drug program when you have prescriptions filled for *maintenance drugs* (medications you take on an ongoing basis). When you order by mail, you can get up to a *90-day supply*. Mail order drugs are conveniently delivered directly to your home. The copayment requirements for a 90-day supply are:

	Actives – Bargained	Retirees	Actives –Non-Bargained
All Generic Drugs*	$30	$30	$50
Brand Name Drug on Formulary	$60	$60	$90
Brand Name Drug NOT on Formulary	$90	$90	$150

* No copayment is required for generic oral contraceptives.

Maintenance medications are prescription drugs that are used on an ongoing basis. These prescriptions can be used to treat chronic illnesses such as:
- arthritis
- diabetes
- heart disorders
- high blood pressure
- Ulcers

FORMULARY

This program uses a formulary, developed by WellDyneRx. The formulary list is a guide for you and your doctor to choose appropriate, cost-effective medicines. Your doctor, of course, will choose the medication you use, regardless of what is on the formulary. Choosing a formulary drug will help keep your out-of-pocket expense low. To find out if your prescription drug is on the formulary, check the WellDyne Rx website, www.WellDyneRx.com.

OVER THE COUNTER DRUGS

The FDA may take action to allow certain drugs that are widely used, that previously required a prescription, to be dispensed over the counter. Because these drugs can be less costly than obtaining a prescription for their generic equivalents, the Trustees may allow you to purchase these drugs without paying any copayment. The following drugs may be obtained **without any copayment** when you use your WellDyneRx ID card at the pharmacy: ***Prilosec***, ***Claritin, Claritin D, Zyrtec, Zyrtec D and Alavert***.

CERTAIN DRUGS REQUIRE PRIOR AUTHORIZATION

Certain drugs must be authorized in advance by the Administrative Office. Before you go to the pharmacy, be sure to contact the Administrative Office (see the *Quick Reference Chart* in the front of this booklet). These drugs include:

- Any prescriptions for weight loss.
- Refills for all narcotic medications (limited to 20 for each 30-day refill).
- Injectable or nasal spray Imitrex (or similar treatments for migraine) in excess of six per month.
- Anabolic steroids.
- Drugs for Attention Deficit Hyperactivity Disorder (ADD).
- Oral drugs for treatment of erectile dysfunction in excess of eight per month.
- Injectable drugs for treatment of erectile dysfunction in excess of six per month.
- Certain injectable drugs, including drugs for treatment of multiple sclerosis, psoriasis, rheumatoid arthritis and HIV.
- Singulair or Xolair for treatment of asthma.
- Byetta or Symlin for treatment of Type II diabetes.
- Growth hormones.
- Botox or other purified neurotoxin complex medications.
- Oral anti-fungal medications.
- Prescriptions for treatment of narcolepsy.
- Cox 2 inhibitors for treatment of arthritic pain.
- Anti-rejection drugs following an organ or tissue transplant.
- Any prescription exceeding $1,000 at retail or $3,000 at mail order.
- Vacation re-fills and other “re-fill too soon” situations, including lost prescriptions.

COVERED DRUGS AND MEDICATIONS

The Plan covers Medically Necessary pharmaceuticals legally requiring a written prescription executed by a Physician or dentist and dispensed by a licensed pharmacist:

- Oral contraceptive in excess of one month supply purchased at retail require one copayment for each month's supply. There is no copayment required for generic oral contraceptives. Contraceptive patches and vaginal contraceptive rings are also covered.
- Insulin and diabetic supplies and injection kits.
- Anaphylactic injectable kits.
- Compounded preparations that must be prepared by a Pharmacist according to your Physician's prescription.
- Retin-A or Accutane are covered for patients under 26 years of age.

EXPENSES NOT COVERED UNDER THE PRESCRIPTION DRUG PROGRAM

The following expenses are not covered under the Prescription Drug Program:

a) Prescriptions dispensed by a licensed hospital during confinement (including "take-home" prescriptions).
b) Drugs or medications that may be procured without a Physician's written prescription, except as specifically allowed by the Plan.
c) Prescriptions for conditions arising out of, or in the course of, employment, including self-employment.
d) Drugs for which reimbursement is provided by a governmental agency.
e) Drugs, medicines or devices to enhance fertility and/or treat infertility.
f) Appliances; prosthetics, medical supplies or equipment except for contraceptive items.
g) Drugs prescribed for any purpose incidental to trans-sexual operations or any resulting medical complications.
h) Drugs used to promote hair growth, anti-pigmentation drugs or any other prescription for any cosmetic purpose.
i) Drugs for tobacco cessation in excess of two 90-day treatment regimens per calendar year.
j) Multiple and non-therapeutic vitamins and dietary supplements except pre-natal vitamins for pregnant women and pediatric fluoride prescriptions.
k) Over-the-counter medications and nutritional supplements, except for tobacco cessation medications approved by the United States Food and Drug Administration, which are limited to two 90-day treatment regimens per calendar year and require a prescription from a health care provider.

DIRECT REIMBURSEMENT

If you do not use a WellDyne Rx pharmacy or you do not present your WellDyne Rx card at the time you purchase your prescription, you must pay for your prescription out-of-pocket and submit a claim for reimbursement directly to WellDyne Rx. The same covered drugs, formulary and copayments, and exclusions and limitations apply. You should be aware of the following:

- Payment is made directly to you.
- Claims must be filed within 90 days from the date on which the prescription is filled. If it is not reasonably possible to submit the claim within 90 days additional time may be granted. However no benefits will be paid for any claim not filed within one year after the date the charges were incurred.
- If the non-network pharmacy charges more than what the Plan allows, you are responsible for the difference in cost.

HEARING AID BENEFIT

For Active & Retired Ironworkers (to age 65), eligible Subscriber Employees, and their eligible Dependents The Hearing Aid Benefit is available to Active Ironworkers and eligible Subscriber Employees and their eligible Dependents. *Retirees are eligible for this benefit only until they reach age 65.*

COVERED EXPENSES

Covered Expenses, when required to restore or aid lost or impaired hearing, are:

- Hearing examination to determine the existence of and evaluate the extent of hearing loss.
- The making and fitting of a permanent hearing aid device.
- For dependent children only, the Plan will cover the cost of molding once every two months for children under one year of age and annually thereafter, up to a maximum benefit payable of $100 for each molding change.

PERCENTAGE PAYABLE AND MAXIMUM BENEFIT

The Hearing Aid Benefit will pay 80% charges incurred for Covered Expenses, up to a maximum benefit payable of $1,500 for each hearing aid device (including initial batteries) during any four-year period. This four-year period will begin on the date the first Covered Expense is incurred.

EXCLUSIONS AND LIMITATIONS

No Hearing Aid Benefit will be extended for:

- A hearing examination without obtaining a hearing aid device.
- Replacement of batteries, cords or other ancillary equipment.
- Repairs, servicing or alterations to the hearing aid, to include replacement of parts.
- Replacement of an existing instrument for any reason more often than once during any four-year period.
- Charges for services or supplies for which benefits are payable under any other benefit of this Plan.
- More than one hearing device for each ear.

FILING HEARING AID BENEFIT CLAIMS

- Obtain a claim form from the Administrative Office.
- Complete your portion of the form and have your Provider complete the rest of the form.
- Attach your proof of payment and submit the form to the Administrative Office.

Claims for Hearing Aid Benefits should be filed within 90 days after you receive the services. Claims will not be paid if they are submitted more than one year after the date on which the services were received.

MEMBER ASSISTANCE PROGRAM (MAP)
PROVIDED BY MANAGED HEALTH NETWORK (MHN)

FOR ALL ACTIVE & RETIRED WELFARE PLAN PARTICIPANTS

The Member Assistance Program is a free, confidential, professional consultation and referral program established for all Welfare Plan Participants. This program is designed to help you and your household members address and resolve personal problems that may be interfering with work or home life. There are no costs to you for these services and counseling up to the covered number of sessions stated below.

The Shop Ironworkers Local 790 Welfare Plan has contracted with MHN to provide these professional services for you 24 hour a day, 7 days a week, 365 days a year. You must receive authorization from MHN in order for benefits to be provided. Information, guidance, or assistance can be obtained by calling: (800) 624-6864.

When you call the Member Assistance Program, a trained intake specialist will assist you with obtaining services. They will provide you with names and telephone numbers for providers best suited to meet your needs. You must call the provider to set up an appointment and then call MHN back to obtain an authorization.

Up to five counseling sessions authorized by *MHN* are provided for each situation for which you seek assistance. These sessions may include:

- Short-term counseling by a qualified specialist
- Face-to-face, telephonic or web video assessments
- Crisis intervention
- Community resources and affiliations referrals
- Family mediation services

CONFIDENTIALITY

Your concerns are your own private business. Any personal information you may share with a MAP counselor is strictly confidential, and all member assistance communications are in accordance with legal requirements for confidentiality.

WHAT PROBLEMS CAN THE MAP HELP WITH?

Just about anything. MAP programs focus on the following problems:

Debt management	Financial counseling
Job stress	Relationship problems
Emotional distress	Anger Management
Child and elder care	Legal problems
Domestic violence	Identity theft

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS PROVIDED BY MANAGED HEALTH NETWORK (MHN)

FOR ALL ACTIVE WELFARE PLAN PARTICIPANTS

You must receive authorization through MHN to receive coverage for inpatient treatment. Contact MHN at (800) 624-6864. If you do not obtain pre-authorization, benefits will be reduced by 10% Your Mental Health benefits are much higher when you obtain services from providers who are contracted with MHN.

If You Are Admitted To A Hospital in an Emergency

If you are admitted to a hospital or treatment center in an emergency, you or someone acting on your behalf must notify MHN at (800) 624-6864, as soon as possible, but in no event more than 48 hours after your admission. if MHN is not notified so that your case and treatment can be reviewed, you may be responsible for the cost of your treatment.

How to Obtain Prior Authorization

Call *MHN* toll-free at (800) 624-6864. When you call MHN, a customer service specialist will assist you and ask questions designed to determine the most appropriate treatment program for you.

SUBSTANCE ABUSE BENEFITS

- Outpatient (including detoxification) visits are at a $25 copayment per visit to MHN contracted providers ($15 for group visits).

- When you use mental health providers who are not contracted with MHN you pay 40% of the Allowable Charge plus any amount that exceeds the Allowable Charge, as determined by MHN, and the calendar year deductible applies.

- Inpatient treatment (including detoxification and residential treatment). Inpatient care is covered at an approved facility. When you obtain services from an MHN contracted provider, you pay 20% of the contract rate and the calendar year deductible applies.

- If you are admitted to a facility that is not contracted with MHN, you must pay 40% of the Allowable Charge plus any amount that exceeds the Allowable Charge, as determined by MHN. The calendar year deductible applies, as well as the additional $500 deductible per admission to a non-contracted facility.

- **Alternate Levels of Care**: (including partial hospitalization, day, and intensive outpatient treatment). Alternate levels of care are covered at an approved facility. When you obtain services from an MHN contracted provider, you pay 20% of the contract rate and the calendar year deductible applies.

If you are admitted to a facility that is not contracted with MHN, you must pay 40% of the Allowable Charge plus any amount that exceeds the Allowable Charge, as determined by MHN. The calendar year deductible applies.

MENTAL HEALTH BENEFITS

All services must be approved by MHN.

- Outpatient visits are at a $25 copayment per visit to MHN contracted providers ($15 for group visits), and the calendar year deductible applies. When you use mental health providers who are not contracted with MHN you pay 40% of the Allowable Charge plus any amount that exceeds the Allowable Charge, as determined by MHN. The calendar year deductible also applies.

- Inpatient care is covered at an approved mental health facility. When you obtain services from an MHN contracted provider, you pay 20% of the contract rate and the calendar year deductible applies. If you are admitted to a facility that is not contracted with MHN, you must pay 40% of the Allowable Charge plus any amount that exceeds the Allowable Charge, as determined by MHN. The calendar year deductible applies, as well as the additional $500 deductible per admission to a non-contracted facility.

EXCLUSIONS AND LIMITATIONS

No benefits are payable for:

- Services or treatment, including medication management visits, that have not been authorized by MHN or those rendered by non-network providers, unless authorized by MHN;

- Treatment of intellectual disability, autism, developmental or learning disabilities other than the initial diagnosis;

- Court-ordered testing, counseling and treatment, including detention under Welfare and Institutional Code, Section 5150;

- Any treatment of medical conditions;

- Ancillary services such as psychological testing, neuropsychiatric testing, vocational rehabilitation, behavioral training, sleep therapy, speech therapy, employment counseling, training or educational therapy for learning disabilities or other education services;

- Services, treatment or supplies which are not Medically Necessary or Clinically Appropriate, such as those primarily for rest, Custodial Care, Domiciliary Care or convalescent care;

- Charges for smoking cessation or weight loss (however, there is coverage for smoking cessation treatments under the Comprehensive Medical Plan and prescription drug program);

- Services, treatment or supplies provided as a result of any Workers' Compensation law or similar legislation or obtained through or required by any governmental agency or program, whether federal, state or any subdivision thereof (exclusive of Medi-Cal); or

- Benefits, services, treatment or supplies that exceed the maximums allowed by the program.

Definitions

For purposes of this section:

- Domiciliary Care means inpatient institutional care provided not because it is Medically Necessary but because care in the home setting is not available, is unsuitable, or members of the patient's family are unwilling to provide the care. Institutionalization because of abandonment constitutes domiciliary care.

- Clinically Appropriate means that the health care services, treatment or supplies meet all of the following conditions:

  - are rendered for the purpose of diagnosis or treatment of a mental disorder or chemical dependency;
  - are non-experimental treatments that can be reasonably expected to improve the patient's condition or level of functioning;
  - are not mainly for the convenience of the patient or the patient's health care provider;
  - are rendered in an environment in which services are performed at the least restrictive level of care providing effective treatment;
  - are "appropriate," that is: (a) consistent with the symptoms and diagnosis; (b) the type, level, length and setting to provide safe and adequate care and treatment; and (c) in keeping with generally accepted standards for good medical practice within the organized medical community. Hospital care is provided when safe and adequate care cannot be received on an outpatient basis or in a less restrictive setting. Professional services must be by a licensed or certified professional acting within the permissible scope of his license and within the rules and regulations of any supervising professional organization.

RIGHTS AND RESPONSIBILITIES

Dignity and Respect

You have the right to be treated with consideration, dignity and respect -- and the responsibility to respect the rights, property, and environment of all providers and other health care professionals, Employees and other patients. You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained. You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture; or economic, educational, or religious background.

Member Accountability/Autonomy

As a partner in your own health care, you have the right to refuse treatment--providing you accept responsibility and the consequences of such a decision--and the right to refuse to participate in any medical research projects. You also have the responsibility to:

- Identify yourself as an ***MHN*** member when receiving services.
- Provide your current ***MHN*** contracted provider with previous treatment records, if requested, as well as provide accurate and complete medical information to MHN and any other health care professionals involved in the course of your treatment.
- Be on time for all appointments and notify your provider's office as far in advance as possible if you need to cancel or reschedule an appointment.
- You have the right at any and all times to contact MHN for assistance with issues regarding your behavioral health plan. It is your right to have all the above rights apply to the person you have designated with legal authority to make decisions regarding your health care.

FILING A CLAIM

MHN and your care providers and facilities take care of claim forms when you receive services from MHN providers. Payment is made directly to the provider. If you received approved services from a provider who is not contracted with MHN, you will need to file your claims directly with MHN.

COMPLAINT AND GRIEVANCE PROCESS

Participants are required to follow MHN grievance procedures. If you have a complaint or grievance, call MHN at (800) 624-6864 or online at: www.MHN.com or write:

MHN
Grievance & Appeals Unit
P.O. Box 10697
San Rafael, CA 94912

The MHN staff will fill out a Grievance Report Form. If the grievance involves quality of care, it will be investigated and resolved by MHN's Quality Management staff. MHN Quality Management will acknowledge receipt of your form in writing within five calendar days.

MHN will resolve most grievances within 30 days of receipt of the Grievance Report Form. However, if additional time is required, you will be notified within 30 days and you will be given the reason for the delay. You will be notified of the resolution of the grievance, in writing if appropriate. If you are dissatisfied with the outcome, you can appeal by writing to the Quality Management Clinical Manager at the address above. If the Quality Management Clinical Manager upholds the original decision, you will receive a letter informing you of your right to appeal.

APPEAL PROCESS

Level I: Internal Review

If you are still in treatment or have an imminent need for treatment, you or your MHN provider can request an expedited appeal by telephone by calling MHN at (800) 624-6864. An appeal determination via telephone will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the request for review. The reviewer will not be the one who issued the initial denial. If treatment is completed, appeals are processed within 30 days of a request. The appeal request should include a complete copy of relevant Hospital information or clinical records and be sent to:

Managed Health Network
Retroactive Review & Appeals Department
503 Canal Boulevard
Point Richmond, CA 94804

A different peer reviewer from the one who issued the initial denial will review the request. MHN will send written notification to you and to the MHN provider within 30 days of the date it receives the written appeal and all relevant clinical information.

Internal Grievance Committee Hearing

You or your MHN provider may request an appeal of a Level I clinical decision by writing to the Appeals Unit.

The request should include the reason for the appeal and any additional relevant information. The appeal will be sent to an external review agency, except in cases where another independent review is mandated by state law or regulations. In this case, MHN will notify you and your provider or facility of the applicable procedure. If an external review agency is used, a written decision by the agency is communicated by the Chair of the MHN Appeals and Grievance Committee or his/her designee within 30 days of the receipt of the written appeal request and all relevant clinical information. If another independent review is mandated, the decision is communicated within the time period and in the manner prescribed by applicable state laws or regulations.

Level II: Independent Medical Review (Voluntary for Members)

Upon receipt of an adverse decision on a mandatory MHN Level I appeal, the Member has the right under California law to apply with the Department for Independent Medical Review ("IMR") when the member's health care service is denied, delayed, or modified due to MHN's determination that such services are not Medically Necessary. See your *Evidence of Coverage* document for further details on procedures and processes.

LIFE INSURANCE BENEFIT AND ACCIDENTAL DEATH & DISMEMBERMENT
UNDERWRITTEN BY RELIASTAR LIFE INSURANCE COMPANY
AVAILABLE TO ACTIVE EMPLOYEES ONLY

LIFE INSURANCE BENEFIT

Complete information regarding the Life Insurance Benefit is included in your *Certificate of Group Insurance* booklet provided by ReliaStar Life Insurance Company. You may also refer to the Group Insurance Policy on file in the Administrative Office. No benefits are provided for Dependent Life Insurance.

Your beneficiary will receive $15,000 as a Life Insurance Benefit in the event of your death from any cause while covered under the Plan.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Complete information regarding the Accidental Death & Dismemberment Benefit is included in your *Certificate of Group Insurance* booklet provided by ReliaStar Life Insurance Company. You may also refer to the Group Insurance Policy on file in the Administrative Office.

Accidental Death and Dismemberment Benefits will be paid for any of the following losses due to an Injury, on or off the job. For AD&D benefits to be payable, the Injury must be sustained while you are insured and the loss must occur within 90 days after such Injury, directly and independently of all other causes. Payment will be made in addition to any other benefits you may receive.

SCHEDULE OF AD&D LOSSES

Life	$15,000
Two Hands	$15,000
Two Feet	$15,000
Sight of Two Eyes	$15,000
One Hand and One Foot	$15,000
One Hand and Sight of One Eye	$15,000
One Foot and Sight of One Eye	$15,000
Speech and Hearing in Both Ears	$15,000
One Hand	$ 7,500
One Foot	$ 7,500
Sight of One Eye	$ 7,500
Speech	$ 3,750
Hearing in Both Ears	$ 3,750
Thumb and Index Finger of Same Hand	$ 3,750

Loss of a hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint. Loss of an eye means irrecoverable and complete loss of sight in the eye.

EXCLUSIONS FROM LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

No benefits are paid for losses directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury while sane or insane;
- Physical or mental illness;
- Bacterial infection or bacterial poisoning with exception of infection from a cut or wound caused by an accident;
- Riding in or descending from an aircraft as a pilot or crew member;
- Any armed conflict, whether declared as war or not, involving any country or government;
- Injury sustained while in the military service for any country or government;
- Injury which occurs when the insured commits or attempts to commit a felony;
- Use of any drug , narcotic or hallucinogenic agent, 1) unless prescribed by a doctor, 2) which is illegal, or 3) not taken as directed by a doctor or the manufacturer; or
- The insured's intoxication. Intoxication means the insured's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

DISABILITY BENEFIT

If you become totally disabled before age 60, your life insurance only will be continued without payment of premium until you recover, you retire, or you reach age 65, whichever comes first.

FILING LIFE AND AD&D INSURANCE CLAIMS

In the event of your death, your beneficiary should call the Administrative Office for help in filing a claim. If you have an injury covered under the AD&D program, you should file a claim. The Plan requires proof of death or loss—usually in the form of a death certificate or physician's statement. In some situations, the Plan has the right to request a physical exam by a physician of its choice or an autopsy. Proof of death or loss must be submitted within 90 days, or as soon as reasonably possible. In no case will a Life and AD&D claim be paid if the claim is submitted more than one year after the loss is incurred.

WEEKLY ACCIDENT & SICKNESS BENEFIT

PROVIDED BY THE PLAN

For Active Bargaining Unit Ironworkers Only

Weekly Accident & Sickness Benefits are available for Active Bargaining Unit Ironworkers only. Retired Ironworkers, Subscriber Employees, and Dependents are not eligible for Weekly Accident & Sickness Benefits. Weekly Accident and Sickness Benefits are not provided to persons on COBRA or to persons whose coverage is extended by self-payment (except in the case of an Employer's delinquency).
Weekly Accident & Sickness Benefits provide coverage to help protect an Active Ironworker against loss of income if the Ironworker is unable to work because of Illness or Injury. If an Active Ironworker, while he/she is actively at work and eligible for coverage, becomes Totally Disabled as a result of Illness or Injury, Weekly Accident & Sickness Benefits are payable up to a maximum of 26 weeks during each period of Total Disability. For partial weeks, the benefit amount for each Working Day is determined by dividing the weekly benefit by five. Claims must be submitted within 180 days.

If you are Totally Disabled on the date you become eligible for benefits, you will not be covered for the Weekly Accident & Sickness Benefit until you return to active work or are available for work.
"Totally Disabled" means that due solely to Injury or Illness, an Active Ironworker is prevented from engaging in any and every duty of his/her regular or customary occupation or employment, and is performing no work of any kind for wage or profit.

Schedule of Weekly Accident & Sickness Benefits:

First Week of Total Disability:	$107.00 ($21.40 per Working Day)
2nd through 26th Week of Total Disability:	$81.00 ($16.20 per Working Day)

"Working Day" refers to any day of a work week during which an Active Ironworker is scheduled to work. Benefits paid are considered taxable income and are reported on a Form 1099. Weekly Accident & Sickness Benefits are subject to federal taxation, including FICA.

If the disabling Illness or Injury is related to employment, your benefit will be reduced so that the sum of this Weekly Accident & Sickness Benefit plus any Workers' Compensation benefit (including any benefit payable under employer's liability law or occupational disease law) does not exceed 66.67% of your regular scheduled gross weekly wage.

When Weekly Accident & Sickness Benefits begin:

- with the first day of a Total Disability resulting from an Injury or if confined to a Hospital due to Illness; or
- with the fourth day of Total Disability resulting from an Illness or if earlier, the first day of Hospital confinement due to such Illness. If Total Disability lasts through four consecutive Working Days, benefits will be paid retroactively from the first day of Total Disability.

To qualify for Weekly Accident & Sickness Benefits, an Active Ironworker must be regularly seen, treated, and certified as Totally Disabled by a Physician.

Successive Periods of Total Disability

Weekly Accident & Sickness Benefits will continue for up to a maximum of 26 weeks as long as an Active Ironworker remains Totally Disabled and eligible for benefits under the Plan rules. (Eligibility terminates if a participant leaves the industry.) A new period of disability will begin if:

- an Active Ironworker returns to full-time work for at least two weeks, then becomes Totally Disabled again from the **same cause**; or
- an Active Ironworker becomes Totally Disabled again from a **different cause**.

Termination of Eligibility

If eligibility terminates after Total Disability is established and benefits are determined payable, Weekly Accident & Sickness Benefits will continue until:

- the Ironworker is no longer Totally Disabled, or
- the maximum benefit has been paid.

When Weekly Accident & Sickness Benefits End

Benefits end automatically on the earliest of the following events:

- The date you are no longer Totally Disabled;
- The date your maximum benefit period ends;
- The date you die;
- The date you begin working for any employer.

Exclusions

No Weekly Accident & Sickness Benefit is payable for any period of disability in which:

a) you are not under the direct care of a Physician (except that if you consult with a Physician within two days of onset of Illness, the Plan considers you to be under the care of a Physician from the day of onset of Illness);
b) the disability was caused or contributed to by war or any act of war. ("War" means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.)
c) you retire and are receiving pension benefits;
d) you are receiving permanent disability benefits;
e) you are not eligible under the Plan Rules; or
f) your membership dues are not paid current.

Filing Weekly Accident & Sickness Benefit Claims

Claims for Benefits should be filed with the Administrative Office within 90 days after the onset of the illness or injury but in no case more than one year after the date on which you became eligible for the Benefits. Claim forms are available from the Administrative Office or your local union office.

VISION CARE BENEFIT
PROVIDED BY VSP

FOR ACTIVE IRONWORKERS, ELIGIBLE SUBSCRIBER EMPLOYEES, AND THEIR ELIGIBLE DEPENDENTS

The Plan has entered into an arrangement with Vision Service Plan (VSP) to administer the Plan's Vision Care Benefit. The Vision Care Benefit is available to Active Ironworkers and their eligible Dependents. It is not available to Retired Ironworkers or their Dependents, or to a Subscriber Employee or their Dependents whose Contributing Employer does not enroll for Vision Care Benefits.

You and your eligible Dependents may obtain services from any licensed and qualified vision care provider but your out-of-pocket expense will be lower with a VSP provider. The VSP plan provides a dual choice to the patient. If the patient elects to receive vision care services from one of the 20,000 in network Doctors, covered services are provided at no out-of-pocket cost except the deductible. If the patient chooses to go to a non-panel doctor, you must file a claim with VSP and you will be reimbursed according to a schedule of allowances.

VSP IN-NETWORK BENEFITS

- One vision exam - every twelve months.
- Lenses - once every twelve months: single vision, bifocal, trifocal, or other complex lenses.
- Medically necessary contact lenses - the VSP in network doctor must secure prior approval for the following conditions: following cataract surgery; to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; certain conditions of Anisometropia; and Keratoconus. When the VSP in network Doctor receives such approval, benefits are fully covered by VSP.
- Elective contact lenses - you may elect to obtain contact lenses in lieu of lenses and frames up to a total allowance of $105 every twelve months for exam and materials.
- Frames - one pair every 24 months.

i. Copayments

There is a copayment of $10.00 for the examination, payable to the VSP in network Doctor at the time services are rendered. If lenses and/or frames are provided, there is an additional $20.00 copayment payable at the time the materials are ordered. This copayment for materials does not apply to elective contact lenses.

ii. Additional Discount

You will receive a 20% discount toward the purchase of additional complete pairs of prescription glasses from a VSP in network Doctor. Additional pair means any complete pair of prescription glasses purchased beyond the benefit frequency allowed under this Plan. If you elect additional glasses from a VSP in network Doctor, you will pay the doctor the discounted purchase price, as the additional pair is not reimbursed under the Plan.

iii. Low Vision Benefit

The Low Vision benefit is available for Participants who have severe visual problems that are not correctable with regular lenses, and is subject to approval by VSP consultants. The maximum benefit payable is $1,000 every two years.

iv. How to use the VSP Plan

To receive benefits from a VSP provider, call your vision care provider and:

- identify yourself as a Shop Ironworkers Local 790 Welfare Plan Participant,
- give them the employee's name and social security number, and the patient's name and date of birth,
- schedule an appointment. Your VSP provider will verify your eligibility and benefits.

You may obtain a VSP provider list from the Administrative Office or from your union local, or you may call Vision Service Plan's customer service department toll-free at (800) 877-7195.

Selecting a doctor from the VSP list assures direct payment to the doctor and VSP's guarantee of quality and cost control.

NON-VSP DOCTOR BENEFITS

Your non-VSP provider may be a licensed ophthalmologist, optometrist or optician providing covered services within the scope of his license. If you elect a doctor who is not a VSP in network Doctor, you will pay the doctor his full fee. You will then be reimbursed in accordance with a fixed Reimbursement Schedule:

i. Reimbursement Schedule

When you use an out-of-network doctor, the benefits are the following scheduled allowances:

Vision Examination	
once every twelve months	$45.00
Spectacle Lenses	
once every twelve months, if necessary	
Single Vision	$45.00
Bifocal	$65.00
Trifocal	$85.00
Lenticular	$125.00
Tints and Photochromic	$5.00
Contact Lenses	
in lieu of all other benefits	
Necessary	$210.00
Elective	$105.00
Frames	
(one pair every 24 months)	$46.00

VSP will determine when contact lenses are "necessary" on the same basis they do with VSP doctors; otherwise, the "elective" allowance will prevail.

ii. Claims

When you obtain services from a non-VSP doctor, and/or obtain glasses from a dispensing optician, be sure to send your itemized statement of charges to VSP along with your benefit form within six months of the date when services were rendered. Send your claim to:

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

LIMITATIONS AND EXCLUSIONS

i. Extra Cost for Options

This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, there will be an extra charge:

- blended lenses;
- contact lenses (except as noted elsewhere herein);
- oversize lenses;
- progressive multi-focal lenses;
- coated lenses;
- laminated lenses;
- a frame that costs more than the plan allowance;
- certain limitations on low vision care;
- cosmetic lenses;
- optional cosmetic processes;
- UV (ultraviolet) protected lenses.

ii. Exclusions

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing, plano lenses, or two pair of glasses in lieu of bifocals;
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Any eye examination or corrective eyewear required by an employer as a condition of employment.

VISION CARE GRIEVANCE PROCESS

i. Complaints and Grievances

If you ever have a question or problem, your first step is to call VSP's Customer Service Department's toll-free number Monday through Friday, 6:00 AM – 7:00 PM Pacific Standard Time. Every effort will be made by VSP's Customer Service Department to answer your question and/or resolve the matter informally. If a matter is not initially resolved to your satisfaction, you may submit a written complaint form to VSP. You may request the form from the Customer Service Department. Complaints and grievances include

disagreements regarding access to care, quality of care, and treatment of service. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than 120 days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within 30 days, a letter will be sent to you to indicate VSP's expected resolution date. Upon final resolution, you will be notified of the outcome in writing.

ii. Claim Appeals

If a claim for benefits is denied in whole or part, VSP will notify the claimant in writing of the reason(s) for the denial. Within 60 days after receipt of the notice, you may make a written request to VSP for a full review of the denial. The written request should include the name and social security number of the Employee and the name and date of birth of the person for whom the appeal is being made.

You may state the reasons you believe the denial was in error and provide any pertinent documents you wish to have reviewe**d**. VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. VSP's review determination, including specific reasons for the decision, on which the decision is based shall be provided and communicated within 30 days after receipt of a request for review unless special circumstances require an extension of time for processing. In that case, a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

iii. Review by the Department of Corporations

The California Department of Corporations is responsible for regulating health care service plans. The department's Health Plan Division has a toll-free number (1-800-400-0815) to receive complaints regarding health plans. The hearing or speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2029 (TTY)) of (1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http//www.corp.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at 1-800-877-7195 and use the plan's grievance process before contacting the Health Plan Division. If you need help with a grievance that has remained unresolved for more than 60 days, you may call the Health Plan Division for assistance. The plan's grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these procedures does not preclude your use of any other remedy provided by law.

iv. Arbitration

Any dispute or question involving the application, interpretation, or performance under this plan shall be settled, if possible, by amicable and informal negotiations. This will allow such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration. The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.

DENTAL CARE BENEFIT
PROVIDED THROUGH CIGNA AND UNITED HEALTHCARE DENTAL PLAN

FOR ACTIVE IRONWORKERS, ELIGIBLE SUBSCRIBER EMPLOYEES, AND THEIR ELIGIBLE DEPENDENTS

Dental Care Benefits are available to Active Ironworkers and their Eligible Dependents. Dental Benefits are not available to Retired Ironworkers or their Dependents, or to a Subscriber Employee or their Dependents whose Contributing Employer does not enroll for Dental Care Benefits.

DENTAL PLAN OPTIONS

You and your eligible Dependents may choose between three dental plans:

- The **CIGNA Dental PPO Plan** lets you choose any licensed Dentist, however, use of a CIGNA Dentist may result in lower out-of-pocket expenses. You or your provider must submit a claim form to CIGNA in order to receive benefits.

- The two prepaid dental plans, **CIGNA Prepaid Plan** and **United HealthCare Dental Plan** require that you choose your Dentist from participating providers and receive your dental care at one of their participating offices. You are not required to submit a claim form.

- A more detailed description of the Dental Care Benefits for each prepaid dental plan is provided in separate brochures available from each dental plan or the Administrative Office.

CIGNA DENTAL PLAN: PPO INDEMNITY PLAN OPTION

A Participant may go to any licensed Dentist. When you use dentists who are not contracted with CIGNA, you will be responsible for any amounts that exceed Delta's allowance for the procedure, in addition to your required coinsurance.

Covered Expenses are deemed to be incurred on the date dental care is received. If a participant selects a more expensive plan of treatment than is customarily provided, an allowance will be made for the least expensive, professionally acceptable alternative treatment plan. Covered Expenses may be rendered by a Dentist or Dental Hygienist working under the supervision of a Dentist.

Percentage Payable and Maximum Benefits

This dental plan pays benefits based on the negotiated rates for a CIGNA Participating Dentist, up to the calendar year maximum benefit payable of $2,000 per Participant. Benefits are payable at the following percentages:

Diagnostic and Preventive Services

- 85% of CIGNA's allowed fees for CIGNA Participating Dentists; or
- 70% of CIGNA's allowed fees for Dentists who do not contracted with CIGNA

  - exams and prophylaxis are covered only twice in a calendar year
  - Bitewing X-rays are provided not more often than twice in a calendar year for children and once in a calendar year for adults year
  - coverage for a full-mouth X-ray is limited to one series every five years

Sealants are provided only to permanent first molars through age eight and second molars without caries or restorations on the occlusal surface through age 15. Cigna benefit is limited to posterior tooth. One treatment per tooth every three years up to age 14.

Basic and Major Services

- 70% of CIGNA's allowed fees for space maintainers, basic restorations (amalgam and composite), major restorations (single crowns and gold restorations), oral surgery (extractions, excisions) including pre- and post-operative care, endodontics (treatment of disease of the pulp chamber and pulp canal), and periodontics (treatment of diseases of tissues supporting teeth).

- Crowns, Jackets, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you are a patient under any CIGNA program, unless CIGNA determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to the tooth structure or supporting tissues since the replacement of the restoration.

Prosthodontics

- 50% of CIGNA's allowed fees for prosthodontics (bridges, partial or complete dentures) and orthodontic services.

Coverage for the replacement of bridgework, or partial and complete dentures is limited to replacement only after five years has elapsed following any prior placement of such appliances under any CIGNA Dental program, unless CIGNA determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory.

Pre-Treatment Estimates

A "treatment plan" is a Dentist's written report explaining proposed treatment. Whenever you expect that your expenses for a treatment plan will be more than $200, a pre-treatment estimate is recommended. The pre-treatment estimate will tell you the total charges for a treatment plan and what part of those charges will be covered by the Delta Dental Plan, so you will know what your out-pocket share will be.

Orthodontic Care through CIGNA Dental Plan

If you are enrolled in the CIGNA PPO Indemnity Plan dental option, the Orthodontic Care Benefit provides coverage for non-surgical services to correct malocclusion (alignment of the teeth and/or jaws) that significantly interferes with their function. Necessary services related to an active course of orthodontic treatment include diagnosis, initial installation of orthodontic appliances and periodic adjustment to the appliances. Repair or replacement of an orthodontic appliance is not covered.

Orthodontic benefits will be paid at 50% of the CIGNA dentist's fee up to a maximum benefit payable of $2,000 per Participant per lifetime.

Orthodontia Benefits are Limited

Benefits for orthodontic services will cease as of the last day of the month:

- In which treatment ceases for any reason, or
- In which eligibility terminates, whether or not the course of treatment has been completed.

Exclusions and Limitations under the CIGNA Dental PPO Plan

All services are subject to CIGNA Dental's claims processing guidelines. Specific limitations that apply to certain services are included above. In addition, the following list of exclusions and limitations (which may not be inclusive, refer to your *Evidence of Coverage* brochure from Delta) apply:

a) Services for injuries that are covered under Workers' Compensation or similar Employer liability laws or are the result of war or service in the armed forces of any country.

b) Serviced which are provided by any Governmental Agency or are provided without cost, unless otherwise required by law, or any services for which there is no legal obligation to pay.

c) Any services with respect to correction of congenital or developmental malformation.

d) Cosmetic surgery or dentistry for purely cosmetic reasons.

e) Services for restoring tooth structure lost form wear (abrasion, erosion, attrition or abfraction), including equilibration and periodontal splinting.

f) Occlusal guards and complete occlusal adjustment.

g) Replacement of existing restoration for any purpose other than active tooth decay.

h) Prescribed drugs, pre-medication or analgesia.

i) Experimental and/or Investigational Procedures.

j) Hospital costs and additional fees charged by a Dentist for hospital treatment.

k) Treatment rendered by someone other than a Dentist or Physician, except for dental prophylaxis by a dental hygienist under the supervision of a dentist.

l) Charges for anesthesia or intravenous sedation, other than general anesthesia administered by a Dentist in connection with covered oral surgery.

m) Extra-oral grafts (grafting tissues from outside the mouth to oral tissues).

n) Implants (materials implanted into or on bone or soft tissue) or the removal of implants.

o) Diagnosis or treatment by any method of any condition related to the temporomandibular joint or associated musculature, nerves and other tissues (For temporomandibular joint dysfunction benefits provided under the Comprehensive Medical Plan see p.63).

p) Prosthodontic services or any single procedure stated prior to the date the patient became a Participant in this Fund or after the Participant is no longer eligible.

q) Any services furnished by a Relative of the Participant or a member of the Participant's household.

r) Any services not specifically listed as Covered Services.

How to File a CIGNA Claim

Claims should be submitted to CIGNA within 90 days after the services are received but in no case more than one year after that date. You may obtain claim forms by contacting CIGNA at 1-800-CIGNA24 or the Administrative Office. Completed claim forms should be sent to:

CIGNA Dental
P.O. Box 188037
Chattanooga, TN 37422-8037

Complaints

The Department of Managed Health Care has assumed responsibility for regulating health care service plans. The Departments toll-free telephone number and web site address are:

Toll-free telephone number: 1-800-HMO-2219
Web site address: http://www.hmohelp.ca.gov.

Complaint response time: CIGNA will respond within three days of receipt to complaints involving severe pain or imminent and serious threat to patient's health.

PREPAID DENTAL PLANS

CIGNA DHMO

The CIGNA DHMO Plan pays covered dental services in full, or with copayments. There is no annual maximum benefit limitation. You must choose your Dentist from the CIGNA DHMO Dentist Network; all dental care must be provided by dentists in the CIGNA DHMO Dental Plan Network.

Orthodontic benefits are provided with a $1,600 patient co-payment for dependents to age 19; or $1,800 co-payment for adults. There is an additional $350 startup fee.

A more detailed description of the dental benefits by CIGNA is provided in a separate brochure available from CIGNA or the Administrative Office. Please refer to the Schedule of Services available from CIGNA or the Administrative Office.

UNITED HEALTHCARE DENTAL PLAN

The United HealthCare Dental Plan pays covered dental services in full with no copayments and no annual maximum. You must use United HealthCare Dental Office facilities for all of your dental care.

Orthodontic benefits will be paid up to $2,250 at a participating provider for up to 24 months of treatment. There is an additional start-up fee of $350 and a fee of $150 for retainers.

A more detailed description of the dental benefits by United HealthCare Dental is provided in a separate brochure available from United HealthCare Dental or the Administrative Office. Please refer to the Schedule of Services available from United HealthCare Dental or the Administrative Office.

EXCLUSIONS AND GENERAL PLAN LIMITATIONS

In addition to any exclusions and limitations described elsewhere in this booklet, the following Exclusions and General Plan Limitations are applicable to all benefits provided under this Plan.

No Plan Benefits are extended for any of the following:

a) Any service rendered or supplies furnished prior to a Participant's date of eligibility or after a Participant's eligibility for coverage terminates (including treatment for an Illness or Injury arising prior to the termination of eligibility). An expense is considered incurred on the date the Participant receives the service for which the charge is made.

b) Care, treatment or services for which there is no legal obligation of the Participant to pay, or for which no charge is made in the absence of eligibility for Plan benefits.

c) Care, treatment, or services that are furnished under any governmental institution or agency, except to the extent that such services are reimbursable to the Veterans Administration for non-military service related Illness or Injury.

d) Services provided by a local, state, or federal government agency, or services for which payment may be obtained from any other local, state, or federal government agency.

e) Expenses due to or as a result of war, act of war, armed invasion or aggression (declared or undeclared), or service in the armed forces of any country.

f) Any charge for services furnished by a Relative of a Participant or a member of a Participant's household.

g) Expenses relating to any Illness or Injury for which Plan benefits are found to be recoverable either by adjudication or settlement under any Workers' Compensation law, employer's liability law, or occupational disease law.

h) Any expense incurred for: (1) services that are not Medically Necessary, (2) Experimental and/or Investigational treatment, (3) fees in excess of the Plan's Allowable Charges, or (4) any services or supplies not considered legal in the U.S.

i) Charges for telephone consultations, cancelled or broken appointments, completion of forms or reports.

j) Services not specifically listed in this Plan as Covered Expenses.

COORDINATION OF BENEFITS (COB) AND DUPLICATE COVERAGE

Many families have more than one family member working and are covered by more than one health care plan. If this is the case with your family, you must let this Plan know about all coverage when you submit a claim.

Coordination of Benefits operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the Covered Expenses incurred. Sometimes, the combined benefits that are paid will be less than total Covered Expenses.

If a Participant has (or is eligible for) Medicare coverage or some other government sponsored programs, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, the coordination provisions are determined by federal or state law.

For all other benefits provided by this Plan the order of benefit determination rules have been established by the National Association of Insurance Commissioners (NAIC) and are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first. If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are briefly summarized below.

If you or your dependents are covered under another plan, you must report the other coverage when you file a claim

WHICH PLAN PAYS FIRST - ORDER OF BENEFIT DETERMINATION RULES

Rule 1: Employee / Dependent

The plan that covers a person as an employee, member or subscriber (that is, other than as a dependent) pays first. The plan that covers that same person as a dependent pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, unless the parents are separated or divorced. “Birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

If the parents are not married or are separated (whether or not they ever were married), or are divorced, the terms of any applicable court decree will determine which parent is responsible for the child’s primary health care expenses. If there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and their spouses is:

- the plan of the custodial parent pays first;
- the plan of the spouse of the custodial parent pays second;
- the plan of the non-custodial parent pays third; and
- the plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee.

The plan that covers the claimant as either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second. 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.

Rule 4: Continuation Coverage.

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second. 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.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; the plan that covered the person for the shorter period of time pays second.

Rule 6: When no Rule Determines the Primary Plan.

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the Participant.

COORDINATION WITH MEDICARE

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker or have end-stage renal disease (ESRD). You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B 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 Part B of Medicare.

Active Employees

If you are an Active Employee, you may elect Medicare as your primary plan over this Plan; however, if you do so, this Plan will not pay any benefits. If you are the Dependent of an Active Employee and you become eligible for Medicare, this Plan will pay benefits primary and Medicare may help with your out-of-pocket costs. If you or your Dependent become eligible for Medicare due to ESRD, this Plan will be the primary payer for the first 30 months starting the earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Contact the Administrative Office for additional information.

Retirees

If you have retired and are no longer eligible for benefits as an Active Employee, or you are the Dependent Spouse of such a Retiree, when you become eligible for Medicare due to age or disability, you will no longer be covered by the Comprehensive Medical Plan described in this booklet. Special rules apply to persons with ESRD. When you lose coverage under this Medical Plan if you have ESRD will be determined by the Medicare Secondary Payer rules of the federal government.

The Trust Fund has contracts with Kaiser to provide medical and prescription drug benefits to Medicare eligible Retirees and their Spouses. Refer to *Benefit Provided to Medicare Eligible Retirees and Spouses* in the *Eligibility Requirements* section of this booklet.

INFORMATION GATHERING

In order to implement the provisions in this coordination of benefits section, the Trustees or the staff may, without the consent of, or notice to, any person, release or obtain any information which the Plan deems necessary for such purposes. Any person claiming benefits under this Plan will provide to the Trustees or to the Administrative Office such information as may be necessary to implement the provisions of this Coordination of Benefits section or to determine their applicability.

FACILITY OF PAYMENT

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

SUBROGATION, REIMBURSEMENT AND ANTI-ASSIGNMENT

If a Participant is injured through the act or omission of another party, benefits are provided only on certain conditions. A Participant is required to promptly reimburse the Plan from any proceeds received by way of settlement, verdict, judgment or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of a claim by the Participant or his heirs, parents or legal guardians, to the extent of benefits paid or to be paid by the Plan for which the third party may be responsible.

Any Participant who accepts Plan benefits agrees that by doing so he is making a present assignment of his rights against a third party to the extent of the payments made by the Plan (and any attorney's fees and costs incurred by the Plan). These rules are automatic, and the Plan will require that a Participant sign an agreement to reimburse or assignment of recovery form(s). Any Participant who refuses to sign an agreement or assignment shall not be eligible for Plan benefit payments related to the injury involved. Any Participant who receives benefits and later fails to reimburse the Plan will be ineligible for future Plan benefits until the Plan has withheld an amount equal to the amount which the Participant failed to reimburse. This amount may also include reasonable interest on such unpaid funds and reimbursement for any attorney fees and costs incurred by the Plan.

By accepting benefits provided by the Plan, a Participant agrees that:

- The Plan has the right to intervene, independently of the Participant, in any legal action brought against the third party or any insurance company, including the Participant's own carrier for uninsured motorist's coverage.

- An equitable lien by agreement shall exist in favor of the Plan upon all funds recovered by the Participant against the third party. The lien may be filed with the third party, the third party's agent, or the court. The Participant shall provide the Plan with all relevant information or documents requested.
- The Plan's Subrogation and Reimbursement rights shall be considered as a first priority claim against another person or entity, to be reimbursed before any other claims (including claims for general damages).

- The Participant will not release any party from liability for payment of medical expenses without first obtaining written consent from the Plan.

- If the Participant enters into litigation or settlement negotiations regarding obligations of or claims against another party, the Participant will notify the Plan and shall take no action to prejudice the Plan's rights.

- The Participant agrees that the Plan shall be responsible only for those legal fees and expenses to which the Plan agrees in writing. Unless the Plan agrees otherwise, the rights of the Plan to recover the amount of benefits issued shall in no way be diminished by the cost of a Participant's legal representation.

- The Participant agrees to hold proceeds of any settlement, verdict, judgment, or other recovery in trust for the benefit of the Plan, and that the Plan shall be entitled to recover reasonable attorney fees incurred in collecting reimbursement of benefits issued.

- In addition to all other remedies that the Plan may have, the Plan shall be subrogated to the rights of the Participant or his beneficiary against the responsible third party or its insurer.

Non-Assignment

The Plan and the Board of Trustees categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply.

Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan Participant, a Participant's dependent or creditor of the Plan Participant without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

CLAIMS AND APPEALS PROCEDURES

I. GENERAL RULES

A. HMO Claims

(1) Plan Eligibility Rules. Issues regarding the Plan's eligibility for benefits rules will be decided by the Plan Administrator in accordance with the eligibility rules of these claims procedures.

(2) Benefit Determinations. Issues regarding the benefits to be provided under an HMO contract will be decided in accordance with the claims procedures contained in that contract or adopted by the HMO.

B. Other Claims

(1) Plan Eligibility Rules. Issues regarding the Plan's eligibility for benefits rules will be decided by the Plan Administrator in accordance with the eligibility rules of these claims procedures.

(2) Benefit Determinations. Issues regarding the benefits to be provided other than under an HMO contract will be decided in accordance with the benefit determination rules of these claims procedures.

C. Plan Administrator. For purposes of these procedures the Plan Administrator is:

I.E.B.C.
131 North El Molino Avenue, Suite 330
Pasadena, CA 91101

II. FILING INITIAL CLAIM FORMS

A. Initial Claims. Initial pre-service urgent care claims may be made orally. All other initial claims must be filed in written form or electronically using such forms or standards as the Plan may specify from time to time. If a pre-service urgent care claim or a pre-service claim does not contain all the necessary information, the Plan Administrator shall notify Claimant or the Claimant's authorized representative as soon as possible but not later than (1) as soon as possible, taking into account the medical exigencies, but not later than 72 hours in the case of pre-service urgent care, or (2) 5 days in the case of pre-service claims. The Plan Administrator's notice of incomplete claims may be oral unless written notification is requested by the Claimant or the Claimant's authorized representative.

B. Written Pre-Service Urgent Care Claims. Any initial pre-service urgent care claim filed in written or electronic form should prominently designate on its cover that it is an urgent claim requiring immediate attention.

C. Eligibility Rules. When a claim is filed, the Plan Administrator will determine if the Claimant is eligible for benefits under the Plan's eligibility rules.

III. TIME OF INITIAL CLAIMS DETERMINATIONS

A. Pre-Service Urgent Care Claims

(1) A pre-service urgent care claim is any claim for medical care or treatment with respect to which the time periods for making non-urgent care determination could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of Claimant's medical condition would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(2) Any claim that a physician with knowledge of the Claimant's medical condition determines is a pre-service urgent care claim shall be treated as one provided that the Plan Administrator is notified of the physician's determination.

(3) If paragraph (2) above does not apply, whether a claim is a pre-service urgent care claim will be determined by the Plan Administrator or other entity to which the Joint Board has delegated this function applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(4) If a pre-service urgent care claim is incomplete, the Plan Administrator will notify the Claimant within 24 hours after receipt of the specific information necessary to complete the claim. The Claimant will be given at least 48 hours to provide the specified information.

(5) The Plan Administrator shall notify the Claimant of the Plan's initial determination as soon as possible, taking into account the medical urgency, but within the following time periods:

(a) If the claim was complete when filed, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim by the Plan.

(b) If the claim was incomplete, within 24 hours after the earlier of the provision of specified information referred to in paragraph (4) or the end of the period afforded to the Claimant to provide such information.

B. Concurrent Care Decisions

(1) Concurrent care decisions can occur when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments.

(2) Any decision by the Plan to reduce or terminate such a course of treatment before the end of such period of time or course of treatment must be given to the Claimant sufficiently in advance to allow the Claimant to appeal and obtain a decision on review before the benefit is reduced or terminated.

(3) Any request by a Claimant to extend the course of treatment that is a claim involving pre-service urgent care shall be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim, provided the claim is made to the Plan at least 72 hours prior to the expiration of the prescribed treatment.

C. Pre-Service Claims

(1) A pre-service claim is any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(2) The Plan Administrator or other entity to which the Joint Board has delegated this function shall notify the Claimant of the Plan's initial determination of a pre-service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.

(3) If the Plan Administrator or other entity to which the Joint Board has delegated this function determines that there is not sufficient information to determine the claim within the time limit in paragraph (2) and notifies the Claimant in writing prior to the expiration of that time limit of the circumstances requiring an extension, including a description of the matters beyond the Plan's control that justify the extension, and the date by which a decision is expected to be rendered, then the time period for a decision can be extended for up to 15 days.

(4) If the extension described in paragraph (3) is necessary due to failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specify the required information and the Claimant will be given at least 45 days from receipt of the notice to provide the information.

(5) The time period limit in paragraph (2) may also be extended if Claimant voluntarily agrees to extension of the time period.

D. Post-Service Claims

(1) A post-service health care claim is any health care claim for a benefit under the Plan that is not a pre-service claim, a concurrent claim, or a pre-service urgent care claim.

(2) The Plan Administrator shall notify a Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim.

(3) If the Plan Administrator determines the claim decision cannot be made within the time limit in paragraph (2) due to matters beyond its control and notifies the Claimant in writing prior to the expiration of that time limit of the circumstances requiring the extension, including a description of the matters beyond the its control that justify the extension, and the date by which a decision is expected to be rendered, then the time period for a decision may be extended for up to 15 days.

(4) If the extension described in paragraph (3) is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specify the required information and the Claimant will be given 45 days from receipt of the notice to provide the information.

(5) The time period limit in paragraph (2) may also be extended if Claimant voluntarily agrees to extension of the time period.

E. Extension of Benefits for Disability Claims.

(1) An Extension due to Disability means a claim for which the plan must make a determination of disability in order for the Claimant to receive an extension of coverage.

(2) The Plan Administrator shall notify a Claimant of any adverse benefit determination within a reasonable period of time but not later than 45 days after receipt of the claim.

(3) If the Plan Administrator or other entity to which the Joint Board has delegated this function determines the claim decision cannot be made within the time limit in paragraph (2) due to matters beyond its control and notifies the Claimant in writing prior to the expiration of that time limit of the circumstances requiring the extension, including a description of the matters beyond its control that justify the extension, and the date by which a decision is expected to be rendered, then the time period for a decision may be extended for up to 15 days.

(4) If prior to the extension period referred to in (3) above, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period may be extended for up to an additional 30 days provided the Plan Administrator notifies the Claimant prior to the expiration of the first extension the circumstances requiring the second extension and the date the Plan expects to render a decision.

(5) Any notice of extension with respect to an extension of benefits for disability claims shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and that the Claimant will be offered at least 45 days from receipt of the notice to provide the specific information.

(6) 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, the time period may be extended if days one time provided that:

(a) The Claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim; and

(b) The extension notice includes a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected.

F. New or Additional Rationale or Evidence. If the Plan bases an adverse benefit decision on new or additional rationale or evidence, Claimant must be provided:

(1) the new rationale or evidence as soon as possible, and

(2) reasonable opportunity to respond prior to the due date for the initial benefit decision.

G. Expiration of Time Periods. If a claim is not acted upon within the time periods prescribed by this Article III, the Claimant may proceed to the appeal procedure as if the claim were denied.

H. Right to Continued Coverage. If the Claimant initiates an internal appeal in compliance with the internal appeals process set forth herein and if the appeal concerns a previously approved ongoing course of treatments to be provided over a period of time or number of treatments, the Plan shall continue to provide such coverage pending the outcome of the internal appeal.

IV. NOTICE OF INITIAL INTERNAL BENEFIT DETERMINATION

A. Contents of Notification. The Plan's notification of the benefit determination, whether adverse or not, on an initial claim shall set forth, in a manner calculated to be understood by the Claimant, the following matters:

(1) The specific reason or reasons for the decision.

(2) Reference to the specific Plan provision on which the decision is based.

(3) A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's procedures and the time limits applicable for appeal of an adverse benefit determination and the right to obtain information about those procedures.

(5) If an internal rule, guideline, protocol or other similar criteria was relied upon, a statement that such document will be provided free of charge upon request.

(6) If the decision was based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances will be provided free of charge upon request or the Plan may provide an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances free of charge.

(7) For Plan years beginning on or after July 1, 2012, a statement describing the availability, upon request, to any diagnosis code(s) (such as an ICD code or DSM-IV code) and the treatment code(s) (such as a CPT code), and the corresponding meaning of such codes. A request for the diagnosis and treatment code information, in itself, shall not to be considered to be a request for an internal appeal.

(8) For Plan years beginning on or after July 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then the notice of adverse benefit determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language.

(9) For Plan years beginning on or after July 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) upon request, the Plan shall provide a notice of adverse benefit determination in that non-English language.

(10) For Plan years beginning on or after July 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) then the notice of adverse benefit determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language.

(11) For Plan years beginning on or after July 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is

literate only in a non-English language (as determined in guidance published by the federal government) then any customer assistance services provided by the Plan shall be provided in that non-English language.

(12) A statement of the Claimant's right in urgent care situations, or when Claimant is receiving an ongoing course of treatment, that Claimant shall be allowed to proceed with expedited external review at the same time as the internal appeals process if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.

(13) A statement of the Claimant's right to bring a court action under ERISA §502(a) following an adverse decision on review.

For Disability Claims, in addition to items (1)-(13) above, the notification shall also include:

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

(a) The views of a treating physician or vocational professional who evaluated the claimant;

(b) The views of medical or vocational experts obtained by the plan; and

(c) Any disability determination made by the Social Security Administration.

(15) A statement when the claim is denied that the claimant is entitled to receive relevant documents upon request.

B. Manner of Notification. The notification shall be in written or electronic form, except that the following special rules will apply to pre-service urgent care decisions:

(l) The information described in paragraph A may be provided to the Claimant orally within the time frame described in III-A, provided that written or electronic notification is furnished not later than 3 days thereafter.

(2) Any notification of an adverse determination concerning pre-service urgent care shall contain a description of the expedited review process available under V-C.

V. INTERNAL APPEALS OF INITIAL INTERNAL ADVERSE BENEFIT DETERMINATION

A. Claimant's Right to Internal Appeal. Any decisions affecting a Claimant's benefits under the Plan may be internally appealed under these claims procedures, including:

(1) A denial, reduction or termination of any Plan benefit.

(2) A failure to provide or make payment in whole or in part for any Plan benefit.

(3) A refusal to provide a Plan benefit based on a determination that the Claimant is not eligible under the terms of the Plan.

(4) A denial, reduction or termination of or failure to provide or make payment for a benefit resulting from the application of any utilization review.

(5) A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

B. Generally. During the internal appeal of an initial internal adverse benefit determination, Claimants shall be provided:

(1) an opportunity to present evidence and written testimony or oral testimony if the named fiduciary for appeals chooses;

(2) reasonable access to and copies of all documents, records and other information that is relevant to the claim for benefits; and

(3) any new or additional rational or evidence that the Plan used as a basis for an adverse benefit determination on appeal, as well as a reasonable opportunity to respond prior to the due date to appeal the benefit claims determination.

C. Pre-Service Urgent Care Claims. All adverse determinations of initial internal benefit claims for urgent care may be appealed by Claimants pursuant to the same rules or pre-service and post-service claims set forth below in Article V, Section D or under the following expedited procedures:

(1) A request for an expedited appeal of a denied urgent care claim may be made orally or in writing by the Claimant or his authorized representative. A written appeal should prominently designate on the cover that it is an urgent care claim requiring immediate attention.

(2) All necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, e-mail or other available similarly expeditious method.

D. Pre-Service and Post-Service Claims. All adverse decisions of initial claims for both pre-service and post-service claims may be appealed by Claimants pursuant to the following rules:

(1) Claimants must file an appeal in writing within 180 days following receipt of a notice of an internal adverse benefit determination by the Plan.

(2) Claimants may submit written comments, documents, records or other information relating to the claim.

(3) Upon written request, Claimant will be provided, free of charge, reasonable access to and copies of any documents, records and other information if they (a) were relied upon in making the initial determination, (b) were submitted, considered or generated in the course of making the internal adverse benefit determination even if not relied upon, (c) demonstrate that the Plan provisions have been followed and applied consistently with respect to similarly situated individuals, or (d) constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, whether or not relied upon.

(4) The appeal will take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination.

(5) The appeal will not afford deference to the initial determination.

(6) The appeal will not be conducted by a person who is either the individual who made the initial adverse determination, or the subordinate of such individual.

(7) In deciding an appeal based in whole or in part on a medical judgment, the named fiduciary for appeals shall consult with a health care professional who has appropriate training and experience in the field of medicine involved, which individual shall not be either an individual consulted in connection with the initial adverse determination or the subordinate of any such person.

(8) Upon request, the named fiduciary for appeals will identify the medical or vocational experts whose advice was obtained in connection with the initial determination, whether or not it was relied upon.

(9) The Claimant shall have no right to personally appear before the named fiduciary for appeals unless the named fiduciary for appeals in its sole discretion concludes that such an appearance would be of value in enabling it to review the adverse initial determination.

E. Concurrent Care Claims. All adverse determinations of concurrent benefit claims for urgent care may be appealed by Claimants pursuant to the same rules Pre-Service Urgent Care Claims. All other concurrent benefit claims may be appealed by Claimants pursuant to the same rules or pre-service and post-service claims set forth below in Article V, Section D.

VI. TIME OF INTERNAL CLAIMS APPEAL DETERMINATIONS

A. Urgent Care. The named fiduciary for appeals shall notify the Claimant of the decision on review as soon as possible taking into account the medical condition of Claimant, but not later than 72 hours after receipt of Claimant's appeal showing that it is an urgent care appeal.

B. Pre-Service Non-Urgent Claims. The named fiduciary for appeals shall notify the Claimant of the decision on review within a reasonable period of time applicable to the medical circumstances, but not later than 30 days after receipt of Claimant's appeal.

C. Post-Service Claims.

(1) In general, the named fiduciary for appeals shall decide appeals at the next regularly scheduled meeting. However, if the appeal is received within 30 days preceding the date of such meeting, the appeal may be decided by no later than the date of the second meeting following receipt of the appeal.

(2) If special circumstances require a further extension, the appeal will be decided not later than the third meeting following receipt of the appeal. Before the start of the extension the Plan Administrator shall notify the Claimant in writing of the extension describing the special circumstances and the date as of which the internal benefit determination will be made.

(3) The Plan Administrator shall notify the Claimant of the decision of the named fiduciary for appeals as soon as possible, but not later than 5 days after the appeal is decided.

D. Concurrent Care Claims. The named fiduciary for appeals shall notify the Claimant of the decision on review according to the following time periods:

(1) if the concurrent care claim concerns a reduction or termination of an initially approved course of treatment, before the proposed reduction or termination takes place; or

(2) for all other claims to extend a concurrent care treatment, the decision must be made in the time periods.

(a) for urgent care appeals the notification period is based on the current urgency of the claim;

(b) for non-urgent pre-service and post-service concurrent appeals the time periods set forth under each standard.

E. Extension of Benefits For Disability Claims. Extension of benefits for disability claims appeals will be decided the same as post-service claims as provided in paragraph C. For disability claims only, the claimant will be provided automatically and free of charge, with any new or additional evidence and/or additional rational considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence/rational will be provided as soon as possible (and sufficiently in advance of the date which the final notice of appeal determination is required to be provided by the Plan) to give claimant a reasonable opportunity to respond prior to that date. The Plan will extend the deadline for the final notice of appeal determination as may be necessary in order to provide a claimant a reasonable opportunity to respond to new or additional evidence and/or additional rational pursuant to the time frames for sending notices of appeal determinations as set forth above

F. Named Fiduciary For Appeals. The Plan's named fiduciary for appeals shall be its Joint Board of Trustees, unless it has designated some other person or entity to this position.

VII. NOTIFICATION OF FINAL INTERNAL APPEALS DECISIONS

A. Manner of Notification. Except in the case of urgent care decisions which may be made orally, decisions on appeals will be communicated to Claimants by written or electronic notification.

B. Contents of Notification. The Notice of Final Internal Adverse Benefit Determinations shall set forth in a manner calculated to be understood by the Claimant the following:

(1) The specific reason or reasons for the decision, with a brief discussion of the decision.

(2) Reference to the specific Plan provisions on which the appeal is based.

(3) A statement that the Claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the determination on Claimant's claim.

(4) If an internal rule, guideline, protocol or other similar criteria was relied upon in deciding the appeal, a statement that such document will be provided free of charge upon request.

(5) If the appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances will be provided free of charge upon request or the Plan may provide an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances free of charge.

(6) For Plan years beginning on or after July 1, 2012, a statement describing the availability, upon request, to any diagnosis code(s) (such as an ICD code or DSM-IV code) and the treatment code(s) (such as a CPT code), and the corresponding meaning of such codes. A request for the diagnosis and treatment code information, in itself, shall not to be considered to be a request for an external appeal.

(7) For Plan years beginning on or after July 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then the notice of adverse benefit determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language.

(8) For Plan years beginning on or after July 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) upon request, the Plan shall provide a notice of adverse benefit determination in that non-English language.

(9) For Plan years beginning on or after July 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) then the notice of adverse benefit determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language.

(10) For Plan years beginning on or after July 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) then any customer assistance services provided by the Plan shall be provided in that non-English language.

(11) A statement of the Claimant's right to external review if the final adverse benefit determination involves either medical judgment or rescission of coverage.

(12) A statement of the Claimant's right in urgent care situations, or when Claimant is receiving an ongoing course of treatment, that Claimant shall be allowed to proceed with expedited external review if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Claimant received emergency services, but has not been discharged from a facility.

(13) A statement of the Claimant's right to bring a court action under ERISA §502(a) after exhaustion of external review if external review is available.

For Disability Claims, in addition to items (1)-(13) above, the notification shall also include:

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

(a) The views of a treating physician or vocational professional who evaluated the claimant;

(b) The views of medical or vocational experts obtained by the plan; and

(c) Any disability determination made by the Social Security Administration.

VIII. EXTERNAL REVIEW OF FINAL ADVERSE INTERNAL APPEALS DECISIONS

A. Claimant's Right to External Review. Following issuance of a final adverse internal appeal decision, Claimant may request an external review by an Independent Review Organization (IRO) of the adverse internal appeal decision that involves either:

(1) medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and

(2) a rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

B. Contracts with Independent Review Organizations ("IRO") To Perform External Review. The Plan Administrator shall contract with at least two IROs by January 1, 2012 to perform external review services and contract with at least three IROs by July 1, 2012 to perform external review services, but only if the Joint Board of Trustees monitors the review process in order to confirm compliance.

C. General Rules for Requesting External Review. Claimants may request external review of final internal adverse benefit determinations, other than requests for expedited external review, pursuant to the following rules:

(1) Claimants must file a request for external review in writing within 4 months after receipt of adverse internal appeals decision.

(2) Claimant may supplement an incomplete request for external review at any time during the 4 month filing period, or, if expired, within 48 hours following receipt of the preliminary review determination notice.

(3) Claimants may submit written comments, documents, records or other information relating to the claim.

(4) The Plan Administrator shall, within 5 business days following receipt of external review request, make a preliminary review determination. The preliminary review shall determine whether:

(a) the Claimant has exhausted the Plan's internal appeals process;

(b) the benefit denial relates to the Claimant's failure to meet the Plan's eligibility requirements;

(c) the Claimant is or was covered under the Plan at the time the initial claim for health care was requested;

(d) the Claimant has provided all information and forms to process the external review.

(5) The preliminary review by the Plan Administrator shall take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination or internal appeal.

(6) The Plan Administrator shall notify Claimant of preliminary review determinations (see "Time of External Review Determinations" below).

(7) The Plan Administrator shall as soon as practicable refer, on a rotating basis, a proper request for external review to one of the IROs with whom the Plan has contracted to perform external review services, or the Plan Administrator shall monitor a third party administrator to whom external appeals are referred to determine if it is referring requests for external review to one of the IROs with whom the third party administrator has contracted to perform external review services.

(8) The Plan Administrator shall provide IRO with all documents and information considered in making the benefit denial within 5 business days after the assignment date.

(9) The Plan Administrator shall monitor to assure that IRO notifies Claimant of:

(a) IRO's acceptance of claim for review, and

(b) Claimant's right to submit additional information to IRO within 10 days from receipt of notice.

(10) The Plan Administrator shall require that an IRO provide the Plan Administrator any information received from Claimant within 1 business day of receipt.

(11) The Plan Administrator may reconsider its initial adverse benefit claim decision or the fiduciary for appeals may reconsider its final adverse decision after receiving the additional information referred to in paragraph (10). If either, upon reconsideration, decides to reverse its adverse benefit claim decision, the Plan Administrator will provide written notice to Claimant and IRO within 1 business day of reconsideration, at which time IRO shall terminate the external review process.

(12) If, upon reconsideration, an adverse determination is not reversed, the IRO shall issue a decision to the Claimant and Plan (see "Time of External Claims Appeal Determinations" below).

(13) The IRO's decision is binding on the Plan and Claimant, except to the extent that other remedies are available under State or Federal law.

D. Expedited External Review. Claimants may request an expedited external review of an adverse internal appeals decision pursuant to the following rules if:

- The expedited urgent care internal appeal timeframe would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed an expedited internal appeal; or

- The request for external review concerns an adverse decision of internal appeals involving:

  - A Claimant's medical condition where the standard external review timeframe would seriously jeopardize the Claimant's life or health or ability to regain maximum function; or

  - An admission, availability of care, continued stay, or health care item or service for which Claimant received emergency services, but has not yet been discharged.

The following expedited procedures will apply to expedited external reviews:

(1) Claimants must file a request for expedited external review in writing with the Plan Administrator.

(2) Claimants may submit written comments, documents, records or other information relating to the claim.

(3) The Plan Administrator shall immediately, upon receipt of expedited external review request, make a preliminary review determination. The preliminary review shall determine whether:

  (a) the Claimant has exhausted the Plan's internal appeals process, if applicable;

  (b) the benefit denial relates to the Claimant's failure to meet the Plan's eligibility requirements;

  (c) the Claimant is or was covered under the Plan at the time the initial claim for health care was requested;

  (d) the Claimant has provided all information and forms to process the external review.

(4) The preliminary review by the Plan Administrator shall take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination or internal appeal.

(5) The Plan Administrator shall notify Claimant of preliminary review determinations (see "Time of External Review Determinations" below).

(6) The Plan Administrator shall immediately after completing its preliminary review and concluding that external review is appropriate refer, on a rotating basis, the request for external review to one of the Independent Review Organizations ("IRO") with whom the Plan Administrator has contracted, or to the third party to whom this requirement has been delegated.

(7) IRO shall issue a decision to the Claimant and Plan (see "Time of External Review Determinations" below).

(8) The IRO's decision is binding on the Plan and Claimant, except to the extent that other remedies are available under State or Federal law.

IX. TIME OF EXTERNAL REVIEW DETERMINATIONS

A. Preliminary Review Determination.

(1) Standard External Review. The Plan Administrator shall notify the Claimant of preliminary review determination within 1 business day of completion of preliminary review.

(2) Expedited External Review. The Plan Administrator shall immediately notify the Claimant of preliminary review determination.

B. IRO External Review Determinations.

(1) Standard External Review. The IRO shall notify the Claimant and Plan of the external review determination within 45 days of receipt of external review request.

(2) Expedited External Review. The IRO shall notify the Claimant and Plan of the external review determination as expeditiously as Claimant's medical condition or circumstances require, but no later than 72 hours following receipt of expedited external review request. The initial notice of decision on an expedited external review may be provided orally but written notice must be furnished no later than 48 hours after the oral notice.

X. NOTIFICATION OF EXTERNAL REVIEW DETERMINATIONS

A. Manner of Notification. Except in the case of urgent care decisions, which initially may be made orally, decisions on external review will be communicated to the Claimant and Plan by written or electronic notification.

B. Contents of Notification. External review determinations shall set forth in a manner calculated to be understood by the Claimant the following information:

(1) A general description of the reason for external review request, including:

- date(s) of service,
- provider,
- claim amount (if applicable),
- diagnosis and treatment codes (and meanings), and
- reason for prior denial;

(2) Date IRO received referral of request for external review;

(3) Date of IRO decision;

(4) References to evidence and documentation considered in reaching the decision, including specific coverage provisions and evidenced-based standards;

(5) Discussion of principal reason(s) for IRO's decision;

(6) Statement that the IRO's determination is binding, unless other remedies are available;

(7) Statement that judicial review may be available to Claimant;

(8) Contact information, including address and telephone number, for the applicable offices of health insurance consumer assistance or ombudsman.

C. No Further Appeals. Following issuance of the IRO's decision on external review, there is no further right under these procedures to appeal or arbitrate the decision.

D. Binding Effect of External Review. The decision of the IRO is binding except to the extent that other remedies may be available under state or federal law to the Plan or Claimant. Upon IRO's issuance of a notice of final external review, if the IRO reverses the Plan's final adverse benefit determination, the Plan must immediately provide coverage or payment for the claim regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

XI. LEGAL PROCEEDINGS

A. Legal Actions. Claimants may pursue their claims for benefits in court under ERISA §502(a) but only after they exhaust their internal appeal and external review remedies as provided in these claims procedures. Failure of a Claimant to exhaust his or her internal appeal and external review remedies will preclude judicial review.

B. Legal Standards.

(1) Except in cases where federal law requires an external review upon request of a Claimant, the named fiduciary for appeals is given full discretionary authority (a) to finally determine all facts relevant to any claim, (b) to finally construe the terms of the Plan and all other documents relevant to the Plan, and (c) to finally determine what benefits are payable from the Plan.

(2) Any decision made by any named fiduciary for appeals shall be binding on all persons affected to the fullest extent permitted by law.

(3) No decision of a named fiduciary for appeals shall be revised, changed or modified by any arbitrator or court unless the party seeking such action is able to show by clear and convincing evidence that the decision of the named fiduciary for appeals was an abuse of discretion in light of the information actually available to it at the time of its decision.

(4) A decision of an IRO shall be final and binding unless a court of competent jurisdiction determines otherwise.

XII. MISCELLANEOUS PROVISIONS

A. Authorized Representatives. A Claimant may appoint in writing an authorized representative to act on his behalf in pursuing a claim or appeal under these claim procedures, including a health care professional with knowledge of the Claimant's medical condition. There is no required form for this purpose. In the case of a claim involving urgent care, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as an authorized representative of Claimant even without written authorization by Claimant.

B. Plan Records. The Plan Administrator shall maintain records designed to ensure and verify that determinations are made in accordance with Plan documents and that, where appropriate, the Plan provisions have been followed and applied consistently with respect to similarly situated Claimants. Plan participants' privacy will be protected at all times.

C. Change in Claim Type. Generally, the claim type is determined at the time the initial claim is filed. If, however, the nature of the claim changes as it proceeds through the claim procedures, the claim may be re-characterized. For example: a claim that was initially characterized as urgent care claim may be re-characterized as a pre-service claim if the urgency subsides.

D. Rights of Joint Board. The Joint Board of Trustees retains the right to amend these Procedures. Furthermore, if these procedures are ambiguous or do not provide an explicit procedure for a specific circumstance, the Joint Board is authorized to adopt such rules as it in its discretion deems necessary and appropriate to provide Claimants with appropriate initial determinations and an opportunity for a full and fair review of any adverse benefit determination.

RIGHTS OF THE BOARD OF TRUSTEES

AUTHORITY TO MAKE CHANGES

The Board of Trustees of the Shop Ironworkers Local 790 Welfare Plan expressly reserves the right to amend, modify, revoke, or terminate the Plan, in whole or in part, at any time. *Benefits provided under this Plan are not vested.*
The Board of Trustees expressly reserves the right, in its sole discretion, to:

a) terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already accrued; and
b) alter or postpone the method of payment of any benefit; and
c) amend, terminate or rescind any provision of the Plan; and
d) merge the Plan with other plans, including the transfer of assets.

The authority to make any such changes to the Plan rests solely with the Board of Trustees. Any amendment, modification, revocation, or termination of the Plan is made by a resolution adopted by the Board of Trustees. In the event the Plan is terminated, all assets remaining in the Plan, after payment of expenses, will be used to continue the benefits provided by the then-existing benefit plans, until such assets have been exhausted.

No individual Trustee, Union representative, or Employer representative is authorized to interpret this Plan on behalf of the Board of Trustees, or to act as an agent of the Board of Trustees. The provisions of the Plan are subject to and controlled by provisions of the Trust Agreement, and in the event of any conflict between provisions of the Plan and provisions of the Trust Agreement, provisions of the Trust Agreement shall prevail.

RIGHT TO RECOVER EXCESS PAYMENTS

If a benefit payment has been made by this Plan which exceeds the amount that should have been paid under the Plan, the Plan has the right to recover (including the right to offset against future benefit payments) overpaid amounts from any person or organization to, or for whom, said payments were made, or from any person whose intentional or negligent acts, omissions, or representations caused overpaid amounts to be paid. No Participant shall be required to pay more than the amount actually overpaid. In the event the Plan brings legal action to recover any overpayment, the Plan is entitled to recover its costs and attorney's fees incurred in such action. (Refer to Subrogation page 95)

ADMINISTRATION AND OPERATION OF PLAN

The Board of Trustees of the Plan is the named fiduciary with the authority to control and manage the operation and administration of the Plan. The Board shall make such rules, interpretations, and computations and take such other actions to administer the Plan as the Board, in its sole discretion, may deem appropriate. The rules, interpretation, computations and actions of the Board shall be binding and conclusive on all persons. The Board of Trustees, and/or persons appointed by the Board of Trustees, shall have full discretionary authority to determine eligibility for benefits and to construe terms of the Plan, benefits payable, and any rules adopted by the Board of Trustees.

The Plan recognizes that new technologies may develop which are not specifically addressed. The Plan reserves the right to determine whether or not a service or supply is covered, and if covered, to determine Covered Expense. If a Participant selects a more expensive service or supply than is customarily provided, or specialized techniques rather than standard procedures, the Plan reserves the right to consider alternate professionally acceptable services and supplies as the basis for benefit consideration.

The Board of Trustees may engage such employees, accountants, actuaries, consultants, investment managers, attorneys and other professionals or other persons to render advice and/or perform services with regard to any of its responsibilities under the Plan, as it shall determine to be necessary and appropriate.

NAMES AND ADDRESSES OF HEALTH PROVIDERS FOR THE PLAN

Blue Cross Prudent Buyer
P.O. Box 60007
Los Angeles, CA 90060-0007

Contracts network, provides utilization review and case management for the Comprehensive Medical Plan. Benefits are self-funded by the Plan.

ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota, 55440

Provides Life insurance and AD&D benefit for active Participants, with guaranteed payment of these benefits.

CIGNA PPO Dental
P.O. Box 188037
Chatanooga, TN 37422-8037

Provides dental benefits to enrolled Participants with guaranteed payment of those benefits.

CIGNA DHMO Dental
P.O. Box 188037
Chatanooga, TN 37422-8037

Provides dental benefits to enrolled Participants with guaranteed payment of those benefits.

HCC
225 TownPark Drive
Suite 145
Kennesaw, GA 30144
Provides specific stop-loss insurance.

WellDyneRx
7472 South Tuscon Way, Suite 100
Centennial, CO 80112

Contracts retail pharmacy network and, provides mail order pharmacy and drug utilization review for the Comprehensive Medical Plan. Benefits are self-funded by the Plan.

MHN
Quality Management Department
1600 Los Gamos Drive, Suite 300
San Rafael, CA 94903

Contracts network, provides utilization review and case management for mental health and substance abuse benefits. Benefits are self-funded by the Plan.

United HealthCare Dental
425 Market Street, 12th Floor
San Francisco, CA 94105

Provides prepaid dental benefits to enrolled Participants, with guaranteed payment of these benefits.

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Provides vision benefits to enrolled Participants with guaranteed payment of those benefits.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

1. The name and type of administration of the Plan:

The Plan is administered and maintained by the Joint Board of Trustees. The Shop Ironworkers Local 790 Welfare Plan is located at:

Shop Ironworkers Local 790 Welfare Plan
c/o Ironworker Employees' Benefit Corporation
131 North El Molino Avenue, Suite 330
Pasadena, CA 91101
(866) 339-7467

2. The Administrative Office will provide any Plan Participant or beneficiary, upon written request, information as to whether a particular Employer is contributing to this Welfare Plan, and if so, that Employer's address.

3. Internal Revenue Service Plan identification number:

The Employer Identification Number (EIN) is 94-6075602. The Plan number is 501.

4. Type of Plan:

For Members eligible for Plan benefits, coverage is provided for life insurance, accidental death and dismemberment, medical, prescription drug, vision, and dental benefits. Benefits for the Comprehensive Medical Plan, Prescription Drug Benefit, mental health and substance abuse benefits, hearing aids and weekly accident and sickness benefits are paid directly from the Plan. Other benefits are fully insured as follows:

- ReliaStar Life Insurance Company receives premiums to provide life insurance and accidental death and dismemberment benefits;
- MHN receives premiums to provide a Member Assistance Program.
- United HealthCare Dental Plan and CIGNA receive premiums to provide dental benefits.

5. Name and address of the person designated as agent for the service of legal process is:

Josh Soriano, Administrator
c/o Ironworker Employees' Benefit Corporation
131 North El Molino Avenue, Suite 330
Pasadena, CA 91101

Service of legal process may also be made upon the Board of Trustees or a Plan Trustee.

6. This Plan is maintained pursuant to various Collective Bargaining Agreements. Copies of the Collective Bargaining Agreements are available for inspection at the Administrative Office during regular business hours, and upon written request, will be furnished by mail. A copy of any Collective Bargaining Agreement which provides for contributions to the Fund will also be available for inspection within ten (10) calendar days after written request at the Union office or at any office of any Contributing Employer to which at least 50 Plan participants report each day.

7. Names and addresses of Trustees:

Employer Trustees

Mr. Rich Barbour
The Herrick Corporation
P. O. Box 9125
Pleasanton, CA 94566-3101

Mr. Michael Newington
Western Steel Council, Inc.
P. O. Box 1810
Rocklin, CA 95677

Mr. Greg McClelland
Western Steel Council
990 Reserve Drive #104
Roseville CA, 95678

Union Trustees

Mr. Jacob Jameson
Shop Ironworkers Local 790
1660 San Pablo Avenue, Suite C
Pinole, CA 94564

Mr. Mike Kilby
Shop Ironworkers Local 790
1660 San Pablo Avenue, Suite C
Pinole, CA 94564

8. The Plan's requirements with respect to eligibility for benefits are outlined in the *Eligibility Requirements* section of this Summary Plan Description.

9. The source of financing of the Plan and identity of any organization through which benefits are provided:

Contributions to the Plan are made by Contributing Employers in compliance with Collective Bargaining Agreements in force with Shop Ironworkers Local 790.

The benefits provided by this Plan, while intended to remain in effect indefinitely, can be guaranteed only so long as the parties to the Collective Bargaining Agreements continue to require contributions into the Plan sufficient to underwrite the cost of the benefits. Should contributions cease and the reserves be expended, the Trustees would no longer be obligated to furnish coverage. These are not vested or guaranteed lifetime benefits.

The organizations through which benefits are provided are: Shop Ironworkers Local 790 Welfare Plan, ReliaStar Life Insurance Company, MHN, Vision Service Plan, CIGNA, and United HealthCare Dental Plan.

10. The date of the end of the Plan Year:

The date of the end of the Fund's fiscal year is June 30.

11. Procedures to be followed in presenting claims for benefits under the Plan:

Claim filing procedures are described in the *Claims and Appeals* section of this booklet.

Remedies are available under the Plan for the redress of claims, which are denied in whole or in part, including provisions required by Section 503 of the Employee Retirement Income Security Act. The remedies are described in the section of this booklet entitled *Claims and Appeals.*

Be sure to state your Social Security Number when communicating with the Administrative Office on any matter concerning your benefits.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a Participant in the Shop Ironworkers Local 790 Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments. ERISA provides that all Plan Participants are entitled to:

- Examine, without charge, at the Plan's Administrative Office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, Collective Bargaining Agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

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

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

- Continue health care coverage for yourself and Dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependent(s) may have to pay for such coverage. Refer to the COBRA Continuation Coverage section of this booklet.

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 your interest and the interest of 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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials required to be furnished by the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have questions about your Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, 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.

GLOSSARY OF DEFINED TERMS

An “Active Ironworker” means a member who meets the Eligibility Rules of this Plan for Active Ironworkers. Generally, this term will also include those persons eligible under a Subscriber Agreement with the Trust Fund as described in the *Eligibility Requirements* section of this booklet. An individual cannot be both an Active and a Retired Ironworker at the same time.

The “Administrative Office” means the Ironworkers Employees’ Benefit Corporation, 131 North El Molino Avenue, Suite 330, Pasadena, California 91101. Phone (866) 339-7467.

The “Allowable Charge” means the lowest of the following:

a) the amount the Plan has determined it will allow for covered Medically Necessary services or supplies provided by Non-Contract Providers as determined by the Plan’s Preferred Provider Organization based on appropriate and reasonable charges for the services in the geographical area where the services are provided. Non-Contract Providers’ bills often exceed the Plan’s Allowed Charge, and in such cases the Plan’s benefits will be based on the Allowed Charge, not the Non-Contract Providers billed rate. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm to assist in determining the Allowed Charge for the submitted claim. When using Non-Contract Providers the Individual is responsible for any difference between the actual billed charge and the Plan’s Allowed Charge, in addition to any Copayment and percentage coinsurance required by the Plan.

b) the charge billed by the Physician or other provider.

An “Alternate Recipient” means a child of an Active Employee who is eligible for benefits from the Plan as a Dependent pursuant to the provisions of a Qualified Medical Child Support Order.

“Collective Bargaining Agreement” means the labor agreement between Shop Ironworkers Local 790 and a Contributing Employer, which provides for contributions to this Welfare Plan in accordance with the provisions of the Trust Agreement.

“Contributing Employer” or “Employer” means a business entity that is required by a Collective Bargaining Agreement with the Union to make payments into this Welfare Plan. A Contributing Employer shall also include a business entity whose participation is permissible under applicable laws (including the Union on behalf of its own employees) and which contributes to the Welfare Plan pursuant to a written agreement with the Board of Trustees. The Board of Trustees may require an Employer to sign a written agreement or Collective Bargaining Agreement acceptable to it before crediting the hours of an Employee.

“Cosmetic Surgery or Treatment” means any surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

“Covered Expenses” means expenses incurred by a Participant while coverage is in force which are:

- for care and treatment of an Illness or Injury as defined in the Plan; and
- Medically Necessary; and
- Not greater than the Plan’s Allowable Charge; and
- for covered services under the provisions of the Plan, and which are not expressly excluded.

“Custodial Care” means services provided mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk, or take drugs or medicines that can normally be self-administered. These services are

custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this plan only under certain limited circumstances such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

The term "Employee" means an individual on behalf of whom a Contributing Employer is obligated to contribute to the Welfare Plan pursuant to a Collective Bargaining Agreement, Subscriber Agreement, or other written agreement between the Welfare Plan and the Contributing Employer.

Experimental and/or Investigational Services. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Precertification under the Plan's Utilization Management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

a) The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply.

b) The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.

c) In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field; shows that recognized medical or scientific experts classify the service or supply as experimental and/or investigational or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

d) With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA.

e) The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health. Except that Routine Patient Costs for items and services furnished in connection with participation in a clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, will not be deemed to be Experimental and/or Investigational.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely on the following specific information and resources that are available at the time the service or supply was performed, provided or considered for Precertification under the Plan's Utilization Management program:

a) Medical records of the covered person;

b) The consent document signed, or required to be signed, in order to receive the prescribed service or supply;

c) Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;

d) Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information" and "American Hospital Formulary Service";

e) The published opinions of: the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, or specialty organizations recognized by the AMA or the National Institutes of Health (NIH) or the Center for Disease Control (CDC) or the Office of Technology Assessment or the published screening criteria of national insurance companies such as Aetna and CIGNA, or the American Dental Association (ADA), with respect to dental services or supplies.

f) Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.

g) The latest edition of "The Medicare Coverage Issues Manual."

"Durable Medical Equipment" means equipment that can withstand repeated use, is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness, is not disposable or non-durable and is appropriate for use in the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

"Emergency Care/Emergency" The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Emergency care means medical care and treatment provided after the sudden unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

"Fund" "Trust Fund" means the Shop Ironworkers Local 790 Welfare Plan.

"Illness" means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. An Illness identified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered to be a mental health disorder for the purposes of this Plan. If there are multiple diagnoses, only the treatment for the Illness identified under the DSM code is considered mental health treatment. Illness does not include a condition incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could be available if application were made under a workers' compensation or occupational injury law or similar legislation.

"Injury" means physical harm sustained as the direct result of a non-occupational accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

The term "Medically Necessary" means:

A) A medical service or supply will be determined to be "Medically Necessary" by the Plan Administrator or its designee if it:

   a) is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it; and

   b) is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical standards; and

c) is determined by the Plan Administrator or its designee to meet all of the following requirements:

- It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
- It is not provided solely for the convenience of the patient, Physician, Hospital, Health Care Provider, or Health Care Facility; and
- It is an "Appropriate" service or supply given the patient's circumstances and condition; and
- It is a "Cost-Efficient" supply or level of service that can be safely provided to the patient; and
- It is safe and effective for the illness or injury for which it is used.

B) A medical service or supply will be considered to be "Appropriate" if:

a) It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

b) It is care or treatment that is as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C) A medical service or supply will be considered to be "Cost-Efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D) The fact that your Physician or other Healthcare Provider may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical coverage provided by the Plan.

E) A medical service or supply that can safely and appropriately be furnished in a Physician's office or other less costly facility will not be considered to be medically necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

The term "Medicare" means the insurance program established by Title XVIII, United States Social Security Act of 1965, as originally enacted and as subsequently amended.

A "Mental Illness" is an Illness defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-9-CM) manual or is identified in the current edition of the Diagnostic and Statistical manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications, regardless of any underlying physical or organic cause. Certain disorders, conditions, and diseases are specifically excluded from coverage in the *Exclusions and General Limitations* section of this booklet.

"Morbid Obesity" under this Plan means:

A) presence of morbid obesity that has persisted for at least 5 years, defined as either:

a) body mass index (BMI) exceeding 40; or
b) BMI greater than 35 in conjunction with ANY of the following severe co-morbidities:

- coronary heart disease; or
- type 2 diabetes mellitus; or

- clinically significant obstructive sleep apnea (as determined by the Plan Administrator or its designee); or
- high blood pressure/hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);

AND

B) Individual has completed growth (18 years of age or documentation of completion of bone growth); AND

C) Individual has participated in a physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:

a) Participation in nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; AND

b) Nutrition and exercise program must be 6 months or longer in duration; AND

c) Nutrition and exercise program must occur within the one years prior to surgery; AND

d) Participation in physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who does not perform bariatric surgery. Note: A physician's summary letter is not sufficient documentation.

"Non-Contract Provider" means a Hospital, Facility, Physician or other health care provider that does not have a contract in effect with the Fund's Preferred Provider Organization.

"Participant" means any person eligible for benefits under the Plan, whether as an Active Ironworker, Retired Ironworker, Subscriber Employee, or eligible Dependent as described in the *Eligibility Requirements* section of this Summary Plan Description booklet.

"Plan Administrator" means the Board of Trustees of the Shop Ironworkers Local 790 Welfare Plan.

The terms "Physician" or "Surgeon" or "Doctor" mean a licensed Doctor of Medicine (M.D.), or Doctor of Osteopathy (D.O.) a Dentist (D.D.S.), licensed Podiatrist (D.P.M.), Chiropodist or Chiropractor (D.C.), Psychologist, Physician Assistant, or Certified Acupuncturist who are all practicing within the scope of their licenses. Where a Physician is specifically defined in a benefit provision that definition shall prevail over this general definition. The term Physician shall not include any person who is the spouse, child, brother, sister, or parent of the Active Employee or his spouse.

"Preferred Provider Organization" and "PPO" mean the entity under contract with the Fund that is responsible for negotiating contracts with Hospitals, Physicians, facilities and other health care providers who agree to provide hospital and medical services to Participants on the basis of negotiated rates.

A "Qualified Medical Child Support Order" means an order providing benefit payments to an Alternate Recipient which meets all of the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended by the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) or thereafter, including approval as a qualified order by the Plan.

"Retired Employee" means an individual who has satisfied eligibility requirements as set forth in the *Eligibility Requirements* section of this Summary Plan Description.

"Routine Patient Costs" applicable to coverage for services and supplies furnished in connection with a clinical trial means all items and services consistent with coverage provided under the Plan to a Participant for the treatment of cancer or another life threatening disease or condition, who is not enrolled in a clinical trial. However, routine patient costs do not include:

a) The cost of the investigational item, device or service furnished in connection with the clinical trial;

b) The cost of items and services solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and

c) The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The term "Totally Disabled" means, with respect to an Active Ironworker or Subscriber Employee, that due solely to Injury or Illness, he is prevented from engaging in any and every duty of his regular or customary occupation or employment and is performing no work of any kind for wage or profit. With respect to a covered Dependent or a Retired Ironworker, this means that due solely to an Injury or Illness, he is prevented from engaging in substantially all of the normal activities of a person of like age and like sex who is in good health.

The term "Trust Agreement" or "Trust" means the Trust Agreement establishing the Shop Ironworkers Local 790 Welfare Plan, and any modification, amendment, extension or renewal. "Trustees" shall mean any person(s) designated as Trustees under the terms of the Trust Agreement, and the successor of such persons from time to time in office. The term "Board of Trustees" and "Board" means the Board of Trustees established by the Trust Agreement.

"Trustees" means persons designated as Trustees pursuant to the terms of the Trust Agreement, and the successors of such persons, from time to time, in office. The term "Board of Trustees" and "Board" means the Board of Trustees established by the Trust Agreement.

The term "Union" means Shop Ironworkers Local 790.

"Utilization Management" means a managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to:

a) Precertification of services;
b) Concurrent and/or continued stay review;
c) Discharge planning;
d) Retrospective review;
e) Case management;
f) Hospital or other Health Care Provider bill audits; and
g) Health Care Provider fee negotiation.

Utilization Management services are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan.