California Ironworkers Field Welfare Plan

Summary Plan Description

Active and Retired Employees
and
Their Eligible Dependents

Effective June 1, 2009

California Ironworkers Field Welfare Plan

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www.ironworkerbenny.com

INTRODUCTION

CALIFORNIA IRONWORKERS FIELD WELFARE PLAN

We are pleased to provide you with this ***Summary Plan Description*** which describes the benefits provided by the California Ironworkers Field Welfare Plan as of January 1, 2009. This document replaces all other documents previously sent to you except for the most recent ***Enrollment / Benefit Comparison*** brochure, which is updated annually and sent during the Open Enrollment period. As a participant in the California Ironworkers Field Welfare Plan, you are eligible for a wide range of benefits:

- Medical
- Prescription Drug
- Dental
- Employee Assistance Program, Mental Health and Substance Abuse Treatment
- Vision
- Life Insurance

Please refer to the SUMMARY OF BENEFITS for your specific plan of enrollment, as not all benefits may be available for Active and Retired participants.

You should refer to the ***Enrollment / Benefit Comparison*** brochure that is sent to you annually for a detailed comparison of the Medical, Dental and Vision plan options available to you based on:

- Your State of residence; and
- The applicable Collective Bargaining Agreement under which you participate in the Plan; and
- Your Participant status, i.e. Active or Retired.

About This Booklet

If you enroll in the Fee-for-Service Medical Plan, you will automatically be enrolled in the Fee-for-Service Prescription Drug Plan, both of which are described in more detail in this ***Summary Plan Description***. If you enroll in ***Kaiser*** or ***Health Plan of Nevada***, all of your medical and prescription drug benefits, including all procedures you should follow if you are dissatisfied with the handling of your claims, are described solely in the ***Evidence of Coverage*** booklet you will receive directly from the HMO. If you enroll in one of the other HMO options, such as PacifiCare, your medical benefits are provided by the HMO and the ***Evidence of Coverage*** booklet provides you with all information. However, your Prescription Drug benefits will be provided under the Fee-for Service Prescription Drug Plan described in this ***Summary Plan Description***.

Likewise, if you enroll in the Fee-for-Service Dental Plan, your benefits are described in this ***Summary Plan Description***. If you enroll in a Pre-Paid Dental Plan, your dental benefits are determined by the ***Evidence of Coverage*** brochure you will receive form your Dental Plan.

Please take special note of the Plan's medical management programs for the Fee-for-Service Medical Plan, which is funded directly by the Trust Fund and is not insured. These medical management programs include a Preferred Provider Organization (PPO) and pre-certification of

hospital admissions (except for childbirth) and certain other services. Anthem Blue Cross provides these services for California residents. First Health provides them for all other plan participants. These programs were implemented to help provide you with quality health care and to also help control medical cost inflation.

The Trustees have also entered into service agreements with **Prescription Solutions** to manage the Prescription Drug Plan, **United Concordia**, **DeltaCare USA**, **Vision Service Plan** (VSP) and **Spectera** to provide access to dental and vision providers and process those claims. **Managed Health Network** (MHN) provides access to substance abuse and mental health providers and oversees the management of those services for Active Employees only. Dependents of Actives are only eligible for mental health services. Retirees are not eligible for any mental health or substance abuse benefits.

Although these benefits are funded directly by the Trust Fund from contributions made by signatory Employers, the Trustees rely on these service providers to determine Covered Charges and make decisions regarding Medical Necessity of services. If you are dissatisfied with an initial decision made by one of these organization, you should first seek assistance through the appeals process that each of them has in place. The Trust Fund Office will assist you with any such appeal. If you cannot resolve an issue directly with the service provider, you may make an appeal directly to the Board of Trustees under the Claims Procedures and Appeals section of this ***Summary Plan Description***.

On the following pages, you will find a listing of **Important Telephone Numbers** if you have questions about your coverage, need to ask about a claim, or need to have medical care pre-certified. This booklet also provides you with the **eligibility requirements** to participate in the Trust Fund benefits, procedures to follow if you are dissatisfied with the Trust Fund's decision on your Fee-for-Services medical, prescription or dental claim and all information required by the Employee Retirement Income Security Act (ERISA) of 1974. We urge you to read the entire booklet at least once. If you are married, share it with your spouse and keep it with your important papers so you can refer to it when needed.

All of us experience *life events* that impact our health and benefit coverage. The ***Life Events*** section of this booklet is designed to show you how your benefits work and how they fit into the different stages of your life. The following sections describe when you and your Dependents become participants in the Plan, and details of each benefit program. There's also a section on how to file claims and appeal denial of claims. There is a ***Glossary of Defined Terms*** at the back of this booklet that contains definitions of many terms that are found in the ***Summary Plan Description.***

Sincerely,

BOARD OF TRUSTEES

- *Benefits provided by this Trust Fund are not in lieu of, and do not affect, any requirements for coverage by Workers Compensation Insurance laws or similar legislation.*
- *All benefit described in this booklet are paid directly out of Trust Fund assets. The Board of Trustees intends to continue these benefits as long as sufficient Trust Fund assets are available. However, the Trustees reserve the right to amend or modify any or all of the Plan benefits at any time, or terminate the Plan and benefits at any time. The benefits provided by this Trust Fund are not vested.*
- *The Board of Trustees has sole discretionary authority to determine all questions of coverage and eligibility for benefits, including sole discretionary authority to construe the terms of the Plan. Any determination or interpretation adopted by the Trustees will be binding on everyone who participates in this Trust Fund. If a decision of the Board of Trustees is challenged in court, it is the intention that such decision be upheld unless it is determined to be arbitrary or capricious.*
- *No employer or local union, nor their representatives or agents are authorized to interpret this Plan on the behalf of the Board of Trustees. Only information that is provided to you in writing, signed by the Board of Trustees or an authorized designee of the Board of Trustees acting on behalf of the Board, is binding on the Board*

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IMPORTANT TELEPHONE NUMBERS

If You Have A Question Or Need Information About …	You Should Contact…	Contact Number
Fee For Service Medical Plan Information		
• Automated Eligibility & Benefits	Trust Fund Office	(866) 983-4353
• Benefit and Enrollment Questions	Trust Fund Office	(800) 527-4613
• Provider Directories (CA, AZ and NV residents)	Trust Fund Office	(800) 527-4613
• Provider Directories (All residents outside of CA, AZ and NV)	First Health Network	(888) 685-7774
• Pre-Certification and Utilization Review for Participants Residing in CA	Anthem Blue Cross	(800) 274-7767
• Pre-Certification and Utilization Review for Participants Residing outside of CA	First Health Network	(800) 572-5508
• Prescription Benefit Questions	Prescription Solutions	(800) 797-9791
• Prescription Pre-Authorization Requests and Eligibility Questions	Trust Fund Office	(800) 527-4613
Medical HMO Plan Information		
Health Net		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	Health Net	(877) 452-2671
Health Plan of Nevada		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	Health Plan of Nevada	(800) 777-1840
Kaiser Permanente *(Northern or Southern CA)*		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	Kaiser Permanente	(800) 464-4000
PacifiCare of AZ		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	PacifiCare	(800) 347-8600
PacifiCare of CA		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	PacifiCare	(800) 624-8822
PacifiCare of NV		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	PacifiCare	(800) 347-8600
PacifiCare Secure Horizons Direct *(All States)* *Medicare Retiree's Only*		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	PacifiCare	(866) 525-6437

Note: Please see the www.ironworkerbenny.com website for related services.

IMPORTANT TELEPHONE NUMBERS

If You Have A Question Or Need Information About …	You Should Contact…	Contact Number
Employee Assistance Program (EAP) and Substance Abuse Treatment		
• Prior Authorization/Utilization Management Services	Managed Health Network	(800) 977-7962
Fee For Service Dental Plan Information:		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	United Concordia	(800) 332-0366
Dental HMO Plan Information:		
Assurant Employee Benefits		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	Assurant Benefits	(800) 443-2995
DeltaCare, USA		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefits Questions and Provider Information	Delta Dental, USA	(800) 422-4234
Health Net Dental		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	Health Net	(800) 880-8113
United Concordia		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	United Concordia	(866) 357-3304
Vision Plan Information:		
Vision Service Plan		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	Vision Service Plan	(800) 877-7195
Spectera Vision Plan		
• Enrollment	Trust Fund Office	(800) 527-4613
• Benefit Questions and Provider Information	Spectera Vision Plan	(800) 839-3242

Note: Please see the www.ironworkerbenny.com website for related services.

LIFE EVENTS

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

Life Events That Can Affect Your Benefits Coverage

- Marriage
- Birth of a child
- Adoption of a child
- Divorce
- Child reaches maximum age
- Stopping work
- Disability
- Death of a Dependent
- Military duty
- Retirement
- Your Death

Getting Married

When you marry, the medical, dental, life insurance and vision programs will cover your spouse. To enroll your spouse for coverage, call the Trust Fund Office and **request an enrollment form and complete and return the form along with the non-certified certificate of marriage within 31 days** to the Trust Fund Office in order for your spouse's coverage to begin on the date of marriage. A copy of your certified and recorded marriage certificate must be provided to the Trust Fund Office within six (6) months of the date of marriage for coverage to continue.

Your step-children will be covered if they meet the eligibility requirements for a Dependent child (refer to page 9).

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

If You Have A Baby or Adopt A Child

If You Have a Baby or Adopt a Child

- Notify the Trust Fund Office immediately.
- Your child will be eligible for coverage on the date of birth or on the date of placement for adoption providing you complete and return the enrollment form for your child within 31 days from the date of birth or adoption.
- You may be able to take an FMLA leave.

Your natural child will be eligible for coverage on the date of birth, **provided you complete and return the enrollment form within 31 days from the date of birth**. The hospital certificate will be accepted for <u>temporary coverage only</u> for a period up to six months from the date of birth. A certified and recorded birth certificate must be received within six (6) months of the date of birth for coverage to continue.

Failure to enroll your child within 31 days from the date of birth could result in a delay of coverage until the next open enrollment.

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 have assumed legal responsibility for the financial support of the child and provided the Trust Fund office with a copy of the certified and recorded birth certificate. See the ***Becoming a Plan Participant*** section 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).

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. *You or your spouse must notify the Trust Fund Office within 60 days after the divorce or legal separation in order for your spouse to obtain COBRA continuation coverage*.

A qualified medical child support order (QMCSO) could have an effect on your benefit coverage or elections. Please notify the Trust Fund 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.

If Your Child Loses His or Her Eligibility

In general, your child is no longer eligible for coverage when he or she marries, reaches age 21 (age 24 if a full-time student), or is no longer dependent upon you for more than half their support. You must provide documentation of your support for a non-student child between the ages of 19 and 21. You should remove your child from the Dependent listing as soon as he or she is no longer eligible. Refer to page 9 complete information on eligibility for Dependent children.

Your child may elect to continue coverage under COBRA for up to 36 months. *You or your Dependent must notify the Trust Fund Office within 60 days after the child no longer qualifies as a Dependent in order for your child 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 the child reaches age 21.

If Your Spouse or Child Dies

Notify the Trust Fund Office as soon as possible after the death of a Dependent to change the Dependent listing and file a claim for Dependent death benefits if you are eligible for Dependent Life Insurance. See the ***Claims and Appeals*** section for more information on how to file a death benefit claim.

You will also want to review your beneficiary designation and determine whether any changes are necessary.

If You Become Disabled While Active

If you become disabled, you must obtain a ***Certificate of Disability*** from the Trust Fund Office. Have the certificate completed by your physician and return it to the Trust Fund Office for processing. If you are undergoing inpatient or residential chemical dependency treatment authorized by Managed Health Network (MHN) you must submit proof of such treatment to the Trust Fund Office for processing**.**

After satisfactory proof of your disability has been received, your hour bank will be frozen and you will be granted a limited extension of eligibility beginning on the first month following the date the disability commenced.

Benefits During Disability

If you are disabled:

- Your medical benefits can be extended for a maximum of six months if your Physician certifies your disability.
- Obtain a ***Certificate of Disability*** from the Trust Fund Office.

Your disability extension will end on the earlier of:

- The last day of the month in which you are no longer disabled; or
- The last day of the sixth month following the date the disability extension began.

If you retire while on a disability extension, you could receive Active benefits for up to a maximum of 6 months, depending on your physician's statement, plus any months for which your hour bank will provide coverage.

If You Stop Working for A Contributing Employer

Coverage for you and your Dependents will end on the last day of the month you cease being eligible because your bank of hours has too few hours left to provide eligibility for the next month's coverage. Coverage will also be terminated the last day of the month in which you perform work for any non-signatory contractor. (refer to page 8)

If Your Employer Approves a Family or Medical Leave Of Absence

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- the birth of a child or placement of a child with you for adoption;
- the care of a seriously ill spouse, parent, or child (note that if the illness or injury was incurred in the line of duty while on active duty in the Armed Forces, you may take up to 26 weeks of leave); or
- to attend to a "qualifying exigency" arising out of the fact that your spouse, son, daughter or parent is on active duty or has been notified of an impending call up to active duty in the Armed Forces; or
- your own serious illness.

You and your employer must meet certain requirements in order for you to be eligible for this unpaid leave. Please contact ***your employer*** for more information about your eligibility for Family and Medical Leave benefits. The Plan will maintain your prior eligible status until the end of the leave, provided your employer properly grants the leave in compliance with federal law and makes the required notification and payment to the Trust Fund Office. The Trust Fund does not make any determinations regarding eligibility for FMLA leave.

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 or more days, **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).**

It is your responsibility to notify the Trust Fund Office.

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.

Generally, the rules governing your right to continue coverage (e.g., notice requirements, timeliness of payments) are the same as the COBRA requirements. Refer to the Section of this ***Summary Plan Description*** titled ***Coverage After Termination***. For more information about self-contributions under USERRA, contact the Trust Fund Office.

IF YOU DO NOT CONTINUE COVERAGE UNDER USERRA

Your coverage will end immediately when you enter active military service. Your Dependents will have the opportunity to elect COBRA continuation.

COVERAGE AFTER YOUR DISCHARGE

When you are discharged or released from military service, you have 90 days to return to work for a contributing employer. **If your employer reports your return to the Trust Fund Office during this 90-day period, your eligibility and your Dependents' eligibility will be reinstated on the day you return to work.** However, if you are disabled at the time of discharge and your disability was incurred during your military service, under USERRA you may be allowed more than 90 days to return to work for a contributing employer.

Reemployment

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

If you are seeking work in the jurisdiction of the Trust Fund, but are unable to find work, be sure to notify the Trust Fund Office within 90 days after your discharge or release from military service.

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 in the ***Becoming a Retired Participant*** section of this ***Summary Plan Description***.

Retirees are eligible for medical/prescription drug and, if elected at the time of retirement, life insurance dental, and vision benefits. You must make self-contributions for retiree coverage. Once you reach age 65, your retiree coverage supplements the benefits you receive from Medicare. **You must enroll in both Part A and Part B of Medicare when you first become eligible.**

In The Event of Your Death

If you die your beneficiary will receive your life insurance benefit. They will also receive an AD&D benefit if your death is caused by an accident. If you are a Retiree, you must have elected life insurance coverage at the time of your retirement and may not add it at any later date. See the ***Life Insurance and AD&D Benefits*** section for more information about these benefits.

If you die while covered, benefit coverage for your surviving Dependents will continue until your hour bank is exhausted and for six months thereafter without charge. Following this period, coverage for your surviving Dependents may continue on a self-pay basis under the Retiree Benefit Plan if the following requirements are met at the time of your death:

- you are not on a disability extension at the time of your death;
- you have earned at least 15 pension credits. For purposes of determining eligibility for this provision, a pension credit is defined as 1,400 hours in the California Ironworkers Field Pension Trust;
- you and your spouse were married for at least 12 months prior to your death; and
- the cause of your death was not the result of any intentional action taken by your spouse.

Extended benefits do not include Dependent Life Insurance. Your Dependents must remain enrolled in the same medical plan you were enrolled in at the time of your death.

After the free six-month period of benefit coverage, your surviving Dependents may continue coverage under the Retiree Benefit Plan (if eligible based on the above) or elect COBRA continuation coverage. If he or she elects to continue benefit coverage under COBRA continuation, he or she waives all rights to continue coverage under the surviving Dependent benefit. Self-payment for coverage of surviving Dependents is required and is subject to change at the sole discretion of the Board of Trustees.

SURVIVING DEPENDENT COVERAGE WILL TERMINATE AT THE EARLIEST OF:

- The date self-payment contributions are not received by the Trust Fund Office (payment is due by the 15th day of the month prior to the month of coverage); or
- The date your surviving spouse remarries; or your Dependents no longer qualify as a Dependent; or
- The date this provision is terminated by the Board of Trustees.

BECOMING AN ACTIVE PLAN PARTICIPANT

New Employee Eligibility

You become eligible for Plan benefits when you work for an Employer who is required to make contributions to the Plan on your behalf. New employees become eligible on the first day of the second calendar month, following a period of not more than four consecutive calendar months in which he or she worked at least 300 hours for one or more contributing Employers. Your coverage will be effective on the first day of the fifth month, even if you meet the 300 hours requirement in your first two months of employment.

Maintaining Your Eligibility

All hours worked for a contributing Employer will be credited to an "Hour Bank" established for you, up to a maximum of 600 hours. Once you have qualified for initial coverage, you will continue to be covered for the period of time you have sufficient hours in your hour bank. The number of hours required for each month of coverage is 100 hours, and this amount will be subtracted from your Hour Bank each month to provide your coverage.

You will maintain your eligibility under the Plan if you have at least 100 hours in your hour bank.

Disability Extension

If you suffer an acute Illness or Injury that prevents you from working sufficient hours to maintain your eligibility, you must obtain a ***Certificate of Disability*** form from the Trust Fund Office. Complete your section of the form, have your doctor complete his/her section and return it to the Trust Fund Office.

After satisfactory proof of disability is received, your Hour Bank will be frozen as of the first day of the month following the date the disability commenced (provided you have not worked any hours in any month that is to be considered part of this extension). This extension will terminate the earlier of:

- the last day of the month you are no longer disabled; or
- the last day of the sixth month following the date the disability extension began.

If you retire while on a disability extension, you will remain eligible for the duration of the extension, provided you are still disabled, and then you may use any hours in your Hour Bank. Once your Hour Bank expires, you will need to begin making the required monthly self-payments, if you applied for and qualified for Retiree coverage at the time of your retirement.

Termination of Your Eligibility

Your eligibility will terminate on the earliest of:

- the last day of the calendar month in which you have fewer than 100 hours in your Hour Bank, after deduction of the current month's coverage; or
- the date you last qualify for any special extensions of benefits described in the ***Life Events*** section of this ***Summary Plan Description***; or
- the date you enter full-time military service except as allowed under USERRA (see the ***Life Events*** section).

All hours credited to your Hour Bank will be cancelled if your Hour Bank does not reach 300 hours within the 12 calendar-month period immediately following the termination of eligibility. In addition, all hours credited to your Hour Bank will be cancelled if:

- You work as an ironworker for any non-contributing employer (non-Union work);
- You knowingly allow a contributing Employer to contribute to the Plan for less than all hours you have worked for the Employer for which contributions are required;
- You continue working for an Employer that has failed to contribute the required contributions to the Plan after you have been advised of the delinquent contributions;
- You are no longer a member in good standing of a Local Union in the District Council of Ironworkers of the State of California and Vicinity, and you are not registered on the "Out-of-Work" list during the period you are not eligible for benefits; or
- You fail to comply with the Plan's subrogation provisions.

Refer to page 18 for information on a "Notice of Creditable Coverage" which will be automatically provided to you when your coverage terminates.

Dependent Eligibility

Your eligible Dependents will be eligible for medical, prescription drug, dental, life insurance, and vision benefits when you become eligible for these benefits. Your Dependents become eligible for coverage on the date you first become eligible. Coverage for a new Dependent starts on the date you acquire the Dependent provided you request and return an updated enrollment form showing your new Dependent to the Trust Fund Office within 31 days. Otherwise, your Dependent will be covered on the first of the month following receipt at the Trust Fund Office of your written notice of a new Dependent and all required documentation for that Dependent. Eligible Dependents will be covered under the same medical programs you select.

In general, your Dependents are your spouse and your unmarried dependent children up to age 21 (age 24 if full-time students). Documentation of your support is required for children between the ages of 19 and 21 who are not full-time students.

Please Note: If you are enrolled in an HMO, the HMO **may** require you to wait until the next open enrollment to cover any dependent that is not enrolled within 31 days of becoming eligible.

Your eligible Dependents are defined as your:

- Your spouse. "Spouse" means the person to whom an Employee is legally married, as determined by applicable state law, until the marriage is ended by divorce or legal separation. A spouse who is also eligible as an Employee or Retiree will also be covered as your Dependent.
- Your unmarried children to age 19 who reside with you for more than half of the year and for whom you provide over half of the financial support.
- Your unmarried children between ages 19 and 21, who are not full-time students, and for whom you provide over one-half of their support if you provide documentation of your financial support. If you do not provide documentation of your support for your children between the ages of 19 and 21 who are not full time students, you will be required to pay taxes on the value of the benefits provided to those children. The Trust Fund Office will advise you of the required documentation. Acceptable documentation will be a tax return

showing Dependent child or other documentation as determined by the Trust Fund Office.

- Your unmarried children to age 24, if they are regular full-time students at an accredited college or university for 12 or more credit hours. Verification of full-time student status for each semester or quarter must be supplied to the Trust Fund Office at the beginning of that semester or quarter.

Eligible children include:

a) Your natural children (children born out of wedlock if you are shown to be the parent by birth certificate or appropriate judicial decree);

b) Your legally adopted children and children placed with you for adoption (to qualify, children must be placed in your home with an expectation that they will live with you, and that you will have legal responsibility for at least one-half of the child's support);

c) Your stepchildren who live in your home for more than one-half of the calendar year and who depend on you for at least on-half of their support;

d) A child for whom you have been named the legal guardian by a Court;

e) A child that the Plan is required to cover for benefits under a ***Qualified Medical Child Support Order*** (QMCSO). Notify the Trust Fund Office if you become aware of an order like this. Such an order could have an effect on your benefit coverage or elections. Refer to the ***Glossary of Defined Terms*** for the definition of a QMCSO. A copy of the Fund's QMCSO procedures is available from the Trust Fund Office.

Eligibility may be continued past the maximum age limit for an unmarried Dependent child who is physically or mentally handicapped and who chiefly depends on the Employee for support and maintenance. Proof of incapacity must be provided. The disabling condition must have been present before the child reaches the age of 21.

When both parents are covered under the Plan, any eligible children will be covered as Dependents of both parents.

YOUR DEPENDENTS' ELIGIBILITY WILL TERMINATE ON THE EARLIEST OF THE FOLLOWING:

- The date your eligibility terminates;
- In the event of your death, the date your eligibility would have terminated based on the accumulated hours in your Hour Bank, unless your spouse qualifies for the surviving spouse coverage;
- The date he or she no longer qualifies as an eligible Dependent;
- The date he or she enters the military, except as provided for under USERRA.

Enrolling For Benefits

When you become eligible for benefits, you and your eligible Dependents will automatically be enrolled in the Ironworkers' Fee-For-Service medical and dental plans. At the next open enrollment period, you will be given the opportunity to change your coverage. The Trust Fund Office will send you a benefits information package. An enrollment card will be included in the package. It is very important that you complete the enrollment card and return it to the Trust Fund Office, otherwise, you may experience a delay in the processing of your benefits. All family members must be enrolled in the same plan.

In order to establish Dependent coverage, you must provide the following to the Trust Fund Office:

- For your spouse's coverage, a certified copy of your marriage certificate;
- For your natural children, a certified copy of their birth certificates;
- For your adopted children, a certified copy of the adoption papers;
- For a child for whom you are the legal guardian, a copy of the Court Order appointing you as the guardian.

On your enrollment card, you will need to list your Dependents with the Trust Fund Office and name a beneficiary for your death benefits.

Choice of Medical Plans

The Plan offers you choices between coverage under the Fee-For-Service Medical Plan or an HMO Medical Plan, and coverage under the Fee-For-Service Dental Plan or a prepaid dental plan. Your options depend upon your geographic area. Coverage under the plans you select will continue as long as you remain eligible or until the next annual Open Enrollment period, at which time you may elect to change your choice of medical and dental coverage. Benefit information will be mailed to you prior to the beginning of the Open Enrollment Period.

SPECIAL ENROLLMENT

If you move out of the service area of an HMO in which you are enrolled, you may enroll in another Plan option. You may also enroll in another Plan option if you exhaust all of your benefits under the Plan option in which you are currently enrolled. In either of these two circumstances, you may change Plan options outside of the annual Open Enrollment period.

NOTICE OF HIPAA SPECIAL ENROLLMENT RIGHTS UNDER SCHIP

Effective April 1, 2009, you and your Dependents may also enroll in this Plan if you (or your Dependents) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or SCHIP coverage ends.

Effective April 1, 2009, you and your Dependents may also enroll in this Plan if you (or your Dependents) become eligible for a premium assistance program through Medicaid or a State Children's Health Insurance Program (SCHIP). However, you must request enrolment within 60 days after you (or your Dependents) are determined to be eligible for such assistance.

Designating Your Beneficiary

You may name more than one beneficiary 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 Trust Fund Office. It's important that you name a beneficiary. If you don't name a beneficiary or if your beneficiary is not living at the time of your death, your death 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.

BECOMING A RETIRED PARTICIPANT

Eligibility

You are eligible for coverage under the Retiree Program if you satisfy following requirements:

- You are a dues paying member of an Ironworkers local Union;
- You are receiving a pension from the California Ironworkers Field Pension Trust; and
- If you retire on or after June 1, 1989, you have at least 15 years of pension credit earned under the jurisdiction of the California Ironworkers Field Pension Trust out of the last 20 years prior to your retirement date

If you are receiving a pro-rata pension from the California Ironworkers Field Pension Trust, you may elect coverage provided:

- You are a dues paying member of an Ironworkers local Union;
- 50% or more of your total pension credits were earned under the jurisdiction of the California Ironworkers Field Pension Trust; and
- If you retire on or after June 1, 1989, you have at least 15 years of pension credit earned under the jurisdiction of the California Ironworkers Field Pension Trust out of the last 20 years prior to your retirement date. For purposes of determining health coverage, a pension credit is defined as 1,400 hours in a Plan year.

For retirees who return to work under the **Manpower Assistance and Mentoring Program Window Benefit** offered by the California Ironworkers Field Pension Trust, you may continue to self-pay for your coverage under the Retiree Program until you become eligible for benefits as an Active Employee.

EFFECTIVE DATE OF RETIREE COVERAGE

If you complete and return the Retiree Health and Welfare Premium Deduction Authorization Form to the Trust Fund Office in a timely manner, your coverage becomes effective on the later of the following dates:

- The first day of the month in which a pension benefits is payable; or
- The date your eligibility as an Active Employee terminates.

ENROLLING FOR BENEFITS

When you become eligible for retiree benefits, the Trust Fund Office will send you information about the Retiree Program. An enrollment form will be included in the package. It is very important that you complete the new enrollment form and return it to the Trust Fund Office. The Trust Fund Office cannot pay any benefits without your completed enrollment form.

You are required to self-pay for your retiree health coverage. Medical coverage is partially subsidized by the Fund depending on your date of retirement. Dental, Vision and Life insurance coverage requires a 100% self payment on your part and must be elected at the time of retirement.

You Must Enroll in Medicare

When you become eligible for Medicare, at age 65 or 24 months after you begin receiving Social Security Disability Benefits or when you are diagnosed with End Stage Renal Disease (ESRD), you MUST enroll in both Part A and Part B of Medicare and pay

the required premium for Part B. If you are enrolled in an HMO and reside in the service area of that HMO's Medicare Advantage Plan, you must assign your Medicare benefits to the HMO. If you are in the Fee for Service Indemnity Plan, the Plan will pay benefits as if Medicare had paid its benefits first and you will incur substantial out-of-pocket expenses. (There is an exception if you are receiving treatment for ESRD, in which case this plan will be the primary payer to the extent required by federal legislation.)

Termination of Retiree Coverage

Your coverage will terminate on the earlier of the following dates:

- The date you are no longer a dues paying member of an Ironworkers Local Union;
- The date you are no longer eligible for a pension;
- The date your pension is suspended for failure to give proper notification that you are working in covered employment for a non-signatory contractor in work covered by the collective bargaining agreement;
- The date you become eligible as an employee for health benefits from another group plan except Medicare;
- The date you enter full-time military duty, except as provided under USERRA;
- The date you become eligible for Plan benefits as an Active Employee; or
- The first day of the month following 60 days from the date the Trust Fund Office receives written notice from you to terminate coverage.

Once your coverage has been terminated you can not reinstate coverage except as provided for below under the Special Enrollment and Reinstatement of Coverage provision.

SPECIAL ENROLLMENT AND REINSTATEMENT OF COVERAGE

You may voluntarily terminate and reinstate your coverage from this plan only in the following situations:

- You were receiving a Disability Pension and returned to work and retire at a later date; or
- You voluntarily terminate your coverage under this Plan because you are covered under your spouse's health plan or under some other group insurance plan as an employee or a dependent and that alternative group coverage terminates and you notify the Trust Fund Office within 31 days of the termination of that alternative coverage. **(Exception: If you and your spouse are both eligible for coverage under a Medicare Advantage Plan, you must enroll under the Field Ironworkers Plan and not your spouse's coverage in order to be eligible for reinstatement.)** or
- You return to covered employment under the Manpower Assistance and Mentoring Program Window Benefit offered by the California Ironworkers Field Pension Trust.

Once terminated, you will not be allowed to reinstate your Retiree coverage at a later date unless you meet the following requirements:

- You apply to the Trust Fund Office within 31 days following loss of coverage; and
- You make timely self-payments to the Trust Fund Office upon termination of other coverage; and
- You otherwise meet the eligibility requirements listed above.

Self-Payments for Retiree Coverage

You must pay for the cost of your benefit coverage for yourself and your Dependents. Your payments must be sent to the Trust Fund Office by the required date or deducted from your monthly pension. The Trust Fund Office will notify you of the amount you need to pay for your coverage. **Note:** Dental, Vision and Life benefits must be elected at the time of retirement and require 100% self-payment from the participant.

Dependents of Retirees

Your eligible Dependents will receive benefit coverage if you make the required self-payments for their coverage (refer to the Self-payments for Retiree Coverage section). Your Dependents will become eligible for coverage under the Retiree Program on the date you become eligible. Coverage for a new Dependent starts on the date you acquire the Dependent, provided you enroll your new Dependent with the Trust Fund Office within 31 days. Otherwise, your Dependent will be covered on the first of the month following receipt at the Trust Fund Office of your written notice of a new dependent and all required documentation for that Dependent. Eligible Dependents will be covered under the same medical plan that you select.

SURVIVING DEPENDENT CONTINUATION OF COVERAGE

If the following requirements are met at the time of your death, benefit coverage for your surviving spouse (not children) will continue for six months without charge:

- your death occurs on or after June 1, 1989;
- you have earned at least 15 years of pension credits. For purposes of determining eligibility for this provision, a pension credit is defined as 1,400 hours in the California Ironworkers Field Pension Trust;
- you and your spouse were married for at least 12 months prior to your death; and
- the cause of your death was not the result of any intentional action taken by your spouse.

After the free six-month period of benefit coverage, your surviving spouse may continue benefit coverage under this Surviving Dependent benefit or elect COBRA continuation coverage. The self-payments under the Surviving Dependent benefit are less than those charged for COBRA and are subject to change at the discretion of the Board of Trustees. Once your spouse chooses to continue benefit coverage under the Surviving Dependent benefit, he or she waives all rights to COBRA continuation coverage. Please refer to the ***COBRA Continuation Coverage*** section for more information.

Your surviving children may also elect coverage under the Surviving Dependent benefit. There is no free six-month coverage period for surviving children. COBRA rights for your Dependent children are waived if they elect the Surviving Dependent benefit. Self-payments for coverage of surviving Dependent children are required and are subject to change at the discretion of the Board of Trustees.

Your surviving Dependents will remain covered under the plan of benefits they are enrolled in at the time of your death and may change their elections at the next open enrollment period.

Surviving Dependent coverage will terminate at the earliest of:

- The date self-payment contributions are not timely received by the Trust Fund Office (payment is due by the 15th day of the month prior to the month of coverage);
- **The date your surviving spouse remarries; or**
- The date this provision is terminated by the Board of Trustees.

COBRA CONTINUATION 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.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and your Dependents may continue health care coverage past the date coverage would normally end. Under certain circumstances, by making self-contributions, you and your Dependents may continue:

- medical and prescription drug benefits, or
- medical, prescription drug, dental, and vision benefits.

The continuation coverage will be identical to the coverage you had under the Plan. You will not be eligible to continue coverage for life and AD&D insurance.

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

Children born, adopted, or placed for adoption, as described above, have the same COBRA rights as a spouse or Dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all Qualified Beneficiaries with COBRA continuation coverage, the child's continued coverage depends on timely and uninterrupted self-contributions on their behalf.

Qualifying Events

You do not have to show that you are insurable for COBRA continuation coverage. It is offered to you if you or your Dependents lose coverage as a result of a Qualifying Event. Qualifying Events include:

- termination of your employment (for causes other than gross misconduct);
- reduction in your hours;
- your death;
- you and your spouse are legally separated or divorced; and
- your child loses Dependent status under the Plan.

Notifying the Trust Fund Office

You or your Dependent must inform the Trust Fund Office of a legal separation, divorce, or a child losing Dependent status under the Plan **within 60 days of the Qualifying Even**t. If you do not notify the Trust Fund Office Eligibility Department within 60 days of such an event, you will lose your right to elect COBRA continuation coverage.

Your employer will notify the Trust Fund Office of your termination of employment, reduction in hours or death, However, because employers contributing to the Plan may not be aware of these events, the Trust Fund Office will rely on its records for determining when eligibility is lost under these circumstances. To help ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Trust Fund Office of Qualifying Events as soon as they occur.

When the Trust Fund Office is notified that one of these events has occurred, you and your Dependents will be notified of the right to elect COBRA continuation coverage. Once you receive a COBRA notice, you have **60 days to respond if you wish to elect COBRA** continuation coverage. If you do not elect coverage, your Dependents may elect coverage independently from you.

HOW TO PROVIDE NOTICE TO THE FUND OFFICE

Notice must be provided in writing. Send a letter to the Trust Fund Office containing the following information:

- your name and Social Security Number,
- the name of the Fund (California Ironworkers Field Welfare Plan),
- the event you are providing notice for,
- the date of the event, and
- the individual(s) affected by the Qualifying Event and their relationship to you.

If the Qualifying Event is your divorce or legal separation from your spouse, you must provide a copy of the divorce decree or legal separation documents as soon as it becomes available.

Paying For COBRA Continuation Coverage

The Trust Fund Office will notify you of the cost of your COBRA continuation coverage when it notifies you of your right to coverage. The cost for COBRA coverage will be determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this coverage. The cost for extended disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

Your **first payment** for continuation coverage must include payments for any months retroactive to the day you and/or your Dependents' coverage under the Plan terminated. This payment is due **no later than 45 days** after the date you or your Dependents signed the election form and returned it to the Trust Fund Office.

Subsequent payments are due on the first business day of each month for which coverage is provided, with a grace period of 30 days. However, in order to consistently maintain your eligibility on the Trust Fund records, it is recommended that you make payment by the 20th of the month prior to the coverage month. No claims will be paid or eligibility reported to a pre-paid plan for any month until payment is received.

If payment is not received by the end of the grace period, all benefits will terminate immediately. Once your COBRA continuation coverage is terminated, it cannot be reinstated.

Period of Coverage

COVERAGE CONTINUES FOR 18 MONTHS

You may elect to purchase continued coverage for yourself and your Dependents for up to 18 months if coverage ends due to your termination of employment (for causes other than gross misconduct) or your reduction in hours.

COVERAGE CONTINUES FOR 29 MONTHS (DISABILITY)

If your coverage ends due to your termination of employment or reduction in hours, and at that time, or within 60 days of the event, you or one of your Dependents is totally disabled (as determined by the Social Security Administration), coverage may continue for an additional 11

months, for a total of 29 months. To continue coverage for the additional 11 months, you must notify the Trust Fund Office of your "Determination of Disability" by the Social Security Administration within 60 days of the date of the determination and before the end of the initial 18-month period of COBRA continuation coverage.

COVERAGE CONTINUES FOR 36 MONTHS

Your Dependents may elect to continue coverage for up to 36 months if coverage ends because of your:

- death;
- legal separation or divorce; or
- dependent child no longer qualifies for Dependent coverage under the Plan.

When your COBRA coverage ends, you will automatically be provided with certification of your length of coverage under this Plan. This may help reduce or eliminate any preexisting limitation under a new group medical plan.

Loss of Continued Coverage

The period of COBRA continuation coverage for you or your Dependents may be cut short for any of the following reasons:

- you or your Dependents do not make the required self-contributions within 30 days of the due date;
- the Plan ceases to provide any group health benefits;
- you or your Dependents become covered under any other group health care plan (provided such plan does not contain any exclusions or limitations with respect to any pre-existing conditions); or
- you or your Dependents exhaust your lifetime maximum benefits under all Plan options; or
- you or your eligible spouse becomes entitled to Medicare (unless the Medicare entitlement is due to End Stage Renal Disease).

EFFECT OF MEDICARE ENTITLEMENT BEFORE A TERMINATION OF EMPLOYMENT OR REDUCTION IN HOURS

If your loss of coverage because of low hours, termination of employment, or retirement occurs less than 18 months **after** the date you become entitled to Medicare (Part A, Part B, or both), the ending date for the maximum period of continuation coverage for your Dependents covered under the Trust Fund will be 36 months from the date of your Medicare entitlement, but not less than 18 months.

Choosing Not to Elect COBRA

If you and/or your Dependents do not elect COBRA within the 60-day period allowed, you will forfeit all rights to COBRA continuation coverage and your health care coverage will end. If you are enrolled in Kaiser, you may apply for an individual conversion policy.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will effect your future rights under Federal law.

First, if you have a gap in health coverage of 63 days or more, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans (election of COBRA continuation coverage may prevent such a gap).

Second, if you do not get continuation coverage for the maximum time available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions.

Finally, you have the right to request Special Enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). Special Enrollment under this provision is allowed within 30 days after your group health coverage ends because of the qualifying events listed above or at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

OPEN ENROLLMENT UNDER COBRA CONTINUATION COVERAGE

COBRA participants may change their coverage option under the medical or dental plans during the Open Enrollment Period.

Certificate of Creditable Coverage

If your coverage under this Plan ends and you become eligible for a new health plan, the length of time you were covered under this Plan may be used to reduce the length of any pre-existing condition exclusion period contained in your new plan.

When your coverage ends, you will automatically receive a Certificate of Creditable Coverage. This certificate provides information your new plan may need. You should check with your new plan's administrator to verify whether your new plan has a limitation for pre-existing conditions and how creditable coverage is applied under that plan. You should present your certificate to your new plan so that your new plan will know to apply your creditable coverage to the preexisting condition exclusion period under your new plan. You may request a copy of this Certificate of Creditable Coverage at any time for up to 24 months after your coverage terminates.

PROCEDURE FOR REQUESTING AND RECEIVING A CERTIFICATE OF CREDITABLE COVERAGE:

You may make a written request to the Trust Fund Office for a copy of your Certificate of Creditable Coverage at any time up to 24 months from the date your coverage terminated. The written request must be mailed or faxed to the Trust Fund Office and should include the name of the employee and names of the individuals for whom a certificate is requested (including spouse and eligible Dependent children) and the address where the certificate should be mailed. A copy of the certificate will be mailed to the address indicated.

ADDITIONAL COBRA ELECTION PERIOD & TAX CREDIT IN CASES OF ELIGIBILITY FOR BENEFITS UNDER THE TRADE ADJUSTMENT ASSISTANCE REFORM ACT OF 2002

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Adjustment Assistance Reform Act of 2002, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your Dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits, you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan.

If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp. The Fund Administrator may also be able to assist you with your questions.

CALIFORNIA COBRA LAW

If your Qualifying Event was low hours, termination of your employment, or retirement and you exhaust the 18 months of coverage normally available after such a Qualifying Event (or the 29 months available in the case of disability), you may continue your insured HMO coverage for an additional 18 months (or an additional 7 months in the case of a disability). If this applies to you, you must contact your HMO directly to continue coverage. This law applies only to your insured HMO coverage, not to any other health care benefits that are self-funded by the Trust Fund. This option is not available in Arizona or Nevada.

INDIVIDUAL CONVERSION COVERAGE FOR INSURED BENEFITS UNDER THE LIFE INSURANCE, MEDICAL HMO, AND PREPAID DENTAL PLANS

If you and your eligible Dependents are enrolled in an insured HMO option offered under the Plan and your eligibility for benefits ceases, you may apply for conversion of your insured group coverage to an individual insured policy.

You should read the material that you receive from the HMO very carefully. In many cases, the coverage is not identical to that which you had while you were a Plan participant. Benefits under individual policies are usually provided at lower levels than those found in group policies.

In order to take advantage of the individual conversion option, you must notify the HMO insurer as soon as possible following your loss of eligibility. You must submit your conversion application and initial premium to the HMO within 31 days from your loss of eligibility. You may elect this option instead of the Plan's COBRA program. Or, when coverage under COBRA is terminated, you may apply for individual conversion at that time.

FEE FOR SERVICE MEDICAL PLAN

CHOICE OF MEDICAL PLANS

You may choose coverage under the Fee-For-Service Medical Plan (described in this section) or an HMO plan. You must live within the service area of an HMO in order to enroll in that HMO. Please refer to the ***Summary of Benefits*** for a list of the HMO options available in your state. Benefits and exclusions and limitations for the HMO plans are described in the ***Evidence of Coverage*** booklets for each HMO.

YOUR RESPONSIBILITY

It is important to remember that the Fee-For-Service Medical Plan is not designed to cover every health care expense. The Plan pays for ***Covered Charges*** up to the limits and under the conditions established by 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.

How the Fee-For-Service Medical Plan Works

The Fee-For-Service 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. This section describes how payment of Covered Charges are shared between you and the Plan and which services are covered.

CALENDAR YEAR DEDUCTIBLE

The Plan deductible is a dollar amount you must pay before the Plan will start paying any benefits in a calendar year. The deductible is higher if you use a non-contract provider than when you use contracted PPO providers. The individual deductible in each case is shown in your ***Summary of Benefits***.

FAMILY DEDUCTIBLE

There is a maximum amount each family needs to pay toward the deductible each calendar year before the deductible is waived for all family members for the remainder to that calendar year. The family maximum deductible is shown in your ***Summary of Benefits*** and is a multiple of the individual deductible.

DEDUCTIBLE CARRY FORWARD

Covered Charges incurred in the last quarter of the calendar year will be used to satisfy each individual's deductible in the following calendar year. If two or more family members are injured in the same accident, only one deductible will apply.

If you need to see a physician:

- 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're taking. Be sure to note how often you take the medications.
- Show your ID card when you go to your appointment.
- If the Physician's office does not file the claim for you, file a claim form with the Trust Fund Office. It's a good idea to make a copy of the claim form and any supporting materials for your records before submitting the claim.

COINSURANCE AND COPAYMENTS

Generally, the Plan pays a percentage of the contract rate for services of PPO contract providers and a lower percentage of ***Allowable Charges*** for services of non-contract providers. This percentage is call Coinsurance. You must pay the remaining amount of Covered Charges, unless you have incurred Covered Charges in excess of the Annual Out-of-Pocket Maximum (see below).

For many routine services from contracted providers, you simply pay a flat copayment at the time you receive services and the Plan pays the balance of the contracted rate. Certain expenses may be covered differently or may be subject to benefit maximums. See your ***Summary of Benefits*** and the ***Fee-For-Service Medical Plan Covered Benefits*** section of this booklet for more information.

You must pay any remaining charges not covered by the Plan, such as for non-covered services or charges that exceed the Plan's Allowable Charge from non-contracted providers. Please refer to the section called ***Maximizing Your Benefits*** below for more information about using contract providers and the Plan's pre-certification and utilization review programs.

ANNUAL OUT-OF-POCKET MAXIMUM

Once your *coinsurance payments* and *Copayments* for Covered Charges for each family member reach the amount shown in your ***Summary of Benefits*** under ***Annual Out-of-Pocket Maximum*** the Plan pays 100% of remaining Covered Charges for the rest of that calendar year for that individual. Note that the Out-of-Pocket Maximum is higher for services of non-contract providers than for services of contract providers, *You must satisfy the Calendar Year Deductible first.*

LIFETIME MAXIMUM

Each Active plan participant and Dependent can receive up to $5,000,000 in medical benefits from the Fee for Service Medical Plan during their active participation, regardless of any breaks in coverage.

Upon retirement, each Retiree and Dependent can receive up to $1,000,000 in medical benefits from the Fee for Service Medical Plan.

Plan payments made for Fee-for-Service Medical and Prescription Drug benefits accumulate towards each Lifetime Maximum benefit.

ALLOWABLE CHARGES

The Plan pays for services of non-contract providers only to the extent that they are Allowable Charges under the Plan. This amount may be less than the billed charges. You are always responsible for any charges that exceed the Plan's Allowable Charges. Refer to the ***Glossary of Defined Terms*** for a more complete definition.

WHAT IS MEDICALLY NECESSARY?

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

- necessary to treat an illness or injury;
- ordered by a Physician;
- appropriate for the patient's circumstances; and
- consistent with the diagnosis
- not Experimental or Investigational.

Refer to the ***Glossary of Defined Terms*** for a more complete definition. The Plan does not pay charges for services or supplies that are determined by the Plan or its designee to not be Medically Necessary.

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.

CONTRACT PROVIDER NETWORK

The Board of Trustees has contracted with organizations that provide contract provider networks. Physicians, hospitals and other health care providers participating in the contract provider networks have agreed to negotiated fees and to meet the organizations' standards. The names of these organizations and contact information are listed under the ***Important Telephone Numbers*** in the front of this ***Summary Plan Description***.

Contract Provider Network

A network of physicians and hospitals that have agreed to charge contract rates. Since contract providers have agreed to these contract rates, you help control health care costs for you and the Plan when you use contract providers.

When you use contract providers, you save money for yourself and the Plan because these providers have agreed to charge a reduced amount for their services. For a free Directory of network providers available to you, contact the Trust Fund Office. For most covered services, your coinsurance obligation will be lower if you use a contract provider, as shown in your ***Summary of Benefits***.

It's your decision whether to use a contract provider. You always have the final say about the physicians and hospitals you and your family use. The Plan only determines how much it will pay for services and which services it will cover.

If you live outside of the service area of a contract provider (more than 30 miles) for the type of medical treatment you require, the Plan will pay 80% of the Allowable Charges subject to the out of network deductible. Note however that if services could have been performed by a contract provider, but it was your choice to receive services from a non-contracted provider, the Plan will reimburse you at the Non-PPO level of benefits. For example, if you receive services from a non-contracted provider who is more distant from your home than a contract provider who could have provided the services, the Plan will reimburse you at the Non-PPO level of benefits.

EXCEPTIONS

In the situations listed below the Plan will reimburse you at the PPO Coinsurance percentage for charges incurred for services of non-contracted providers:

- Non-PPO Anesthesiologist when surgery is performed by a PPO surgeon providing services at a PPO facility.
- Non-PPO Assistant Surgeon when surgery is performed by a PPO surgeon providing services at a PPO facility.
- Non-PPO Emergency Room Physician services received at a PPO facility.
- A PPO Physician refers you for an *initial* consultation to a Non-PPO Specialist.

- You receive diagnostic testing (laboratory or radiology services) at a PPO facility and ordered by a PPO Physician, but the professional services to interpret the test results is performed by a Non-PPO Provider.
- When the closest facility is a Non-PPO provider and the condition meets the Plan's definition of "Emergency" .

PRE-CERTIFICATION AND UTILIZATION REVIEW PROGRAM

The Board of Trustees has also contracted with an organization that provides pre-certification and utilization review (UR) 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, you need to become involved in the decisions regarding your care. The name of the company that provides pre-certification and utilization review is shown under the ***Important Telephone Numbers*** in the front of this ***Summary Plan Description***.

It is very important to call for pre-certification if your Physician recommends hospitalization. When hospital admission is pre-certified, the Plan pays the highest level of benefits in accordance with the ***Schedule of Benefits*** that applies to you. If the hospital admission is **not** pre-certified, the Plan will reduce the level of benefits otherwise paid by 10%.

The professional medical review staff can provide you with treatment alternatives, pre-certification, and referrals when needed. When you or your physician calls the UR provider 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**, the UR provider must be notified the **next working day** after admission.

Except for childbirth, if your physician recommends a hospitalization, you or your physician must 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 on the next working day following your admission to the hospital.

UTILIZATION REVIEW WHILE YOU ARE HOSPITALIZED

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 certified for the appropriate number of additional days of inpatient care.

EXCEPTION FOR CHILDBIRTH

Under federal law, the Plan may not restrict benefits for a mother's or newborn child's hospital stay in connection with childbirth to 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).

FEE-FOR-SERVICE MEDICAL PLAN COVERED CHARGES

The Fee-For-Service Medical Plan covers a portion of the charges listed in this section to the extent that they are:

- Medically Necessary, except as specifically provided for under Preventive Services;
- not in excess of the Plan's Allowable Charges;
- due to illness or injury;
- performed or ordered by a physician;
- incurred while you and your Dependents are eligible under the Plan; and
- within the maximum limits specified by the Plan.

All Covered Charges are subject to the Deductible, Coinsurance and/or Copayments shown in your ***Schedule of Benefits***.

Physicians' Services

- Physicians' services to diagnose or treat an illness or injury provided in your Physician's office, a hospital, other facility, or at home.
- Emergency services in a contract hospital from a non-contract Physician, will be paid at the contract level of benefits.

Hospital Services and Supplies

- Room and board up to the hospital's average semiprivate room rate and care in an intensive care unit and cardiac care unit, when medically necessary.
- Hospital services and supplies provided during admission, including surgical suite, imaging procedures, laboratory tests and therapeutic treatments.
- Diagnostic, surgical, or therapeutic services provided by a hospital on an outpatient basis.

Surgery

- 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 necessary.
- Anesthetics and their administration.
- Services and supplies related to the surgical procedure performed.

Certain outpatient surgeries require pre-authorization. Check with the Trust Fund Office prior to receiving any surgical services at an out-patient facility, whether it is a free-standing surgical center or is part of a hospital.

IMPORTANT: Plan payments for elective outpatient surgeries performed at a non-contract surgical facility are limited to $1,500 and are subject to the non-PPO deductible. Payments for Physician charges are determined by their status as either a PPO contracted provider or a non-contracted provider.

RECONSTRUCTIVE SURGERY

The Plan will cover Medically Necessary reconstructive surgery, procedures or treatment intended to improve bodily function and/or correct a deformity resulting from disease, infection, trauma, or congenital anomaly in a child that causes a functional defect or results from a prior therapeutic procedure, including a mastectomy. Covered individuals should contact the Trust Fund Office to determine if a proposed surgery or service will be considered cosmetic surgery or Medically Necessary. In order to determine medical necessity for any reconstructive surgery, procedure, or treatment, the Plan reserves the right to request any and all medical records, including but not limited to: history and physical reports, chart notes, test results, operative reports, pathology reports and pre-operative color photos.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under this Federal law, all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery must include both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of mastectomy, including lymphedemas. These services are elective and are chosen by the patient in consultation with the attending physician. They are subject to the Plan's usual copayment, coinsurance and deductible provisions.

Emergency Transportation (Ambulance)

- Local professional ambulance service is covered subject to a Copayment (shown in your ***Schedule of Benefits)*** when the medical condition of the patient requires paramedic support.
- 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.
- Air Ambulance is generally covered as a non-PPO provider.

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

Radiological and Laboratory Services

- Radium, radioactive isotopes, and radiation therapy.
- Diagnostic x-rays and laboratory services.
- Major imaging procedures such as MRIs and CT scans.

Medical Supply Charges

- Casts, splints, braces, crutches, shoes for the treatment of foot disfigurement, and surgical dressings.
- Blood, blood plasma, and its administration.
- Oxygen and its administration.
- Breast prosthesis following a mastectomy; subsequent prosthesis ordered by a physician.
- Initial purchase of eyeglasses or contact lenses as a result of cataract surgery.

Durable Medical Equipment and Prosthetics

Subject to approval by the Trust Fund Office, rental (or purchase, if cost effective) of medically necessary Durable Medical Equipment and Prosthetics are subject to the following limitations:

- External prosthetic devices to replace a missing body part. Replacement is covered only as necessitated by a physiological change in the patient that renders the prosthetic non-functional. Damaged or lost items will not be covered.
- Internally placed prosthetic devices are covered under surgery benefits; however, cochlear implants and similar internally implanted prosthetic devices to improve hearing are covered only for eligible Dependent children who are born with a severe congenital hearing deficit.
- Medically Necessary repair, adjustment and servicing, or replacement of the Durable Medical Equipment due to a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired, but only if due to normal wear and tear.

Refer to the ***Glossary of Defined Terms*** for a more complete definition of DME.

Outpatient Therapy

Outpatient physical and respiratory therapies are limited to a **combined maximum of $2,000 per calendar year**. Additional coverage may be provided upon approval by Case Management if treatment is for an accident or occurs as a result of major surgery, stroke or heart attack. Speech and Occupational therapy are only covered if prior authorization is obtained.

Only care that demonstrates progressive improvement in the patient's functional capacity is covered. No benefits are provided for pervasive developmental delay, learning disabilities or that are primarily provided to enhance academic achievement of Dependent children.

Comprehensive Well Baby Care

Plan benefits are limited to **$600 per calendar year** and are limited to Dependent children up to 14 years of age and include the following:

- Immunizations.
- Periodic Physical Examinations.
- Laboratory services in connection with periodic physical examinations.

Annual Physical Examinations

Charges for annual physical examinations including male and female routine exams are limited to **$300 per calendar year** for combined contract and non-contract providers.

Annual Well Woman Care

Charges for annual routine pelvic exams and screening mammography are limited to **$300 per calendar year** for combined contract and non-contract providers.

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 providers combined.

Podiatry Benefits

Orthotic Appliances are limited to **$200 per calendar year** for contract providers and ***are not covered for non-contract providers.*** This benefit is only provided to Active Employees and not to retired employees or any Dependent.

Hearing Aid Benefit

Covered charges are payable at 100% of the contract rate up to **$2,000 per device** and coverage is limited to one device per ear every three years. Exams are paid at 100% and are limited to $100 per calendar year. Replacement batteries are not covered.

Skilled Nursing Facility

- Charges for room and board and other services and supplies, not including fees for professional services.
- Charges must be incurred while under the continuous care of a physician and while confined as an inpatient within 7 days of discharge from a hospital stay that lasted at least 5 days.
- Coverage for Skilled Nursing Facility care is paid at 45% for contract facilities and 35% for non-PPO facilities. Covered charges are limited to 55 days per period of disability unless:
  - The confinement is due to an accident;
  - The confinement is separated by a return to full-time work for one full working day for an Active Employee; or
  - The confinement is separated 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 Retired Employee or a Dependent.

Hospice Care Benefits

Plan benefits are paid at 100% and not subject to the calendar year deductible for the following services provided by a licensed Hospice Care Provider:

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

Temporomandibular Joint Dysfunction

Limited to a lifetime maximum of **$1,000** per person.

Dental Care Expenses

Most expenses for dental care are covered under the dental program. However, the medical program covers expenses related to treatment of an accidental injury to a jaw or natural teeth when treatment occurs within six months after the date of the accident.

Supplemental Accident Benefit

If you are injured in an accident and your medical benefits do not cover your expenses, you will receive an additional benefit to help with your medical expenses. 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% up to **$300 for medical** and **$100 for lab/x-ray** expenses.

Supplemental Accident Services 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 after 90 days of the accident.
- Ptomaine poisoning.
- Disease or infections other than those related to the accident.
- Eye glasses
- Hearing aids
- Injuries sustained in an altercation, however this exclusion does not apply to any injury that results from a medical condition or domestic violence

EXPENSES NOT COVERED UNDER THE FEE-FOR-SERVICE MEDICAL PLAN

Although the medical program 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 Administrator or its designee.

b) Dental services and supplies except as specifically provided for.

c) Treatment for mental health disorders except as described in the Section called ***Employee Assistance***, ***Mental Health and Substance Abuse Benefit***s in this ***Summary Plan Description.*** Benefits are provided for Active Employees only and not for Retirees or any Dependents.

d) Accidental bodily injury or sickness arising out of, or in the course of, employment, including self-employment. Refer to the section of this booklet regarding the Fund's "*Right of Reimbursement*" on page 56.

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 reasonable charges are reimbursable to the Veterans Administration to the extent required by federal law under 38 U.S.C. 629 for non-service connected conditions.

g) Any injury or sickness resulting from or occurring during the commission of a felony by an Eligible Individual, however this exclusion does not apply to any injury that results from a medical condition or domestic violence.

h) Cosmetic 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 or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The Plan complies with the ***Women's Health and Cancer Rights Act of 1998***. Refer to the ***Glossary of Defined Terms*** for the definition of Cosmetic Surgery.

i) Injuries or illness resulting from, or aggravated by, any form of warfare or invasion or while on active duty with the Uniformed Services.

j) Treatment received from a relative or member of the patient's household.

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

l) Experimental or Investigative procedures (refer to the ***Glossary of Defined Terms***).

m) Services and supplies not recommended or approved or prescribed by a Physician.

n) Orthopedic shoes or other wearing apparel except as specifically provided for.

o) Orthotics for any Retiree or any Dependent.

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

q) Exercise equipment, whirlpools, Jacuzzis, saunas, pillows, non-prescription items any over-the-counter, none-custom braces or supports.

r) Eye refractions and any surgical procedure to correct refractive errors of the eyes.

s) Custodial care (refer to the ***Glossary of Defined Terms***).

t) Reversal of sterilization.

u) All services related to infertility treatment, including but not limited to In Vitro Fertilization, Assisted Reproductive Technology and fertility drugs.

v) All services related to any surrogate parenting arrangement, including but not limited to maternity care, obstetrical care and medical expenses of any child born out of any surrogacy arrangement.

w) Charges related to the treatment of obesity, other than surgical intervention for morbid obesity (refer to the ***Glossary of Defined Terms***). If your provider prescribes surgical intervention, prior authorization from the Plan is required. You may be required to use a facility and/or surgeon contracted with the Plan and designated a "Center of Excellence" for this procedure.

x) Charges for services provided outside the United States except for Emergency care.

y) Any services received after termination of eligibility except as provided for in the section of this Summary Plan Description called ***Coverage After Termination***.

FEE-FOR-SERVICE 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 a Prescription Drug Manager listed under the ***Important Telephone Numbers*** in the front of this booklet. The Prescription Drug Manager features a network of conveniently located participating pharmacies and a mail order program. When you have your prescriptions filled at a participating pharmacy or through the mail order program, you save money for yourself and the Plan.

When you need a medication for a short time—an antibiotic for example—it's best to have your prescription filled at a participating retail pharmacy. If you are taking a medication on a long-term basis, it's usually best to have it filled through the mail order program.

The Fee-For-Service Prescription Drug Plan covers participants who are enrolled in the following medical plans:

- Fee-For-Service
- Health Net (California)
- PacifiCare

Plan payments made for Fee-For-Service Prescription Drug benefits accumulate toward the Lifetime Maximum benefit described under the Fee-For-Service Medical Plan.

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 30-day supply per prescription are as follows:

Generic	$5
Brand	
No generic available	$20
Generic available	$40

IMPORTANT

If you use a non-participating pharmacy, no benefits are payable. There is a limited exception for emergencies. You will need to pay the full cost of the prescription and file a claim with Prescription Solutions for direct reimbursement.

When you have a prescription filled at a participating retail pharmacy:

- Present your Prescription Solutions ID card.
- Pay your copayment.

Mail Order Pharmacy 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 delivered directly to your home. The copayment requirements for up to a 90-day supply are:

Generic	$10
Brand	
No generic available	$20
Generic available	$40

The mail-order program is mandatory for maintenance medication. After your 3rd prescription at a retail pharmacy for maintenance medication, you will be charged two copayments for one prescription. You save money when you use the convenience of the mail order prescription drug program for your long-term medication needs.

Covered Drugs and Medications

The Plan covers legend drugs that require a written prescription from a physician or dentist. A licensed pharmacist must dispense these prescriptions. You must use a participating retail pharmacy or the mail order program.

Drugs used for the treatment of mental disorders are covered only with prior authorization from the Prescription Drug Manager.

Expenses Not Covered Under The Prescription Drug Program

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

- **Prescriptions obtained at a non-participating pharmacy.**
- Prescriptions dispensed by a licensed hospital during confinement (including "take-home" prescriptions).
- Drugs or medications that may be procured without a Physician's written prescription.
- Any drugs related to the treatment of infertility.
- Appliances or prosthetics.
- Prescriptions for conditions arising out of, or in the course of, employment, including self-employment.
- Any non-drug item.
- Drugs used to promote hair growth.
- Smoking deterrents.

- Drugs for which reimbursement is provided by a governmental agency except to the extent that the Veterans Administration may request reimbursement for prescriptions to treat illness or injury that is not related to service in the Armed Forces.
- Multiple and non-therapeutic vitamins and dietary supplements.
- Health and beauty aids.
- Drugs not Medically Necessary
- Retin-A for anyone over 25 years of age.

How to File a Prescription Claim

If you have an emergency and need to fill a prescription at the pharmacy that does not participate with Prescription Solutions, you will need to fill out a Prescription Solutions claim form. The claim form is available on the Prescription Solutions website at www.rexsolutions.com or from the Trust Fund Office.

You will need a pharmacy receipt including: patient name, name and address of pharmacy; date of service, name of medication, NDC number, strength, quantity, Rx number, physician name and phone number, cost and a brief explanation as to why you had to pay out-of-pocket for the medication. Cash register tapes and credit card receipts alone are not acceptable.

Send you claim to:

Prescription Solutions Claims / DMR
Mail Stop LC07-190
P.O. Box 6037
Cypress, CA 90630-0037

DENTAL BENEFITS

Choice of Dental Plans

The following benefits describe the Fee-For-Service Dental Plan. Depending on your geographic area, you may have the option to enroll in a prepaid dental plan. Prepaid plans operate similar to the medical HMOs where covered procedures are paid 100% after you pay the required copayment. Copayments vary by procedure and plan. Please refer to the ***Plan Summaries*** and ***Evidence of Coverage*** provided by the dental carrier for more information. The ***Important Telephone Numbers*** in the front of this ***Summary Plan Description*** shows which carriers are available in each state.

Prior Authorization:

It is strongly recommended that if your dentist proposes services that exceed **$200** that you request that he submit the proposed claim for prior authorization to ***United Concordia*** for a determination of whether the services will be covered.

Retirees must elect dental benefits at the time of retirement.
Otherwise they must wait until the next open enrollment to add this benefit.

CONTRACT PROVIDERS

The Plan contracts with a preferred provider network, ***United Concordia***. If you receive covered dental treatment at one of the preferred dentists, you will have **no out-to-pocket expenses** except for the deductible and charges exceeding the calendar year maximum. Please refer to the ***Important Telephone Numbers*** in the front of this ***Summary Plan Description*** for information on how to contact ***United Concordia***.

SCHEDULE OF ALLOWANCES—NON-CONTRACTED PROVIDERS

The Plan pays for services from dentists who are not contracted with United Concordia based on a Schedule of Allowances for each covered service. The Plan pays 100% of the Schedule and you pay any amounts the dentist charges that exceed the Schedule of Allowances. The Schedule of Allowances is available from United Concordia.

Calendar Year Deductible

Each eligible individual must satisfy a **$50** calendar year deductible before the Plan pays for any covered services. Each family is only responsible for three times the individual deductible each year. Covered charges incurred in the last quarter of the calendar year also will be applied to the following year's deductible. Orthodontia benefits are not subject to the annual deductible.

Calendar Year Maximum Benefits

The maximum benefits paid for each covered individual in a calendar year is limited to **$3,000**. Orthodontia benefits are subject to a separate lifetime maximum.

Covered Dental Expenses

DIAGNOSTIC AND PREVENTIVE CARE

Provides all necessary procedures to assist the dentist in evaluating the existing condition of your teeth and the dental care required. Oral exams are covered every 6 months, a full mouth series of x-rays is covered every 12 months, prophylaxis is covered every 6 months, and fluoride application is covered every 12 months.

GENERAL ANESTHESIA

Is covered when administered for covered oral surgery performed by a dentist.

ORAL SURGERY

Provides for extractions and other oral surgery including pre and postoperative care.

RESTORATIVE DENTISTRY

Provides amalgam, synthetic porcelain and plastic restorations. Gold restorations, crowns and jackets are covered when teeth cannot be restored with other materials. Sealants are covered for children up to age 16.

ENDODONTICS

Includes pulpal therapy and root canal filling.

PERIODONTICS

Periodontal scaling and root planing for the treatment of diseases of the gums and bones supporting the teeth is a benefit once for each quadrant each 24-month period if dentally necessary. Following active therapy, periodontal maintenance is a benefit every three months if dentally necessary.

PROSTHETICS

Provides bridges, partial dentures, complete dentures and dental implants. Replacement will only be covered if the existing appliance is unsatisfactory and cannot be made satisfactory. If the Plan had paid for the existing appliance, **replacement will not be made until five years have elapsed from the date the expense was incurred** for the existing appliance, unless:

- The replacement is necessary due to the initial placement of an opposing full denture or the extraction of natural teeth;
- The appliance is temporary and is being replaced by a permanent appliance; or
- The appliance was damaged beyond repair by an accidental injury.

Orthodontics

Treatment associated with the straightening and realignment of the teeth. Benefits are provided for Dependent children only. The Plan will pay of 50% of Usual, Customary, and Reasonable charges, up to a **$1,000 lifetime maximum for each child**.

Dental Expenses That Are Not Covered

- Dental services provided purely for cosmetic reasons.
- Replacement of more than one orthodontic appliance per Dependent child.
- Gold crowns or restorations in excess of the amount payable for amalgam restorations, except:
  - When used in teeth as bridge abutments; or
  - When required to restore a tooth to its proper contour and there is no other reasonable restoration available.
- Replacement of a prosthetic appliance if it is satisfactory or can be made satisfactory.
- Any services provided after termination of eligibility except for any treatment program initiated and authorized prior to termination and completed within sixty (60) days of termination.

VISION BENEFITS

Eye care is an important part of your overall health. You can save money on your vision expenses by using providers who are part of the Vision Service Plan (VSP) or Spectera Vision Network. At open enrollment, you must choose which vision plan you wish to enroll in. If you do not choose a vision plan, VSP will be your assigned plan. ***Retirees must elect vision benefits when they retire and cannot add them at any later date.***

Spectera Vision Providers

If you elect Spectera during Open Enrollment, you must use Spectera providers. The Plan provides covered services at 100% after a $10 copayment for each exam and a $10 copayment for materials. This copayment is payable to the Spectera provider each time you receive services.

You will receive up to a $100 allowance for frames purchased at a Spectera provider. You are covered for one frame in a 24-month period. Exams and lenses are covered in full once in a 12-month period after the copayment has been paid.

Active Employees may purchase an additional pair of glasses in a 12-month period for an additional $10 copayment. **Dependents and Retirees do not have this additional purchase option**.

VSP Providers

Eye care is an important part of your overall health. You can save money on your vision expenses by using providers who are part of the Vision Service Plan (VSP). If you select a VSP provider, the Plan provides covered services at 100% after a $25 deductible. This deductible is payable to the VSP provider each time you receive services.

You will receive up to a $150 allowance for frames purchased at a VSP provider. You are covered for one frame in a 12-month period. Exams and lenses are covered in full once in a 12-month period after the deductible has been met.

Active employees may purchase an additional pair of glasses in a 12-month period for an additional $10 copayment. Dependents and Retirees do not have this additional purchase option.

Non-Contract Providers

If you choose to receive vision care from a non-contract provider, you will be reimbursed for covered charges according to the schedule shown in your ***VSP*** or ***Spectera Evidence of Coverage*** brochure. You will need to submit a claim along with an itemized statement of expenses to your vision plan. Please contact VSP, Spectera or the Trust Fund Office for a brochure if you do not have one available.

Covered Charges

The Plan is designed to cover visual rather than cosmetic needs. When you select any of the following extras, your vision plan will pay the basic cost of the allowed lenses and you will pay the additional costs for:

- blended lenses;
- contact lenses (except as provided in the schedule of benefits);
- oversize lenses;

- progressive multifocal lenses;
- coating of a lens or lenses;
- laminating of a lens or lenses; and
- frames that cost more than the Plan allowance.

Vision Expenses That Are Not Covered

The Plan does not cover the following vision care expenses:

- Orthoptics or vision training and any associated supplemental training, plano lenses, or a second pair of glasses in lieu of bifocals.
- Lenses and frames furnished under this program that are lost or broken cannot be replaced, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of eyes.
- Corrective vision treatment of an Experimental nature.

Please refer to your Vision Service Plan or Spectera ***Evidence of Coverage*** for additional information regarding your vision benefits.

EMPLOYEE ASSISTANCE PROGRAM (EAP)
SUBSTANCE ABUSE TREATMENT
MENTAL HEALTH SERVICES

These benefits are available for <u>Active Employees Only</u>. Retired Employees may not access any of these services.

Preauthorization and Exclusive Providers

All treatment for mental health and substance abuse treatment must be pre-authorized by the designated Employee Assistance Program (EAP) and must be provided by providers approved by the EAP, except in cases of emergency. In cases of emergency, the patient or a family member must contact the EAP as soon as possible, but no later than 72 hours after an inpatient admission. The EAP is listed in the ***Important Telephone Numbers*** in the front of the ***Summary Plan Description.***

Employee Assistance Program

HMO ENROLLEES MAY ALSO RECEIVE THESE SERVICES

You may receive up to three (3) Counseling sessions per calendar year. After an initial assessment, employees who require additional services will be referred to either a contracted substance abuse treatment program or mental health provider or to community resources. Note that HMO enrollees must receive all additional Mental Health services from their HMO medical plan.

The EAP can also provide telephonic counseling for such Work-Life issues as: child and elder care, financial counseling, brief legal counseling and identity theft. Online assessments and referrals are also available for such issues as: smoking cessation, weight loss and health risk assessments.

Substance Abuse Treatment

AVAILABLE ONLY TO ACTIVE EMPLOYEES—NO DEPENDENT COVERAGE

HMO ENROLLEES MAY ALSO RECEIVE THESE SERVICES

Coverage is provided at 100% subject to Plan limitations. All services must be preauthorized by the Employee Assistance Program. All services will be paid at the contracted rate.

<u>LIMITATIONS AND EXCLUSIONS</u>

- Detoxification is limited to a maximum of **$4,000 per episode** and $**8,000 per lifetime**. Not more than one episode of Detoxification will be covered in any one calendar year.
- Substance abuse benefits are limited to **2 treatment episodes in a lifetime**.
- Rehabilitation is limited to **30 days per calendar year**. Services may include any of the following levels of care: Inpatient, Residential, Partial Day Treatment, Day Treatment and Intensive Outpatient.
- There is no coverage for services from providers who are not contracted with the EAP.

- The Plan will not pay for services and supplies for which patients are not required to pay, or which are furnished by a Hospital or facility operated by the federal government or any authorized agency thereof, or furnished at the expense of such government agency.
- No payment shall be made for court-ordered services, except those that the EAP would have deemed clinically necessary and appropriate, were the court not involved.
- No payment shall be made for injury or illness arising out of or in the course of employment, including self-employment

Mental Health Services

AVAILABLE TO ACTIVE EMPLOYEES IN THE FEE FOR SERVICE MEDICAL PLAN AND THEIR DEPENDENTS. HMO ENROLLEES MUST OBTAIN SERVICES FROM THEIR HMO.

Coverage is provided at 100% subject to Plan limitations and Copayments. Services must be preauthorized by the Employee Assistance Program. All services will be paid at the contracted rate.

LIMITATIONS AND EXCLUSIONS

- Mental Health Services are limited to **$25,000 in each individual's lifetime**.
- Inpatient care is limited to **30 days per calendar year**.
- Outpatient care is limited to **30 visits per calendar year** and subject to the following **Copayments:**
  - *Individual therapy: **$30** per visit*
  - *Group therapy: **$15** per visit*
- There is no coverage for services from providers who are not contracted with the EAP.
- Mental retardation, pervasive developmental disorders, and learning disabilities are not covered.
- The Plan will not pay for services and supplies for which patients are not required to pay, or which are furnished by a Hospital or facility operated by the federal government or any authorized agency thereof, or furnished at the expense of such government agency.
- No payment shall be made for court-ordered services, except those that the EAP would have deemed clinically necessary and appropriate, were the court not involved.
- No payment shall be made for injury or illness arising out of or in the course of employment, including self-employment

LIFE INSURANCE AND AD&D BENEFITS

Life insurance and accidental death and dismemberment (AD&D) benefits are funded directly from Plan assets. Below is a summary of your benefits under the Welfare Plan. *Retirees must elect Life Insurance Benefits at the time of retirement and may not add it at any later date.*

Life Insurance Benefit

In the event of your death, your beneficiary will receive a life insurance benefit of **$12,000**.

If your Dependent dies, you will be paid a benefit as follows:

Dependent	**Amount Payable**
Eligible Spouse	$1,500
Eligible Child Over Six Months of Age	$1,500
Eligible Child Under Six Months of Age	$ 150

Life Insurance benefits are paid in a lump sum. You should also refer to the ***Designating Your Beneficiary*** section on page 11.

Accidental Death And Dismemberment

Available For Active Employees Only (No Retired Employee or Dependent Coverage).

Accidental death and dismemberment (AD&D) benefits are paid if you die or are seriously injured in an accident. You have **$10,000 of AD&D** coverage. The Plan pays all or a portion of that amount based on the type of loss.

Type Of Loss	**Amount Payable**
Life	$10,000
Both hands; Both feet; or Sight in both eyes	$10,000
One hand and one foot; One hand and sight of one eye; or One foot and sight of one eye	$10,000
One hand; or One foot; or Sight of one eye	$5,000

Benefits are payable only if a death or injury is a direct result of an accidental bodily injury sustained (work-related or non work-related) while you are covered by the Plan. The loss must occur within 90 days after the date of the accident.

Benefits are paid directly to you for an injury or to your beneficiary for your death. AD&D benefits are in addition to any death benefits that may be paid. Only one benefit—the largest—is payable for more than one loss.

When AD&D Benefits Are Not Paid

Benefits are not paid for losses caused by:

- suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;
- bodily or mental infirmity, disease of any kind, or as a result of medical or surgical treatment;
- the individual's participation in a riot or the commission of or the attempt to commit a crime;
- war, whether declared or undeclared, or insurrection;
- service, travel or flight in any species of aircraft, except as a fare-paying passenger in a licensed commercial aircraft operated on a regular schedule by a certified passenger carrier over its established air route.

Designating Your Beneficiary

You may name more than one beneficiary 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 Fund.

It's important that you name a beneficiary. If you don't 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.

CLAIMS FOR BENEFITS

Filing Claim Forms

Filing a claim is easy if you follow the steps described in this section. If a claim is denied or reduced, there is a process you can follow to have your self funded claim reviewed by the Trustees. Note that if you are in an insured HMO or Pre-Paid Dental Plan, the Trustees have no authority to hear your appeal of a denied claim except for issues related to eligibility.

FEE-FOR-SERVICE MEDICAL CLAIMS

Most health care providers will submit your claims for you. Be sure to show your ID card so your physician will know where to submit your claim. If your provider does not submit your claim for you, it is your responsibility to do so.

All claims should be submitted within 90 days after you receive a bill for services or supplies. Claims will not be paid if they are submitted more than one year from the date on which the services were received.

To assist in processing claims as quickly as possible, please be sure to include the information below:

- Your social security number and signature. If the claim is for a Dependent, provide the name of the Dependent.
- If you or a Dependent has coverage under more than one health plan, be sure to include the name of the other health plan(s).
- Have your health care provider complete any portion of the claim form that requests his or her information.
- Provide all bills or receipts relating to the service provided.
  - Make sure each bill clearly identifies the service or supply, the fee, the patient's name, and the date of service.
  - If Medicare also covers you, attach a copy of the itemized bill relating to the health service provided and a copy of Medicare's explanation of benefits. Both the bill and Medicare's explanation of benefits must be submitted.
- Forward the completed form and all related bills to the Trust Fund Office.

If you or a Dependent has coverage under more than one health care plan, benefits are coordinated as explained in the **Coordination of Benefits** section.

If you are enrolled in a medical HMO or prepaid dental plan, you generally do not need to fill out claim forms.

FEE-FOR-SERVICE DENTAL CLAIMS

Your Fee-For-Service Dental Plan **strongly recommends** that a pre-determination of benefits be obtained for charges of **$200** or more, for any orthodontic treatment plan for a Dependent child. Be sure to advise your dentist of this requirement. For pre-certification, your dentist should contact United Concordia at **866-604-8517**.

All claims should be submitted within 90 days after you receive a bill for services or supplies. Claims will not be paid if they are submitted more than one year from the date on which the services were received. You dentist may submit claims on your behalf.

If you are submitting a claim, please follow the steps listed below.

- Complete and sign your claim form.
- Have your dentist complete his portion of the claim form.
- Submit the form to United Concordia for processing.

LIFE AND AD&D INSURANCE CLAIMS

In the event of your death, your beneficiary should call the Trust Fund 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.

Coordination of Benefits

The health care programs have been designed to help you meet the cost of sickness and/or injury. It is not intended, however, that you receive greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will be coordinated with any coverage you or a covered Dependent has under any other group or other government plans.

Specifically, in a calendar year, this Plan will always pay to you either its regular benefits in full or a reduced amount which, when added to the benefits payable to you by the other plan or plans, will equal the total "Covered Charges." However, no more than the maximum benefits payable under this Plan will be paid.

ORDER OF PAYMENT

If you or your Dependent is covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits payable does not exceed 100% of the Covered Charges incurred.

The following rules determine which plan is the primary plan:

- A plan that does not have a coordination of benefits rule is always primary.
- A plan that covers an individual as an employee is primary.

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

The following rules determine which plan's benefits are primary if a Dependent child is covered under more than one plan:

- If the parents are not divorced or separated, the order of payment used to determine the primary plan is as follows:
  - If a plan does not use the "birthday rule" to determine which plan pays first, the rules of that plan determine the order of benefit payments.
  - The plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding the year of birth, is primary.
  - If the birthday of both parents occurs on the same date, the plan that has covered either of the parents for the longer period of time is primary.

- If a plan does not use the "birthday rule" to determine which plan pays first, the rules of that plan determine the order of benefit payments.
- If none of the above apply, the plan covering the patient the longest will be primary.

- If the parents are separated, divorced, or have never been married and are not living together, the order of payment used to determine the primary plan is as follows:
  - Where there is a court decree that establishes financial responsibility for medical expenses, the plan covering the Dependent child of the parent who has financial responsibility will pay first.
  - If there is a court decree establishing joint custody without specifying that one parent has responsibility for medical expenses, the plan which covers the parent whose birthday falls first in the calendar year is primary.
  - Where there is no court decree, the plan of the:
    a) parent with custody is primary;
    b) stepparent with custody of the child pays second; and
    c) parent not having custody of the child pays third.

If the Plan makes payments it is not required to pay, it may recover and collect those payments from you, your Dependents, or any organization or insurance company that should have made the payment.

Coordination of Benefits with Medicare for Actives

Medicare is a two-part program. The first part is officially called "Hospital Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part A of Medicare. The second part is officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part B of Medicare. Part A of Medicare primarily covers hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers physician services, although it, too, covers a number of other items and services.

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, dependent widow, or have chronic 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.

You may elect Medicare as the primary plan over this Plan; however, if you do this, this Plan will not pay any benefits. Contact the Trust Fund Office or a Social Security Office for more information.

Coordination of Benefits with Medicare for Retirees

Retired participants and their eligible Dependents who are eligible for Medicare are covered under the Plan as the secondary payer. Medicare will be primary payer and the Plan will pay secondary. (There is an exception for ESRD patients during the 30 month "coordination period."

It is very important to send your Medicare explanation of benefits to the Trust Fund Office when you file your claims. The Plan will first determine the amount it would have paid if you were not Medicare eligible and then subtract the amount paid by Medicare. For all purposes of this

provision, if you or your Dependents are eligible for benefits under Medicare, the Plan will reduce your benefits by the amount Medicare would have paid, even if you are not enrolled or participating. The Plan will pay benefits AS IF Medicare had paid benefits primary.

HMO members eligible for Medicare benefits must also enroll for such benefits since they are required to assign the benefits to the HMO. Members who fail to do this may be required to pay any surcharge applied to premiums by the HMO for your failure to enroll in both Part A and Part B of Medicare. You should verify your Medicare enrollment at least 90 days prior to your 65th birthday. Contact your nearest Social Security Office.

If you were receiving reimbursement for a portion of your Medicare Part B premium prior to June 1, 1992, you may continue to submit your reimbursement requests to the Trust Fund Office.

CAUTION REGARDING ENROLLMENT IN A MEDICARE PRESCRIPTION DRUG PLAN

The prescription drug benefit provided by this Trust Fund is "Creditable Coverage" under the Medicare Part D Prescription Drug Plan. Therefore you do not need to enroll in any individual Part D plan. You will receive a Notice of Creditable Coverage from the Trust Fund Office each year prior to November 15. That Notice will advise you if there has been any change in the status of the Trust Fund's prescription benefits that affects its' creditable status and will also advise you of the consequences to your current prescription benefits provided by the Trust Fund if you do enroll in an Part D drug plan.

Since the prescription drug coverage you receive from the ***California Ironworkers Field Welfare Plan*** is better than the standard Part D plan that is offered to individuals, you should NOT enroll in any individual Part D policy until you have discussed the consequences with the Trust Fund Office.

SPECIAL CAUTION FOR RETIREES ENROLLED IN KAISER SENIOR ADVANTAGE

If you are enrolled in Kaiser Senior Advantage and you enroll in an individual prescription drug plan approved by Medicare, the Centers for Medicare and Medicaid Services (CMS) you will be AUTOMATICALLY DIS-ENROLLED FROM KAISER SENIOR ADVANTAGE for both prescription drugs and medical benefits. You will have to pay a much higher cost to continue your retiree medical coverage with this Trust Fund.

Information Gathering

In order to implement the provisions in this coordination of benefits section, the Trustees or the Administrator 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 Trust Fund Office such information as may be necessary to implement the provisions of this section or to determine their applicability.

CLAIMS AND APPEALS PROCEDURES

Authorized Representatives

An Authorized Representative, such as your spouse, may submit the claim for you if you have previously designated the individual to act on your behalf. A form can be obtained from the Trust Fund Office to designate an Authorized Representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

A health care professional with knowledge of your medical condition may act as an Authorized Representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

What is NOT a "Claim"

The following are examples of interactions you may have with the Plan, the Trust Fund Office or service providers to the Plan that are not subject to the timelines and requirements of this section.

- Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits.
- A request for a determination regarding the Plan's coverage of a medical treatment or service that your physician has recommended, but the treatment or service has not yet been provided and the treatment or service is for non-urgent care for which the Plan does not require prior authorization, is not a "Claim" under these procedures. In this circumstance, you may request a determination from the Trust Fund Office, Blue Cross (for participants residing in California), or First Health (for participants residing outside California) regarding the Plan's coverage of the treatment or service. However, this will not be a guarantee of payment because such a request is not a "Claim" under these procedures, and therefore will not be subject to the requirements and timelines described in this section.
- When you present a prescription to a pharmacy to be filled under the terms of this Plan, that request is not a "Claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

Claims Procedures

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures, which are described in this section. These procedures cover all self-funded Fee-For-Service medical, dental and prescription drug claims. If you are covered under an HMO plan such as Kaiser, PacifiCare, Health Net, Health Plan of Nevada or under a Pre-Paid Dental Plan, you should refer to the ***Evidence of Coverage*** brochure provided by the underwriter. This notice also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Eligibility Disputes: If your claim is denied because you are not shown as eligible on the records of the Trust Fund Office, your eligibility status will be resolved by the Trust Fund Office, working with Blue Cross (for participants residing in California), First Health (for participants residing outside California), your HMO or any other insurer or service provider as necessary, in accordance with the time lines described below, depending on the classification of your claim as either Urgent, Pre-Service or Post Service.

HOW TO FILE A CLAIM FOR 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 Trust Fund Office to be able to process your claim:

- Participant name
- Patient name
- Patient Date of Birth
- SSN of participant
- Date of Service
- CPT (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) or Provider Identification Number (PIN) 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

Hospitals For participants residing in California, hospitals will file your claim electronically to Blue Cross. For participants residing outside California, First Health should bill your claims directly to the Trust Fund at the address provided below. Claims for **Medical services** that have already been provided will be considered to have been filed as soon as they are received at the Trust Fund Office. All non-hospital Medical, Life and Accidental Death and Dismemberment (AD&D) claims should be filed with the Trust Fund Office at the following address:

California Ironworkers Field Welfare Plan

131 N. El Molino Avenue, Suite 330

Pasadena, California 91101-1878

Prescription drug claims will be filed by pharmacies directly to Prescription Solutions unless you did not use your Prescription Solutions card when you purchased your prescriptions. In that case you must file your claim directly to Prescription Solutions at the following address:

Prescription Solutions Claim / DMR

Mail Stop LC07-190

P.O. Box 6037

Cypress, CA 90630-0037

Vision claims for providers contracted with VSP or Spectera (if you are enrolled in Spectera) will be sent to VSP or Spectera by the provider. Any claims for providers that are not contracted with VSP or Spectera should be sent to:

Vision Services Plan
3333 Quality Drive
Rancho Cordova, CA 95670

WHEN CLAIMS MUST BE FILED

Claims for medical services that have been received should be filed with the Trust Fund Office within 90 days after you receive a bill for the services or supplies. Claims for Life/AD&D should be filed with the Trust Fund Office within 90 days after the date of death or injury. Claims will not be paid if they are submitted more than one year after the date on which the services were received.

Urgent Care and ***Pre-Service Claims*** (defined below) must be submitted to the **Blue Cross** Utilization Review Department (for participants residing in California), the **First Health** Utilization Review Department (for participants residing outside California), or Managed Health Network (**MHN**) for mental health or substance abuse by phone. They are **not** to be submitted via the U.S. Postal service.

For participants residing in California: Urgent and Pre-Service Hospital Claims should be called to the Blue Cross Utilization Review Department—Phone: (800) 274-7767
For participants residing outside California: Urgent and Pre-Service Hospital Claims should be sent to First Health Utilization Review Department—Phone: (800) 572-5508
Urgent and Pre-Service EAP, Mental Health and Substance Abuse Claims should be sent to Managed Health Network. Phone: (800) 977-7962. These benefits are only provided to Active participants. *Dependents of Active Employees are NOT eligible for Substance Abuse services* .

Please note that the Urgent Care Claims procedures described in this notice do not apply to emergency care. If you experience a medical emergency, such as acute onset of chest pain, major trauma, or sudden shortness of breath, you should go to the nearest hospital emergency room. The charges for these services will be submitted as Post-Service Claims.

FEE-FOR-SERVICE MEDICAL, MENTAL HEALTH AND DENTAL BENEFITS

The claims procedures for comprehensive medical benefits will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Claim, or a Post-Service Claim. Read each section carefully to determine which procedure is applicable to your request for benefits.

PRE-SERVICE CLAIMS

A Pre-Service Claim is a claim for a benefit for which the Plan ***requires*** approval of the benefit (in whole or in part) from Blue Cross (for participants residing in California), First Health (for participants residing outside California), or MHN for mental health and substance abuse benefits before care is obtained in order to receive the maximum benefits provided by the Plan. Under the terms of this Plan, prior approval of services by Blue Cross (for participants residing in California) or First Health (for participants residing outside California) is required for hospital services (except emergencies, hospitalization for childbirth up to 48 hours following normal delivery, or 96 hours following a caesarian section, or when the Plan is the secondary payer).

Pre-Service Hospital Claims should be submitted by your provider to Blue Cross (for participants residing in California) by phone: (800) 274-7767 or First Health (for participants residing outside California) by phone: (800) 572-5508.

It is strongly recommended that you pre-certify **dental charges of $200** or more and any orthodontic treatment for a Dependent child. Your dentist should contact United Concordia at (866) 604-8517 for pre-certification.

You must certify all services for the EAP, mental health or substance abuse program by calling MHN at (800) 977-7962. These services are only covered by the Plan when they are provided by MHN contracted Physicians and facilities.

If your provider improperly files a Pre-Service Claim, the Review Organization will notify you and/or your provider as soon as possible but not later than *five days* after receipt of the claim of the proper procedures to be followed in filing a Claim. Notice of an improperly filed Pre-Service Claim will only be sent if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a Claim.

For properly filed Pre-Service Claims, you and your Physician will be notified of a decision within *15 days* from receipt of the Claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the Review Organization. If an extension is necessary, you will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Review Organization needs additional information from you, the extension notice will specify the information needed. In that case you and/or your Physician will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Review Organization then has *15 days* to make a decision on a Pre-Service Claim and notify you of the determination.

Note: A determination on a Pre-Service Claim by the Review Organization is not a guarantee of benefits nor is it a claim payment determination.

URGENT CARE CLAIMS

An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

- 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 the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above shall be treated as an Urgent Care Claim.

If your physician improperly files an Urgent Care Claim, Blue Cross (for participants residing in California) or First Health (for participants residing outside California) will notify you and/or

your physician as soon as possible but not later than *24 hours* after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a Claim.

Generally, Blue Cross (for participants residing in California) or First Health (for participants residing outside California) will respond to you and your Physician with a determination as soon as possible, taking into account the medical circumstances, but not later than *72 hours* after receipt of the Claim.

However, if an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, Blue Cross or First Health will notify you or your Physician as soon as possible, but not later than *24 hours* after receipt of the claim, of the specific information necessary to complete the claim. You and/or your Physician must provide the requested information not later than *48 hours* after receiving the request for information. If the information is not provided within that time, your claim will be denied. Notice of the decision will be provided no later than *48 hours* after Blue Cross or First Health receives the specified information, but only if the information is received within the required time frame.

CONCURRENT CLAIMS

A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by plan amendment or termination), will be made by Blue Cross (for participants residing in California) or First Health (for participants residing outside California) or MHN for mental health and substance abuse for inpatient care, or the Trust Fund Office in consultation with an independent review organization if appropriate (for other services) as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved Urgent Care treatment will be acted upon by Blue Cross (for participants residing in California) or First Health (for participants residing outside California) within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to Pre-Service or Post-Service timeframes, whichever applies.

POST-SERVICE CLAIMS

Post-Service Claims are all claims that are not Pre-Service, Urgent or Concurrent claims. Usually these will be claims submitted for payment after health services have been obtained. The procedure to follow for filing Post-Service Claims is described at the beginning of this Claims and Appeals section. Be sure that all the applicable information is provided and that you have submitted all itemized bills (if applicable). By doing so, you will speed the processing of your claim. You do not have to submit an additional claim form if your bills are for a continuing illness and you have filed a *signed* claim form within the past calendar year. Mail any further bills or statements for medical or dental services covered by the Plan to the Trust Fund Office as soon as you receive them.

Ordinarily, you will be notified of the decision on your Post-Service Claim within *30 days* after the Plan's receipt of the claim. The Plan may extend the period once, for up to *15 days*, if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If the Plan needs additional information from you, your claim will be denied and the Plan will notify you of the denial, state the reason for the denial and specify the additional information needed. If you submit the necessary information *within 45 days* after receipt of the notification of the denial, there is no need to file a new claim. Once the Plan receives this information, it then has *15 days* to make a decision on a Post-Service Claim and notify you of the determination.

LIFE INSURANCE / ACCIDENTAL DEATH AND DISMEMBERMENT CLAIMS

In the event of death or dismemberment, you or your beneficiary must obtain a claim form and submit the completed claim form and a certified copy of the death certificate (if applicable) to the Trust Fund Office. The Plan will make a decision on Life and AD&D claims and notify you or your beneficiary of the decision within *90 days* of receipt of the claim by the Trust Fund Office. If the Plan requires an extension of time due to matters beyond its control, you will be notified of the reason for delay and the date by which it expects to render a decision. This notification will occur before the expiration of the 90-day period. The period for making a decision may be delayed an additional 90 days.

Notice of Decision

You will be provided with written notice of denial of a claim, whether denied in whole or in part. Notice will be sent by Blue Cross (for participants residing in California) or First Health (for participants residing outside California) or by MHN for mental health or substance abuse for all Urgent Care and Pre-Service Claims. Notice will be sent by the Trust Fund Office, Blue Cross, First Health or MHN for Concurrent Claims, depending on the type of service being received. Notice will be sent by the Trust Fund Office for all Post-Service Claims. The notice will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon written request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon written request at no charge.

For ***Urgent Care Claims***, the notice will describe the expedited review process applicable to Urgent Care Claims. The notice of determination for Urgent Care Claims will be made in writing or orally and followed with written notification within 3 days thereafter.

Request for Review of Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must meet the following criteria:

- made in writing
- state the reason(s) for disputing the denial;
- accompanied by any pertinent material not already furnished to the Plan; and
- submitted within 180 days after you receive notice of denial (90 days for Life or AD&D)

Appeals involving an adverse determination of an ***Urgent Care Claim*** may be made by calling:

> Blue Cross (for participants residing in California) at (800) 274-7767 or First Health (for participants residing outside California) at (800) 572-5508 or MHN for mental health or substance abuse services at (800) 977-7962.

Appeals involving an adverse determination of a Pre-Service, Post Service, Life or AD&D Claim must be submitted to the Trust Fund Office.

Appeals involving an adverse determination on a Concurrent Claim should be sent to either Blue Cross (for participants residing in California), First Health (for participants residing outside California), MHN for mental health and substance abuse services or the Trust Fund Office, depending on which organization made the adverse determination.

Failure to file an appeal that meets all of these criteria will constitute a waiver of your right to a review of the denial of your claim.

REVIEW PROCESS

You have the right to submit comments, documents, records and other information in support of your claim for benefits. Upon written request, and free of charge, you will be provided with reasonable access to copies of all documents, records and other information relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated in connection with the claim (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

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

Urgent Care Claim Appeals should be submitted to Blue Cross (for participants residing in California) or First Health (for participants residing outside California) or MHN for mental health and substance abuse. Your appeal will be reviewed by a different person at Blue Cross. First Health or MHN than the one who made the original decision and who is not a subordinate of the person who denied your claim. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental) an independent health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you relating to the claim.

If your ***Urgent Care Claim Appeal*** is denied by Blue Cross (for participants residing in California) or First Health (for participants residing outside California) or MHN for mental health and substance abuse, the Trust Fund offers you the opportunity to voluntarily re-submit your appeal, under the Pre-Service Claim rules, directly to the Trust Fund Office to be re-reviewed by the appeals sub-committee of the Board of Trustees. The sub-committee of the Board of Trustees will review your claim and notify you of the final determination within *15 days*. If your claim was denied on the basis of a medical judgement, an independent health care professional, who has appropriate training and experience in a relevant field of medicine, will be consulted. The reviewer will not give deference to any prior adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you relating to the claim.

Pre-Service Claim Appeals should be filed with the Trust Fund Office. If appropriate, the Trust Fund Office will send the appeal to an independent review organization. If your claim was denied on the basis of a medical judgment, an independent health care professional who has appropriate training and experience in a relevant field of medicine, will be consulted. The appeals sub-committee of the Board of Trustees will then review all relevant information and make a determination on your appeal within *30 days* of receipt of the appeal by the Trust Fund Office.

Post-Service Claim Appeals will be reviewed by the Board of Trustees at their next regularly scheduled meeting as described below. The appeal must be submitted in writing to the Board of Trustees and must include the patient's name, participant's name, a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees, the date of the Adverse Benefit Determination and the basis of the appeal. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), an independent health care professional, who has appropriate training and experience in a relevant field of medicine, will be consulted.

TIMING OF NOTICE OF DECISION ON APPEAL

Urgent Care Claim Appeals: You will be sent a notice of a decision on appeal by Blue Cross (for participants residing in California) or First Health (for participants residing outside California) or MHN for mental health and substance abuse as soon as possible, but no later than *72 hours* after receipt of the appeal by Blue Cross, First Health or MHN. If Blue Cross, First Health or MHN denies your appeal, you may request a review directly by the Board of Trustees, as described above.

Pre-Service Claim Appeals: You will be sent a notice of decision on appeal by the Trust Fund Office within *30 days* after receipt of the appeal by the Trust Fund Office.

Post-Service Claim Appeals: Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received in the Trust Fund Office within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified by the Trust Fund Office of the decision as soon as possible, but no later than *5 days* after the decision has been reached.

Life and AD&D Claims: The decision will be made in the same manner as for Post-Service Claims.

NOTICE OF DECISION ON APPEAL

The decision on any appeal of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

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

The denial of a claim to which the right to review has been waived, or the decision of the Board or its designated Appeals Committee with respect to a petition for review, is final and binding upon all parties including the claimant or the petitioner, subject only to any civil action you may bring under ERISA. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or any right to arbitration.

Limitation on When a Lawsuit may be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate timeframe described above has elapsed since you filed a request for review, and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

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 this Trust Fund because you are incompetent, incapacitated or in a coma, this Trust Fund 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 Trust Fund benefits will completely discharge this Trust Fund's obligations to the extent of that payment. Neither this Trust Fund, the 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

RIGHT OF REIMBURSEMENT: THIRD PARTY CLAIMS

If you or your Dependent receives benefits from this Plan for bodily injuries or illnesses sustained from the acts or omissions of any third party, the Plan shall have the right to be reimbursed in the event you and/or your Dependent recovers all or any portion of the benefits paid by the Plan by legal action, settlement or otherwise, regardless of whether such benefits were paid by this Plan prior to or after the date of any such recovery. **You and/or your Dependent will not be entitled to receive any benefits for such expenses under this Plan unless you and/or your Dependent agree in writing to all of the following conditions:**

a) To reimburse the Plan, to the extent of all benefits paid by this Plan as a result of such injuries, immediately upon obtaining any monetary recovery from any party or organization whether by action of law, settlement or otherwise by the execution of a Subrogation Agreement;

b) To irrevocably assign to the Plan all rights to recover monetary compensation from the third party to the extent of all benefits paid by this Plan and to give notice of this assignment directly to such third parties, their agents or insurance carriers, or to any agent or attorney who may represent the you or your Dependent. The assignment shall entitle the Plan to reimbursement from any sums held or received by the following third parties which are due to you and/or your Dependent prior to any distribution of funds to the you and/or your Dependent, and shall provide that such parties shall hold such sums in trust as a fiduciary for the benefit of the Plan. The parties who shall be bound by such assignment are:

   – any party or its insurance carriers making payments to or on behalf of the participant; or

   – any agent or attorney receiving payments for or on behalf of you and/or your Dependent.

c) To notify the Plan of any claim or legal action asserted against any third party or any insurance carrier(s) for such injuries as well as the name and address of such third parties, insurance carrier(s), any agent or attorney who is representing or acting on behalf of you and/or your Dependent or your estate, or any person claiming a right through you on a form to be supplied by the Plan;

d) To cooperate fully with the Trustees in the exercise of any Assignment or Right of Subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Plan; and

e) To acknowledge that this Plan shall have the Right of Recovery as provided under this Section should you and/or your Dependent fail to execute an Assignment, Subrogation Agreement or any other documents required herein, or breach any of the terms of this Section.

The order of proceeds from any settlement or judgment in any claim made against a third party will be allocated as follows:

   – A sum sufficient to fully reimburse the Plan for all benefits advanced will be paid to the Plan;

   – Any remainder, less reasonable attorney's fee and a pro rata share of costs of prosecution, will be paid to you.

The order of proceeds will be made as outlined above, regardless of whether you or your Dependent has been fully compensated for the damages arising from injury, sickness or death.

In addition, the Trust shall have the independent right to bring suit in your and/or your Dependent's name. The Trust shall also have the right to intervene in any action brought by you and/or your Dependent against any third party, to and including your insurance carrier under any uninsured or underinsured motorist provision or policy. You and/or your Dependent further must agree to take no action inconsistent with the requirements of this provision.

The Trustees expect full compliance with this Reimbursement Section. Therefore, the Trustees reserve the right to withhold future medical benefits from you and/or your Dependent if you and/or your Dependent have obtained a recovery from another source, as described above, and you and/or your Dependent has not reimbursed the Plan as required. Future benefits will be withheld in an amount equal to the amount previously owed to the Plan until such time as the Plan's claim for reimbursement has been completely satisfied. The Trustees also reserve the right to file suit against you and/or your Dependent if you fail to comply with the terms of the Plan or the Subrogation Agreement.

NOTICE OF PRIVACY PRACTICES

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.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the California Ironworkers Field Welfare Plan ("Health Plan" or "Plan").

The Health Plan needs to create, receive, and maintain records that contain health information about you to administer the Health Plan and provide you with health care benefits. This notice describes the Health Plan's health information privacy policy with respect to your medical, dental, vision, and prescription drug benefits that are not insured by a third party. The notice tells you the ways the Health Plan may use and disclose health information about you, describes your rights, and the obligations the Health Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed:

The privacy rules general allow the use and disclosure of your health information without your permission (known as authorization) for purposes of health care Payment activities, Health Care Operations and Treatment. Below are some examples of what that might entail:

Payment. Includes activities by this Health Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Health Plan may use or disclose health information for its own operations to facilitate the administration of the Health Plan and as necessary to provide coverage and services to all of the Health Plan's participants and beneficiaries. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.

- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of Health Plan, including customer service and resolution of internal grievances.

For example, the Health Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment . The Health Plan may use and disclose your health information to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as a result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

Other allowable uses or disclosures of your health information.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Business Associates. Certain services are provided to the Health Plan by third parties known as "business associates". For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In doing so, the Plan will disclose your health information to its business associate so it can perform its claims payment function. However, the Plan will require its business associates to appropriately safeguard your health information.

For Treatment Alternatives. The Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Health Plan may use or disclose your health information to provide your information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor. The Health Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of Health Plan. In addition, the Health Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Health Plan also may disclose to the plan sponsor information on whether you are participating in the Plan.

When Legally Required. The Health Plan will disclose your health information when it is required to do so by any federal, state or local law, including those that require the reporting of certain types of wounds or physical injuries.

To Conduct Health Oversight Activities. The Health Plan may disclose your health information to health oversight agencies authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs and civil rights laws.

In Connection With Judicial and Administrative Proceedings. The Health Plan may disclose your health information as permitted or required by law. The Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Health Plan makes

reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by law, the Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

In the Event of a Serious Threat to Health or Safety. The Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require the Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Worker's Compensation. The Health Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

For Victims of Abuse, Neglect, or Domestic Violence. The Health Plan may release your health information to government authorities, including social services or protected services agencies authorized by law to receive reports or abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk).

For Public Health Activities. The Health Plan may release your health information as authorized by law for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Corners, Medical Examiners, and Funeral Directors. The Health Plan may release your health information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. The Health Plan may also release your health information to a funeral director, as necessary to carry out his/her duty.

Organ, Eye, or Tissue Donation. If you are an organ donor, the Health Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Research. Under certain circumstances, the Health Plan may disclose your health information for medical research purposes.

Individual Involved in Your Care or Payment of Your Care. The Health Plan may use or disclose your health information to a close friend or family member involved in or who helps pay for your health care. The Plan may advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

HHS Investigations. The Health Plan may release your health information to the Department of Health and Human Services ("HHS") to investigate or determine the Health Plan's compliance with the HIPAA privacy rule.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Health Plan will not disclose your health information other than with your written authorization. If you authorize Health Plan to use or disclose your health information, you may revoke that authorization as allowed under the HIPAA rules. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Health Plan maintains:

Right to Request Restrictions. You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment or Health Care Operations, except for uses or disclosures required by law. You have the right to request a limit on Health Plan's disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. **However, the Health Plan is not required to agree to your request**. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan, or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. If you wish to make a request for restrictions your request must be in writing. For further information please contact the Privacy Official or its designee.

Right to Receive Confidential Communications. You have the right to request that the Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to Privacy Official or its designee. The Health Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. With certain exceptions, you have the right to inspect and copy your health information. This may include your plan eligibility, claim and appeals records and billing records. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Official or its designee. If you request a copy of your health information, the Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. With certain exceptions, if you believe that your health information records are inaccurate or incomplete, you may request that the Health Plan amend the records. That request may be made as long as the information is maintained by the Health Plan. A request for an amendment of records must be made in writing to the Privacy Official or its designee. The Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Health Plan, if the health information you are requesting to amend is not part of the Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if Health Plan determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You may receive information on disclosures of your health information going back for six (6) years

from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information.

In addition, your right to an accounting of disclosures to a health oversight agency or law Enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request must be made in writing to the Privacy Official or its designee. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Official or its designee.

DUTIES OF HEALTH PLAN

The Health Plan is required by law to maintain the privacy of your health information and to provide you with this Notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer.

Changes to the Information in this Notice

The Plan must abide by the terms of this Notice by April 14, 2003. However, the Plan reserves the right to change the terms of its privacy policies as described in this Notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this Notice, you will be provided with a revised Privacy Notice which will be sent to you in the same manner as this Notice was provided.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact the Privacy Official or its designee.

CONTACT PERSON

For more information on the Plan's privacy polices or your rights under HIPPA, contact the Privacy Official or its designee at 131 N. El Molino Ave., Suite 330, Pasadena, Ca 91101/626-792-7337.

SUPPLEMENTAL RETIREE BENEFIT ACCOUNT

Effective March 1, 2009

Active Employees

The California Ironworkers Field Welfare Fund established a Supplemental Retiree Benefit (SRB) account for each Active Employee. The SRB account may only be used by the Active Employee to pay for the active employee's COBRA premiums (including the COBRA premiums of his eligible Dependents as defined in section 152 of the Code). Active Employees may use the SRB for COBRA premiums only.

Retired Employees

- The SRB can be used to pay for retiree self payments for retiree coverage in the California Ironworkers Field Welfare Plan, Medicare supplemental insurance premiums, or for reimbursement for non-covered expenses (including co-payments) for medical care (as defined in section 213(d) of the Code) which are excludable from the gross income of the retiree under section 105(b) of the Code. These payments will not be taxable to the retiree.
- If the participant is not eligible for retiree coverage under the California Ironworkers Field Welfare Plan and ceases to have contributions for 24 months and the Participant signs a statement stating that they intend to retire, then the participant's account will not remain in the SRB and shall be paid out to the participant as taxable wages.
- If the retiree is eligible for retiree coverage but elects out of coverage under the Plan then:

  a) If the retiree is covered under his spouse's health plan, the retiree's SRB balance will be preserved and can be used by the retiree for self-payments and non-covered medical expenses (as defined in section 213(d) of the Code) which are excludable from the gross income of the retiree under section 105(b) of the Code once he resumes coverage under the Welfare Plan.

     The retiree may also use the SRB account to obtain reimbursements for premiums paid for the spouse's plan, Medicare supplemental insurance premiums, and for non-covered expenses (including co-payments) for medical care (as defined in section 213(d) of the Code) which are excludable from the gross income of the retiree under section 105(b) of the Code. These payments would not be taxable.

  b) If the retiree obtains an individual plan, the retiree may use the SRB account to obtain reimbursements for premiums paid for the individual plan, Medicare supplemental insurance premiums, and for non-covered expenses (including co-payments) for medical care (as defined in section 213(d) of the Code) which are excludable from the gross income of the retiree under section 105(b) of the Code. These payments would not be taxable.

  c) If the retiree obtains no coverage, the retiree may use the SRB account to obtain reimbursements for Medicare supplemental insurance premiums and for non-covered expenses (including co-payments) for medical care (as defined in section 213(d) of the Code) which are excludable from the gross income of the retiree under section 105(b) of the Code. These payments would not be taxable.

- If a retiree or active employee dies with a balance in his SRB, the balance shall be payable to the retiree's or active employee's beneficiary or estate in the calendar year after the retiree or active employee's death. These payments will be taxable income (but not taxable wages).

FACTORS THAT COULD AFFECT YOUR RECEIPT OF BENEFITS

NOTE: If you are enrolled in an HMO or pre-paid Dental Plan, see your Evidence of Coverage for information about factors that might affect your receipt of benefits under those Plans.

Certain factors could interfere with payment of benefits from this Trust Fund (result in your disqualification or ineligibility, denial of your claim, or loss, forfeiture, or suspension of benefits you might reasonably expect). Examples of such factors include the following:

- **Failure to follow your plan's requirements for obtaining prior authorization**. If you wish to receive the maximum benefits available, you must comply with any prior authorization requirements your health care plans have.
- **Failure to use contract or network providers**. You will not receive the highest level of coverage available for many health care services unless you use contract/participating providers. To receive mental health and chemical dependency benefits from this Trust Fund, you must use contract providers.
- **Provisions for coordination of health care benefits**. If you or an eligible Dependent has other group or government coverage for medical benefits (including Medicare), payment of benefits under this Trust Fund will be coordinated with payment of benefits under that other coverage. See *Coordination of Benefits* section for more information.
- **Provisions regarding payment from another source**. This Trust Fund has a right to be reimbursed from monies paid by any person, organization, or insurer who may be responsible to you or your eligible Dependent for an injury or illness for which a claim has been submitted to this Trust Fund. This includes denying payments for future benefits until amounts paid by this Fund have been repaid. See *Subrogation and* Reimbursement section for more information.
- **Failure to submit claims in a timely manner**. You should submit all claims within the times stated in this booklet in the *Claims Procedures* section.
- **Failure to provide notice of changes in your family situation**. You must contact the Trust Fund Office regarding any changes in your family status. You will be held liable for benefit payments based on incorrect information about family members (for example, if you fail to notify the Trust Fund Office that you have divorced or legally separated or a child has ceased to be an eligible Dependent). In addition, you may be liable for other costs incurred by this Trust Fund as a result of the incorrect information. These costs include (but are not limited to) attorneys' fees, administrative costs, and reasonable interest.

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Trust Fund Office. See also Sections 2 and 3 for information on eligibility and termination of eligibility.

INFORMATION REQUIRED BY ERISA

Information About The Plan

PLAN SPONSOR AND ADMINISTRATOR

The Plan is sponsored and administered by the Board of Trustees. The Board of Trustees consists of employer and union representatives selected by the employers and unions who have entered into collective bargaining agreements which relate to this Plan. If you wish to contact the members of the Board of Trustees you may use the address below:

Union

Mr. Dan Hellevig
Ironworkers Local 377
570 Barneveld Avenue
San Francisco, CA 94124-1804

Mr. Hart Keeble
Ironworkers Local 416
P.O. Box 1166
Norwalk, CA 90651-1166

Mr. Martin Murphy
Ironworkers Local 75
950 E. Elwood Street
Phoenix, AZ 85040-1227

Mr. John Rafter
Ironworkers Local 118
2840 El Centro Road, Suite 118
Sacramento, CA 95833-9700

Mr. Emilio Rivera
Ironworkers Local 378
3120 Bayshore Road
Benicia, CA 94510-1232

Mr. Don Savory
Ironworkers Local 155
5407 E. Olive Avenue, Suite 16
Fresno, CA 93727-2541

Mr. Joe Standley
District Council of Ironworkers of CA & Vicinity
1660 San Pablo Avenue, Suite C
Pinole, CA 94564

Mr. Bill Stuckey
Ironworkers Local Union No. 229
5155 Mercury Point
San Diego, CA 92111

Mr. Doug Williams
Ironworkers Local 433
17495 Hurley St. East
City of Industry, CA 91744

Employer

Mr. Charles L. Krebs
Rebar Engineering, Inc.
10706 Painter Avenue
Santa Fe Springs, CA 90670-4525

Mr. Nick Lee
NLE, Inc.
6 Ribera
Irvine, CA 92620

Mr. Dave McEuen
California Erectors Bay Area
4500 California Court
Benicia, CA 94510-1021

Mr. Bill Myers
CMC Fontana Steel, Inc.
P.O. Box 2219
Rancho Cucamonga, CA 91729-2219

Mr. Michael Newington
Western Steel Council, Inc
151 North Sunrise Ave.. #1002
Roseville, CA 95661

Mr. Joel Raschke
Paradise Rebar
2548 West Jackson Street
Phoenix, AZ 85009

Mr. Michael Vlaming
Crane Owners' Assoc., Inc.
447 Georgia Street
Vallejo, CA 94590

Mr. Daniel Welsh
Washington Iron Works
17926 S. Broadway
Gardena, CA 90248

Mr. Richard Barbour
The Herrick Corporation
2000 Crow Canyon Place, Suite 360
San Ramon, CA 94583

CONTRACT ADMINISTRATOR

The Board of Trustees has delegated day-to-day administrative responsibility to the following organization:

Administrator
Ironworker Employees' Benefit Corporation
131 N. El Molino Avenue, Suite 330
Pasadena, CA 91101-1878
800-527-4613

AGENT FOR SERVICE OF LEGAL PROCESS

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees at the address of the California Ironworkers Field Welfare Plan Trust Fund Office at the address immediately above. Service of Legal Process may also be made upon any individual Trustee or to the following organization:

Bailey and Associates
909 North Sepulveda Blvd., Suite 460
El Segundo, CA 90245

PLAN NAME AND NUMBERS

The name of the Plan is the California Ironworkers Field Welfare Plan.

The Plan number is 501.

The employer identification number (EIN), assigned to the Board of Trustees by the Internal Revenue Service, is 95-6042868. Taken together, the Plan's name, number, and the Trustees' EIN identify our Plan with government agencies.

FISCAL YEAR

The accounting records of the Plan are kept beginning on each June 1st and ending the following May 31st.

TYPE OF PLAN

This Plan is considered a welfare plan, providing the following benefits: a choice between a self-funded medical/prescription plan or one of the medical health maintenance organizations contracted with the Plan; a choice between a self-funded dental/orthodontic plan and one of the prepaid dental plans; an insured EAP/mental health and substance abuse treatment plan administered through MHN; self-funded vision plans administered through VSP and Spectera; and self-funded Life/AD&D benefits.

PARTIES TO THE COLLECTIVE BARGAINING AGREEMENT

Contributions to this Plan are made on behalf of each employee in accordance with collective bargaining agreements between Local Unions 75, 118, 155, 229, 377, 378, 416, 433 and 844 of the International Association of Bridge, Structural and Ornamental Ironworkers and employers in the industry. Participants and Dependents may obtain, upon written request to the Trust Fund Office, information as to the address of a particular employer and whether an employer is required to pay contributions to the Plan. A copy of any such agreement may be obtained by Plan participants upon written request to the Plan Administrator, and is available for examination by Plan participants.

PLAN FUNDING

Employer contributions and self-contributions finance the benefits described in this booklet. All employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements between the unions and employers. The Board of Trustees holds all assets in trust. Benefits, premiums and administrative expenses are paid from the Plan.

If the Plan terminates, any and all monies and assets remaining in the Trust Fund , after payment of expenses, will be used for the continuance of Plan benefits in a manner permitted by ERISA for so long as Trust assets permit.

Rights of the Board of Trustees

The Board of Trustees of the Trust Fund is the named fiduciary with the authority to control and manage the operation and administration of the Trust Fund. The Board shall make such rules, interpretations, and computations and take such other actions to administer the Plans of Benefits offered by the Trust Fund 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 Plans of Benefits payable, and any rules adopted by the Board of Trustees.

The Board of Trustees intends to continue these benefits as long as sufficient Trust Fund assets are available. However, the Trustees reserve the right to amend or modify any Plan benefits or to terminate the Plan.

The Trust Fund recognizes that new technologies may develop which are not specifically addressed. The Trust Fund reserves the right to determine whether or not a service or supply is covered, and if covered, to determine Covered Charges. If a Participant selects a more expensive service or supply than is customarily provided, or specialized techniques rather than standard procedures, the Trust Fund 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 Trust Fund, as it shall determine to be necessary and appropriate.

YOUR ERISA RIGHTS

As a participant in the California Ironworkers Field Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Employee Benefits Security Administration of the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration of the U.S. Department of Labor.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The 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 GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a Qualifying Event. You or your Dependents must pay for such coverage.

Review this ***Summary Plan Description*** and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

There is a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $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 Employee Benefits Security Administration of the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration of the U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration of the 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 Benefits Security Administration of the U.S. Department of Labor.

GLOSSARY OF DEFINED TERMS

ACTIVE EMPLOYEE

The term "Active Employee" shall mean any person who, by reason of their active employment, meets the eligibility requirements established by the Plan and as amended from time to time. Refer to the section of this ***Summary Plan Description*** entitled "*Becoming a Plan Participant*."

ALLOWABLE CHARGES

The "Allowable Charge" is the lesser of:

a) the contract rate of a PPO Provider, or

b) the amount determined by the applicable Plan provision, or

c) the charge billed by the Physician or other provider, or

d) the maximum benefit allowable as determined at the sole discretion of the Board of Trustees.

ALTERNATE RECIPIENT

The term "Alternate Recipient" shall mean a child of an Employee who is eligible for benefits from the Plan as a Dependent pursuant to the provisions of a Qualified Medical Child Support Order.

CONTRACT PROVIDER

The term "Contract Provider" shall mean a Hospital, Physician, or other Health Care Provider under contract with the Plan's contracting organization to provide health care services and supplies at negotiated rates as payment in full, except with respect to the copayment or coinsurance percentage for which the Eligible Individual is responsible.

CONTRIBUTIONS

The term "Contributions" shall mean the contributions specified by the collective bargaining agreements to be made by the Employers to the California Ironworkers Field Welfare Plan.

COSMETIC SURGERY

The term "Cosmetic Surgery" means surgery or treatment to change the shape or structure of, or otherwise alter a portion of the body, performed solely or primarily for the purpose of improving appearance and not as a result of a disease or condition which, in accordance with accepted medical practice, requires surgical intervention to cure, alleviate pain, or restore function. Restorative surgery performed during or following mutilative surgery required as a result of Illness or Injury shall not be considered cosmetic. The Board of Trustees or its designee has the sole discretionary authority to determine if a surgery or treatment is "cosmetic."

COVERED CHARGES

The term "Covered Charges" means the expenses incurred by an individual while eligible under the Plan, which are not excluded and which are payable in whole or in part under the terms of the Plan.

CUSTODIAL CARE

The term "Custodial Care" shall mean care and services (including room and board needed to provide that care or services) given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are training or helping patients to get in and out of bed, as well as help with bathing, dressing, feeding or eating, use of the toilet, ambulating, or

taking drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care.

DRUGS

The term "Drugs" shall mean any article which may be lawfully dispensed, as provided under the Federal Food and Drug Administration, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

DURABLE MEDICAL EQUIPMENT

The term "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.

ELIGIBLE INDIVIDUAL

The term "Eligible Individual" shall mean any person eligible for benefits under the Plan, whether as an eligible Active Employee or eligible Retiree or eligible Dependent.

EMERGENCY

The term "Emergency" means an accidental injury or the sudden onset of a medical condition with symptoms so severe, including severe pain, that without immediate medical attention the Eligible Individual could reasonably expect:

a) that his health would be in serious jeopardy;

b) that a body organ or part would be seriously damaged;

c) permanent disability or prolonged temporary disability;

d) prolongation or more complex or hazardous treatment; or

e) inordinate physical or psychological suffering.

Final determination as to whether services were rendered in connection with an Emergency will be made by the Plan.

EMPLOYER OR CONTRIBUTING EMPLOYER

The term "Employer" or "Contributing Employer" means an Employer who is required to make a contribution on the Eligible Active Employee's behalf to the Plan under the terms of a collective bargaining agreement. This term also includes eligible employees of I.E.B.C. and the Apprenticeship union locals.

EXPERIMENTAL

The term "Experimental" shall mean any of the following:

a) Any medical procedure, equipment, treatment or course of treatment, drug or medicine which is not normally and regularly used or prescribed by the medical community, for the reason that it remains under clinical or laboratory investigation, or has not been exposed to clinical or laboratory investigation; or

b) Any drug, device or medical treatment or procedure which is the subject of on-going phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its

toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

c) If Reliable Evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

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

The Trustees may rely on the advice of medical consultants in determining whether a service or supply is "Experimental" under this definition.

HEALTH MAINTENANCE ORGANIZATION OR HMO

The term "Health Maintenance Organization" or "HMO" shall mean Hospital-Medical-Surgical benefits provided by an organization licensed under the federal HMO Act or the California Knox-Keene Act.

HOSPICE CARE PROGRAM

The term "Hospice Care Program" shall mean a coordinated, interdisciplinary program approved by a Terminally Ill Individual's attending Physician and the medical director of the hospice, for the meeting of special physical, psychological, spiritual and social needs of the terminally ill Individual and his parents, spouse, and/or children.

If approved by the attending Physician and hospice director, the Hospice Care Program may be extended for a period up to six months.

HOSPITAL

The term "Hospital" means a state or federally licensed institution that meets all of the following requirements:

a) It is primarily engaged in providing diagnostic, surgical and therapeutic facilities for medical and surgical care of sick and injured persons on an inpatient basis at the patient's expense.

b) It continuously provides 24-hour-a-day supervision by a staff of physicians licensed to practice medicine (other than physicians whose license limits their practice to one or more specified fields) and 24-hour-a-day nursing care by or under the supervision of registered nurses (R.N.'s).

c) It is not, other than incidentally, a place of rest, a nursing home, a convalescent home, a place for the aged, a pain clinic or a place for recovery from drug or alcohol addictions.

HOUR BANK

The term "Hour Bank" means the account established for an Active Eligible Employee to which all hours are credited from contributing Employers for which contributions are made or are required to be made to the Plan on his behalf. One hundred hours are deducted from the Eligible Active Employee's Hour Bank for each month of eligibility. The maximum hours in an Eligible Active Employee's Hour Bank cannot exceed 600 after the deduction of 100 hours for the current month's eligibility.

ILLNESS

The term "Illness" means any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician. Pregnancy will be considered to be an Illness only for the purpose of coverage under the Plan. However, neither infertility or surrogacy should be considered an Illness for the purpose of coverage under this Trust Fund.

INJURY

The term "injury" or "accidental injury" generally refers to disability that results from an accident, i.e. a sudden and unforeseen event as a result of an external or extrinsic source.

LICENSED PHARMACIST

The term "Licensed Pharmacist" means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

MEDICALLY NECESSARY

Services and supplies ordered by a Physician are "Medically Necessary" or provided due to "Medical Necessity" if such service or supply is determined by the Plan to be:

a) Appropriate and necessary for the symptoms, diagnosis or treatment of the injury or illness;

b) Not Experimental, as defined above, or primarily to enhance educational achievement or social functioning;

c) Within the standards of good medical practice accepted and followed by the medical community;

d) Not primarily for the convenience of the Eligible Individual, the Eligible Individual's Physician or another provider;

e) The most appropriate supply or level of service that can be safely provided. For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Eligible Individual is receiving or the severity of the Eligible Individual's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting; and

f) Not primarily for Custodial Care.

MEDICARE

The term "Medicare" shall mean the insurance program established by Title XVIII, United States Social Security Act of 1965, as originally enacted or as subsequently amended.

MORBID OBESITY

The term "morbid obesity" means the presence of morbid obesity that has persisted for at least 5 years, defined as either:

- body mass index exceeding 40; or
- BMI greater than 35 in conjunction with ANY of the following severe co-morbidities:
  - coronary heart disease; or
  - type 2 diabetes mellitus; or
  - high blood pressure/hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);

AND

- Individual has completed growth (18 years of age or documentation of completion of bone growth);

AND

- 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:
  - Participation in nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; AND
  - Nutrition and exercise program must be 6 months or longer in duration; AND
  - Nutrition and exercise program must occur within the two years prior to surgery; AND
  - 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-CONTRACTING PROVIDER

The term "Non-Contracting Provider" shall mean a Hospital, Physician, or other Health Care Provider that does not contract with the Plan's contracting organizations to provide health care services and supplies at negotiated rates.

OUTPATIENT SURGICAL CENTER

The term "Outpatient Surgical Center" or "Surgi-Center" shall mean a state licensed or Medicare approved facility, which is not a Hospital, but meets all of the following requirements:

a) It is primarily engaged in providing diagnostic and surgical facilities for ambulatory, outpatient surgical care;

b) It is equipped with permanent facilities for diagnosis and surgery and is staffed by Registered Nurses, Physicians and Anesthetists licensed to practice medicine; and

c) It is a place other than the Physician's office or surgical suite.

PHYSICIAN, SURGEON OR DOCTOR

The terms "Physician" or "Surgeon" or "Doctor" shall mean a licensed Doctor of Medicine (M.D.), or Doctor of Osteopathy (D.O.) a Dentist (D.D.S.), licensed Podiatrist (D.P.M.), 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 Employee or his spouse.

PLAN

The term "Plan" shall mean the California Ironworkers Field Welfare Plan adopted and thereafter amended by the Board of Trustees as described in this ***Summary Plan Description*** and includes insurance policies, HMO policies, Evidence of Coverage documents, written policy and procedure documents that have been formally adopted by the Board of Trustees and all other legal documents governing the Plan, including the Trust Agreement establishing the California Ironworders Field Welfare Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The term Qualified Medical Child Support Order, including a National Medical 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.

A qualified medical child support order (QMCSO) could have an effect on your benefit coverage or elections. A "Medical Child Support Order is a Court Order which:

- provides for child support or health benefit coverage with respect to a child of a participant under the Plan; and
- is made pursuant to a state domestic relations law or National Medical Support Order; and
  - either relates to benefits under the Plan, or
  - enforces a law relating to medical child support under section 1908 of the Social Security Act.

A "Qualified" Medical Child Support Order is a Medical Support Order which:

- creates, assigns, or recognizes a child's right to receive benefits for which a participant is eligible under the Plan;
- clearly specifies the name and last known mailing address of the participant and child; however, the name and mailing address of a state or local government official may be substituted for the mailing address of the child if the order so provides;
- clearly specifies the type of coverage to be provided by the Plan to the child;
- clearly specifies the period of time for which the order applies;
- clearly specifies the plans to which the order applies; and
- does not require the plan to provide any benefits not already provided, except as specified in Section 1908 of the Social Security Act.

Notify the Trust Fund Office if you become aware of an order like this. A copy of the Fund's QMCSO procedures is available from the Trust Fund Office.

RETIRED EMPLOYEE

The term "Retired Employee" shall mean any person who meets the eligibility requirements established by the Plan and as amended from time to time and who timely makes application for enrollment as a Retired Employee and who makes timely self-payment of required contributions. Refer to the section of this ***Summary Plan Description*** entitled "*Becoming a Retired Participant*."

SKILLED NURSING FACILITY

The term "Skilled Nursing Facility" means a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and

- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
- It provides services under the supervision of Physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
- It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
- It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and
- It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of the Indemnity Medical Plan.

TERMINALLY ILL INDIVIDUAL

The term "Terminally Ill Individual" means a person whose life expectancy is six months or less.

TOTAL DISABILITY OR TOTALLY DISABLED

The term "Total Disability" or "Totally Disabled" shall mean, because of bodily injury or illness, an Eligible Active Employee is unable to engage in any occupation for wages or profit.

TRUST AGREEMENT

The term "Trust Agreement" means the Agreement and Declaration of Trust establishing the California Ironworkers Field Welfare Plan dated March 1, 1953 and any modification, amendment, extension or renewal thereof.

TRUST FUND OFFICE

The term "Trust Fund Office" shall mean the Ironworker Employees' Benefit Corporation.

TRUSTEES

The term "Trustees" shall mean 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.

UNION

The term "Union" means any of the local unions and district council affiliated with the International Association of Bridge, Structural, and Ornamental Ironworkers.

URGENT CARE CENTER

The term "Urgent Care Center" shall mean a facility that meets all of the tests that follow:

a) While it may provide routine medical management, it mainly provides urgent or emergency medical treatment for acute conditions;

b) It does not provide services or accommodations for overnight stays;

c) It is open to receive patients each day of the calendar year;

d) It has on duty at all times a Physician trained in emergency medicine and nurses and other supporting personnel who are specially trained in emergency care;

e) It has x-ray and laboratory diagnostic facilities; and emergency equipment, trays and supplies for use in life threatening events;

f) It has a written agreement with a local acute care Hospital for the immediate transfer of patients who require greater care than can be furnished at the facility; written guidelines for stabilizing and transporting such patients; and direct communication channels with the acute care Hospitals that are immediate and reliable; and

g) It complies with all licensing and other legal requirements.

UTILIZATION MANAGEMENT

The term "Utilization Management" means, with regard to the Fee-For-Service Medical Benefits or Mental Health and Substance Abuse Benefits 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;

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.

UTILIZATION MANAGEMENT COMPANY

The term "Utilization Management Company" means the independent utilization management organizations, staffed with licensed health care professionals, operating under a contract with the Plan to administer the Plan's Utilization Management services.