

IRONWORKERS INTERMOUNTAIN HEALTH & WELFARE PLAN AND SUMMARY PLAN DESCRIPTION

May 1, 2013

**Covering Members of the International Association of Bridge, Structural, and
Ornamental and Reinforcing Iron Workers**

**Colorado, Local Union 24
Idaho, Local Union 732
Iowa, Local Union 21A
Kansas, Local Union 24A
Montana, Local Union 732A**

**Nebraska, Local Union 21
New Mexico, Local Union 495
Utah, Local Union 27
Wyoming, Local Union 27A**



shu0078 www.fotosearch.com

Dear Participants:

This is the Plan and Summary Plan Description for the Ironworkers Intermountain Health and Welfare Plan. This Plan describes benefits funded by the Trust: medical, prescription drug, dental, vision, hearing aid, and weekly disability benefits. The Plan also provides insured benefits: life and accidental death and dismemberment insurance. The insured benefits are described in the attached insurance certificate. In the event of conflict or ambiguity between an insurance contract and the Plan or other documents, the insurance contract controls. You can ask the Administrative Office for a copy of the insurance contracts, where your insured benefits are described in full.

The Plan was adopted for the exclusive benefit of Participants who are employed by certain companies in the iron work industry. The Plan's benefits are funded by contributions from these employers. Plan benefits are designed to help cover some of your expenses when you become sick, are injured, or die. This version of the Plan describes benefits for claims incurred on and after May 1, 2013.

Here are some important tips on using Plan benefits:

- To receive benefits, you must complete an enrollment form.
- Submit your claims for benefits as soon as possible, and never later than 12 months after the date of service or when the supply or drug is dispensed. Some Physician offices may offer to submit claims for you.
- Inform the Administrative Office if your address changes to ensure that you receive updated information.
- Inform the Administrative Office of any changes in your Dependents, including if you marry or divorce.
- Capitalized terms in the Plan have very specific meanings. If you see a capitalized term, see the definitions section for its meaning.

As your Trustees, we make every effort to administer the Trust carefully and make changes to the Plan as the Trust's financial condition changes. Eligibility provisions and benefits may be increased or decreased from time-to-time. You will be notified if there are changes.

We wish you good health. But if you become ill, the Plan is designed to help you pay many of your expenses.

Sincerely,

Board of Trustees

Mike McDonald, Chairman
Mike Baker, Union Trustee
Jerry Romero, Union Trustee
Lonzo West, Union Trustee
Mark Calkins, Union Trustee

George Bosiljevac, Secretary
Dick DeVries, Employer Trustee
Tom Moen, Employer Trustee
Mark Mundy, Employer Trustee
James L. Helgoth, Employer Trustee

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Contact Information:

Administrative Office and COBRA Administrator
CompuSys of Utah, Inc.
(888)-867-9510
(801)-606-2425

2156 W 2200 S
Salt Lake City, UT 84119-1326
P.O. Box 30124
Salt Lake City, UT 84130-0124
www.iiv.compusysut.com

QUICK ANSWERS

Here are some quick answers to a few commonly asked questions. However, these quick answers don't explain all of the Plan's rules and limits. To know the Plan's rules and limits, you must read the rest of this booklet.

When will I first be covered by the Plan?

If you work for the Union or under a collective bargaining agreement, your employer reports and the Administrative Office tracks your Hours of Work. This is called the hour bank system. If you have 360 Hours of Work in no more than 4 months, you will participate in the Plan two months later. 240 Hours of Work is required to begin coverage, and 120 Hours of Work is required in each month to continue coverage. Amounts over that remain in your hour bank, up to 480 hours. *See Section 2.01 for details.*

Example: John begins working in February. He works as follows:

| | |
|-----------|------------------|
| February: | 160 hours |
| March: | 170 hours |
| April: | <u>100 hours</u> |
| Total: | 430 hours |

At the end of April John satisfies the Plan's initial eligibility requirements (360 hours). His coverage begins two months later, on June 1. His hour bank is credited with 70 hours (430 total hours, less 240 hours to begin, less 120 hours for June coverage).

What do I have to do to continue coverage?

You must have at least 120 Hours of Work in your hour bank. If your Employer timely makes contributions on your behalf, you will be credited with your Hours of Work in the month you work the Hours to provide coverage two months later.

If I lose coverage, how do I regain it?

You must have 120 Hours of Work credited to your Hour Bank within 3 months of the month in which it dropped below 120, to regain coverage. If you don't, you must reestablish initial eligibility, by again working 360 hours.

Example: In the above example, John has coverage in June, with 70 hours left in his bank. He doesn't work in May. With only 70 hours in his bank, John has no coverage in July. But if John works 50 hours in June, he will have 120 hours in his bank—70 left over from work through April, plus another 50 for work in June. That's enough to get him coverage in August.

What if I lose coverage because I'm out of work?

You will be eligible to pay to continue your health coverage under COBRA.

What if my employer pays less than the hourly amount required by the Board of Trustees for each Hour of Work?

If your employer is in the Plan's geographic jurisdiction and pays at an hourly rate that is less than the hourly rate required by the Board of Trustees, contributions will be rejected and you will receive no credit.

What if my employer doesn't make timely contributions?

If your employer doesn't pay the proper amount on time to the Fund for your Hours of Work, you will receive no credit. There is one exception: if you can prove you worked (save your pay stubs!), once each year up to 240 hours (120 hours in each of two months) will be credited to your hour bank account. Refer to Article I, Definitions, 1.27, Hour of Work.

What if I am working in another jurisdiction?

If your work is covered by a reciprocity agreement with the Plan, you can arrange for your health contributions for that work to be sent to this Plan. The amount received is divided by this Plan's current hourly contribution rate, to arrive at your hours of work.

Example: John travels to Las Vegas to work a Union job. John completes reciprocity paperwork in Las Vegas. The Las Vegas Ironworkers health plan sends this Plan \$800. The current contribution rate for this Plan is \$5.00 per hour. John earns 160 ($\$800 \div \5) Hours of Work toward coverage in this Plan.

Is my spouse covered? My children?

Yes, if you enroll them within 30 days of your initial eligibility and if you provide a marriage certificate (spouse) and birth certificates (children). Common law and same sex marriages are not recognized by the Plan, and the Plan has special rules on coverage of children. *See the Definition of "Dependent" in Article I.*

What must I do to keep my spouse and children enrolled in the Plan?

You must verify, enroll, or remove your Dependents every year during Annual Enrollment (generally in November). Your Dependents will lose Plan coverage if the Administrative Office does not timely receive your Enrollment Form (*See the Enrollment Rules in Section 2.05*).

What is a Deductible? What is Coinsurance? What is a Copay?

You must pay a portion of the cost of your healthcare expenses that are covered by the Plan. These are called Deductibles, Copays, and Coinsurance. Each year you pay for medical

expenses up to the amount of your Deductible, before the Plan covers any expenses. Coinsurance is the percentage of Covered Charges you pay, after payment of the Deductible and Copay. A Copay is the fixed dollar amount you pay to the doctor, pharmacy, or medical facility each time you receive treatment. *See Sections 4.05 and 4.06.*

How do I get the most value out of the Plan?

- Precertify your surgeries and hospital visits. That way, you'll know if your procedure is covered and you won't pay the Plan's failure to precertify penalty.
- Ask your Physician if a generic drug is appropriate for you. You'll pay less for generic than for brand name drugs. *See Article V.*
- Use PPO providers. They charge less, and you pay less. *See Section 4.06.*

I'm over 65. Should I enroll in Medicare Part B if I am covered under the Plan as a Retiree?

Yes. Whether or not you enroll in Medicare Parts A and B, the Plan pays benefits as if you did enroll with Medicare, and as if Medicare is reimbursing your medical expenses. *See Article X.*

How about Medicare Part D?

You do not have to enroll in Medicare Part D. If you enroll in Medicare Part D and are a Retiree, the Plan won't pay your prescription expenses.

What do I do to qualify for Retiree coverage?

You must have been covered by the Plan for 5 of the last 7 years, retire from one of three specified pension plans, and begin retiree coverage immediately after you lose active coverage (because your hour bank runs out or your employer stops contributing to the Plan). If you instead elect COBRA, you will forever lose the opportunity to elect retiree coverage under the Plan. *See Section 2.06.*

How much does Retiree coverage cost?

The cost of retiree coverage is established by the Board of Trustees, and adjusted periodically. In making adjustments, the Board may consider the Plan's funding status, costs, anticipated contributions, and other relevant factors.

What types of Retiree coverage are there?

Retirees may elect medical, dental, and vision coverage, or medical-only coverage. Retirees don't receive AD&D and Life Insurance, or Accident and Sickness Weekly Disability Benefits. *See Section 2.08.*

SUMMARY OF BENEFITS

Note: this is just a summary. See the rest of the Plan for details, limits, and exclusions.

ACCIDENT AND SICKNESS WEEKLY BENEFITS FOR ACTIVE EMPLOYEES

| | |
|---------------------------------------|--|
| Weekly Benefit | \$200 minus FICA tax |
| Benefit duration per disability | 21 weeks |
| Benefit Commencement: Injury..... | 1 st day |
| Benefit Commencement: Illness | 8 th day (or 1 st day hospitalization) |

MAXIMUM MEDICAL BENEFITS

Calendar Year Maximum for Essential Health Benefits

| | |
|---|-------------|
| Essential Health Benefits (2012-2013) | \$2,000,000 |
| Essential Health Benefits (2014 and later)..... | No limit |

Lifetime Maximums

| | |
|--------------------------------|---------|
| TMJ | \$2,500 |
| Skilled Nursing Facility | 70 days |

Other Calendar Year Maximums

| | |
|-----------------------------------|-----------|
| Orthotics..... | one pair |
| Chiropractic..... | 12 visits |
| Acupuncture | 20 visits |
| Anesthesia for oral surgery | \$750 |

MEDICAL BENEFITS: *Your calendar Year Deductible/Copays*

| | Class I | Class II | Class III |
|---|---------|----------|-----------|
| Individual Deductible | \$1,000 | \$750 | \$500 |
| Maximum Family Deductible | \$2,000 | \$1,500 | \$1,000 |
| Physician/other practitioner office visit Copay | \$0 | \$0 | \$30 |
| Hospital Admission Copay | \$100 | \$100 | \$100 |
| Emergency Room Copay | \$300 | \$300 | \$300 |

- * Copays are not applied toward the Deductible or maximum Coinsurance. Deductibles are not applied toward maximum Coinsurance.
- * The emergency room Copay is waived if following treatment in the emergency room the Covered Individual is admitted on the same day to a Hospital.
- * There is no Copay for acupuncture or Preventive Care.
- * There is no Deductible for Preferred Provider Physician office visits (non-surgical services) and Preventive Care.

MEDICAL BENEFITS: *Percentage of Covered Charges you pay - Coinsurance*

| | Class I | Class II | Class III |
|---|-----------------|-----------------|-----------------|
| PPO Physician office visits | 30% | 25% | 0% |
| PPO services and supplies | 30% | 25% | 20% |
| Non-PPO services and supplies within PPO Service Area | 50% | 50% | 40% |
| Preventive Care (PPO only—non-PPO not covered) | 0% | 0% | 0% |
| Maximum Coinsurance—PPO providers/non-PPO | \$4,500/\$7,500 | \$3,750/\$7,500 | \$3,000/\$6,000 |

- * If a Covered Individual has surgery performed by a PPO Physician in a PPO facility, other services, such as anesthesia, if rendered by a Non-Preferred Provider will be paid at the PPO percentage.
- * In case of a life-threatening Emergency, the Plan pays benefits at the PPO percentage.
- * The Plan pays nothing for Preventive Care services and supplies you receive from a non-PPO provider.
- * Only medical benefit Coinsurance counts toward the Coinsurance maximum. For example, outpatient prescription drug payments do not count toward the Coinsurance maximum.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Copay or Percentage you pay for Prescriptions

| | PPO Retail Pharmacy** | PPO Mail Order Pharmacy** | Pharmacy Benefit Manager (Envision) |
|----------------------------|---|--|-------------------------------------|
| Generic Drugs | \$10 34 day supply limit | \$20 90 day supply limit | N/A |
| Preferred Brand Drugs* | 15% \$20 min and \$40 max 34 day supply limit | 15% \$50 min and \$100 max 90 day supply limit | N/A |
| Non-Preferred Brand Drugs* | 15% \$50 min and \$100 max 34 day supply limit | 20% \$100 min and \$200 max 90 day supply limit | N/A |
| Specialty Drugs | No coverage | No coverage | \$75 30 day supply limit |

*If a Generic Drug is available and you or your Doctor choose a Brand Drug, the Plan will not pay the difference between the Generic cost and Brand cost—you will have to pay that cost, plus the Brand Drug Copay/percentage.

**Costco Retail 90 - Mail order copays available at Costco pharmacy's for a 90 day supply. Costco membership is not required to use Costco Retail 90.

HEARING AID (PARTICIPANTS ONLY, PPO ONLY)

\$2,000 per ear every 3 years

\$60 for comprehensive audiogram once every 3 years

DENTAL BENEFITS

| | Adults | Children (under age 19) |
|--------------------------|---------|---------------------------------|
| Calendar Year Maximum | \$1,500 | No maximum |
| Calendar Year Deductible | \$25 | \$25 for basic & major services |

**LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
(ACTIVE EMPLOYEES ONLY)**

| | |
|----------------------|----------|
| Active Employee..... | \$10,000 |
|----------------------|----------|

See the attached insurance certificate of coverage for a description of benefits.

VISION

A portion of exams and eyewear may be covered. *See Article VII.*

PRECERTIFICATION

PRECERTIFY YOUR VISITS TO THE HOSPITAL

Precertification is required for inpatient hospital admissions, and outpatient hospital surgical procedures.. If you don't obtain precertification, the Plan reduces its reimbursements by \$200—that means you will have to pay an additional \$200 of Covered Charges. In addition, certain medical procedures, such as eye surgery procedures and organ transplants, require precertification to obtain any Plan coverage. See Article IV for details.

You can precertify a procedure or hospital admission by calling the Plan's medical reviewer, CIGNA at (800) 768-4695. The precertification will be provided to you in writing.

In an emergency, you don't have to precertify a hospital admission. But you do have to contact CIGNA within two working days of admission, or the Plan will reduce its reimbursements by \$200.

You also don't have to obtain precertification if Medicare is the primary payor of your health benefits. See Article X, Medicare coordination of benefits, for more information on when Medicare is the primary payor of your health benefits.

The \$200 penalty for failure to precertify does not count toward your Deductible or Coinsurance, unless otherwise required by law.

PRECERTIFY YOUR HEARING AIDS

Precertification is required to obtain a hearing aid. If you don't obtain precertification, the Plan covers no expenses related to a hearing aid.

You can precertify by calling EPIC. Their contact information is under "PREFERRED PROVIDER ORGANIZATIONS", on the following page. The precertification will be provided to you in writing.

You must also purchase your hearing aid through Epic. See Article VI for details.

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

The Fund has entered into agreements with Preferred Provider Organization(s) (“PPO”), which in turn contract with certain medical providers, such as Hospitals, Physicians, and laboratories. These medical providers have agreed to charge reduced amounts for certain services or supplies. That means you will pay a lower percentage of the cost of medical services and supplies from a PPO Hospital, Physician, and laboratory. In addition, a PPO Provider has agreed to bill no more than the Plan’s Allowable Fee. With a non-PPO provider, you pay the difference between the Provider’s bill and the Allowable Fee.

PPO Hospitals, Physicians, and other providers are listed in the respective directories published periodically by each PPO, and available on their websites. Providers are added and deleted at the discretion of the PPO, and without notice to the Plan. You should contact the PPO network to verify the provider is still participating in the network.

MEDICAL BENEFIT PREFERRED PROVIDER (1-800-768-4695)

CIGNA

To locate a Cigna PPO provider, visit Cigna’s web site at www.cignasharedadministration.com and click on FIND A DOCTOR, and then select “Shared Administration OAP Provider Directory” or visit www.iw.compusysut.com and click on the Cigna link.

HEARING AID BENEFIT PREFERRED PROVIDER (1-866-956-5400):

EPIC HEARING HEALTHCARE HEARING SERVICE PLAN (EPIC HSP)

(www.epichearing.com)

PHARMACY BENEFIT MANAGER (1-800-361-4542)

Envision RX

1100 Investment Blvd.

El Dorado Hills, CA 95762

(www.envisionrx.com)

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

This Notice is intended to inform you and your Dependents of COBRA Self-Pay rights and obligations. Both you and your family should take the time to read it carefully.

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), Participants and their covered Dependents may Self-Pay to continue their group health coverage in certain situations called Qualifying Events where their coverage would otherwise terminate. Once you lose coverage under the Plan, you may not continue your Life and AD&D, or Accident and Sickness Weekly Disability coverage.

COBRA continuation coverage is a temporary continuation of coverage, the length of which depends on the nature of the Qualifying Event. Subject to the conditions described below, COBRA coverage is available to persons who are Qualified Beneficiaries. Qualified Beneficiaries who elect COBRA continuation coverage must pay for that coverage.

Any Qualified Beneficiary who does not elect COBRA within the specified periods and according to the procedures described below will lose his or her right to elect COBRA coverage.

WHAT ARE QUALIFYING EVENTS?

If you are an Active Employee covered under the Plan, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of either of the following Qualifying Events:

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

If you are a covered spouse of a Participant, you will become a Qualified Beneficiary if you lose coverage under the Plan because of any of the following Qualifying Events:

- Your spouse dies;
- Your spouse is an Active Employee, and your spouse's hours of employment are reduced;
- Your spouse is an Active Employee, and your spouse's employment ends for any reason other than gross misconduct;
- You become divorced or legally separated from your spouse.

If you are a covered Dependent child of a Participant, you will become a Qualified Beneficiary if you lose coverage under the Plan because of any of the following Qualifying Events:

- Your parent is an Active Employee, and his or her employment ends for any reason other than gross misconduct;
- Your parent is an Active Employee, and his or her hours of employment are reduced;
- The Participant, who is your parent, dies;

- The Participant, who is your parent, divorces or legally separates; or
- You cease to be eligible for coverage under the Plan as a Dependent child.

Under the above rules, a loss of Hour Bank eligibility may result in a Qualifying Event that is a reduction in the hours of the Active Employee's employment or the Active Employee's termination of employment (for reasons other than gross misconduct),

HOW LONG DOES COBRA LAST?

When the Qualifying Event is the end of your employment or a reduction of your hours of employment, coverage may be continued for up to 18 months. When the Qualifying Event is your death, your divorce or legal separation, or a child losing eligibility as a Dependent child, a Dependent's coverage may continue for up to 36 months.

The period of continuation coverage may be extended past these time limits in the following circumstances: if you become eligible for Medicare, you or a Dependent is determined to be disabled by the Social Security Administration, or you or a Dependent has a second Qualifying Event.

Medicare Eligibility Extension. When the Qualifying Event is the end of employment or a reduction of your hours of employment, and you become entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than you may last for up to 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your covered spouse and covered children may last for 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Disability Extension. If after you experienced a Qualifying Event because of a reduction in hours or a termination of employment, you or any covered Dependent is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage, **and if you give timely notice (described below) of the disability determination to the COBRA Administrator**, you and your entire family (if covered under the Plan) can receive up to an additional 11 months of COBRA coverage, for a maximum of 29 months. The disability must last at least until the end of the 18-month period of continuation coverage. Each Qualified Beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension. If the Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event Extension. If you or your covered spouse or children experience a second Qualifying Event while receiving 18 months of COBRA coverage, your covered spouse and children may purchase up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, **if you give timely notice (described below) of the second Qualifying Event to the COBRA Administrator**. This extension is available to your covered spouse and covered children if you die, get divorced, or obtain a legal separation. It is also available to a

covered child when he or she stops being eligible under the Plan as a Dependent child. These events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred.

Special Second Election Period for Certain Eligible Individuals under the Federal Trade Act of 2002. Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit under Section 201 of the Federal Trade Act of 2002. These individuals are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second period beginning on the first day of the month in which the employee becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the employee's group health plan coverage ended. If you believe you may qualify for the health coverage tax credit, contact the COBRA Administrator at the address or phone number shown in "How Do I Give Notice That I Want To Elect COBRA", below, for more information.

WHEN SHOULD I PROVIDE COBRA NOTIFICATION?

The Plan will offer COBRA coverage to Qualified Beneficiaries only if the Administrative Office receives timely and proper notice that one of the following Qualifying Events has occurred. If the Qualifying Event is your divorce or legal separation from your covered spouse, a covered child losing eligibility for coverage as a Dependent, or a determination of disability by the Social Security Administration, **you or another Qualified Beneficiary must notify the COBRA Administrator in writing within 60 days after the later of the Qualifying Event or the loss of coverage, using the notice procedures described below. If these notice procedures are not followed, or if notice is not provided to the COBRA Administrator during the 60-day notice period, the Qualified Beneficiaries will lose their right to elect COBRA.**

| |
|---|
| You must, in writing, tell the COBRA Administrator that you divorced, or that your child aged out or is no longer a covered Dependent, within 60 days of that event. Otherwise, no COBRA coverage will be provided. |
|---|

If the Qualifying Event is the end of employment, a reduction of hours of employment, or the death of the Participant, you do not need to give notice of these Qualifying Events.

HOW DO I GIVE NOTICE THAT I WANT TO ELECT COBRA?

Your notice must be in writing. Verbal notice, including notice by telephone, notice by fax, or notice by email are not acceptable. You must mail or deliver your written notice to the Administrative Office at the following address:

COBRA Administrator
CompuSys of Utah, Inc.
P.O. Box 30124
Salt Lake City, UT 84130 – 0124
Phone No.: (801) 606-2425 or (888) 867-9510

You must include the name and address of the Participant and the name(s) and address(es) of the Qualified Beneficiaries. Your notice must also state the type of Qualifying Event and the date it occurred. You should include a copy of the divorce decree or legal separation agreement, if applicable. For a Social Security extension of COBRA, you must include a copy of the Social Security Administration's determination of disability.

If you use the mail, your envelope must be postmarked by no later than the last day of the 60-day deadline specified above. If you hand deliver your notice and documentation, it must be received by an authorized individual at the above address by no later than the last day of the 60-day deadline.

Once the COBRA Administrator is properly and timely notified that a Qualifying Event has occurred, the COBRA Administrator will notify each Qualified Beneficiary of his or her right to elect COBRA coverage. You will have 60 days to elect COBRA coverage beginning on the later of the date coverage ends due to the Qualifying Event, or the date the COBRA Administrator provides you notice of your right to elect COBRA coverage. Each Qualified Beneficiary may elect COBRA coverage for himself or herself, even if other Qualified Beneficiaries do not. Participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA on behalf of their dependent children.

WHAT HEALTH COVERAGE MAY BE CONTINUED?

You are eligible to continue only those medical, vision, and dental benefits for which you were previously covered. If you were covered under medical and other health benefits, you may elect to continue either just medical benefits or the full package of medical, vision, and dental benefits.

WHAT ARE THE ELECTION AND PAYMENT PROCEDURES?

Upon receipt of notice of a Qualifying Event, the COBRA Administrator will mail you a COBRA election form. The Qualified Beneficiaries who want to purchase COBRA coverage must complete and return the election form within 60 days from the later of termination of coverage under the Plan or receipt of the form. You should mail the completed form to the COBRA Administrator at the address noted on the election form and shown above, postmarked within the 60-day period.

| |
|--|
| If you do not timely return the election form, no COBRA coverage will be provided. |
|--|

You will have 45 days from the date you elect COBRA to make your initial Self-Payment. The payment amount is established by the Board of Trustees, and is adjusted from time-to-time. This initial Self-Payment must include the COBRA payments due from the date you lost coverage through the end of the last full month before you pay. (This could mean payment for more than one month of coverage is due at one time.) Before the end of the grace period, which is the 30th of the month in which you pay, you must submit payment for that month. Subsequent payments are due on the first day of the coverage month. All payments must be made by check timely sent to the COBRA Administrator at the above address.

COBRA coverage will be cancelled if the COBRA Administrator does not receive your payment within the grace period, which is 30 days after each payment due date. If mailed, your payment

is considered made on the date your envelope is postmarked. If your check bounces, you have not made payment.

You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

WHEN WILL COBRA COVERAGE BEGIN?

For each Qualified Beneficiary who elects it, COBRA coverage will begin on the date that health coverage under the Plan would otherwise have been lost. However, if you waive your right to COBRA, and within the 60-day election period decide to revoke your waiver, COBRA coverage will begin on the date the revocation of the waiver is postmarked. There will be no coverage for the period between the date you elect to waive COBRA and the date this election was revoked.

WHEN WILL COBRA COVERAGE END?

COBRA coverage will terminate before the end of the 18-month, 29-month, or 36-month continuation period under any one of the following circumstances:

- Payment is not made on time (taking into account the 30-day grace period);
- The date a Qualified Beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the Qualified Beneficiary;
- The date a Qualified Beneficiary becomes entitled to Medicare;
- The date the Trust no longer provides group health coverage;
- The first day of the month that is 30 days after the date of a determination by the Social Security Administration that a Qualified Beneficiary on extended disability coverage is no longer disabled. This applies to the extended disability coverage of all Qualified Beneficiaries, but only to the 19th through the 29th month of extended disability coverage; and
- The first day of the month that follows the date the Participant's employer stops maintaining this Plan and starts maintaining another group health plan that covers the same class of employees as the Participant when he worked for the employer.

IF YOU HAVE QUESTIONS

If you have any questions about COBRA coverage, please contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, see the Statement of Rights Under ERISA at the end of this booklet.

KEEP YOUR PLAN INFORMED OF ANY ADDRESS CHANGES

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

ARTICLE I. - DEFINITIONS

The Plan has many technical definitions. When you see a capitalized term, look here to see what it means.

- 1.01 Active Employee.** “**Active Employee**” means an employee who currently participates pursuant to the Eligibility Rules in section 2.01 or 2.02 of Article II.
- 1.02 Administrative Office.** “Administrative Office” means CompuSys of Utah, which is the entity selected by the Board of Trustees to perform certain administration functions for the Plan.
- 1.03 Allowable Fee.** “Allowable Fee” means the charge for a service or supply furnished by a provider, which meets all of the following criteria: The charge is no more than the charge the provider actually charges the individual and that the provider most frequently makes to the majority of his or her patients for the service or supply. The charge is equal to or less than the 90th percentile rate established for the geographic area by the Plan’s third party service. And finally, the charge is within reasonable utilization limits, and is justifiable considering the circumstances involved.
- With respect to individuals covered by Medicare, the term “Allowable Fee” is further limited to the maximum amounts allowed by Medicare for participating and non-participating Medicare Physicians.
- A PPO provider’s Allowable Fee is the fee set forth in the agreement between the provider and the PPO.
- 1.04 Ambulatory Surgical Facility.** “Ambulatory Surgical Facility” means a place which maintains and operates facilities for surgery and surgical diagnosis and treatment on an open panel basis by a person licensed to practice medicine and surgery in all its branches, licensed to practice podiatry or licensed to practice dentistry or oral surgery, which shall have an attending medical staff consisting of one (1) or more anesthesiologists or a nurse anesthetist under the supervision of a licensed Physician or surgeon. This term shall not mean a Hospital, nursing or convalescent home, home for the needy, home for the nursing and domiciliary care of children of preschool age, infirmary or orphanage, private sanitarium, private office or clinic or licensed health care professionals, maternity home for prenatal or postnatal care, mental health facilities, home or institutions, or any other facility which exists for the purpose of providing health care services.
- 1.05 Annual Enrollment.** “Annual Enrollment” means the period toward the end of each year (generally the month of November) during which Participants must complete and return an Enrollment Form to the Administrative Office. If the Administrative Office does not timely receive the Enrollment Form, the Participant’s Dependents will have no Plan coverage during the following year.
- 1.06 Board of Trustees or Board.** “Board of Trustees” or “Board” or “Trustees” is the named fiduciary and the Plan Sponsor. The members of the Board are individuals appointed to serve as Trustees, according the procedures in the Trust Agreement.

- 1.07 Claims Administrator.** The Claims Administrator for each benefit under the Plan is set forth in the “Claims Administrator/Claims Fiduciary” chart in *HOW TO FILE A CLAIM FOR BENEFITS* at the end of this booklet.
- 1.08 Claims Fiduciary.** The “Claims Fiduciary” for each benefit under the Plan is set forth in the “Claims Administrator/Claims Fiduciary” chart in *HOW TO FILE A CLAIM FOR BENEFITS* at the end of this booklet.
- 1.09 Coinsurance.** “Coinsurance” means the percentage of Covered Charges each Covered Individual pays. See Section 4.06, The “Coinsurance Maximum” applies only to Medical Benefits described in Article IV.
- 1.10 Contributing Employer.** “Contributing Employer” means any employer who is required by a Written Agreement to make contributions to the Fund. The term Contributing Employer also includes a Union and any Training and Apprenticeship Funds affiliated with such Union, provided such Union or Training and Apprenticeship Funds are required by the Trust Agreement, a participation agreement approved by the Trustees, or collective bargaining agreement to make contributions to the Trust.
- 1.11 Copay.** “Copay” means the flat fee each Covered Individual pays to a medical provider for Covered Charges. See Section 4.05.
- 1.12 Covered Charge.** “Covered Charge” means the Allowable Fee that the Plan fully or partially reimburses for a Participant’s and Dependent’s Medically Necessary health care services or supplies, incurred while such individual is covered by the Plan.
- 1.13 Covered Employment.** “Covered Employment” means any employment or work covered by a Written Agreement for which a Contributing Employer is required to make contributions to the Fund.
- 1.14 Covered Individual.** A Plan Participant, or a Dependent covered under the Plan.
- 1.15 Creditable Coverage.** “Creditable Coverage” means periods of previous health coverage as defined by the Health Insurance Portability and Accountability Act, which may be used to satisfy a portion or all of a preexisting condition period under this Plan. See Section 4.03.
- 1.16 Custodial Care.** “Custodial Care” means any care intended primarily to help a person meet basic personal needs when there is no plan of active medical treatment to reduce the disability or the plan of active medical treatment cannot reasonably be expected to reduce the disability. Custodial Care includes nursing home or assisted living expenses/charges.
- 1.17 Deductible.** “Deductible” means the amount of Article IV (Medical Benefit) Covered Charges a Participant and Dependent must pay during a calendar year before the Plan reimburses a percentage of medical benefit Covered Charges. See Section 4.05.
- 1.18 Dentist.** “Dentist” means only a person who is licensed and certified to practice dentistry and who is practicing within the scope of the license or certification as a Doctor of Dental Surgery or a Doctor of Dental Medicine.

1.19 **Dependent.**

If you properly complete enrollment forms, your Spouse and children will be covered under the Plan, if they qualify as your “Dependents.”

“Dependent” means:

- a. the Participant’s lawful spouse. For purposes of this Plan, a “spouse” must be recognized as such by the law of the state in which the Employee resides and must be claimed as the employee’s spouse for Federal income tax purposes under Section 151 of the Internal Revenue Code (interpreted in accordance with 1 U.S.C. Section 7). The term “spouse” does not include a spouse by a common law marriage or a spouse who is the same gender as the Participant.
- b. the Participant’s children, as follows:
 - (i) biological, adopted (and placed for adoption), and stepchildren, age 25 and younger;
 - (ii) grandchildren for whom the Participant has, by reason of a State Court order, full financial responsibility and permanent legal custody, age 25 and younger; and
 - (iii) children in (i) or (ii) who are incapable of self-sustaining employment by reason of mental retardation or a physical handicap provided the Participant continues the child’s coverage under the Plan; the child was covered by the Plan and such incapacity commenced prior to the date the Dependent child’s coverage would have otherwise terminated; and the child is dependent upon the Participant for support and maintenance. To obtain coverage, the Participant must submit notification and proof of incapacity to the Administrative Office within thirty-one (31) days of the date the Dependent child’s coverage would otherwise terminate. The Administrative Office may, on occasion, request proof of continued incapacity and dependency.

The Plan may at initial enrollment and on occasion request proof of status as a Dependent, and other information (such as a Social Security number) required to administer the Plan. The Plan may terminate Dependent coverage for failure to timely submit the requested information.

1.20 Durable Medical Equipment. “Durable Medical Equipment” means reusable medical equipment such as walkers, hospital beds, wheelchairs, and home oxygen equipment, and has the same meaning as Medicare-covered Durable Medical Equipment.

1.21 Emergency. “Emergency” means an unforeseen Injury or Illness that requires immediate medical attention to avoid serious and permanent risk to health.

1.22 Essential Health Benefit. “Essential Health Benefit” means a service or supply on which the Patient Protection and Affordable Care Act of 2010 prohibits the Plan from imposing lifetime dollar limits.

- 1.23 Home Health Care.** “Home Health Care” means services rendered by an organization or agency which meets the requirements for participation as a home health agency under Medicare.
- 1.24 Hospice Benefit Period.** “Hospice Benefit Period” means the period that begins on the date the Physician certifies that an individual is a Terminally Ill Patient and ends six (6) months after it began or on the death of the individual, if sooner. If the Hospice Benefit Period ends before the death of the individual, a new Hospice Benefit Period may begin if the Physician again certifies that the individual is a Terminally Ill Patient.
- 1.25 Hospice Care.** “Hospice Care” means palliative and supportive medical, health and other services provided to Terminally Ill Patients to meet special physical or emotional needs as part of dying so that a hospice patient may remain at home, to the maximum extent possible, with home-like inpatient care utilized only if and while it is necessary.
- 1.26 Hospital.** “Hospital” means an institution licensed by the State in which it operates as a Hospital and is primarily engaged in providing (for compensation from its patients) medical, diagnostic, therapeutic, and surgical facilities for the care and treatment of Illnesses and Injuries on an inpatient basis, and which provides such facilities under the supervision of the staff of Physicians and with twenty-four (24) hours a day nursing service by registered nurses (R.N.). In no event, however, shall such term include any institution or part thereof which is used principally as a clinic, a rest facility, nursing facility, convalescent facility, facility for the chronically ill, residential facility, a halfway house, a survival skills facility, a facility of the aged, or a facility providing Custodial Care, maintenance care, or educational care.
- 1.27 Hour of Work.** “Hour of Work” means an hour of work for which a Contributing Employer is required by Written Agreement to contribute to the Trust. The Plan credits an Hour of Work only if the Trust timely receives the correct contribution for such Hour of Work. If the Plan is presented with convincing proof an employer failed to make a required contribution, it will credit the Participant with up to 120 Hours of Work in each of two months. Such credit shall be made for the earliest delinquencies, and no more than once in a 12-month period. However, credit without receipt of contributions is unavailable with respect to reciprocal contributions. Section 2.01 describes crediting of Hours of Work upon receipt of reciprocal contributions.
- 1.28 Illness.** “Illness” means a disease or infection and all related symptoms or conditions related to the same Illness.
- 1.29 Injury.** “Injury” means a condition resulting from an external violent force and all related symptoms and conditions resulting from the same force, independent of Illness and all other causes.
- 1.30 Intensive Care Unit or Coronary Care Unit.** “Intensive Care Unit” or “Coronary Care Unit” means a section or wing within the Hospital which is operated for critically ill patients and provides special supplies, equipment and supervision and care by a registered nurse (R.N.) or other trained Hospital personnel.
- 1.31 Legend Drug.** “Legend Drug” means any drug which Federal or State law prohibits dispensing without a prescription order as follows:
- a) Legend Drugs plus injectable insulin on prescription only;

- b) compounded medications of which at least one (1) ingredient is a prescription Legend Drug.
- 1.32 Licensed Ambulatory Surgical Facility.** “Licensed Ambulatory Surgical Facility” means a place which maintains and operates facilities for surgical and surgical diagnosis and treatment on an open panel basis by persons licensed to practice medicine and surgery in all its branches, licensed to practice podiatry or licensed to practice dentistry or oral surgery, which shall have an attending medical staff consisting of one (1) or more anesthesiologists or a nurse anesthetist under the supervision of a licensed Physician or surgeon. This term shall not mean a Hospital, extended care facility, nursing or convalescent home, home for the needy, home for the nursing and domiciliary care of children of pre-school age, infirmary or orphanage, private sanitarium, private office or clinic of licensed health care, mental health facility, home or institution, or any other facility which exists for the purpose of providing health care services.
- 1.33 Licensed Substance Abuse Treatment Center.** “Licensed Substance Abuse Treatment Center” means a treatment center licensed by the state of its situs as a facility providing treatment of substance abuse.
- 1.34 Medically Necessary.** “Medically Necessary” means a service or supply which is required, appropriate, and consistent to treat or diagnose the patient’s Illness or Injury, is in accordance with accepted standards of medical practice (or, as applicable, practice of dentistry), and could not have been omitted without adversely affecting the patient’s condition or quality of medical care.
- 1.35 Medicare.** “Medicare” means the benefits provided under Title XVIII of the Social Security Act of 1965, as amended from time to time.
- 1.36 Mental Illness.** “Mental Illness” means those disorders listed in the International Classification of Diseases as psychoses, neuroses, personality disorders, eating disorders and other nonpsychotic mental disorders. No other disorders or conditions are included in the term “Mental Illness” for purposes of the benefit provisions of the Plan.
- 1.37 Occupational Therapy.** “Occupational Therapy” means the use of Rehabilitative techniques to improve a patient’s functional ability to live independently.
- 1.38 Participant.** “Participant” means an Active Employee or a Retiree.
- 1.39 Pharmacy Benefit Manager** “Pharmacy Benefit Manager” means the entity designated by the Trustees to process outpatient prescription drug claims. Their contact information is under *PREFERRED PROVIDER ORGANIZATIONS*, earlier in this booklet.
- 1.40 Physical Therapy.** “Physical Therapy” means the use of Rehabilitative techniques to improve a patient’s functional ability to live independently.
- 1.41 Physician.** “Physician” means a person who is licensed by the State in which he or she practices, and is acting within the scope of that license when he or she renders services as: a Doctor of Medicine or a Doctor of Osteopathy, Doctor of Dentistry, Doctor of Podiatry, Doctor of Optometry, Doctor of Chiropractic, or Optometrist. In addition, the term Physician will include, to the extent that benefits are provided for herein and while practicing within the scope of his/her license, the following licensed providers of care: psychologist, clinical social worker, clinical specialist psychiatric registered nurse

(CSPRN), acupuncturist, and audiologist. “Physician” does not include any other practitioner, including homeopath or naturopath.

- 1.42 **Physician Assistant.** “Physician Assistant” means an individual who is qualified by academic and clinical training to provide primary care patient services under the supervision and responsibility of a Physician, and must be certified by the state to practice.
- 1.43 **Plan Administrator.** “Plan Administrator” means the Board of Trustees for self-funded benefits, and the applicable insurer for insured benefits.
- 1.44 **Plan Year.** “Plan Year” means the Plan’s fiscal year which begins November 1 and ends October 31 of each year.
- 1.45 **Precertification.** “Precertification” means that an individual must get prior certification from the agent designated by the Board of Trustees for services listed in the Precertification section earlier in this booklet.
- 1.46 **Preferred Provider or Preferred Provider Organization (PPO).** “Preferred Provider” means a service provider that is a member of a “Preferred Provider Organization” that has contracted with the Plan to provide services or supplies for a reduced or fixed charge.
- 1.47 **Preferred Provider Service Area or Preferred Provider Organization (PPO) Service Area.** “Preferred Provider Service Area” or “Preferred Provider Organization Service Area” means the geographic area in which a PPO operates.
- 1.48 **Preventive Care.** “Preventive Care” means those services and supplies required by Health Care Reform. Preventive Care excludes services and supplies which are, based on the individual’s diagnosis, Medically Necessary. See Section IV for more detail.
- 1.49 **Rehabilitation or Rehabilitative Therapy.** “Rehabilitation or Rehabilitative Therapy” means services or supplies to help an individual regain a skill that has been acquired but then lost or impaired due to Illness or Injury.
- 1.50 **Rehabilitation Facility.** “Rehabilitation Facility” means a facility that is licensed by the State in which it operates to perform rehabilitative health care services.
- 1.51 **Respite Care.** “Respite Care” means care that is furnished to a Terminally Ill Patient when confined as an inpatient so that family members may have relief from the stress of the care of the patient, who is a Participant or Dependent.
- 1.52 **Retired Employee or Retiree.** “Retired Employee” or “Retiree” means a Participant who qualifies for and elects Retiree coverage under the Plan. The terms Retired Employee or Retiree shall not include a Dependent or the surviving spouse of a deceased Retiree.
- 1.53 **Self-Pay Participant.** “Self-Pay Participant” means an individual who loses Plan coverage and properly elects to continue coverage under COBRA or as a Retiree.
- 1.54 **Skilled Nursing Facility.** “Skilled Nursing Facility” means a state-licensed and lawfully operated institution for the care and treatment of persons convalescing from an Illness or Injury which provides room and board and twenty-four (24) hour nursing service by licensed nurses and is under the full-time supervision of a Physician or a registered nurse (R.N.).

- 1.55 Specialty Drug.** “Specialty Drug” is an outpatient prescription drug that is covered only if dispensed by the Pharmacy Benefit Manager. For a current list of Specialty Drugs, contact the Pharmacy Benefit Manager (contact information is under *PREFERRED PROVIDER ORGANIZATIONS*, earlier in this booklet).
- 1.56 Speech Therapy.** “Speech Therapy” means the use of Rehabilitative techniques for treatment of speech and language disorders, incurred as a result of Illness or Injury.
- 1.57 Terminally Ill Patient.** “Terminally Ill Patient” means a patient whose Physician certifies that such patient is terminally ill and who is expected to live six (6) months or less.
- 1.58 TRICARE.** “TRICARE” includes Champus, and means the federal government’s managed health care program for active members of the United States uniformed services and their families, retired members of the United States uniformed services and their families, and the survivors of members of the United States uniformed services who died while on active duty.
- 1.59 Trust Agreement or Trust or Fund.** “Trust Agreement” means the Agreement and Declaration of Trust establishing the Ironworkers Intermountain Health & Welfare Trust dated May 1, 2008 as modified or amended. “Trust” or “Fund” refers to the assets held pursuant to the Trust Agreement.
- 1.60 Union.** “Union” means Local Unions No. 21, 24, 27, 495, and 732 of the International Association of Bridge, Structural, and Ornamental and Reinforcing Ironworkers, and any other union admitted by the Trustees.
- 1.61 Vocational Rehabilitation.** “Vocational Rehabilitation” means teaching and training which allows an individual to resume his/her previous job or to train for a new job.
- 1.62 Written Agreement.** “Written Agreement” means a collective bargaining agreement (including the applicable compliance agreement) that provides for contributions to the Trust, or a participation agreement that is approved by the Trustees. The Trustees reserve the right to reject any Written Agreement.

ARTICLE II. – ELIGIBILITY RULES FOR ACTIVE EMPLOYEES AND RETIREES

2.01 Hour Bank Eligibility for Active Employees.

a. Eligibility.

If you work under a collective bargaining agreement or for the Union or an affiliated training fund, your eligibility for Plan benefits is determined by the hour bank system.

The following Active Employees participate in the Plan under the hour bank system:

1. Employees whose Contributing Employer makes contributions to the Fund on behalf of the employee's Hours of Work as required by a collective bargaining agreement; and
2. Employees whose Contributing Employer is a local Union or affiliated training fund, and makes contributions to the Fund on behalf of the employee's Hours of Work as required by a participation agreement.

For an owner to participate in the hour bank system, at least 50% of their work must be under the jurisdiction of a collective bargaining agreement.

A Contributing Employer may be required to make written application to the Board of Trustees to participate in the Plan under the hour bank system. The Board of Trustees may, in its discretion, accept or reject any such application.

b. Initial Eligibility and Class of Coverage.

You must earn 360 Hours of Work to satisfy the Plan's initial eligibility requirements. Your coverage will begin the second month after you satisfy the Plan's initial eligibility requirements.

New employees are eligible to participate in the Plan two months after they earn 360 Hours of Work within 4 consecutive months. Hours of Work in excess of 360 are credited to the Active Employee's hour bank following initial eligibility.

Once an Active Employee satisfies the initial eligibility requirements above, Article IV, medical benefits are paid by the Plan according to the following coverage classifications:

| Classification | Hours of Work |
|-----------------------|----------------------|
| Class I | 0 – 3000 |
| Class II | 3001 – 6000 |
| Class III | More than 6000 |

Each coverage classification has a different Medical Plan Deductible, Coinsurance, and Copay level (described in the Summary of Benefits chart. All new or rehired employees following loss of coverage under the Plan must complete the initial eligibility period to again become covered under the Plan, and are eligible for the Class I level of benefits. However, an Active Employee who was covered by the Plan for a period of at least six (6) continuous months of the most recent twenty-four (24) months prior to reestablishing eligibility, is eligible for coverage under the coverage classification for which he/she was previously eligible.

- c. Effective Date of Coverage. The effective date of coverage for any Active Employee is the first day of the second month after performing 360 Hours of Work within 4 consecutive months. See the example in *Quick Answers*.
- d. Continuation of Eligibility. Hours of Work are credited to an Active Employee's hour bank the month in which the hours are worked to provide coverage two months following the month of work. After initial eligibility, an Active Employee must have 120 Hours of Work in his/her hour bank to receive coverage. 120 Hours of Work are deducted from the Active Employee's hour bank for each month of coverage. See the example in *Quick Answers*.
- e. Hour Bank Accumulation. Active Employees may accumulate up to 480 Hours of Work in their hour bank. Benefits and hour banks are not accrued or vested, and may be terminated at any time in the discretion of the Trustees.
- f. Continuation of Eligibility While Disabled. Active Employees may make written application for disability continuation. Disability continuation is available only if you are disabled from your own occupation. Application must be made within 12 months of first becoming disabled. If the application is granted, an Active Employee who becomes continuously disabled for more than thirty (30) consecutive days will have Plan coverage without reduction of hours from their hour bank. In other words, the hour bank will be frozen and the entire program of health and welfare benefits will remain in effect for the Active Employee and his/her Dependents. This extended coverage will continue until the earlier of: (1) the last day of the month in which the disability ends, or (2) the last day of the 12th month in which the disability began, or (3) the last day of the month in which the disabled employee is awarded a Social Security benefit or applies for a pension benefit.

g. Termination of Eligibility. An Active Employee's hour bank coverage will terminate on the earliest to occur of the following:

1. The first day of the month in which his/her hour bank contains less than one hundred twenty (120) Hours of Work.
2. The last day of the month in which he/she works in the Plan's geographic area and in a trade or craft covered by the Plan, for an employer not subject to a Written Agreement requiring the payment of contributions to the Fund;
3. The date as of which the Active Employee or his/her Contributing Employer has not provided all requested information (including social security number) or has misrepresented information to the Plan;
4. The date the Active Employee or his employer fails to comply with material terms of the Plan, the Trust, a reimbursement agreement, or a Written Agreement (including payment requirements);
5. The date he/she enters full-time active duty in the United States armed forces or other armed forces, except as otherwise provided by law;
6. The date the Plan, or the Participant's or his employer's participation in the Plan, is terminated by the Board of Trustees.

h. Reinstatement of Eligibility.

- If your hour bank account drops below 120 hours, you will lose Plan coverage.
- If within 3 months you work enough Covered Hours for your hour bank account to grow to at least 120 hours, you will regain coverage.
- If it takes you more than 3 months to build your hour bank account to 120 hours, your hour bank account will drop to zero. You must again satisfy the Plan's initial eligibility requirements to regain coverage—that is, you must work 360 hours in 4 months.

An Active Employee whose hour bank dropped below 120 hours or whose eligibility terminated either under the hour bank or the Self-Payment provisions for COBRA shall again become eligible if his/her hour bank is credited with at least 120 Hours of Work within three (3) calendar months.

If an employee is not credited with 120 Hours of Work within three (3) calendar months, any remaining hours in his/her hour bank is forfeited. He/she will again become eligible for coverage upon completion of the eligibility requirement as set forth in the "Initial Eligibility" provisions.

- i. Reciprocity Agreements. The Board of Trustees has entered into the Iron Workers' International Reciprocity Health and Welfare Agreement. If you work outside the jurisdiction of this Plan, contact that plan for the appropriate forms. When the Administrative Office receives reciprocal contributions from the other plan, it will divide the amount received by the Plan's then-current hourly contribution rate, to arrive at Hours of Work to be credited to your hour bank. Participants receive credit for hours under reciprocal plans only to the extent the Plan timely receives an accurate employer report of hours and corresponding payment of contributions. However, see the HRA at Exhibit A for a special rule when the Plan receives reciprocal contributions for your work in Canada.

If you want the Administrative Office to transfer contributions to your Home Fund, contact the Administrative Office or your Local Union and complete the reciprocity paperwork.

- j. Waiver of Initial Eligibility Requirements with Respect to Employees of a Newly Organized Contributing Employer. The Trustees may, in their sole discretion, waive the Plan's initial eligibility requirements with respect to employees of a newly organized Contributing Employer that had previously offered their employees group medical coverage. The requirements to receive and effect of this waiver shall be as follows:

1. The Plan will provide eligibility for bargaining employees' first month of Coverage on the basis of one hundred twenty (120) Hours of Work for each bargaining employee.
2. The newly organized Contributing Employer will make an initial contribution equal to 120 times the Fund's current hourly contribution rate, on all bargaining employees. This initial contribution will provide eligibility for bargaining employees' second month of Coverage.
3. In addition, the newly organized Contributing Employer shall make contributions on behalf of all such bargaining employees based on the actual Hours of Work beginning with the first month of Coverage. Such hours shall be used for the purpose of the third month's eligibility and so forth, as described in section 2.01, e. Excess hours, if any, will be credited to the bargaining employee's hour bank.
4. In the event the employee's hour bank falls below one hundred (120) hours in any subsequent month of his/her employment with a newly organized Contributing Employer, his/her eligibility will be terminated and he/she shall be eligible to continue coverage in accordance with Continuation Coverage Rights Under COBRA..

5. This waiver of initial eligibility shall apply only in those instances where an employee remains in the employment of a newly organized Contributing Employer.
 6. This provision shall apply only to those bargained employees who were employed by the newly organized Contributing Employer on the employer's effective date of participation and for whom the employer had previously provided group medical coverage. Employees employed on and after the employer's initial effective date of participation shall be subject to the initial eligibility requirements described in section 2.01, c.
 7. Bargaining employees covered under a Written Agreement with a Contributing Employer subject to this provision will have their hour bank eligibility terminated at the end of the month following the date such Contributing Employer elects to withdraw from participation in the Ironworkers Intermountain Health & Welfare Trust, whether or not such employer maintains a collective bargaining agreement with the Union.
- k. Hourly Rate-Contribution Amount. The hourly contribution rate or (other contribution amount) to be remitted by Contributing Employers on behalf of each Active Employee is the rate established by the Trustees from time-to-time, in their discretion. If the Administrative Office receives contributions representing less than the hourly rate established by the Trustees, the contributions will be rejected and no credit for Hours of Work will be granted. If the Administrative Office receives late contributions it will apply the amount received to the earliest contributions owed.

2.02 Flat Rate Eligibility for Active Employees.

A Contributing Employer must make written application to the Board of Trustees to participate in the Plan under the flat rate system. The Board of Trustees may, in its discretion, accept or reject any such application.

- a. Initial Eligibility.

| |
|--|
| <p>If you don't work under a collective bargaining agreement but your Employer has signed a participation agreement and has agreed to contribute to the Fund for you, then you have coverage on a flat rate basis. For every month of work, your employer must, without interruption, make the correct amount of contributions to the Fund on your behalf. In addition, you must satisfy all the requirements of your employer's Participation Agreement with the Fund. You may contact the Administrative Office for a copy of your employer's Participation Agreement.</p> |
|--|

The following Active Employees may participate in the Plan under the flat-rate system:

1. Employees who are not covered by a collective bargaining agreement, but who work for an employer that contributes to the Fund for other employees who are covered by a collective bargaining agreement with the Union.
 2. Employees of Unions and affiliated training funds, but only to the extent required by a collective bargaining agreement with a craft other than the Union's.
- b. Flat Rate Employee Application for Participation and Enrollment. Each prospective Active Employee under the flat rate system must complete an application and enrollment form and submit it to the Administrative Office within 30 days of the employee's initial date of employment or, if later, the employee's satisfaction of the participation requirements set forth in the participation agreement applicable to the employee.
- c. Flat Rate Employees Eligible. A Contributing Employer must contribute to the Plan for those employees who meet the requirements set forth in the participation agreement approved by the Trustees. Also, an employee must work at least 20 hours per week to be eligible for coverage under the Plan.

Example: Iron Co. has signed the Local 27 Compliance Agreement. Mary owns Iron Co., and she works full-time for Iron Co. Her work isn't covered by the Collective Bargaining Agreement. Iron Co. and the Trustees sign a participation agreement, and Iron Co. begins making contributions to the Fund for Mary. Mary's eligibility for coverage is determined under these flat rate rules, not the hour bank rules.

- d. Contributing Employer Participation Effective Date. The effective date of the Contributing Employer's flat rate participation shall be the first day of the calendar month specified in the employer's participation agreement; provided, however, that the effective date of participation shall not be earlier than the first day of the month after latest of the following: (1) the date of notification from the Administrative Office that the application has been approved by the Board of Trustees, (2) the date the participation agreement has been executed, or (3) the date the Contributing Employer has paid to the Fund an amount equal to two months of contributions for current employees covered under the participation agreement. The initial two months of contributions provides no Plan coverage.

e. Flat Rate Employee Initial Eligibility and Effective Date of Coverage.

Flat rate employees also have a lag month: if after initial eligibility they work enough hours for their employer to make a contribution, they are eligible to participate in the Plan two months later.

Prospective flat rate Active Employees covered under a Contributing Employer's participation agreement will become eligible for coverage on the latest of: (1) the Contributing Employer's flat rate participation effective date (described above), (2) satisfaction of the eligibility requirements in the participation agreement, and (3) the Contributing Employer's payment of two months of contributions for the employee. Thereafter, coverage is provided on the following schedule: if an employee satisfies the eligibility requirements in month 1 and the Contributing Employer makes timely contributions to the Trust in month 2, this contribution provides Plan coverage in month 3.

Flat rate Active Employees will be entitled to the medical benefits as described in Article IV in accordance with the following coverage classifications:

| Classification | Months for which Contributions Are Received |
|-----------------------|--|
| Class I | 1 – 18 |
| Class II | 19 – 36 |
| Class III | Over 36 months |

Following loss of coverage under the Plan, employees must complete the initial eligibility period to again become covered under the Plan. An employee who was covered by the Plan for a period of at least six (6) continuous months of the most recent twenty-four (24) months prior to reestablishing eligibility, is eligible for coverage under the coverage classification for which he/she was previously eligible.

f. Monthly Contributions. The amount of monthly contributions a Contributing Employer must make to the Fund for each participating flat rate Active Employee is established by the Board of Trustees from time to time, and in their sole discretion. Currently the monthly contribution required for each flat rate Active Employee is 160 hours times the then-current contribution rate for Hour Bank Employees under Section 2.01. Contributions for flat rate coverage are due on the same schedule as contributions for Hour Bank Active Employees. If for any month a Contributing Employer fails to make contributions owed under a collective bargaining agreement that requires contributions to the Fund, all contributions made for flat rate employees in that month will be applied toward employees working under the collective bargaining agreement. If the Administrative Office receives partial or late contributions, it applies the amount received to the earliest contributions owed.

- g. No Hour Bank. Flat rate employees have no hour bank. Their coverage ends the month after the month their employer stops making contributions to the Plan.
- h. Termination of Coverage. For Active Employees participating under the flat rate system, coverage will terminate on the earliest of the following dates:
 - 1. the last day of the month following the month in which termination of employment occurs;
 - 2. the last day of the month following the month in which the employee fails to satisfy the eligibility requirements set forth in the participation agreement;
 - 3. the date the Plan is discontinued;
 - 4. the date the employee's Contributing Employer (other than the Union or affiliated training fund) is no longer signatory to a collective bargaining agreement that requires contributions to the Plan;
 - 5. the date as of which the Contributing Employer, employee (including Dependents) has not provided all requested information (including social security number) or has misrepresented information to the Plan;
 - 6. the date the employee or his employer fails to comply with material terms of the Plan, the Trust, a reimbursement agreement, or a Written Agreement (including payment requirements);
 - 7. the date the employee enters full-time active duty in the United States armed forces or other armed forces, except as otherwise provided by law;
 - 8. the date as of which the employee's Contributing Employer terminates its participation agreement in accordance with permissible termination events in that agreement, or the date as of which the Trustees terminate the Contributing Employer's participation; or
 - 9. the month for which the employee's Contributing Employer fails to make a required contribution under a collective bargaining agreement or participation agreement.
- i. Reinstatement Provision. Once coverage terminates the Contributing Employer and/or Active Employee (as applicable) may recommence participation in the Plan as a new Contributing Employer and/or Active Employee (as applicable), but only subject to the rules and procedures previously described for new Contributing Employers and/or Active Employees (as applicable).

2.03 Family and Medical Leave Act. Participants are entitled to benefits under the Plan during a family or medical leave in accordance with the provisions of the Family and Medical Leave Act of 1993, as may be amended, The Plan will accept contributions made by Contributing Employers as required by the FMLA, but the Plan will not, without contributions, provide coverage during a FMLA leave.

2.04 Leave for Military Service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”). If an Active Employee leaves employment to perform “service in the uniformed services” as defined by USERRA (hereafter “Uniformed Service”) for a period of up to thirty (30) days, his/her coverage will continue during such period in accordance with section 2.01 or section 2.02. If an Active Employee leaves employment to perform Uniformed Service for a period of more than thirty (30) days, the Active Employee and his/her Dependents may continue coverage in accordance with USERRA for up to twenty-four (24) months measured from the date the Active Employee’s absence begins. The requirements and procedure to elect continuation coverage under USERRA; the terms and conditions of such coverage; the applicable payment options; and the rules for reinstatement of Plan coverage on reemployment following Uniformed Service are described in the Plan’s USERRA Procedures. Continuation coverage under USERRA runs concurrently with continuation coverage under COBRA. If there is any conflict between this section or the Plan’s USERRA Procedures and the requirements of USERRA, the requirements of USERRA shall control.

2.05 Eligibility for Dependents.

Once you become eligible for coverage, so will your spouse and children. The Plan doesn’t cover same sex spouses or spouses by common law marriage. Children include your biological children, adopted children, stepchildren and some grandchildren over whom you have permanent legal custody, through age 25. See the definition of “Dependent” in ARTICLE I for details.

- a. Effective Date. Dependents of a Participant become eligible for coverage on the latest of the following:
 1. the date the Participant becomes eligible for coverage under Section 2.01 or 2.02 (as applicable);
 2. the date the Participant acquires the Dependent. A Dependent spouse becomes eligible on the date of marriage. A Dependent child becomes eligible on the date the child satisfies the Plan’s definition of a Dependent; or
 3. the effective date of the Dependent’s enrollment in the Plan (see Enrollment Requirement, below).
- b. Dual Coverage. If a Dependent is also covered as Participant or is covered as a Dependent of two Participants, the Plan coordinates benefits with itself. In addition, the Plan will never pay more than actual expenses incurred or benefits otherwise promised in the Plan.
- c. Enrollment Requirement for Dependents of Active Employees.
 1. When you are first eligible for coverage (or if you lose coverage and then regain it), you must enroll your Dependents before the Plan will cover their medical expenses. The Plan offers no coverage for expenses incurred

before the effective date of enrollment. You have 30 days to enroll your Dependents after you are first eligible for coverage. Their coverage will then be effective the date your coverage begins. If you do not complete and return the Enrollment Form within 30 days, your Dependents will have no Plan coverage for the rest of the year.

2. Each year during the Annual Enrollment period, you will receive a list of your currently enrolled Dependents. If you do not want to make any changes, no action is required by you. If you would like to enroll or drop a Dependent for coverage the following calendar year, you must complete and return an Enrollment Form. The Annual Enrollment period is established each year by the Trustees, and lasts at least 30 days.
3. You may enroll a Dependent mid-year within 60 days of the following events:
 - (i) you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption (you may also enroll your spouse in this situation); or
 - (ii) you did not previously enroll your Dependent because they had other healthcare coverage, and the Dependent loses eligibility for other healthcare coverage in which they were previously enrolled due to (a) legal separation, divorce, death of an employee, loss of status as a dependent, termination of employment, reduction in the number of hours of employment, exhaustion of the other plan's lifetime limit on all benefits, termination of employer contributions, or any other reason for which a special enrollment opportunity is required by HIPAA, if the other coverage was non-COBRA coverage; or (b) exhaustion of the COBRA coverage period, if the other coverage was COBRA coverage; or
 - (iii) your Dependent (a) loses eligibility under a Medicaid plan or a state child health plan offered under the State Children's Health Insurance Program ("SCHIP"), or (b) becomes eligible for a premium assistance subsidy through a Medicaid plan or a state child health plan offered under SCHIP.

If you enroll your Dependent mid-year because of one of the above events, their enrollment is effective as of the date of the event.

4. To enroll your Dependent you must properly complete the Plan's Enrollment Form, and the Administrative Office must receive your completed Form within the time limits described above.
- d. Enrollment Requirement for Dependents of Retirees. See Section 2.06 for the rules on enrolling Dependents of Retirees.

- e. Termination of Dependent Eligibility. A Dependent's eligibility shall terminate for any of the following reasons, whichever should occur first:
1. the date the Participant's eligibility terminates;
 2. the date the Dependent ceases to qualify under the definition of Dependent;
 3. the date the Dependent enters into full-time active duty with the armed forces of the United States (except as prohibited by law);
 4. the date the Dependent fails to comply with material terms of the Plan, the Trust, a reimbursement agreement, or a Written Agreement (including payment requirements);
 5. the date the Participant fails to provide confirming proof of Dependent status (such as marriage or birth certificates), as requested by the Administrative Office;
 6. the date the Dependent has not provided all requested information (including social security number) or has misrepresented information to the Plan; or
 7. the date the Trustees discontinue coverage for the Dependent.

The Administrative Office must be notified of a Dependent's loss of eligibility within 60 days of the event causing loss (e.g., divorce). Participants are responsible and liable to reimburse the Plan for any payments made for a family member following loss of eligibility. *See Article XI.*

- f. Benefits Available to Dependents. Dependents are covered by the same medical coverage classification as the Participant who enrolls the Dependent. However, Dependents are ineligible for Accident and Sickness Weekly Benefits, Life Insurance and Accidental Death and Dismemberment Benefits, and Hearing Aids; in addition, Dependent children are ineligible for Eye Surgery.

2.06 Retiree Coverage.

If when your coverage as an Active Employee ends you also retire from certain pension plans, you may elect retiree health coverage under the Plan. You must pay each monthly contribution on time. If you are late, you will forever lose Retiree coverage under the Plan. The Administrative Office can arrange for automatic payment from some pension plans.

- a. Eligibility and Application. Active Employees may elect to become a Retiree as follows:
 1. Application deadline. File an application on the Plan's form after your Pension retirement date, but before your Hour Bank runs out or your coverage under the Plan terminates.
 2. Eligibility. Be an Active Participant in the Plan for 60 of the 84 months immediately before Retiree coverage is to begin.
 3. No gap in coverage. Coverage must begin the month you lose Active Employee coverage immediately following your Pension retirement date. Participants who lose Plan coverage before their Pension retirement date are ineligible for Retiree coverage. And following a Participant's Pension retirement date there can be no gap between Active and Retiree Plan coverage.
 4. One-time opportunity to elect Retiree coverage. Participants who have a Pension Retirement date and do not timely elect Retiree coverage may not later elect Retiree coverage, even if they return to Covered Employment.
 5. No COBRA. Retiree coverage is unavailable immediately following COBRA coverage.
 6. Pension retirement date. A Pension retirement date is the date as of which the Participant receives his or her first monthly retirement payment from one of the following Pension plans: the Intermountain Ironworkers Pension Plan, the Omaha Construction Industry Pension Plan, or the Colorado Ironworkers Pension Plan. Participants who are not eligible for a Pension benefit from one of the above referenced plans may be eligible for Retiree Coverage if they apply timely, meet all other Retiree provisions, including being an Active Participant in the Plan and meet the following service requirement prior to disability or retirement: Active eligibility five (5) of the last seven (7) years.
 7. No Active Employee coverage. Once you elect Retiree Coverage, you may not return to coverage as an Active Employee. However, if you return to Covered Employment, the Plan will credit Contributing Employer contributions toward your monthly payments due for Retiree Coverage.

- b. Coverage of Dependents. A Retiree must enroll all Dependents when electing Retiree coverage—there is no later enrollment of Dependents. However, a Retiree who later marries, has a newborn biological child, or adopts a child (or has a child placed for adoption) may later enroll that new Dependent as well as the Retiree’s Dependent spouse by giving written notice and remitting payment to the Administrative Office within thirty-one (31) days from the date of marriage, birth, or adoption. Enrollment must be effective on the date of marriage, birth, or adoption.

Coverage ends when the spouse or child is no longer a Dependent, when the Retiree’s coverage ends, if the Retiree does not complete and return the Enrollment Form (if required) to enroll a Dependent during Annual Enrollment, or the first of the month for which the Plan doesn’t timely receive the payment for coverage.

- c. Payment for coverage. Retirees make monthly payments for coverage. Premium rates are established from time-to-time by the Board of Trustees, and may be changed periodically. The first payment must accompany the application for coverage. Each subsequent payment is due in the Administrative Office by the fifteenth (15th) day of the month for which the coverage is intended.

- d. Cancellation of coverage. A Retiree’s coverage (and a Retiree Dependent’s coverage) is cancelled upon the first of the following to occur:

1. The date the Retired Employee goes to work in the occupational jurisdiction of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers Union in the United States, Mexico, or Canada, and the work is not subject to an agreement with such union. However, coverage will not end if the work is in the geographic jurisdiction of the Plan but would not be suspendible employment under the Intermountain Ironworkers Pension Plan.
2. The date the Plan changes or terminates coverage for Retired Employees.
3. The month for which the Administrative Office does not timely receive the full payment for coverage.
4. The date the Retiree (or his/her Dependent) fails to comply with material terms of the Plan, the Trust, or a reimbursement agreement.
5. The date the Retiree (or his/her Dependent) enters into full-time active duty with the armed forces of the Unites States (except as prohibited by law).
6. The date the Retiree (or his/her Dependent) has not provided all requested information (including social security number) or has misrepresented information to the Plan.

7. Death of the Retiree, unless the Retiree's surviving spouse makes timely payment of the Retiree contribution amount and elects to immediately continue coverage for herself and the Participant's Dependent children, in which case coverage ends upon remarriage of the surviving spouse, or when it would have otherwise ended for the Retiree had he survived.

Once cancelled, the Participant is forever ineligible to again elect Retiree coverage.

- e. Benefits. Retirees may elect and pay for the type of benefits the Trustees, from time-to-time, make available to Retirees. Currently, retirees may elect Medical benefits, or Medical, Vision, and Dental benefits. Retirees may not elect coverage for Accident and Sickness Weekly Benefits, or Life Insurance and Accidental Death and Dismemberment Benefit.
- f. Medicare Eligibility. Medicare eligible retirees need to enroll for both Medicare Part A and Medicare Part B or benefits payable under this Plan will be reduced by the amount Medicare would have paid.

ARTICLE III. – ACCIDENT AND SICKNESS
WEEKLY BENEFITS

Accident and Sickness Weekly Benefits are available only to Active Employees.

If you can't work because you are sick or injured (outside of work), the Plan pays you a weekly stipend to help you make ends meet.

3.01 Amount of Benefit.

- a. Requirements to Receive Benefit. To receive an Accident and Sickness Weekly Benefit, the Participant must be totally disabled from his or her own occupation, and produce an uncontroverted physician's certification to that effect.
- b. Amount of Benefit. \$200 per week (less FICA taxes) in which the Participant is disabled every day. The benefit is not paid for days the Participant is not totally disabled, and so is prorated for partial weeks of total disability.
- c. First Day of Benefits. Benefits begin on the first day for Injuries, the eighth day for Illnesses or, if earlier, the first day of hospitalization.
- d. Maximum Period. Benefits are paid for a maximum period of twenty-one (21) weeks, whether for one or multiple Illnesses or Injuries. If the Participant returns to Covered Employment for not less than 32 hours per week for 2 consecutive weeks, the Participant may again become eligible for a new Maximum period of benefits.

3.02 Exclusions. Accident and Sickness Weekly Benefits are not payable:

- a. when the Active Employee is not under the care of a Physician;
- b. when the Active Employee is receiving a benefit from any workers compensation fund or insurance, or a pension or a disability pension benefit;
- c. when the Active Employee is working or receiving remuneration for any other work or service;
- d. if the Injury or Illness is related to war or any act of war; and
- e. if the Illness or Injury arises out of or occurs in the course of employment or work for wage or profit.

ARTICLE IV – MEDICAL BENEFITS

How Medical Benefits Work. The Plan pays a portion of the cost of Covered Charges after you pay an annual Deductible, and for some Covered Charges, a Copay. Participants are responsible to pay the rest. However, if a Charge is excluded in Article IX, the Plan will not reimburse any related expenses. And if an expense is not a “Covered Charge,” the Plan pays none of it.

- 4.01 Benefits.** The Plan pays a portion of the cost of Medically Necessary health care expenses that are Covered Charges. The Plan pays no more than the Allowable Fee for a health care expense.
- 4.02 Maximum Benefits Payable.** There is a maximum amount the Plan pays for certain benefits, during a Covered Individual’s life and each calendar year. See the Summary of Benefits earlier in this booklet for these maximum amounts.
- 4.03 \$5,000 Payment Limit for Preexisting Conditions.**

The Plan pays up to \$5,000 toward medical and drug expenses in a Covered Individual’s first 12 months under the Plan, for a pre-existing condition. To avoid the \$5,000 limit, the Covered Individual must have not been without health coverage for 12 months preceding this Plan’s coverage, and provide the Administrative Office with a Certificate of Creditable Coverage. The \$5,000 limit does not apply to individuals under age 19.

During the first twelve (12) months after an Active Employee earns his or her first Hour of Work which counts toward Initial Eligibility, the Medical Benefits payable to such Active Employee and Dependents will be limited to \$5,000 for all Covered Charges (including medical and drug charges) for which such individual received any medical advice, diagnosis, care or treatment (including taking a prescribed drug) which was recommended or received within ninety (90) days immediately preceding the effective date of coverage under the Plan (the look-back period). This 12-month period is reduced by Creditable Coverage. One day of Creditable Coverage is granted for each day of prior health coverage under many group and individual health plans and insurance policies. If you had a significant break in coverage (63 days or more between the date coverage ended under your prior health care plan and your first Hour of Work which counts toward your Initial Eligibility) only coverage after the break is counted to reduce the Plan’s pre-existing condition exclusion period.

For Dependents enrolled by reason of marriage after the Active Employee’s Initial Eligibility, this limitation on Medical Benefits payable lasts for the first 12 months of the Dependent’s coverage, and the look-back period begins six months prior to the Dependent’s enrollment in the Plan.

A leave under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act does not count toward a break in coverage.

The Plan provides Creditable Coverage to the extent reflected on a proper Certificate of Creditable Coverage from your prior health plan. You must provide the certificate to the Administrative Office.

This \$5,000 limitation does not apply to individuals younger than age 19 or to pregnancy of a Participant or spouse.

4.04 Arrangements with Preferred Provider Organizations.

The Plan has contracted with certain physicians and hospitals to charge no more than the Contracted or Allowable Fee. See the contact information before Article I for the Preferred Provider Organization (“PPO”) in your area. In general, if you visit a PPO provider, that is, a provider with whom the Plan has a contract, you receive a discount on your charges, therefore, your Coinsurance is lower.

4.05 Deductible and Copays.

Covered Individuals pay the Deductible and the Copay for Covered Charges. There is no Copay for many services, and there is no Deductible for Preventive Care.

The Deductible is the amount of Covered Charges each Covered Individual, and each family must pay in a calendar year before medical benefits are payable by the Plan. The Copay is the amount each Covered Individual pays for each Physician office visit (if applicable), Hospital admission, and emergency room admission. Your Deductible and Copay depend on your coverage classification (Classification I, II, or III—see Sections 2.01 and 2.02 to determine your coverage classification). The longer a Participant has been in the Plan, the lower the Deductible. See the Summary of Benefits for the Copay and Deductible applicable to your coverage classification.

4.06 Percentage of Covered Charges Payable: Coinsurance

The Plan pays a percentage of medical benefit Covered Charges, and you pay the rest. The percentage of Covered Charges you pay is called “Coinsurance.”

- a. Coinsurance amount. Medical benefit Coinsurance depends on the Participant’s coverage classification (Classification I, II, or III—see Sections 2.01 and 2.02 to determine your coverage classification). The longer you’ve been in the Plan, the lower your Coinsurance. And if you use a PPO provider, your Coinsurance is lower. See the Summary of Benefits for your Coinsurance percentage. Coinsurance applies to Covered Charges still owing after you pay the Copay and/or Deductible.

- b. Annual Coinsurance Maximum.
Once a Covered Individual's Coinsurance payments for medical benefit Covered Charges reach the annual maximum indicated in the Summary of Benefits chart at the beginning of this booklet, that Covered Individual owes no further Coinsurance on medical benefits for that calendar year.
- c. Exceptions to Coinsurance Maximum. The Plan only counts medical benefit claims that are Covered Charges toward the Coinsurance Maximum.

4.07 Covered Charges. Covered Charges are services and supplies that are Medically Necessary and no more than the Allowable Fee, and are described below and not otherwise excluded by the Plan.

Covered Individuals must pay Copays, Deductibles, and Coinsurance when a service or supply is a Covered Charge. If a service or supply is not a Covered Charge, the Plan pays nothing.

- a. Hospital services and supplies, as follows:
 1. room and board up to the daily average semi-private room rate.
 2. routine nursery care of a newborn child.
 3. services and supplies provided while an inpatient, excluding charges for private duty nursing.
 4. Intensive Care Unit or Coronary Care Unit room and board.
 5. Prescription drugs dispensed while an inpatient.
 6. Hospital emergency room (ER) and ancillary charges (such as lab or x-ray) performed during the emergency room visit for a medical emergency.
- b. Anesthesia during performance of a surgical procedure.
- c. Whole blood or blood plasma, if not replaced, and the cost of its administration.
- d. Autologous blood donation for use by the donor during a scheduled surgery.
- e. Professional ambulance service to transport an individual to or from a Hospital or Skilled Nursing Facility where emergency medical treatment is given.
- f. Skilled Nursing Facility. Services and supplies, up to seventy (70) days per lifetime, to the extent such would have been payable if the individual had instead been confined in a Hospital; a Physician certifies in writing that in lieu of such services being provided in a Skilled Nursing Facility the individual would have to be confined in a Hospital; and the Physician submits a written treatment plan.
- g. Licensed Ambulatory Surgical Facility. Services and supplies for outpatient surgery.

- h. Dental Anesthesia. When determined to be Medically Necessary by a Physician, outpatient Hospital, surgical, anesthesia services and supplies provided for dental treatment up to \$750 per year when the patient has a physical, mental or medically compromising condition that makes anesthesia medically necessary to perform the dental procedure, or the patient is under age 5.
- i. Pregnancy and childbirth benefits. Services and supplies delivered as a result of pregnancy, childbirth or related medical condition. Dependent children receive no childbirth benefits, and no benefits for complications of childbirth. Dependent children covered maternity services include only those benefits mandated by federal health care reform regulations.
- j. Rehabilitation Facility. Inpatient services and supplies.
- k. Surgery. Services and supplies for the following surgical services:
 - 1. professional surgical services rendered by the operating Physician in the performance of a surgical procedure.
 - 2. professional surgical services rendered by an assistant surgeon, in the performance of a surgical procedure where an assistant surgeon is Medically Necessary, not to exceed 20% of the operating surgeon's benefit allowed by the Plan.
 - 3. professional surgical service rendered by a legally licensed and qualified Physician Assistant, registered nurse (R.N.), or surgical assistant who is acting in the stead of an assistant surgeon (where an assistant surgeon is Medically Necessary) as part of the surgical team not to exceed 10% of the benefit allowed.
 - 4. professional services rendered by an anesthesiologist during performance of a surgical operation.

When multiple or bilateral surgical procedures which add significant time or complexity to patient care are performed at the same operative session, through the same incision, the total amount payable shall be for the major procedure, plus 50% of the lesser procedures. When multiple procedures are carried out through separate incisions or on separate sites, the total shall be the value of the major procedure plus 50% of the lesser procedure.

- l. Radiologist services and supplies, including X-rays, ultrasounds, catscans, and MRI's.
- m. Chemotherapy. Chemotherapy services and supplies to treat malignant conditions and diseases of certain body systems.
- n. Laboratory services and supplies
- o. Physician Services. Physician services as follows:
 - 1. daily visits when confined in a Hospital as a registered inpatient.

2. office visits and consultations.
3. emergency room visits.

Benefits are not payable for charges which are considered post-operative care for which surgical benefits are payable, or any charge for more than one (1) treatment per day, except for a consultation when referred by a Physician.

- p. Chiropractic Benefits. Office visits, examinations, manipulations, modalities, and diagnostic X-ray for treatment of spinal maladjustments or subluxation. See the Summary of Benefits for visit limits. No other benefits are payable for services rendered by a chiropractor.
- q. Appliances, Nursing Care and Durable Medical Equipment for the following:
 1. rental of a wheelchair, hospital bed and other similar Durable Medical Equipment. When purchase of Durable Medical Equipment would be less expensive than renting, or such equipment is not available for rental, purchase is covered.
 2. purchase of a prosthetic device. However, replacement of a prosthetic device is a Covered Charge only if the device is too worn to be repaired or there has been a change in physical condition and the current device is no longer usable.
 3. cast, splints, trusses, braces and crutches, and surgical dressings.
 4. oxygen and rental of oxygen equipment.
 5. services of a registered nurse (R.N.) or licensed practical nurse.
 6. orthotics.
- r. Home Health Care. Services and supplies furnished on a visiting basis in a private residence (not necessarily the residence of such individual) only for the following:
 1. services of a home health aide on a part-time or intermittent basis.
 2. Rehabilitation Therapies that are Physical, Occupational or Speech Rehabilitation Therapies (all described below under "Therapies"), respiratory or inhalation therapy.

A Home Health Care benefit will be payable only if all of the following conditions are met:

1. a Physician must certify that the individual would require inpatient confinement in a Hospital or Skilled Nursing Facility if Home Health Care were not available.
2. the Home Health Care must be provided according to a plan of treatment ordered by a Physician.

3. the continuing need for Home Health Care must be certified periodically by the attending Physician.
4. the provider of the Home Health Care may not be a person who ordinarily resides with the individual or is a member of the individual's family.
5. the provider of the Home Health Care may not be a person who owns the private residence where the care is provided or who ordinarily resides there.

Home Health Care benefits will not be provided for the following services:

1. a masseur, physical culturist or physical education instructor.
2. routine housekeeping chores
3. any services rendered to the individual which could have been provided by any other properly trained person of the household without endangering the individual's life or seriously impairing his/her condition.
4. any services or supply that would be excluded if the individual were confined as an inpatient in a Hospital or Skilled Nursing Facility.

s. Hospice Care. Services and supplies for the following:

1. the inpatient confinement of the Terminally Ill Patient. The Plan will not pay for more than a total of eight (8) days of inpatient care for Respite Care.
2. home Hospice Care furnished to the Terminally Ill Patient in a private residence. Covered Charges for home Hospice Care include only the following:
 - (a) services of a home health aide.
 - (b) professional services of a registered nurse (R.N.).
 - (c) Rehabilitation Therapy (physical) and respiratory therapy.
 - (d) nutrition counseling and special meals.
 - (e) services of a licensed or certified social worker for medical social services rendered during a Hospice Benefit Period not to exceed a maximum of six (6) visits.
 - (f) Room and board that is furnished by a licensed hospice organization.

No benefits will be paid for Hospice Care that is rendered by volunteers or individuals who do not normally charge for their services.

t. Therapies. Physical, Occupational, and Speech Rehabilitation Therapy services prescribed by a Physician are payable to treat an Illness or Injury when in the judgment of the Physician, significant improvement can be obtained. The Plan

does not cover habilitative therapy, that is, therapy to attain a skill or function never learned or acquired.

Therapy must be certified by the attending Physician to be Medically Necessary. Benefits are not payable for therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement can be expected. When non-therapy treatment is available (whether or not the therapy is prescribed by a Physician, e.g., exercise), therapy is not a Covered Charge.

When prescribed or provided by a Physician, the following types of therapy are covered:

1. Physical Therapy performed by a Physician or a registered physical therapist.
 2. Occupational Therapy performed by a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA);
 3. Speech Therapy when performed by a qualified speech therapist.
- u. Dental Benefits. Services and Supplies for repair to sound, natural teeth (not decayed or extensively restored) as a result of an accidental Injury, so long as the charges are incurred within 6 months of the date of the accident.
- v. Mental Health and Substance Abuse Benefits. The Plan provides benefits for Licensed Substance Abuse Treatment Centers and Hospital charges for inpatient mental health and/or substance abuse treatment and physician covered charges incurred for outpatient mental health and/or substance abuse treatment.
- w. Organ Transplants. The Plan provides benefits with respect to the following types of organ transplants:
- allogeneic bone marrow/stem cell
 - autologous bone marrow/stem cell
 - cornea
 - heart
 - lung
 - heart and lung combination
 - kidney
 - pancreas
 - pancreas and kidney combination
 - liver
 - intestinal which includes small bowel alone or in combination with liver and/or pancreas

1. Transplant services for Covered Individuals (Recipients must be Covered Individuals) are as follows:
 - (a) Recipient's medical, surgical and hospital services
 - (b) inpatient immunosuppressive medications
 - (c) organ or bone marrow/stem cell procurement (explained further below)
2. Travel expenses for donor and recipient to and from the treatment facility (except for cornea transplant): actual reasonable transportation cost; lodging and food up to \$200 per day, limited to \$10,000 per transplant.
3. Procurement costs related directly to the procurement of an organ/tissue including surgery necessary for organ/tissue removal; organ/tissue transportation; transportation, hospitalization, surgery of a live donor. These donor expenses are paid by the Plan only when the Recipient is a Covered Individual.
4. Certification. Transplant services are not paid by the Plan unless first pre-authorized by the Plan's Medical Reviewer as Medically Necessary.
5. Re-certification. For Covered Individuals on a transplant waitlist, regular and ongoing updates and reviews are performed on a case-by-case basis, and must be initiated by the Participant no less than once a year. Benefits and eligibility will also be checked and verified at least once per year.
6. Concurrent Review. Determines whether a continued inpatient stay is Medically Necessary. Such reviews are required for all Covered Individuals during a hospital stay for the actual transplant procedure.
7. Transplant services and facilities. Transplant services must be performed at a PPO Network facility that is a Medicare-approved facility, has a Medicare provider agreement, and the transplant program must comply with all Medicare conditions.
- x. Reconstruction Following a Mastectomy. Benefits are payable in accordance with Plan provisions for reconstructive surgery following a mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.
- y. Preventive Care. The Plan pays for immunizations recommended by the Centers for Disease Control, and other Preventive Care services based on published guidelines and as required by the Health Care Reform Law when services are rendered by a PPO provider. The Plan does not cover Preventive Care services if received from a non-PPO provider. For an up-to date list see <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services->

[list.html](#); [www. brightfutures.aap.org](http://www.brightfutures.aap.org); and <http://cdc.gov/vaccines/schedules/index.html>.
In general, preventive care includes:

- Well-child visits (8 in first year, 3 in second year, then one per year through age 18)
- Routine Physicals/Wellness Exam (one per year age 19+)
- Breast Cancer Screening: One mammogram per year (beginning at age 40)
- Cervical Cancer Screening: One Pap test and routine pelvic exam per year
- Colon and Rectal Cancer Screening: yearly fecal occult blood test, colonoscopy every 5 years for adults ages 50 - 75.
- Prostate Cancer Screening: one prostate-specific antigen (PSA) blood test per year, one digital rectal exam (DRE) per year (after age 50).

Reasonable medical management techniques such as age, location for service and test frequency also apply in determining whether a Preventive Care service or supply is a Covered Charge.

- z. Acupuncture Benefits. Charges for acupuncture treatments performed by a licensed acupuncturist. (See the Summary of Benefits for visit limits.) No other benefits are payable for services rendered by an acupuncturist.

ARTICLE V – OUTPATIENT PRESCRIPTION DRUG BENEFITS

5.01 **Benefits.**

If you need medication, take your doctor's prescription, plus your prescription drug card, to a pharmacy. If you use a PPO pharmacy you will pay less. You will also pay less if you request a generic drug rather than a brand name drug. For a list of PPO pharmacies near you, call the Pharmacy Benefit Manager identified in the beginning of this booklet in the PPO chart.

5.02 **Prescription Drug Card Retail Program.**

- a. **Participating Pharmacies.** Each Participant and Dependent will be issued a prescription drug identification card which must be presented to the participating pharmacy with each prescription to be filled or refilled. The Participant and Dependents must pay, to the PPO Pharmacy, the amount in the Benefit Summary chart at the beginning of this booklet. For a current list of PPO pharmacies, contact the Pharmacy Benefit Manager (identified in the PPO chart).
- b. **Non-Participating Pharmacies.** If you go to a non-PPO pharmacy, you will have to pay the full cost for the prescription and file a claim for reimbursement with the Plan's Pharmacy Benefit Manager. See the PPO chart at the beginning of this booklet for contact information.
- c. **Pre-authorization.** For some drugs, the Plan only pays if you have received a pre-authorization from the Plan's Pharmacy Benefit Manager. For a current list of drugs that require pre-authorization, contact the Pharmacy Benefit Manager.

5.03 **Mail Order Benefits.** For prescription drugs you regularly use (such as maintenance medications), you will save money by using the mail order program. Contact the Pharmacy Benefit Manager (see the PPO chart) for information on mail order prescription drugs. See the Benefit Summary chart at the beginning of this booklet for the amount you pay when you order prescriptions through the mail order program.

5.04 **Specialty Drugs.** The Plan only pays for specialty drugs that you obtain from the Plan's Pharmacy Benefit Manager. The list of specialty drugs changes from time-to-time; for a current list of the Plan's specialty drugs contact the Plan's Pharmacy Benefit Manager (see the PPO chart for contact information). See the Benefit Summary chart at the beginning of this booklet for the amount you pay for specialty drugs. The Plan only pays for those specialty drugs that were pre-authorized by the Plan's Pharmacy Benefit Manager.

5.05 Covered Charges for Prescription Drugs.

- a. Legend drugs (drugs that Federal Law prohibits dispensing without a valid prescription).
- b. Insulin.
- c. Disposable needles/syringes.
- d. Disposable blood/urine glucose/acetone testing agents, (e.g. Chemstrips, Clinitest tablets, Diastix Strips, and Tes-Tape).
- e. Lancets.
- f. Compounded medication of which at least one (1) ingredient is a legend drug.
- g. Any other drug which, under applicable state law, may only be dispensed upon the written prescription of a Physician or other lawful prescriber.
- h. Growth hormones subject to pre-authorization and approval as medically necessary.
- i. Birth control drugs, medications and devices.

5.06 Exclusions. In addition to the General Exclusions and Limitations in Article IX, outpatient prescription drug benefits are not payable for:

- a. drugs or medications procured or procurable without a Physician's written prescription (over-the-counter).
- b. immunization agents, blood or blood plasma.
- c. hair growth stimulants/
- d. non-Legend drugs/
- e. therapeutic devices, appliances or supplies, support garments, appliances, prosthetics, bandages, heat lamps, braces, splints, other non-drug items and over-the-counter items, regardless of intended use.
- f. anorectics, and any drug used for the purpose of weight loss).
- g. anti-wrinkle agents (e.g. Renova, Retin A).
- h. drugs labeled: "Caution – limited by federal law to investigational use," or experimental drugs, even though a charge is made to the Participant or Dependent.
- i. charges for the administration or injection of any drug.
- j. medication which is to be taken by or administered to the Participant or Dependent, in whole or in part, while confined on an inpatient or outpatient basis in any facility or institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- k. any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the original order of a Physician.
- l. prescription drugs which may be properly received without charge under local, state, or federal programs including Worker's Compensation.

- m. infertility or fertility medications (e.g., antagon, Lutrepulse, Profasi, Pregnyl, Follistim, Gonal-F, Fertinex, Pergonal, Clomid, Serophene).
- n. smoking deterrent or medications to treat nicotine addiction or any other smoking cessation aids, all dosage forms.
- o. impotence medications (e.g., Viagra, Cialis, Levitra, Edex, Cverject, Muse).
- p. Tretinoin, all dosage forms (e.g. Retin-A), for individuals age 20 or older.
- q. cosmetic products, including hair enhancement or removal products (e.g. Vaniga, Renova, Minoxidil).
- r. blood monitoring units.
- s. Vitamins and minerals (except as required by the Affordable Care Act).
- t. anabolic steroids (or other athletic enhancement drugs).
- u. drugs that are illegal or purchased in a foreign country.
- v. drugs not approved for marketing or for the prescribed use by the FDA.

ARTICLE VI – HEARING AID BENEFIT

- 6.01 Hearing Aid Benefit: Device.** The Plan will pay benefits for the cost of hearing aid devices and the fitting thereof for Participants up to the maximum benefit identified in the Summary of Benefits.
- 6.02 Hearing Aid Benefit: Audiogram.** The Plan will pay for a comprehensive audiogram, up to the maximum benefit identified in the Summary of Benefits.
- 6.03 Provider Limitation.** The Plan will pay benefits for hearing aid devices purchased from, and an audiogram administered by, a Plan Hearing Aid Benefit Preferred Provider. See the PPO listing at the front of this booklet to obtain a list of Hearing Aid Benefit Preferred Providers near you.
- 6.04 Coverage Limitation.** Dependents (spouses and children) are ineligible for hearing aid benefits.
- 6.05 Exclusions.** The General Exclusions and Limitations in Article IX apply to hearing aid benefits.

ARTICLE VII. – VISION CARE BENEFITS

7.01 Benefits. Benefits for vision care will be paid for each Participant and Dependent up to the maximum amount in the following Schedule of Allowances, subject to Sections 7.03 and 7.04 and any other applicable limitations or restrictions. There are no deductibles, no copays, and no coinsurance for vision care benefits.

7.02 Schedule of Allowances.

a. Examination

| | Calendar Year Maximum Benefit |
|---------------------------|--|
| With or without tonometry | \$50 |
| Vision survey | \$22.50 |
| Individuals under age 19 | No maximum for Preventive Care |

b. Materials and Dispensing Fee

| | Calendar Year Maximum Benefit |
|---|--|
| Single vision lenses (pair) | \$30 |
| Bifocal lenses (pair) | \$75 |
| Trifocal lenses (pair) | \$90 |
| Lenticular lenses (pair) | \$240 |
| Frames | \$50 |
| Contact lenses (pair) – following cataract surgery or when visual acuity cannot be corrected to 20/70 in the better eye except by their use | \$500 |
| Other – when contact lenses are in lieu of glasses (including disposable contact lenses) | \$100 |

c. Eye Surgery Procedures (Participants and their spouses only)

Benefits are payable for the following procedures (up to the following lifetime maximums) per Participant and spouse for moderate, severe, and extreme degrees of myopia or hyperopia:

| | |
|--|---------|
| Radial Keratotomy (RK), per eye | \$1,400 |
| Photorefractive Radial Keratotomy (PKR), per eye | 1,400 |
| LASIK (in-site Keratomileusis) surgery, per eye | 2,000 |

7.03 Availability of Benefits. An eye examination, lenses, and frames are available to each Participant once each calendar year. Eye surgery procedures are available up to the lifetime maximums described in section 7.02, c, above.

7.04 Exclusions and Limitations. In addition to the General Exclusions and Limitations in Article IX, vision care benefits are not payable for:

- a. contact lenses (except as noted above);
- b. subnormal vision aids;
- c. aniseikonic lenses;
- d. coated lenses;
- e. no line bifocals (blended type);
- f. two (2) pairs of glasses in lieu of bifocals;
- g. tinted lenses;
- h. photochromatic lenses;
- i. sunglasses;
- j. any lenses that do not require a prescription;
- k. oversized lenses;
- l. replacement or repair of lost or broken lenses or frames, except at the normal intervals when services are otherwise available;
- m. medical or surgical treatment of the eyes, except as specifically provided for in section 7.02, c. and section 7.03;
- n. any eye examination required by an employer as a condition of employment; and
- o. orthoptics, eye therapy, vision training, or other vision treatment.

ARTICLE VIII. – DENTAL BENEFITS

- 8.01 Benefits.** If a Participant or Dependent receives dental care, the Fund will pay the expenses incurred for covered dental services according to the Summary of Benefits chart at the beginning of this booklet.
- 8.02 Deductible.** The dental Deductible is the amount of covered dental services which first must be incurred during each calendar year before benefits are payable. The deductible amount is at the Summary of Benefits Chart at the beginning of this booklet. The Deductible applies to all covered dental services.
- 8.03 Maximum Dental Benefit.** The maximum dental benefit payable for any individual, after the Deductible has been satisfied, is at the Summary of Benefits Chart. Benefits are payable at 100% up to the calendar year maximum (if applicable) of the Allowable Fee.
- 8.04 Covered Dental Services.** The Plan covers only the following dental services and supplies, delivered by a Dentist:
- a. Diagnostic and Routine Services and Supplies.
 - 1. Complete mouth X-rays are covered once in a three year period.
 - 2. Bite-wing X-rays are covered twice per calendar year.
 - 3. Oral examinations and prophylaxis are covered twice per calendar year.
 - 4. Topical fluoride application is allowed for children under age 19, once each calendar year.
 - 5. Periodontal maintenance is covered four times per calendar year. Combined periodontal maintenance and prophylaxis (item 3. above) is covered a maximum four times per calendar year.
 - b. Basic Services.
 - 1. Restorative – Provides the necessary procedures to restore the teeth, other than cast restoration.
 - 2. Oral Surgery – Provides the necessary procedures for extractions and other oral surgery including pre- and post-operative care.
 - 3. Endodontics – Provides the necessary procedures for pulpal and root canal therapy.
 - 4. Periodontics – Provides the necessary procedures for treatment of the tissues supporting the teeth.
 - 5. Sealants for permanent molars--for individuals younger than age 19 are covered once every 36 months
 - c. Major Services.
 - 1. Prosthodontics – Provides the necessary procedures associated with the construction, placement, or repair of fixed bridges, partial and complete dentures.

2. Cast Restorations – Provides for gold restorations, crowns and jackets when teeth cannot be restored with other materials.
- d. Limitations (Major Services).
1. Appliances for the replacement of the same natural teeth are covered only once in a five (5) year period.
 2. Replacement of an existing prosthetic appliance is covered only if the appliance is unsatisfactory and cannot be made satisfactory.
 3. Temporary partial dentures are covered only when anterior teeth are missing.
 4. Specialized techniques, precision attachments, personalization, and characterizations are not covered dental services.
 5. Fixed bridges and/or cast partials are not covered for children under age sixteen (16).
 6. A posterior fixed bridge is not a covered dental service when done in connection with a removable appliance in the same arch.
 7. Porcelain, gold, porcelain veneer, and acrylic veneer precious metal crowns over vital teeth are not covered dental services for children under age twelve (12).

8.05 Exclusions. In addition to the General Exclusions in Article IX, dental benefits are not payable for:

- a. charges for general anesthesia except when administered by a dentist in association with oral surgery and except as provided under medical benefits (up to \$750 annually);
- b. charges for prescription drugs (see the prescription drug plan);
- c. charges for hospitalization, including Hospital visits;
- d. charges for completion of forms;
- e. charges for lost or stolen appliances;
- f. correction of congenital, developmental, or acquired malformations, except intraoral dental services for treatment of a condition which is related to or developed as a result of cleft lip and/or cleft palate.
- g. treatment for the disturbances of the temporomandibular joint (TMJ) (see the medical plan for TMJ benefits)
- h. procedures necessary to alter or correct occlusion or vertical dimension, or restoration of tooth structure lost through attrition;
- i. analgesics and sedation (including intravenous sedation and nitrous oxide);
- j. hypnosis;
- k. pre-medication;
- l. treatment for cosmetic reasons;
- m. plaque control programs;
- n. photographs of teeth, gums, or oral cavities;

- o. study models or molds;
- p. infection control procedures;
- q. mouth guards;
- r. orthodontics; and
- s. inlays.

ARTICLE IX. – GENERAL EXCLUSIONS AND LIMITATIONS

9.01 General Health Plan Exclusions and Limitations.

Because the Plan has limited funding, it cannot cover all of your health care needs. If a service or supply is not a Covered Charge, then it won't apply toward your Deductible or out-of-pocket Coinsurance medical benefit maximum, even if the treatment is Medically Necessary.

The Plan does not cover services or supplies rendered for or in connection with any treatment directly or indirectly related to the following. The phrase “in connection with” means any services, supplies which would not be necessary but for the occurrence of the excluded type of service, treatment, supply, or accommodations.

- a. any services or supplies not specifically identified as a Covered Charge.
- b. services or supplies for which coverage is available or furnished under any federal, state, or government program, or while incarcerated, except as required by law.
- c. unless specifically provided otherwise, no benefits are payable for any charge under more than one (1) coverage.
- d. charges for which the individual is not obligated to pay, is not billed or would not have been billed except for the fact that the individual was covered under this Plan, except for care rendered in a Veterans Administration Hospital for a non-service connected disability.
- e. charges submitted to the Plan more than 12 months after the service was rendered or supply was dispensed.
- f. services or supplies that are not provided for the treatment or diagnosis of a bodily Injury or Illness, and services or supplies that are not prescribed by, or provided at the direction of, a Physician
- g. Charges for any Injury or Illness resulting from, arising out of, or occurring in the course of, any work, employment, or activity for wages, compensation or profit.
- h. Injury or Illness resulting from military service, any act of war, armed invasion or aggression, insurrection, rebellion, riot, or military service (except as required by law).
- i. Injury or Illness resulting from any release of nuclear energy, except only when being used solely for medical treatment of a bodily Injury or Illness under the direction and prescription of a Physician.
- j. Injury or Illness resulting from or occurring during the commission or attempted commission of a felony, being engaged in an illegal occupation or activity, or driving under the influence of alcohol or drugs.
- k. expenses for learning deficiencies, behavioral problems, and education,

- l. Vocational Rehabilitation.
- m. orthopedic shoes, or supportive devices for feet such as arch supports, heel lifts,, callous or corn paring, toenail trimming or excision for toenail trimming, treatment of chronic conditions of the foot, such as weak or fallen arches, flat pronated foot metatarsalgia, hallux valgus, foot strain, except removing nail roots and care prescribed by a Physician treating metabolic or peripheral vascular disease.
- n. services or supplies to diagnose or treat infertility or assist in conception or to reverse surgically induced infertility, in-vitro fertilization, sexual impotency, genetic studies, family planning, and elective abortions, except the Plan will cover tubal ligation and vasectomy procedures.
- o. humidifiers, air conditioners, exercise equipment, or whirlpools, health spa, and swimming pool, or air filtration units, vaporizers or humidifiers, heating lamps or pads, blood pressure monitors or machines.
- p. charges incurred for services rendered or supplies delivered prior to the individual's effective date of coverage or after coverage ends.
- q. dental services or supplies not covered under Article VIII. The medical plan does cover dental treatment for accidental damage to sound natural teeth which have not been extensively restored or become extensively decayed or diseased, if the damage results from an accidental Injury and the charges are incurred within 6 months of the accident.
- r. services or supplies to treat transsexualism, psychosexual identity, psychosexual dysfunction or gender dysphoria.
- s. services rendered by an individual that ordinarily resides in the patient's home or who is a member of the patient's immediate family.
- t. reduction of weight, regardless of adjunctive, medical or psychological condition; gastric or intestinal bypass, gastric stapling or other similar surgical procedure; services or supplies to treat obesity; or physical fitness programs;
- u. supplies for special formulas, food supplements, special diets, laetrile, and enzymes.
- v. Biofeedback.
- w. nutrition counseling, except as specifically provided herein under hospice care.
- x. hair loss or restoration.
- y. educational material, literature, or charges related to scholastic education, vocational training, learning disabilities, or behavior modification, or for dealing with normal living such as diet, or medication management for Illness.
- z. situational disturbances, stress, strain, financial, marital or family counseling, environmental and social maladjustments, dissocial behavior or chronic situation reactions, except as required by law.
- aa. Physician's Hospital visits following surgery, except for a separate Illness unrelated to the surgery.
- bb. foreign travel immunizations.

- cc. motor vehicles, motor vehicle devices such as hand controls, lifts or specialized vehicle alterations.
- dd. wheelchair ramps, handrails or other specialized construction in or around the home; commode, bath bench, or other convenience items for activities of daily living; batteries or routine maintenance of equipment or repair of wheelchair upholstery.
- ee. prescription drugs not dispensed while an inpatient or outpatient (see also the outpatient prescription drug benefit (Article V)).
- ff. smoking cessation services, supplies, drugs and/or devices.
- gg. reports or appearances in connection with legal proceedings whether or not an Injury or Illness is involved; for Physician's telephone consultations and/or travel time; charges in connection with shipping, handling, postage, interest, or finance.
- hh. services and supplies to treat eating disorders such as bulimia and anorexia, and diet aids.
- ii. personal convenience and/or hygiene items, radio, television, and the like.
- jj. services or supplies provided by any camp, public or private school, or halfway house, or by employees thereof, or provided solely to satisfy institutional or legal requirements.
- kk. charges for missed appointments, concierge fees, insurance.
- ll. inpatient care and treatment when it was not Medically Necessary to obtain such care and treatment on an inpatient basis.
- mm. any surcharges as a result of state laws (e.g. New York Health Care Reform Act).
- nn. any charges incurred through Medicare private contracting arrangements.
- oo. genetic testing except as required by the Health Care Reform Law.
- pp. Services or supplies which are experimental or investigative. A service or supply is experimental or investigative if:
 1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
 2. the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
 3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
 4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, 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 a 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) utilized by other facilities studying substantially the same drug, device, medical treatment or procedure; or the written informed consent document used by the treating facility or by other facilities studying substantially the same drug, device, medical treatment or procedure.

- qq. charges payable under any other program, plan or insurance (including any type of automobile insurance), or charges for which a third party is responsible for paying (except that the Plan may coordinate benefits as described in Article X. or advance payment of expenses as described in Article XI.).
- rr. charges that would have been paid or reimbursed by automobile insurance for health expenses, in the greater of the following amounts: (1) the amount of such insurance that the Participant or Dependent did not purchase, but which state law requires be purchased; or (2) the amount of such insurance that the Participant or Dependent did not purchase, but which is the minimum amount that state law requires insurance brokers/agents offer.
- ss. charges for services or supplies incurred outside of the U.S.A, and any transportation originating or ending outside of the U.S.A.
- tt. cosmetic services or supplies.
- uu. court-ordered services or supplies.
- vv. services or supplies that are not Medically Necessary, that exceed the Allowable Fee, are in excess of the maximum benefits provided by the Plan, or that were incurred before or after the individual's effective date of coverage under the Plan.
- ww. therapies that are habilitative or habilitation therapies, that is, therapies to help an individual gain a skill or function never attained or acquired.
- xx. the following therapies: hypnotism, carbon dioxide therapy, primal therapy, rolfing, bioenergetic therapy, vision perception training, cranial sacral therapy.
- yy. Services or supplies delivered by or under the supervision of a non-Physician or non-Physician's Assistant, such as a naturopath or homeopath.

ARTICLE X. – COORDINATION OF BENEFITS

If you are covered by another health plan, let the Administrative Office know. The Plan will then coordinate benefits, which usually results in you paying for less of your health expenses. You can never receive more from your health plans than you are charged by your doctor and other providers.

Many people enroll in more than one health care plan in order to protect themselves against the high costs of medical or dental care. To keep the cost of Plan benefits as low as possible, the Plan coordinates benefit payments with other health care plans, automobile insurance, Medicare, and other governmental plans, and in situations where a person has dual coverage under the Plan.

If you or your Dependents are covered under another health plan, Medicare, or other governmental plan, you must submit identical itemized bills to both plans. Coordination of benefits operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan (called the secondary plan) pays after the primary plan and may reduce the benefits it pays so that the payments from all plans do not exceed 100% of the total allowable expenses. An “allowable expense” is a health care expense covered by this plan, including Copays, Coinsurance and Deductibles. Sometimes the combined benefits that are paid will be less than total allowable expenses.

Effect on Plan Benefits

When the Plan is primary, it pays its regular benefits in full. When the other plan is primary, the Plan pays a reduced amount.

If your primary plan reduced benefits because you did not use a primary plan preferred provider or you did not comply with the primary plan’s provisions, such as pre-certification requirements, the Plan will not pay those reductions.

In no event will the Plan reimburse an expense that is or should be covered by another plan, government program, insurance, or other source.

If you have dual coverage under the Plan (for example, because you are a Participant and you are married to another Participant), the Plan will coordinate benefits—Participant coverage is primary and dependent coverage is secondary.

To administer coordination of benefits, the Plan has the right to: exchange information with other plans involved in paying claims; require that you, your Physician, or your health care provider furnish information; reimburse any plan that made payments the Plan should have made; and recover overpayments.

Coordination with Other Health Plans

The Plan uses the following rules to determine which plan is primary. If the first rule does not determine which plan is primary, the next rule is applied, and so on until the order of benefits is determined.

- If the other plan does not have a coordination of benefits provision, or if it has a coordination of benefits provision different from these rules, that plan is primary.
- If a person is covered by a plan as a dependent and by another plan other than as a dependent (for example, as an employee, member, subscriber, policyholder, or retiree), the plan covering the person other than as a dependent is primary.

However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person other than as a dependent, then the order of benefits between the two plans is reversed (so that the plan covering the person as a dependent is primary and the plan covering the person other than as a dependent is secondary).

- If a child is covered under more than one plan and a court decree provides that one plan shall be primary, that plan is primary.
- For a child of parents who are married or living together, whether or not they have ever been married, the “birthday rule” applies: the plan of the parent whose birthday comes first in the calendar year is primary (unless the parents’ birthdays are the same, in which case the plan of the parent that has provided coverage to that parent for the longer period is primary).
- For a child of parents who are divorced or legally separated or are not living together, whether or not they have ever been married, the following rules apply:
 - If a court decree states that *one* of the parents is responsible for the child’s health care expenses or coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the child’s health care expenses, but that parent’s ex-spouse does, the ex-spouse’s plan is primary.
 - If a court decree states that *both* of the parents are responsible for the child’s health care expenses or coverage, or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the child’s health care expenses or coverage, then the birthday rule applies.
 - If there is no court decree allocating responsibility for the child’s health care expenses or coverage, benefit payments are made in the following order by the plan covering:
 - The custodial parent;
 - The non-custodial parent;
 - The custodial parent’s spouse; and then
 - The non-custodial parent’s spouse.

The “custodial parent” means the parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides for more than one-half of the calendar year without regard to any temporary visitation.

- For a child covered under more than one plan of individuals who are not the child's parents, the order of benefits shall be determined, as applicable, under the birthday rule or the above rule for children of parents who are divorced or separated or are not living together, as if those individuals were the child's parents.
- A plan covering a person as an active employee (that is, an employee who is neither laid-off nor retired and, if the plan is a multiemployer plan, for whom employer contributions are being made to the plan) or as a dependent of an active employee is primary over a plan covering the person as other than an active employee or as a dependent of a person other than an active employee.
- If a person has COBRA or other continuation coverage pursuant to state or other federal law and is covered by another plan, the plan providing continuation coverage is secondary to the plan covering the person as an employee, member, subscriber or retiree (or as a dependent of an employee, member, subscriber or retiree).
- The plan that has covered the person for the longer period of time is primary.

Note that the Plan does not coordinate with certain other types of plans, such as student accident plans.

If You Are Eligible for Medicare

Medicare is a health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (ESRD). When you or your spouse reaches age 65, Medicare Part A (hospital insurance) is generally automatic if you apply for Social Security benefits. Medicare Part B (medical insurance) requires enrollment and monthly premium payments. Contact your local Social Security Administration Office for information about enrolling in Medicare.

You need to enroll for both Medicare Part A and Medicare Part B to receive maximum available benefits under this Plan. If you do not enroll in and utilize Medicare Parts A and B when eligible, benefits payable under this Plan will be reduced by the amount Medicare would have paid under Medicare Parts A and B.

To maximize your coverage, enroll in Medicare when you are eligible, and pay for Part B. However, do not enroll in Part D, or the Plan won't pay for your prescription drugs.

Coordination with Medicare

Medicare is primary if:

- You or your Dependent are entitled to Medicare on the basis of age (65 or over), and you are *not* an Active Employee, or
- You or your Dependent are entitled to Medicare on the basis of a disability, and you are *not* an Active Employee, or
- After being entitled to Medicare on the basis of age (65 or over) or disability, you or your Dependent become eligible for Medicare because of end stage renal disease (ESRD), and

- you are *not* an Active Employee. In these circumstances, Medicare will continue to pay benefits as the primary provider.

This Plan is primary if:

- You or your Dependent are entitled to Medicare on the basis of age (65 or over) and you are an Active Employee (unless the exemption below applies), or
- Your Dependent is entitled to Medicare on the basis of a disability, and you are an Active Employee, or
- You or your Dependent become eligible for or entitled to Medicare as a result of having end-stage renal disease (ESRD). Medicare acts as the secondary payer for the first 30 months of eligibility or entitlement. After 30 months, Medicare becomes primary.

If you are eligible for Medicare, the Plan pays benefits as if you had elected Parts A and B, whether or not you actually do so.

Coordination With Medicaid, TRICARE & Other Coverage Provided By Law

This Plan is always primary to Medicaid, TRICARE, and any other coverage provided by any other state or federal law that requires the Plan pay primary.

However, if you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related condition, benefits are not payable by the Plan. If you receive services in a U.S. Department of Veterans Affairs Hospital or facility on account of any illness or injury that is *not* a military service-related condition, benefits are payable only to the extent those services are otherwise covered by the Plan.

Notifying the Plan of Other Coverage

It is your responsibility to notify the Administrative Office if you or your Dependents have coverage other than Plan coverage, or if your other coverage terminates. Failure to provide this notice may result in loss of your Plan benefits. In addition, you will be required to fully reimburse the Plan for any claims paid in excess of the amount that should have been paid under the Plan.

By participating in the Plan, you agree that if the Plan pays primary and later determines that it is the secondary plan, the Plan will be subrogated to all the rights you may have against the other plan, and you agree to execute any documents required or requested by the Plan to pursue its claims for reimbursement of the amount advanced.

ARTICLE XI. – GENERAL PROVISIONS

- 11.01 Assignment of Benefits.** Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale transfer, assignment, pledge, encumbrance or charge by any person; however, the Plan will pay benefits directly to a provider who provided Services or Supplies to a covered person, or to the legal guardian of a covered person. Any payment in accordance with the provisions of the Plan shall discharge the obligation of the Fund hereunder.
- 11.02 Discretion of the Board of Trustees.** The Board of Trustees, or where Board of Trustee responsibility has been delegated to others, such other persons shall, for benefits funded by the Trust, have the sole and exclusive discretionary authority to interpret the terms of the Plan and determine benefits hereunder. Decisions of the Board of Trustees, or their delegates, shall be final and binding. For insured benefits, the applicable carrier has authority to interpret and decide the terms of benefits provided under the insurance contract.
- 11.03 Right of Examination.** The Fund, at its own expense, shall have the right and opportunity to hire a physician to examine an individual when and so often as it may reasonably require to determine the legitimacy of a claim involving that individual.
- 11.04 Trust Agreement.** The provisions of this Plan are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Plan and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.
- 11.05 Amendment and Termination.** The Board of Trustees may exercise its discretionary authority, at any time and from time to time, to:
- a. terminate, change, or amend either the amount or the conditions with respect to any benefit;
 - b. alter or postpone the method of payment of any benefit;
 - c. change the eligibility rules of the Plan or eliminate coverage for any class of persons, including retired persons;
 - d. determine the amount of the required contribution by the Participant;
 - e. change the providers for any portion of the plan of benefits; or
 - f. terminate the Plan in its entirety or in part.
- 11.06 Payment of Benefits.** None of the benefits provided in this Plan Document are guaranteed by the Board of Trustees, any Contributing Employer, Union or any other individual or entity. The Board has, however, purchased certain insurance policies, which are held by the Trust. Plan benefits are paid from amounts in the Fund and from insurance.

11.07 Titles. Titles of provisions are for convenience of reference only and are not to be considered in interpreting this Plan.

11.08 Plan's Rights to Recovery. Payment is made for claims based upon your representations and those of your Covered Dependents and/or providers concerning the services rendered and is contingent upon benefits being covered under the terms of the Plan.

By accepting benefits, you and your Covered Dependents agree:

- To promptly refund to the Plan any amount that exceeds the amount covered by the Plan or any amount that is subject to the Plan's subrogation or reimbursement rights, discussed in the following section,
- That the Plan may reduce or deny coverage of your claims or the claims of your Covered Dependents as a way of obtaining reimbursement, even if any such claims do not relate to the overpayment, and
- To reimburse the Plan in full for any benefits from the Plan to which the individual is later found not to be entitled.

The Plan may also recover interest on the amounts paid by the Plan from the time of the payment until the time the Plan is reimbursed.

Furthermore, whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan will be authorized to pay such benefits to the other party. Any payment made by the Plan in accordance with this provision will fully release the Plan of any liability to you. Any participant or individual who receives (or whose family receives) benefits from the Plan to which he or she is later found not to be entitled will be required to reimburse the Plan in full.

11.09 Plan's Right to Subrogation, Reimbursement, and Equitable Lien. The Plan does not cover health expenses for Covered Individuals ("you," "your," or "your Covered Dependent")'s Injury or Illness if a third party is responsible for paying the expense of the Injury or Illness. This applies regardless of whether the Illness or Injury results from your negligence or actions, or from the negligence or actions of someone else. For example, if your expenses are recoverable under automobile or motor vehicle insurance, uninsured or underinsured motorist insurance, umbrella insurance, homeowners insurance, personal injury protection coverage (PIP), or any other type of insurance, or under a workers' compensation program, the Plan will not cover your expenses, regardless of who maintains the insurance or coverage.

If you make a claim for recovery against an insurer or other third party, you must promptly notify the Administrative Office. The Plan may refuse to pay any claims the Plan believes to be the responsibility of a third party, or the Plan may advance payment of health expenses (which you will be required to reimburse out of any third-party recovery). The Plan may require that you and/or your Covered Dependents sign the Plan's Reimbursement Agreement, and provide specified information regarding the

illness or injury and potentially liable third parties, as a condition of advancing payment (or any further payment) of your health expenses. The Reimbursement Agreement may incorporate any or all of the Plan's rules regarding its subrogation and reimbursement rights, and any other requirements the Plan determines are necessary and appropriate to protect such rights.

You and/or your Covered Dependents agree to refund to the Plan the amount of any and all health expenses advanced by the Plan for the injury or illness, regardless of when such expenses are paid or incurred (including, for example, expenses incurred after the date you receive your third-party recovery), and not to release any party from liability for payment of medical expenses without first obtaining written consent of the Plan. If you, your Covered Dependents, or any attorney for you or your Covered Dependents does not cooperate with the Plan in providing information about the claim or in protecting the Plan's reimbursement rights, the Plan will stop advancing payments. If you, your Covered Dependents, or any attorney for you or your Covered Dependents fail to promptly pay the Plan the amount that is owed from any recovery, or otherwise do not cooperate in protecting the Plan's reimbursement rights, the Plan will offset the amount owed from any future benefits for you and your Covered Dependents. The Plan may also take legal action against you and your Covered Dependents to recover these amounts.

The Plan will have a first priority claim and equitable lien on any recovery from a third party for an injury or illness sustained by you or your Covered Dependents, regardless of how the recovery is characterized, and regardless of whether the recovery results from a court judgment, settlement, or otherwise. This lien applies regardless of whether the recovery you receive makes you or your Covered Dependents whole, and without regard to any state insurance laws or doctrines regarding "made whole" status or an implied "common fund." The recovery will be deemed to be held in a constructive trust on behalf of the Plan, and the Plan is entitled to restitution from the amounts held in the constructive trust. The Plan has the right to demand that the insurer or other third party reimburse the Plan directly for the advanced expenses before the remaining recovery is paid to you. During the time period that you, your Covered Dependents, or your attorney holds funds recovered from a third party (such as an insurer), you, your Covered Dependents, and your attorney must take steps to ensure that the funds are preserved until the Plan has been reimbursed for the advanced expenses. Such steps include holding the funds in a separate identifiable account or in an attorney trust account. The Plan has the right to be reimbursed first, before any amounts are disbursed to you, your attorney, or any other party. Also, if a sufficient portion of the funds is not preserved for the purpose of reimbursing the Plan for any further expenses advanced, the Plan may refuse to advance any further expenses. In addition to these rights, the Plan has the right to sue the third party (if it chooses to do so) in your name or in the name of your Covered Dependents, if applicable, to recover the amount of payments advanced.

The Plan is not required to limit or reduce its recovery for any expenses or attorney's fees incurred in making the claim that produces a recovery requiring reimbursement to the Plan. In its sole discretion, the Plan may compromise its rights to reimbursement, subrogation, and/or equitable lien. The Plan's subrogation and reimbursement rights also apply to your and your Covered Dependents' estates or heirs in the event of death.

By accepting benefits under the Plan, you and your Covered Dependents are deemed to agree to all of the above terms.

- 11.10 Attorney's Fees.** The covered person and the health care provider shall be liable for the Plan's collections costs, including court costs, witness fees, and reasonable attorneys' fees, if after demand for payment by the Fund, the individual or health care provider fails to pay to the Fund any excess payments paid by the Fund resulting from claims payment made in error or fails to pay any money due the Fund under in section 11.09.
- 11.11 No Vested Rights.** No person shall have any vested right to any current or future benefit provided by this Plan, whether funded by the Trust or insured. In addition, the Trustees may, at any time, discontinue your right to benefits or to participate in the Plan.
- 11.12 Submission of Falsified or Fraudulent Claims.** All claims submitted to the Fund shall be honest, accurate and complete. If an intentionally false or fraudulent claim is submitted with an individual's knowledge or consent, that individual's coverage under the Plan will terminate. If the coverage terminated is that of a Participant, then the coverage of that Participant's Dependents shall also terminate. Termination of coverage under this section is not a COBRA qualifying event and forever eliminates all rights to Self-Pay coverage.
- 11.13 Non-Reversion of Employer Funds; Mistaken Payments.** Plan assets shall not revert to the Contributing Employers or Participants or be subject to any claims of any kind or nature by the Contributing Employers or Participants, except for benefits payable under the Plan, provided, however, that contributions made by a Contributing Employer by mistake of fact or law may be returned to such Contributing Employer within six (6) months after the Plan Administrator determines that the contribution was made by such a mistake.
- 11.14 Disclosure of Protected Health Information (PHI)** to the Board of Trustees. Unless otherwise permitted by law, the Plan may disclose protected health information ("PHI"), including electronic PHI, to the Board of Trustees (as Plan sponsor) only if the information is exempt information, or if the disclosure is for plan administration functions.
- a. **Definitions.** The following terms, as used in this section, shall have the meanings given below:
1. "Protected health information" or "PHI" means information that is created or received by the Plan that identifies a living or deceased individual, or for which there is a reasonable basis to believe the information can be used to identify the individual, and which relates to: the past, present, or future physical or mental health or condition of the individual; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual.

2. “Electronic PHI” means PHI that is transmitted or maintained in electronic media.
 3. “Exempt information” means: (a) summary health information, if requested for purposes of obtaining premium bids or modifying amending, or terminating the Plan; (b) information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from health insurance offered by the Plan; and (c) PHI that may be disclosed pursuant to an authorization that satisfies the applicable requirements of 45 C.F.R. § 164.508.
 4. “Summary health information” means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals provided health benefits under the Plan, and from which information described at 45 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.
 5. “Plan administration functions” are administration functions performed by the Board of Trustees on behalf of the Plan (such as quality assurance, claims appeals, auditing and monitoring), and exclude functions performed by the Board of Trustees in connection with any other benefit or benefit plan of the Board of Trustees.
 6. “Security incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
- b. Certification by Board of Trustees. With respect to PHI and electronic PHI (other than exempt information, which is not subject to this subsection) that it creates, receives, maintains or transmits while performing plan administration functions, the Board of Trustees certifies that it will:
1. not use or further disclose PHI other than as permitted or required by this section or as required by law;
 2. ensure that any agents, including a subcontractor, to whom the Board of Trustees provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such PHI, and agree to implement reasonable and appropriate security measures to protect any electronic PHI received from the Board of Trustees;
 3. not use or disclose PHI for employment-related actions and decisions;
 4. not use or disclose PHI in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees;
 5. report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in this section of which it becomes aware, and report to the Plan any security incident of which it becomes aware;

6. make PHI available for purposes of the access, amendment, and accounting of disclosures provisions in 45 C.F.R. §§ 164.524-528, and incorporate any amendments to PHI;
 7. make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with 45 C.F.R. Part 164;
 8. if feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);
 9. ensure that the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) between the Plan and Board of Trustees (the "firewall") is established, and ensure that such adequate separation is supported by reasonable and appropriate security measures; and
 10. implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI.
- c. Firewall. The members of the Board of Trustees shall have access to PHI (other than exempt information, which is not subject to this subsection) only to the extent necessary to perform plan administration functions, or as otherwise permitted by law. If any member of the Board of Trustees does not comply with the requirements of this section, that Trustee may be subject to removal under Article III of the Trust Agreement.
- d. Hybrid entity designation. To the extent the Plan qualifies as a "hybrid entity" under 45 C.F.R. § 164.103, only its health care components are subject to this section. The Plan designates as its "health care components" all benefits provided by the Plan except for accident and sickness weekly benefits, life insurance benefits, and accidental death and dismemberment benefits.

EXHIBIT A – HEALTH REIMBURSEMENT ARRANGEMENTS

You are eligible for benefits from the Plan's Health Reimbursement Account (HRA) if your employer contributes to the HRA, according to a collective bargaining or other Written Agreement. HRAs are subject to all of the other terms and conditions of the Plan.

1. **Effective date.** The HRA benefit is effective January 1st, 2012.
2. **Amount.** Your HRA benefit is the amount of employer contributions actually made to your HRA, less HRA benefits you have already received, and less administrative expenses. If the Plan receives reciprocal contributions for your work in Canada, then the amount received in excess of the then current hourly contribution rate will be credited to your HRA.
3. **Administrative Expenses.** Administrative expenses are assessed monthly, and used to pay service providers to operate the HRA and for other applicable expenses. Currently, administrative expenses are \$0.55 per month once you are eligible for reimbursement. Administrative expenses will be adjusted from time-to-time, and will be reflected on a quarterly statement and mailed to you.
4. **Eligibility.** You are eligible for reimbursement from your HRA once you have received contributions in the amount of \$120.00.
5. **Termination.** Your HRA balance will be eliminated if you are not available for Covered Employment or, if you are a Retiree, under age 65, and you have lost eligibility for Retiree Coverage because you work for an employer that does not have a Written Agreement with the Plan. If your HRA is terminated, it is also not available for your Dependents' medical care expenses and can never be reinstated.
6. **Benefits.** You may use your HRA to pay for medical care expenses (as defined by the Tax Code and as permitted by law). The expenses must be incurred by you or your enrolled Dependents, while you are eligible to receive reimbursements from the HRA. *Note: an expense is "incurred" when the service is rendered or the supply is delivered; a provider's billing practices do not matter.*
7. **Medical care expenses that are reimbursable under the HRA:** Medical care expenses under Tax Code Section 213(d), such as COBRA payments to the Plan, deductibles, co-pays and coinsurance, prescriptions, chiropractic care, acupuncture, vision care (including LASIK), hearing aids, and medically necessary orthodontics.
8. **Examples of medical care expenses that are not reimbursable under the HRA:** Non-Tax Code Section 213(d) expenses, wage replacement/cash, tuition, long-term care, most cosmetic procedures, toiletries, non-FDA-approved drugs, drugs obtained outside the U.S., over the counter medications (unless you also have a doctor's prescription for the medication), expenses for which the

Participant has no payment responsibility or that are otherwise reimbursable, health insurance premiums, COBRA for another Plan, and payments toward Medicare or other health coverage.

9. **Debit Card.** You will receive a special debit card that you can use to pay medical care expenses you incur at participating IAS pharmacies and medical facilities.

The debit card will be activated after you agree to use it only according to the terms of the Plan and Tax Law. (The Administrative Office will provide you with further details about the debit card program before your card is activated.)

10. **Request Reimbursement for other Services and Supplies.** You may also apply to the Administrative Office for reimbursement of medical care expenses not charged to your debit card within 90 days of when the expense is incurred. A claim form is available from the Administrative Office or via the Trust Fund website. When you submit a claim for reimbursement, you will be asked to include written statements and/or bills from an independent third party describing the service or product, the amount of the expense, and the date of the service or sale. Depending on the circumstances, this would include an invoice, prescription, an affidavit, and/or other documentation required by the Administrative Office. Cash register receipts are not, alone, an acceptable form of substantiation. (Further details about required documentation are on the claim form.)
11. **COBRA.** If you have a COBRA qualifying event that causes you to lose coverage under the Plan you will be given an opportunity to elect to continue your Plan coverage, with or without your HRA. However, even if you don't elect COBRA, your HRA will continue to be available to you as long as you otherwise meet the HRA eligibility requirements and your HRA is not terminated. You must notify the Administrative Office in writing if you wish to use your HRA to pay the monthly contributions required for COBRA.
12. **Retirement.** If your active coverage ends and you elect coverage as a Retiree, your HRA will remain available to you for payment of eligible medical care expenses. You must notify the Administrative Office in writing if you wish to use your HRA to pay the monthly contributions required for Retiree Coverage.
13. **Death.** If you die, your surviving spouse (who is also covered under the Plan as your Dependent) may use your HRA to pay for eligible medical care expenses, and for COBRA or continued coverage (if available) under the Plan.

OTHER INFORMATION ABOUT THE PLAN

NAME AND TYPE OF ADMINISTRATION OF THE PLAN

Name: The Ironworkers Intermountain Health & Welfare Plan.

Type: The Fund is a collectively bargained, joint-trusteed, labor management trust.

IDENTIFICATION NUMBERS

Employer Identification No. 87-6123188.

The plan number is 501.

TYPE OF PLAN

The Plan provides certain hospitalization, medical, prescription drug, vision, dental, AD&D, life insurance, and accident and sickness weekly benefits, to participants and beneficiaries, as described in this Plan and SPD.

SOURCE OF FUNDING OF PLAN BENEFITS AND METHOD OF ADMINISTRATION

The Plan is funded through Employer contributions as specified in collective bargaining agreements and participation agreements. Self-Payments by participants are also permitted, as described herein. The amount of Self-Payments is fixed from time to time by the Board of Trustees.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying administrative expenses. All of the benefits provided by the Plan are set forth in this Plan and certain insurance company booklets. Some benefits are provided directly under a group insurance policy or contract with an insurance company ("insured benefits"), and some benefits are funded by the Trust. (Details about insured benefits are contained in separate booklets.) For each type of benefit, the following chart states how the benefit is funded. The Claims Administrator and the Claims Fiduciary (and the contact information for each) is listed in the claims procedure section of the Plan.

| Benefit Type | Source of Benefits and Type of Funding |
|---|---|
| Medical, Dental, Vision Care, Disability (i.e. Accident and Sickness Weekly Benefits), Hearing Aid, Outpatient Drug | Funded by the Trust |
| Life Insurance and Accidental Death & Dismemberment Insurance | Insured by United Healthcare |

In addition, the Trust owns stop loss coverage.

**NAME AND ADDRESS OF THE PERSON DESIGNATED
AS THE AGENT FOR SERVICE OF LEGAL PROCESS**

For the uninsured benefits:

Ellen Mondress
Song Mondress PLLC
720 Third Avenue, Suite 1500
Seattle, WA 98104
(206) 398-1500

Agent for legal service of process on the insurance companies is the supervisory official of the insurance company in the state in which you reside.

Service of legal process may also be made by service on the Plan Administrator or any Plan Trustee. The Plan Administrator for insured benefits is the insurance carrier.

NAME AND CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR

The Board of Trustees is the Plan Administrator, except with respect to insured benefits. The Plan Administrator for an insured benefit is the insurer. The Trustees have engaged the independent contractor, CompuSys of Utah, Inc., to perform the routine administration of the Plan. Both the Board of Trustees and CompuSys of Utah, Inc., can be reached at:

P.O. Box 30124
Salt Lake City, Utah 84130-0124
2156 West 2200 South
Salt Lake City, UT 84119
Phone (801) 606-2425
Toll free (888) 867-9510

NEWBORN AND MATERNITY COVERAGE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing the length of stay not in excess of 48 hours (or 96 hours).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Benefits under this Plan are subject to the provisions of Qualified Medical Child Support Orders (QMCSO). Participants and Dependents can obtain, without charge, a copy of the procedures governing QMCSOs from the Administrative Office.

NAME AND ADDRESS OF ANY TRUSTEE OR TRUSTEES

| <i>UNION TRUSTEES</i> | <i>EMPLOYER TRUSTEES</i> |
|---|---|
| <p>Michael McDonald, Chairman Ironworkers Local Union No. 27 2261 South Redwood Road Salt Lake City, UT 84119</p> <p>Mike Baker Ironworkers Local Union #21 14515 Industrial Road Omaha, NE 68144</p> <p>Lonzo West Ironworkers Local Union #732 456 North Arthur/P.O. Box 220 Pocatello, ID 83204</p> <p>Jerry Romero Ironworkers Local Union #495 2524 Baylor SE Albuquerque, NM 87106</p> <p>Mark Calkins Ironworkers Local Union #24 501 West 4th Avenue Denver, CO 80223</p> | <p>George Bosiljevac, Secretary Structural Services 3520 4th Street N.W. Albuquerque, NM 87107</p> <p>Tom Moen, Jr. Moen Steel Erection 4115 Lake Street Omaha, NE 68111</p> <p>Dick DeVries Montana Contractors' Association 1119 Noblewood Drive Billings, MT 59101</p> <p>Mark Mundy SME Steel Contractors 5801 Wells Park Road West Jordan, UT 84081</p> <p>James L. Helgoth Elward Systems Corporation 680 Harlan Lakewood, CO 80214</p> |

ELIGIBILITY AND BENEFITS

Only the Board of Trustees or personnel of the Administrative Office, as authorized by the Board of Trustees, are allowed to respond to questions regarding eligibility or benefits. No one member of the Board of Trustees speaks officially for the entire Board, and all communication regarding benefits and eligibility is in writing.

SPONSORS OF THE PLAN

The Administrative Office will provide you, upon written request, with information as whether to a particular employer is contributing to this Plan pursuant to a collective bargaining agreement, and, if applicable, a copy of the relevant collective bargaining agreement.

PLAN FISCAL YEAR

The Plan Year ends each October 31.

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

As a participant in the Ironworkers Intermountain Health & 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 U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly Pension and Welfare Benefit Administration).

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 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

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to

pay for such coverage. Review this summary plan description and the comments governing the Plan in the rules governing your COBRA continuation coverage rights.

ERISA provides that all Plan participants shall be entitled to 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 welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need

assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Board of Trustees has the sole, exclusive, and discretionary authority to make any and all decisions with regard to benefits and eligibility, and to interpret the Plan. The Board communicates with you in writing, and only through the Administrative Office. Any contrary or unwritten communication about the Plan is ineffective, and you should not rely on it. No one Trustee or other person speaks for the entire Board. The Trustees reserve the right to change eligibility rules, reduce or eliminate benefits or hour bank accruals, or change the Plan entirely, including benefits and coverage provided to retirees and their families. Rights under the Plan do not accrue and do not vest.

HOW TO FILE A CLAIM FOR BENEFITS

This section describes the procedures for filing a claim for benefits and for appealing a denied claim. A “claim for benefits” means a request for Plan benefits made in accordance with the procedures described in this booklet. This section (“How to File a Claim for Benefits”) applies to the Plan’s Accident and Sickness Weekly Benefits and health benefits. See the applicable insurance contracts for claims procedures for the Life and Accidental Death and Dismemberment (“AD&D”) benefits.

For purposes of this section, the term “Disability Benefits” refers to the Accident and Sickness Weekly Benefits and the term “Medical Benefits” refers to all health benefits, including dental, hearing aid, and vision.

GENERAL CLAIMS INFORMATION

Enrollment form. You **must** complete and submit an enrollment form to the Plan Administrative Office before your claims will be processed. You can obtain an enrollment form from the Administrative Office. You must also submit all information requested by the Administrative Office that is reasonably necessary to administer the Plan and pay benefits, such as Social Security numbers for you and your Dependents, proof of marriage, divorce, death, or birth, and evidence of employment. Claims will not be paid if the enrollment form and information are not timely received by the Administrative Office.

Where to obtain claim forms. In general, you can obtain a claim form for Medical Benefits or Disability Benefits from your Local Union office or from the Administrative Office. However, you may obtain a claim form for Life and AD&D Insurance benefits from the Administrative Office or from UnitedHealthcare, which is the insurer for these benefits.

Where to file claim forms and appeals. All claims must be filed with the Claims Administrator (identified below). However, a claim for Life and AD&D Insurance benefits should be submitted to the Administrative Office, which will assist in the filing of your claim with the life insurance Claims Administrator. All appeals of denied claims must be filed with the Claims Fiduciary (identified below).

CLAIMS ADMINISTRATOR/CLAIMS FIDUCIARY CHART

| PLAN BENEFITS | CLAIMS ADMINISTRATOR | CLAIMS FIDUCIARY |
|--|--|---|
| Medical and Disability Benefits | Administrative Office CompuSys of Utah, Inc. P.O. Box 30124 Salt Lake City, UT 84130-0124 (888)-867-9510 (801)-606-2425 | Board of Trustees c/o Administrative Office (see contact information at left) |
| Outpatient Prescription Drug Benefits | Envision Rx 1100 Investment Blvd. El Dorado Hills, CA 95762 (800) 361-4542 | Board of Trustees –c/o Administrative Office (see contact information above) |
| Life Insurance & AD&D Insurance Benefits | c/o Administrative Office (see contact information above) Or, you may contact UnitedHealthcare directly at: UHC specialty benefits P.O. Box 7149 Portland, ME 04112-7149 Tel.: 1-888-299-2070 | United Healthcare (see contact information at left) |
| Hearing Aids | Epic 17870 Castleton Street Suite 308 City of Industry, CA 91748 www.epichearing.com Tel.: 1-866-956-5400 | Board of Trustees c/o Administrative Office (see contact information above) |

How to complete your claim form for Medical Benefits. In order for a medical claim form to be considered complete, you must:

1. Complete the employee portion of the claim form.
2. For claims after service or treatment, attach all itemized bills or provider's statements that describe the services rendered and return the claim form to the Claims Administrator.

Before submitting a claim, check the claim form to be certain that applicable portions of the form are completed and, for claims after service or treatment, that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim form has to be returned to you for information, delays in payment will result.

Claims must show the applicable procedure codes adapted from: (1) the Current Physician Terminology (CPT) Uniform Codes on Medical Procedures; (2) the American Dental Association (ADA) recommended Uniform Codes on Dental Procedures and Nomenclature, and

(3) the actual charges to the Participant for all services or procedures. Most Physician's offices will submit claims for you directly to the Claims Administrator.

Time limit for filing claims for Medical Benefits. Your completed claim form with all itemized bills generally must be received by the Claims Administrator within 90 days after the date your claim was incurred. **NO BENEFITS WILL BE PAID IF YOUR CLAIM IS SUBMITTED MORE THAN ONE YEAR AFTER THE DATE IT WAS INCURRED**, unless you establish it was not reasonably possible to submit the claim within one year of the date it was incurred.

PPO Preferred Providers and most Non-PPO Providers will file a claim on your behalf if notified of your coverage. When you visit a Preferred Provider or Non-PPO Provider, advise the personnel in the Provider's office that your coverage is through the Ironworkers Intermountain Health and Welfare Trust and present your Plan identification card. The Provider's office will then file the claim on your behalf. If a Provider submits a claim on your behalf, the Plan will remit any reimbursement it owes directly to the Preferred Provider. Non-PPO Providers will be reimbursed directly if you have assigned benefits.

How to complete your claim form for Disability Benefits. In order for a Disability Benefits claim form to be considered complete, you must complete the Employee section and your Physician must complete the Physician section of the form. Return the completed form to the Claims Administrator.

Time limit for filing claims for Disability Benefits. All claims for Disability Benefits must be submitted within one year of the date of your Illness or Injury.

Life and AD&D Insurance claims. Contact the Administrative Office to file a claim for Life and AD&D Insurance benefits. Life and AD&D Insurance claims, along with any required proof of loss, should be submitted as soon as possible following the date of death or dismemberment.

Your "authorized representative" may file a claim or appeal a denied claim on your behalf. Your "authorized representative" means a person you authorize, in writing, to act on your behalf with respect to a claim. It also means a person authorized by court order to submit claims on your behalf. For a healthcare claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

CLAIMS REVIEW PROCESS

A claim for benefits under the Plan arises only if you have filed a written request for a benefit determination with the Claims Administrator. The following sets forth the Plan's timelines for deciding your claim, and your appeal rights if your claim for benefits is denied. Please note that what follows are separate claim procedure rules that apply depending on whether your claim is for Medical Benefits, or Disability Benefits. Moreover, if your claim is for Medical Benefits, different claim and appeal procedures apply based on whether your claim is for prior approval of a benefit before the service or treatment is obtained, or is after service or treatment, and your claim may also be eligible for an external review process. In addition, the Claims Fiduciary

may, outside of the timelines set forth herein, reconsider an initial claim or appeal determination at any time if facts that were not within the control of the Claims Fiduciary become known subsequent to the initial determination.

GENERAL PROVISIONS APPLICABLE TO MEDICAL BENEFIT CLAIM DETERMINATIONS

Initial Denial Decisions and Appeal Decisions will be provided in a culturally and linguistically appropriate manner in a non-English language upon request, but only if you live in a county where 10 percent or more of the population is literate only in the same non-English language as determined by applicable federal guidance.

If the above percentage threshold standard is met, the following three conditions will apply to claimants in such counties: Oral language services such as a telephone hotline in the applicable non-English language will be available to answer questions and assist in filing claims and appeals; the Plan will provide upon request a notice in the applicable non-English language; and the Plan will include in the English version of all notices a statement in the applicable non-English language clearly indicating how to access the language services.

The Plan ensures that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of persons, including medical experts or review organizations, involved in making decisions and no hiring or retention decisions will be based upon the likelihood that the person will support a denial of benefits.

If the Plan fails to adhere to all the requirements of the Claims Review Process, you may be deemed to have exhausted the internal claims and appeal process and may submit a request for external review if applicable. A deemed exhaustion, however, does not occur if violations of the claims review process are *de minimis* violations that do not cause, and are not likely to cause prejudice or harm to you so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between you and the Plan. You may request a written explanation of the violation from the Plan, which must be provided within 10 days, including the bases for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. In case there is a deemed exhaustion, you may also be entitled to remedies under Section 502 of ERISA by filing a case in court. Unless otherwise specified herein, you are required to exhaust the internal claim and appeal process before filing a request for external review or filing a lawsuit.

MEDICAL BENEFIT CLAIM DETERMINATIONS AND APPEALS

The following procedures apply to any claim for Medical Benefits:

Timing of Initial Determination – Precertification Medical Benefits Claims.

The Plan requires that you get prior review or approval before you receive certain covered services or treatments in order to receive higher levels of benefits under the Plan than if prior approval is not obtained. The following rules apply to these claims for prior review or approval required by the Plan. All prior review or approval procedures required by the Plan are referred to in these procedures as “precertification” claims.

Urgent precertification claims. If your precertification claim is determined by the Plan to be a claim involving urgent care (as defined below), notice of the Plan’s decision will be provided to you as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of your claim by the Plan. For this purpose, the Plan shall defer to a determination of urgent care by the attending provider. If, however, you do not provide sufficient information to decide your claim, a notice requesting specific additional information will be provided to you within 24 hours of receipt of your claim. The Plan’s decision regarding your claim will then be issued no later than 48 hours after the earlier of 1) the Plan’s receipt of the requested information or 2) the expiration of the time period set by the Plan for you to provide the requested information (at least 48 hours). Benefit denials may be oral or in writing. If the denial is provided orally, written notice will also be provided within three days after the oral notice.

A “claim involving urgent care” is a claim for precertification where application of the normal time periods for deciding your claim 1) could seriously jeopardize your life or health or your ability to regain maximum function, or 2) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot adequately be managed without the care or treatment being sought. If a physician with knowledge of your medical condition determines that your claim meets this definition of urgent care, the claim will be treated by the Plan as involving urgent care.

Regular precertification claims. If your precertification claim is not an urgent care claim, written notice of the Plan’s decision will generally be provided to you within a reasonable period of time, but no later than 15 days after receipt of your claim by the Plan. If matters beyond the control of the Plan so require, one 15-day extension of time for processing the claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to you before the end of the initial 15-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Failure to follow precertification procedures. If your communication to the Plan concerning precertification does not comply with the Plan’s procedures for filing pre-certification claims, notice of the proper procedures will be provided to you within five days of the communication. If, however, the communication involves urgent care, notice will be provided within 24 hours. Such corrective notice will be provided only if your communication specifically names the claimant, medical condition or symptoms, and the treatment, service or product being requested. Notice may be oral, unless you request written notice.

Timing of Initial Determination – Medical Benefits Claims After Service or Treatment

If your claim for a benefit does not require pre-approval in advance of receiving medical care, written notice of a denial will generally be provided to you within a reasonable period of time,

but no later than 30 days after receipt of your claim by the Plan. If matters beyond the control of the Plan so require, one 15-day extension of time for processing the claim beyond the initial 30 days may be taken. A written notice of the extension will be furnished to you before the end of the initial 30-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Timing of Determination – Concurrent Care Medical Decision – Medical Benefits Claims

Reduction or termination of ongoing course of treatment. If the Plan has previously approved an ongoing course of treatment to be provided over a period of time or a number of treatments, notice of any later decision to reduce or terminate the ongoing course of treatment (other than by Plan amendment or termination) shall be treated as an adverse benefit determination that you can appeal. Such notice will be provided to you sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the treatment is reduced or terminated, so that generally your benefits for an ongoing course of treatment would continue pending an appeal.

Extension of ongoing course of treatment involving urgent care. If your request that the Plan extend an ongoing course of treatment beyond the previously approved period of time or number of treatments involves urgent care, you will be notified of the decision by the Plan within 24 hours after its receipt of the request, provided the request is received at least 24 hours prior to the expiration of the pre-approved period of time or number of treatments.

Contents of Initial Denial – Medical Benefits Claims

If your claim is denied, in whole or in part, you will be notified in writing by the Plan. The written notice will include the following:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- the specific reason or reasons for the denial, including to the extent applicable the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim;
- references to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed;
- an explanation of the Plan's available internal appeal and external review processes for denied claims, including information regarding how to initiate an appeal and the applicable time limits for submitting your appeal (claims involving urgent care will have a description of expedited appeal procedures);

- a statement of your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on appeal;
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request;
- if the decision was based on a medical necessity or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- the availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process.

Appeal Procedure for Denied Medical Benefits Claims

A denial of a claim includes a denial in whole or in part, and for purposes of appeal rights, includes a rescission of coverage whether or not the rescission has an adverse impact on any particular benefit at that time. If you wish to appeal a denial of a claim, you or your authorized representative must file a written appeal with the Claims Fiduciary within 180 days after receiving notice of denial, unless your claim concerns the reduction or termination of a previously approved ongoing course of treatment. In that case, you must file a written appeal within a shorter time period that permits the Claims Fiduciary to issue an appeal decision before the treatment is reduced or terminated. You or your authorized representative may submit a written statement, documents, records, and other information. You may also, free of charge upon request, have reasonable access to and copies of Relevant Documents (defined below). The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents. In addition:

- the appeal decision will not defer to the initial decision denying your claim and will be made by the Claims Fiduciary, who is not a person who made the initial decision, nor a subordinate of such person;
- if the initial denial decision was based in whole or in part on a medical judgment, the Claims Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person;
- any medical or vocational expert whose advice was obtained in connection with the decision to deny your claim will be identified upon request, whether or not the advice was relied upon;
- if your claim involves urgent care, your request for an appeal may be submitted orally or in writing, and all necessary information, including the appeal decision, is to be transmitted between the Plan and you by telephone, facsimile, or other similarly expeditious method;
- you will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan or at the direction of the Plan in connection with the

claim, and such information will be provided as soon as possible and sufficiently in advance of the date the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date; and

- if a final internal appeal decision is based on a new or additional rationale, you will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date.

The Claims Fiduciary reviews appeals of denied claims and makes final determinations. The Claims Fiduciary has the discretionary authority to administer, construe and interpret the terms and provisions of the Plan, SPD and Trust Agreement in order to determine benefits under the Plan.

Bringing an appeal within applicable timelines is a prerequisite to filing a lawsuit in court regarding your claim.

Timing of Appeal Decision – Precertification Medical Benefits Claims

Urgent care precertification claims. A decision on your appeal will be made as soon as possible, but no later than 72 hours after an appeal is received.

Regular precertification claims. A decision on your appeal will be made within a reasonable period of time, but no later than 30 days after an appeal is received.

Timing of Appeal Decision – Medical Benefits Claims After Service or Treatment

If you or your representative would like to appear before the Board of Trustees when they consider your appeal, notify the Administrative Office when you file your appeal. The Administrative Office will notify you of the time and date you may appear.

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Claims Fiduciary after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Contents of Appeal Decision – Medical Benefits Claims

If you appeal a denied claim, the decision on review will be in writing and will include the following information:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- the specific reason or reasons for the decision, including to the extent applicable the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim that includes a discussion of the decision;
- reference to the specific Plan provisions on which the decision is based;
- a statement of your right to receive, upon request free of charge, reasonable access to and copies of all Relevant Documents;
- an explanation of the Plan's available external review process for denied claims, including information regarding how to initiate the external review and the applicable time limits;
- a statement of your right to bring a civil action under Section 502(a) of ERISA;
- a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits on review, or a statement that such was relied upon and that a copy will be provided free of charge upon request;
- if the decision on review was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- the availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act section 2793 to assist individuals with the internal and external claims and appeals process.

Standard External Review Process for Denied Claims

If your claim for medical benefits is denied in an Initial Determination or Appeal Decision and you have exhausted the Plan's internal appeal process or are not required to exhaust that process, you may submit a request for external review of the denial but only if the denial involves 1) medical judgment (including but not limited to requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that treatment is experimental or investigational), as determined by the external reviewer; or 2) a rescission of coverage, regardless whether the rescission has any effect on a benefit at that time. The request must be filed with the Claims Fiduciary within four months after the date of receipt of the denial decision. If there is no corresponding date four months after the date of receipt of the denial decision, the request must be filed by the first day of the fifth month following the receipt of the denial decision. If the last filing date falls on a weekend or Federal holiday, the filing date is extended to the next week day that is not a weekend or Federal holiday.

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

- the claim was covered under the Plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under the Plan at the time the health care item or service was provided;
- the denial decision does not relate to the claimant's failure to meet eligibility requirements under the terms of the Plan;
- you have exhausted the Plan's internal appeal process unless you are not required to exhaust the internal appeals process under applicable final regulations; and
- you have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, the Plan shall issue a written notice to you as to whether your claim is eligible for external review. If your request is complete but not eligible, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272) at the Department of Labor. If the request is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notice, whichever is later.

If your request for external review is complete and eligible, it will be assigned to an independent review organization ("IRO") that has been accredited by URAC or a similar nationally recognized accrediting organization to conduct the external review. The Plan has contracted with IROs for assignments under the Plan and uses unbiased methods for selecting the IRO for your claim.

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. It will provide you a written notice of your request's eligibility and acceptance for external review which will include a statement that you may submit within ten business days after receipt of the notice additional information that the IRO must consider when conducting its review. The IRO is not required to, but may consider, information submitted after ten business days. Within five business days after assignment of the IRO, the Plan shall provide the IRO the documents and information considered in making the denial decision. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the denial decision. The IRO shall notify you and the Plan of its decision within one business day after it is made. The IRO shall forward information submitted by you to the Plan within one business day. Upon receipt of the information, the Plan may reconsider its denial decision and if it decides to reverse its decision, notify you and the IRO within one business day after making such a decision. The IRO shall terminate its external review upon receipt of such notice.

The IRO will review your claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claim and appeal process. In addition to the documents and information provided, the IRO to the extent such information is available and the IRO considers them appropriate, will consider the following in its decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and documents submitted by the Plan, you and your treating provider;
- the terms of the Plan;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with terms of the Plan or applicable law; and
- the opinion of the IRO's clinical reviewer after considering documents and information to the extent they are available and the clinical reviewer considers them appropriate.

The IRO shall provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the request for external review. The IRO's decision shall include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the dates of service, health care provider, claim amount if applicable, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act Section 2793.

After a final external review decision, the IRO shall maintain records of the claim and notices for six years. Such records are available for examination by you, the Plan or applicable governmental oversight agencies upon request, except where such disclosure would violate applicable privacy laws.

Upon receipt of a final external review decision reversing a denial decision, the Plan shall immediately provide coverage or payment for the claim.

Expedited External Review Process for Denied Claims

If your claim is eligible for the external review process, you may request an expedited external review if:

- an Initial Determination involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- a final internal Appeal Decision involves a medical condition where the timelines for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the Appeal Decision concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Plan shall determine whether the request meets the reviewability standards set for preliminary reviews under the Standard External Review Process discussed above. The Plan shall immediately send you a notice that complies with the requirements for standard external reviews as to whether your request for an expedited external review is eligible.

If your request for an expedited external review is complete and eligible, it will be assigned to an IRO. The Plan shall provide all necessary documents and information considered in making its denial decision to the IRO electronically or by telephone or facsimile or other available expeditious method. The IRO, to the extent information or documents are available and the IRO considers them appropriate, shall consider the documents and information described above for standard external reviews. The IRO shall review the claim de novo and is not bound by any decision or conclusions reached during the Plan's internal claims and appeals process.

The IRO shall provide a notice of its final expedited external review decision in accordance with the requirements for standard external review decisions as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours of the notice, the IRO shall provide written confirmation of the decision to you and the Plan.

DISABILITY BENEFIT CLAIM DETERMINATIONS AND APPEALS

The following procedures apply to any claim for Disability Benefits.

Timing of Initial Denial - Disability Benefits Claims

A written denial notice will be provided to you within a reasonable period of time, but not later than 45 days after receipt of your claim by the Plan. If matters beyond the control of the Plan require an extension of the time for processing your claim, the initial period may be extended for up to 30 days. Written notice of an extension will be sent before the end of the initial 45-day

period. In addition, another 30-day extension of time for processing your claim due to matters beyond the control of the Plan may be taken. Written notice of such second extension will be sent before the end of the first 30-day extension period. The extensions shall not exceed a period of 60 days from the end of the initial 45-day period.

An extension notice will explain the reasons for the extension, the expected date of a decision, the standards for a benefit entitlement, any unresolved issues that prevent a decision on your claim, and any additional information needed to resolve those issues. If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Contents of Initial Denial – Disability Benefits Claims

If your claim for a benefit is denied, you will be notified in writing. The written notice will include the following:

- the specific reason or reasons for the denial;
- references to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed;
- an explanation of the Plan's review procedure for denied claims, including the applicable time limits for submitting your claim for review;
- a statement of your right to bring a civil action under Section 502(a) of ERISA, if your claim is denied on appeal;
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request; and
- if the decision was based on a medical necessity or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.

Appeal Procedure for Denied Claim – Disability Benefits Claims

If you wish to appeal a denial of a claim, you or your authorized representative must file a written appeal with the Claims Fiduciary within 180 days after receipt of written notice of the denial. You or your authorized representative may submit a written statement, documents, records, and other information. You may also, free of charge upon request, have reasonable access to and copies of Relevant Documents (defined below). The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

In addition, the following procedures apply:

- the appeal decision will not defer to the initial decision denying your Disability Benefits claim and will be made by the Claims Fiduciary, who is not the person who made the initial decision, nor a subordinate of such person;
- if the initial denial decision was based in whole or in part on a medical judgment, the Claims Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person; and
- any medical or vocational expert whose advice was obtained in connection with the decision to deny your Disability Benefits claim will be identified upon request, whether or not the advice was relied upon.

The Claims Fiduciary reviews appeals of denied claims and makes final determinations. The Claims Fiduciary has the discretionary authority to administer, construe and interpret the terms and provisions of the Plan, SPD and Trust Agreement and to determine eligibility for benefits under the Plan.

Bringing an appeal within applicable timelines is a prerequisite to filing a lawsuit in court regarding your claim.

Timing of Appeal Decision – Disability Benefits Claims

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Claims Fiduciary after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

Contents of Appeal Decision – Disability Benefits Claims

If you appeal a denied claim, the decision on review will be in writing and will include the following information:

- the specific reason or reasons for the decision;
- reference to the specific Plan provisions on which the decision is based;

- a statement of your right to receive, upon request free of charge, reasonable access to and copies of Relevant Documents;
- a statement of your right to bring a civil action under Section 502(a) of ERISA.
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits on review, or a statement that such was relied upon and a copy will be provided free of charge upon request;
- if the decision on review was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request, and
- the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency.”

RELEVANT DOCUMENTS

For purposes of this section (“How to File a Claim for Benefits”), “Relevant Document” means any document, record or other information that:

- was relied upon in making a decision to deny benefits;
- was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits;
- demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the Plan and that Plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals; or
- if the claim was a medical or disability claim, constitutes a statement of policy or guidance with respect to the Plan concerning a denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the decision to deny benefits.

LIMITATIONS PERIOD FOR LAWSUITS

In order to bring a lawsuit in court regarding your claim, you must file suit within two years after your appeal is denied or, if earlier, the date your cause of action first accrued. If a different limitations period is specified in a contract for an insured benefit, then that limitations period applies to that benefit.

IF YOU HAVE QUESTIONS

If you have questions about filing your claim or an appealing a denied claim, please do not hesitate to contact the appropriate Claims Administrator. Each Claims Administrator’s contact information is listed above in Section I of this booklet.

KEEPING INFORMATION CURRENT

1. It is your responsibility to make sure the Administrative Office has current information regarding you and your dependents. Advise the Administrative Office promptly of any change in your home address so their records will be kept current.
2. **BENEFICIARY DESIGNATION.** Contact the Administrative Office to obtain the necessary form in the event you wish to change your beneficiary for your life and AD&D insurance benefits. A new enrollment form will be sent to you when you notify the Administrative Office of a beneficiary or family composition change.
3. **FAMILY COMPOSITION.** Give prompt, written notice to the Administrative Office about any change in your family such as marriage or divorce, birth of a child, the marriage or loss of Dependent status of any of your children, or the death of any Dependent. A new enrollment form will be sent to you when you notify the Administrative Office of a beneficiary or family composition change.
4. **OTHER INSURANCE COVERAGE.** Give prompt written notice to the Administrative Office about any other insurance coverage you or your Dependents may have. Also give written notice of changes in employment of Dependent spouse or children.

It is your responsibility to notify the Administrative Office of a change in Dependent status, such as a divorce. If notice is not given and the Fund pays the claims of a person who is not eligible for coverage, you will be responsible to reimburse the Fund. If you do not promptly reimburse the Fund, the Fund will not pay your and your Dependents' future claims, which the Fund would otherwise cover. The Fund may also sue you to recover overpaid amounts.

**ATTACHED – LIFE AND ACCIDENTAL DEATH AND DISABILITY
INSURANCE CERTIFICATE**



UnitedHealthcare®

**GROUP LIFE
ACCIDENTAL DEATH AND DISMEMBERMENT
CERTIFICATE OF COVERAGE

FOR IRONWORKERS INTERMOUNTAIN
HEALTH & WELFARE TRUST FUND**

GROUP NUMBER: 300231

CERTIFICATE EFFECTIVE DATE: November 1, 2009

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(5-12)

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United HealthCare Insurance Company
450 Columbus Boulevard Hartford, Connecticut (Home Office)

Policyholder: Ironworkers Intermountain Health & Welfare Trust Fund

Effective Date of Policyholder: November 1, 2004

Policy Number: 300231

Covered Person: As on file with the Administrator Certificate Number: As

on file with the Administrator Certificate Effective Date: As on file with

the Administrator Beneficiary: As on file with the Administrator

We, United HealthCare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in this Certificate insure the Covered Person eligible for insurance.

Read the Group Certificate Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

If the Policyholder or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 1-800-554-5413.

It is signed at the Home Office of United HealthCare Insurance Company as of the Effective Date shown above.



Secretary



President

**Group Life, Accidental Death and
Dismemberment Insurance Policy
Non-Participating**

**Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343**

SCHEDULE OF BENEFITS

Class of Employees

This schedule covers the following class(es) of Employees of companies and affiliates controlled by the Policyholder:

All full-time Employees, excluding temporary and seasonal employees

Refer to ARTICLE II. ELIGIBILITY RULES of the Ironworkers Intermountain Health & Welfare Trust in the Restated Plan Document issued June 2004.

Covered Person Insurance:

Basic Life Insurance Benefit:

\$10,000

Basic Life Insurance Benefit will terminate at retirement.

Basic Accidental Death and Dismemberment Benefit:

\$10,000

Basic Accidental Death and Dismemberment Benefit will terminate at retirement. Basic

Accidental Death and Dismemberment Benefits are issued on an

occupational (24 hour) basis non-occupational basis

Accelerated Death Benefit: Up to 50% of the Basic Life Insurance amount in force to a maximum of \$5,000. Employee must have at least \$10,000 in Basic Life Insurance in-force to qualify for this benefit.

GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

Active Work or Actively at Work: The Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform the material and substantial duties of his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless Disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave.)

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: The Employee insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

Dependent: Includes

1. a legal Spouse; and
2. any unmarried Child under the age shown in the Schedule of Benefits.

A Child will not be insured over the limiting age as stated on the Schedule of Benefits unless the Child is physically or mentally Disabled.

The term "Child" includes a natural child, legally adopted child, stepchild, foster child, or any child who lives with the Covered Person in a regular parent-child relationship.

Employee: A person who is:

1. directly employed in the normal business of the Policyholder; and
2. paid for services by the Policyholder; and
3. Actively at Work for the Policyholder, or any subsidiary or affiliate insured under the Policy.

No director or officer of the Policyholder will be considered an Employee unless he meets the above conditions.

Hospital or Medical Facility: A legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

GENERAL DEFINITIONS (continued)

Injury: A bodily Injury resulting directly from an accident and independently of all other causes.

Physician: A practitioner of the healing arts who is:

1. duly licensed in the state in which the Treatment is received; and
2. practicing within the scope of that license.

The term Physician does not include the Covered Person, the Covered Person's spouse, children, parents, parents-in-law, or siblings.

Regular Care: The Covered Person personally visits a Physician as often as is medically required to effectively manage and treat his disabling condition(s), according to generally accepted medical standards. The Covered Person is receiving appropriate Treatment and care, according to generally accepted medical standards, by a Physician whose specialty or experience is appropriate for the disabling condition(s).

Sickness: An illness, disease, pregnancy or complication of pregnancy.

Treatment: consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

We, Our and Us: United HealthCare Insurance Company.

CERTIFICATE GENERAL PROVISIONS

Discretionary authority: When making a benefit determination under the Policy, We have discretionary authority to determine the Covered Person's or Dependent's eligibility, if applicable, for benefits and to interpret the terms and provisions of the Policy. This provision applies, however, only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

Fraud: We will focus on all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Covered Person or the employer knowingly, and with intent to injure, defraud or deceive Us, files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums or fraudulent misrepresentations, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, nor unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

Information To Be Furnished: The Policyholder may be required to furnish any information needed to administer the Policy. Clerical error by the Policyholder will not:

1. affect the amount of insurance which would otherwise be in effect; or
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an equitable adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period, which precedes the date We receive proof such an adjustment should be made. We may inspect any of the Policyholder's records which relate to the Policy.

Misstatement Of Age: If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

Payment of Premiums: No insurance provided by the Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at Our Home Office. A Grace Period of 45 days from the Premium Due Date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will remain in effect provided the premium is paid before the end of the Grace Period. Should a premium otherwise due, not be paid during the Grace Period, the Policy will termination without further notice as of the end of the Grace Period. The Policyholder is liable for the pro-rata premium for the time coverage under this Policy was in force during such Grace Period. Payment of Premium for a period before it is due will not guarantee that the insurance will remain in effect for that period.

CERTIFICATE GENERAL PROVISIONS (continued)

Premium Rate Change: We have the right to change premium rates as of any Premium Due Date but not more than once in any 12-month period. We will notify the Policyholder in writing at least 31 days prior to the change in rates.

The premium rate may change prior to this time however, for reasons that affect the insured risk, which include:

1. a change occurs in benefits;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of Employees insured changes by 25% or more;
4. a new Law or a change in any existing Law is enacted which applies to the Policy.

A change may take effect on an earlier date if both the Policyholder and We agree to it. Except in the case of fraud, premium adjustments, refunds or charges will be made for only the current Policy year.

Records: The Policyholder must furnish all information required by Us to:

1. compute premiums; and
2. maintain necessary administrative records.

Records of the Policyholder, which have a bearing on insurance, will be available for inspection by Us at any reasonable time.

Workers' Compensation: The Policy is not to be construed to provide benefits required by Workers' Compensation laws.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who work on a full-time basis for a Policyholder are eligible for insurance after completion of the required Employee Waiting Period, provided they are in a class of Employees who are included. Employees will be considered to work on a full-time basis if they customarily work at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee's class; or
4. the date the Employee enters a class eligible for insurance.

Effective Date of Covered Person Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
 - a. the date the Employee is eligible for insurance, regardless of when he applies; or
 - b. the date the Employee's application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if an Employee applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class.

Effective Date of Change in Amount of Insurance: If there is an increase in the amount of the Covered Person's insurance, the increase will take effect on:

1. the policy anniversary date on or next following the date of the increase, if the Covered Person is Actively at Work on the date of increase;
2. the date the Covered Person returns to Active Work if the Covered Person is not Actively at Work on the policy anniversary date on or next following the date of the increase;
3. the policy anniversary date on or next following the date of the increase, if the policy anniversary date is a non-working day and the Covered Person was Actively at Work on his last scheduled working day before the non-working day;
4. the date of the increase if the Covered Person is on an approved layoff or leave of absence, for reasons other than a Sickness or Injury.

If evidence of insurability is required, the increase will take effect on the later of the dates indicated above or the date We approve his application.

A decrease in the amount of the Covered Person's insurance will take effect on the date of the decrease.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Family and Medical Leave of Absence: If the Covered Person is on a Family or Medical Leave of Absence, his insurance will be governed by his employer's policy on Family and Medical Leaves of Absence.

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid and his Leave of Absence is approved in advance and in writing by his employer.

The Covered Person's insurance will continue for up to the greater of:

1. the leave period required by the Federal Family and Medical Leave Act of 1993; or
2. the leave period required by applicable state law.

While the Covered Person is on a Family or Medical Leave of Absence, We will use earnings from his employer just prior to the date his Leave of Absence started to determine Our payments to him.

If the Covered Person's insurance does not continue during a Family or Medical Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period including a Waiting Period for insurance of a Pre-Existing Condition, if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Termination of Covered Person Insurance: The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date he ceases to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the date he ceases to be Actively at Work.
 - a. If active work ceases during an approved layoff, medical leave or non-medical leave of absence, the insurance will not continue more than 3 months from the date he stopped active work.
 - b. If active work ceases due to a sickness or accidental injury, and the Covered Person is eligible for the Waiver of Premium provision in this Certificate, the Policyholder may continue the Covered Person's insurance for up to 12 months from the date he stopped active work.
5. the date he is no longer Actively at Work due to a labor dispute, including but not limited to a strike, work slow down or lock out.

LIFE INSURANCE BENEFIT FOR COVERED PERSON

Death Benefits: We will pay the Covered Person's beneficiary the amount of insurance in force on the date of death when We receive satisfactory proof of a Covered Person's death. The benefit will be paid in accordance with the beneficiary section.

Assignment: Life insurance as provided by the Policy may be assigned as an absolute assignment only. In making an assignment, the Covered Person must transfer all his present and future ownership rights to the person to whom he assigned the insurance. This includes the right to change the beneficiary and to convert the insurance. The Covered Person may not make a collateral or partial assignment of his insurance.

Beneficiary: The Covered Person's beneficiary will be the person(s) he names in writing to receive any amount of insurance payable due to his death.

The Covered Person may name or change a beneficiary by giving Us written notice at Our Home Office on a form acceptable to Us. When We receive the notice, it will be effective on the date made, subject to any payment We may have made before We receive it.

If the Covered Person names more than one beneficiary, those who survive will share equally unless the Covered Person specifies otherwise. If there is no named beneficiary living at the Covered Person's death, We will pay any amount due to the estate or, at Our option, to his:

1. legal spouse;
2. natural or legally adopted children in equal shares; or
3. estate.

Notice of Claim: Written notice of a claim for death must be given to Us at Our Home Office by the Covered Person's beneficiary within 30 days of the date of death. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's employer, or can be requested from Us. If the form is not received from Us within 15 days of a request, written proof of claim should be sent to Us without waiting for the form. Written proof must show the cause of death. Also, a certified copy of the death certificate must be given to Us.

Proof of Claim: Written proof of claim must be filed within 90 days of the loss. However, if it is not possible to give proof within 90 days, it must be given as soon as reasonably possible.

Payment of Claim: Payment of Claim for loss of life will be paid in accordance with the beneficiary section. All other benefits under the Policy are paid to the Covered Person.

If the Covered Person has chosen an option, no one may change it unless the Covered Person consents in writing. The Covered Person's beneficiary may choose an option within 60 days after death if one has not been chosen.

Legal Action: The Covered Person may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought more than three years after the date of loss.

LIFE INSURANCE BENEFIT FOR COVERED PERSON (continued)

Physical Examination and Autopsy: We have the right to have a Physician of Our choice examine the Covered Person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Settlement Options: Instead of a single payment, the Covered Person may choose to have all or part of the insurance paid under one of the settlement options We have available. We will give the Covered Person full information about the options upon request.

Conversion Privilege: The Covered Person may convert:

1. all or part of his Life Insurance to an individual policy of life insurance, other than term, if his insurance terminated because he ceases to be a member of a class eligible for insurance;
2. the amount of insurance to an individual policy of life insurance, other than term, that is lost due to a reduction of insurance because of age;
3. a limited amount of insurance to an individual policy of life insurance, other than term, if he has been continuously insured under the Policy (or the policy it replaced) for five years and the insurance terminated due to termination or amendment of the Policy. The amount the Covered Person may convert in this case is the smaller of the following:
 - a. the amount of Life Insurance which terminates, less the amount he became eligible for under any Policy within 31 days after this insurance terminated; or
 - b. \$10,000.

The Covered Person may convert to any policy, other than term, We are issuing for the purpose of conversions. The conversion policy will not have disability or other supplementary benefits. No evidence of insurability will be required. Written application and the first premium payment for the conversion policy must be received in Our Home Office within 31 days after his insurance terminates. The premium will be based on the amount and the form of the conversion policy, and on his class of risk and age on the date the conversion takes effect.

If the Covered Person dies within the 31 days allowed for making application to convert, We will pay the amount he was entitled to convert. We will do this whether or not application was made.

A conversion policy is in lieu of benefits under this section of the Policy. However, if the Covered Person is qualified for the Waiver of Premium-Total Disability provision, the converted policy will be cancelled. Premiums paid for the converted policy will be returned.

The conversion policy will take effect on the later of:

1. its date of issue; or
2. 31 days after the date this insurance terminates.

The insurance under the Policy may be reinstated within one year after termination of employment, if the Covered Person has converted and he:

1. gives Us proof that he was Totally Disabled when his insurance terminated and that his insurance would have continued in force under the Waiver of Premium-Totally Disabled provision if he had not converted; and
2. surrenders the conversion policy to Us without claim in return for premiums paid less any unpaid policy loans.

Employees rehired after converting insurance must either lapse that insurance or provide evidence of insurability to keep that individual policy.

WAIVER OF PREMIUM – TOTAL DISABILITY FOR COVERED PERSON

We will continue the Covered Person's Life Insurance in force without premium payment while he remains Totally Disabled if he:

1. becomes Totally Disabled before age 60;
2. remains Totally Disabled continuously for at least nine consecutive months;
3. gives Us proof of Total Disability, as required.

We will waive the Covered Person's premium payment on a monthly basis, beginning the first day of the month after the month he became Totally Disabled. We will refund any premium paid for the Life Insurance after that day. We will not refund premiums for any period more than 12 months before the date proof of disability was furnished. This Waiver of Premium will continue

to be effective even if the Policy terminates after the Covered Person becomes Totally Disabled.

Amount of Life Insurance Under the Total Disability Benefit: The amount of insurance continued would be the amount in force on the date the Covered Person became Totally Disabled. This amount will be reduced or terminated, based on the Schedule of Benefits in effect on the date of Total Disability. This amount will not be increased while the Covered Person remains Totally Disabled. All other Benefits will be terminated.

Death While Totally Disabled: If the Covered Person dies while his Life Insurance is being continued under Waiver of Premium, We will pay the amount of insurance if We receive proof:

1. of the Covered Person's death; and
2. that Total Disability was continuous from the date it began to the date of death.

Proof of Total Disability: We will provide forms which the Covered Person must use when giving Us proof of Total Disability. The Covered Person must give Us proof no later than 12 months after the date he became Totally Disabled. We may at any time require proof that Total Disability continues. The Covered Person must give Us proof within 60 days after Our request. After the Covered Person has been Totally Disabled for more than two years from the date of Total Disability, We will not request proof any more than once a year. We may require the Covered Person to be examined, at Our expense, by a Physician of Our choice.

Total Disability or Totally Disabled: For purposes of this section, the Covered Person will be considered Totally Disabled if he is unable to perform each and every duty of his occupation at his usual place of employment and he is unable to do the material and substantial duties of any job suited to his education, training or experience.;

We may require the Covered Person to be examined by a Physician, other medical practitioner or vocational expert of Our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so.

Termination of the Total Disability Benefit: The Covered Person will no longer be eligible for the Total Disability Benefit and his Life Insurance will terminate on the earlier of the following dates:

1. the date the Covered Person ceases to be Totally Disabled. However, if he is still eligible for Life Insurance when he returns to Active Work, his Life Insurance may be continued in force if premium payments are resumed. If this is done, any increased amount of Life Insurance he may then be eligible for will take effect as described in the Effective Date of insurance provision; or

**WAIVER OF PREMIUM – TOTAL DISABILITY FOR COVERED PERSON
(continued)**

2. the last day of the 60-day period following Our request for proof of Total Disability, if he does not give Us proof or refuses to take a medical exam;
3. the date the Covered Person reaches age 65;
4. the date premium has been waived for 12 months and the Covered Person is considered to reside outside the United States. The Covered Person is considered to reside outside the United States when he has been outside the United States for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

If the Covered Person's Total Disability ends and he does not return to Active Work, then the Covered Person may exercise the Conversion Privilege.

ACCELERATED DEATH BENEFIT FOR COVERED PERSON

The Accelerated Death Benefit payment may be taxable to the Covered Person. The Covered Person should seek assistance from his personal tax advisor regarding taxes the Covered Person may have to pay as the result of claiming Accelerated Death Benefits.

If while insured under the Policy, the Covered Person becomes terminally ill (called the “qualifying event”) with a life expectancy of less than 12 months and the Covered Person has met all of the conditions set forth below, We will pay the Covered Person the amount of insurance shown in the Schedule of Benefits.

The Covered Person may elect to receive an Accelerated Death Benefit amount that is stated on the Schedule of Benefits. However, an Accelerated Death Benefit payment against the Covered Person’s Life Insurance Benefit can only be made once in the Covered Person’s lifetime.

The Life Insurance Benefit amount will be reduced by the amount paid under this provision.

The Covered Person must submit written medical evidence signed by the treating Physician and acceptable to Us that he is:

1. under a Physician’s care for that condition, and
2. has a life expectancy of less than 12 months.

The Accelerated Death Benefit amount will be paid to the Covered Person after the Covered Person meets all of the conditions listed above.

We reserve the right to ask for a medical exam in connection with a claim.

The Covered Person must continue to pay any applicable premium for the amount of Life Insurance Benefits remaining after the reduction.

Upon the Covered Person’s death, the amount of Life Insurance Benefits paid to the Covered Person’s beneficiary will be reduced by the amount already paid under this provision.

Limitations: Accelerated Death Benefits will not be payable if:

1. the Covered Person has assigned his Life Insurance Benefits; or
2. We have been notified that all or a portion of the Life Insurance Benefits are to be paid to the Covered Person’s former spouse as part of a divorce agreement; or
3. the Covered Person is required by law to accelerate benefits in order to meet the claims of creditor(s);
or
4. the Covered Person is required by a government agency to accelerate benefits in order to qualify for a government benefit or entitlement.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED PERSON

If the Covered Person suffers a loss described below, We will pay the amount of insurance that applies. The Covered Person, or the Covered Person's beneficiary, must give Us proof that:

1. Injury occurred while the insurance was in force under this section;
2. the Sickness began while the Covered Person was insured under the Policy;
3. loss occurred within 180 days after the Injury; and
4. loss was due to Injury independent of all other causes.

Amount of Insurance: The amount of insurance shown in the Schedule of Benefits will be paid according to the following table:

| | |
|---------------------------------------|------|
| Loss of life | 100% |
| Loss of both hands or both feet | 100% |
| Loss of sight of both eyes | 100% |
| Loss of one hand and sight of one eye | 100% |
| Loss of one foot and sight of one eye | 100% |
| Quadriplegia | 100% |
| Paraplegia | 75% |
| Loss of one hand | 50% |
| Loss of one foot | 50% |
| Loss of sight of one eye | 50% |
| Loss of speech | 50% |
| Loss of hearing | 50% |
| Hemiplegia | 50% |

Loss of sight means total and irrecoverable loss of sight. Loss of hands or feet means severance at or above the wrist or ankle. Loss of thumb and index finger means the actual, complete and permanent severance through or above the metacarpophalangeal joints. Loss of speech means the total and irrecoverable loss of speech. Loss of hearing means total and irrecoverable loss of hearing. Quadriplegia means total and permanent Paralysis of both upper and lower limbs. Paraplegia means total and permanent Paralysis of both lower limbs. Uniplegia means the total and permanent Paralysis of one limb. Triplegia means the total and permanent Paralysis of three limbs. Hemiplegia means total and permanent Paralysis of upper and lower limbs on one side of the body. Paralysis means permanent impairment and loss of the ability to voluntarily move or to have sensation in any entire extremity. Paralysis must be the result of an Injury to the brain or spinal cord and without the severance of a limb.

In paying this benefit, We will consider only losses sustained while insured under this section of the Policy. We will pay no more than the full amount shown in the Schedule of Benefits for losses resulting from any one Injury.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED PERSON (continued)

Seat Belt Benefit for Covered Person: We will pay an additional amount equal to 10% of the full amount for the loss of the Covered Person's life that results from injuries sustained while driving or riding in a private Passenger Car if such Covered Person's Seat Belt was properly fastened. However, the amount payable will not exceed \$10,000. A benefit is not payable under this provision, if:

1. the Covered Person is either a driver or passenger, and the driver was legally intoxicated or under the influence of drugs at the time of the accident; or
2. the driver of the private Passenger Car does not hold a current and valid driver's license at the time of the accident.

Passenger Car means, for the purposes of this Accidental Death and Dismemberment Benefit, any validly registered four-wheel private Passenger Car. **Seat Belt** means any restraint device which meets published federal safety standards, has been installed by the car manufacturer and has not been altered after such installation. The investigating officer must certify the correct position of the Seat Belt. A copy of the police report must be submitted with the claim.

Limitations: We will not pay a benefit for a loss caused directly or indirectly by:

1. disease, bodily or mental infirmity, or medical or surgical Treatment of these;
2. suicide or intentionally self-inflicted Injury, while sane or insane;
3. participation in a riot or insurrection, or commission of an assault or felony;
4. war or any act of war, declared or undeclared;
5. use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician;
6. driving while intoxicated, as defined by the applicable state law where the loss occurred;
7. engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, dirt bike riding, mountain climbing, Russian Roulette, autoerotic asphyxiation, bungee jumping or using off-road vehicles;
8. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which the Covered Person is entitled to benefits under any Workers Compensation Law, Employers Liability Law or similar law, unless this insurance is issued on an occupational (24 hour) basis as shown in the Schedule of Benefits;
9. travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on: a) a scheduled route; or b) a charter flight seating 15 or more people.

Notice of Claim: Written notice of a claim for death or Injury must be given to Us at Our Home Office by the Covered Person or his beneficiary within 30 days of the date of death or the date the Injury occurred. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's employer, or can be requested from Us. If the Covered Person does not receive the form from Us within 15 days of his request, written proof of claim should be sent to Us without waiting for the form. Written proof should establish facts about the claim such as date of occurrence, nature, and extent of the loss involved.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED PERSON (continued)

Proof of Claim: Written proof of claim must be filed within 90 days of the loss. However, if it is not possible to give proof within 90 days, it must be given as soon as reasonably possible.

Payment of Claim: Payment of Claim for loss of life will be paid in accordance with the beneficiary section. All other benefits under the Policy are paid to the Covered Person.

If the Covered Person has chosen an option, no one may change it unless the Covered Person consents in writing. The Covered Person's beneficiary may choose an option within 60 days after death if one has not been chosen.

Legal Action: The Covered Person may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought more than three years after the date of loss.

Physical Examination and Autopsy: We have the right to have a Physician of Our choice examine the Covered Person as often as necessary while the claim is pending. We may also have an autopsy made in case of death, unless not allowed by law. We will pay the cost of the exam and autopsy.

Assignment: Accidental Death and Dismemberment insurance provided by the Policy cannot be assigned.

STATUTORY PROVISIONS

ARKANSAS

Residents of the state of Arkansas, the following provision is included to bring your Certificate into conformity with Arkansas state law:

Insurer Information Notice

Any questions regarding the Policy may be directed to: UnitedHealthcare Insurance Company
Administrative Offices
6300 Olson Memorial Highway
Golden Valley, MN 55427
1-866-615-8727

If the question is not resolved, you may contact the Arkansas Insurance Department: Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
Little Rock, Arkansas 77204
Telephone: 1-800-852-5494

IDAHO

Residents of the state of Idaho, the following provision is included to bring your Certificate into conformity with Idaho state law:

Incontestability

The Incontestability provision as contained in the section entitled CERTIFICATE GENERAL PROVISIONS is hereby changed to read as follows:

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums or fraudulent misrepresentations, after it has been in force for one year from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been force prior to the contest for a period of one year during such person's lifetime, unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

LOUISIANA

Residents of the state of Louisiana, the following provision is included to bring your Certificate into conformity with Louisiana state law:

Applicable to Policies that include an Accelerated Death Benefit:

NOTICE: This is a Life Insurance Policy which pays Accelerated Death Benefits at the Policyholder's option under conditions specified in the Policy.

MINNESOTA

Minnesota has determined that its statutory requirements apply to Minnesota residence when non- Minnesota sitused Employers have 25 or more Employees residing in Minnesota.

Any questions regarding these statutory requirements may be directed in writing to:

UnitedHealthcare Specialty Benefits
Contract Services
MN010-W115
6300 Olson Memorial Highway
Golden Valley, MN 55427

MISSOURI

Residents of the state of Missouri, the following provision is included to bring your Certificate into conformity with Missouri state law:

Suicide

When a Suicide Limitation for Life Insurance is included in the Certificate of Coverage, no benefit will be paid for any loss caused directly or indirectly from suicide occurring within one year after the Covered Person's initial effective date or effective date or any increase of additional insurance.

In the event the insured dies as a result of suicide within one year from the date of issue of the policy, the Policyholder shall promptly refund all premiums paid for coverage.

Waiver

When a WAIVER OF PREMIUM section is included in the Certificate of Coverage the definition of Total Disability or Totally Disabled is replaced with the following:

Total Disability or Totally Disabled: For purposes of this section, means the Covered Person's inability, because of sickness or injury to perform the material and substantial duties of the Covered Person's occupation for a period of at least twelve (12) months, unless the total benefit period is less than twelve (12) months. After the initial benefit period, total disability shall mean the Covered Person's inability to perform the material and substantial duties of any occupation for which the insured is qualified by education, training or experience.

MONTANA

Residents of the state of Montana, the following provision is included to bring your Certificate into conformity with Montana state law:

Conformity with Montana Statutes: For Montana residents, the provisions of this Policy are intended to conform to the minimum requirements of Montana law. If any provision of the Policy conflicts with any Montana statutes, the provision will be deemed to conform to the minimum requirements of the Montana law.

Discretionary Authority

When a Discretionary Authority provision is shown in the CERTIFICATE GENERAL PROVISIONS section it is hereby deleted in its entirety.

Dependent Definition

When dependent coverage is included in the Certificate of Coverage, the definition of a Dependent Child shall include a child placed for adoption.

When dependent coverage is included in the Certificate of Coverage and Domestic Partners are described in the definition of a Dependent, the definition of a Domestic Partner will be expanded to include a person of the opposite or same sex.

MONTANA (continued) Conversion Privilege

The Conversion Privilege provision shown in the LIFE INSURANCE BENEFIT FOR COVERED PERSON section is modified to allow a Covered Person to convert a limited amount of insurance to an individual policy of life insurance, other than term, if he has been continuously insured under the Policy (or the policy it replaced) for three years and the insurance terminated due to termination or amendment of the Policy.

When dependent life insurance coverage is included in the Certificate of Coverage, the Conversion Privilege provision shown in the LIFE INSURANCE BENEFIT FOR DEPENDENTS section is modified to allow a Dependent to convert a limited amount of insurance to an individual life policy, other than term, if he was continuously insured under the Policy (or the policy it replaced) for three years if his insurance terminated due to the Policy being terminated or amended.

NEW HAMPSHIRE

Residents of the state of New Hampshire, the following provision is included to bring your Certificate into conformity with New Hampshire state law:

Conversion Privilege

The Conversion Privilege provision shown in the LIFE INSURANCE BENEFIT FOR COVERED PERSON section is expanded to include the following:

The Covered Person will be given written notice of this conversion privilege and its duration within 15 days after the date of termination of the Policy. If this notice is given more than 15 days after the date of termination, the time allowed for the exercise of the privilege of conversion will be extended for a period of 15 days following the date of the written notice. Such notice will be mailed to the Covered Person at the last address furnished to the Policyholder.

When dependent life insurance coverage is included in the Certificate of Coverage, the Conversion Privilege provision shown in the LIFE INSURANCE BENEFIT FOR DEPENDENTS section is expanded to include the following:

The Dependent will be given written notice of this conversion privilege and its duration within 15 days after the date of termination of the Policy. IF this notice is given more than 15 days after the date of termination, the time allowed for the exercise of the privilege of conversion will be extended for a period of 15 days following the date of the written notice. Such notice will be mailed to the Dependent at the last address furnished to the Policyholder.

Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate of Coverage is modified to include the following:

Failure to furnish such proof of claim within the Certificate of Coverage stated time limit will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as it was reasonably possible.

Discretionary Authority

When a Discretionary Authority provision is shown in the Certificate of Coverage GENERAL PROVISIONS section it is hereby deleted in its entirety.

NORTH CAROLINA

Residents of the state of North Carolina, the following provision is included to bring your Certificate into conformity with North Carolina state law:

Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate is modified as follows:

Written proof of claim must be filed within 180 days of the loss. However, if it is not possible to give proof within 180 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Occupational Injury or Sickness Exclusion

Any exclusion that applies to an Occupational Injury or Sickness is hereby replaced by the following: An

Occupational Injury or Sickness for treatments which are paid under the North Carolina Worker's Compensation Act only to extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

NORTH DAKOTA

Residents of the state of North Dakota, the following provision is included to bring your Certificate into conformity with North Dakota state law:

10 Day Right to Examine Certificate: There is a 10 day right to review this Certificate. If You decide not to keep it, it may be returned to Us within 10 days of the original Certificate Effective Date. In that event, We will consider it void from the Certificate Effective Date and refund all premium paid. Any claims paid during the initial 10 day period will be deducted from the refund.

OKLAHOMA

Residents of the state of Oklahoma, the following provision is included to bring your Certificate into conformity with Oklahoma state law:

Certificates delivered to residents of the state of Oklahoma are subject to Oklahoma laws.

Dependent Child Definition

The term "Child" includes a natural child, legally adopted child, stepchild, foster child or any child who is under the custody of the Covered Person

Incontestability

The Incontestability provision shown in the Certificate GENERAL PROVISIONS section is replaced by the following:

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

OKLAHOMA (continued)

Life Insurance Payment of Claim:

The Payment of Claim provision shown in the LIFE INSURANCE BENEFIT FOR COVERED PERSON section is replaced by the following:

Payment of Claim: Payment of Claim for loss of life will be paid in accordance with the beneficiary section. We will make payment within 60 days of receipt of due proof of death. All other benefits under the Policy are paid to the Covered Person.

If the Covered Person has chosen an option, no one may change it unless the Covered Person consents in writing. The Covered Person's beneficiary may choose an option within 60 days after death if one has not been chosen.

When dependent coverage is included in the Certificate of Coverage, the Payment of Claim provision shown in the LIFE INSURANCE BENEFIT FOR DEPENDENTS section is replaced by the following:

Payment of Claim: Payment of Claim for loss of life will be paid in accordance with the beneficiary section. We will make payment within 60 days of receipt of due proof of death. All other benefits under the Policy are paid to the Covered Person.

If the Covered Person has chosen an option, no one may change it unless the Covered Person consents in writing. The Covered Person's beneficiary may choose an option within 60 days after death if one has not been chosen.

TEXAS

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call UnitedHealthcare Insurance Company's toll-free telephone number for information or to make a complaint at

800-554-5413

You may also write to UnitedHealthcare Insurance Company at:

UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:
800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

Form No. ACN-TX-MP (8/95)

AVISO IMPORTANTE

Para obtener información or para someter una queja:

Usted puede llamar al numero de telefono gratis de UnitedHealthcare Insurance Company's para información o para someter una queja al

800-554-5413

Usted también puede escribir a UnitedHealthcare Insurance Company's:

UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343

Puede comunicarse con el Departamento de Seguro de Texas para obtener informacion acerca de compañías, coberturas, derechos o quejas al
800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX #(512)475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compañía primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

ADJUNTAR ESTE AVISO A SU POLIZA:

Esto aviso es solo para propositio de informacion y no se convierte en parte o condición del documento adjunto.

TEXAS (continued)

Accelerated Death Benefit

Death benefits will be reduced if an acceleration-of-life insurance benefit is paid.

DISCLOSURE: Receipt of Acceleration Death Benefits may affect You, Your spouse or Your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect You, Your spouse and Your family's eligibility for public assistance.

DISCLOSURE: The Accelerated Death Benefits offered under this Policy may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as Your life expectancy at the time benefits are accelerated or whether you use the benefits to pay necessary long-term care expense, such as nursing home care. If the Accelerated Death Benefits qualify for favorable tax treatment, the benefits will be excludable from Your income and to subject to federal taxation. Tax laws relating to Accelerated Death Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive Accelerated Death Benefits excludable from income under federal law.

We reserve the right to ask for a medical exam in connection with a claim. In the event that the Physician's examinations result in conflict with the medical evidence signed by the treating Physician, a second examination from a Physician of Our choice (at Our expense) will be requested. This second exam will determine if the Covered Person has met the conditions stated above.

At the time of payment of the Accelerated Death Benefit, We will send a statement to the Covered Person specifying:

1. the amount of benefits paid;
2. the affect of the Accelerated Death Benefit payment on the death benefit face amount and future premiums; and
3. the amount of Life Insurance benefits remaining.

Incontestability

The Incontestability provision under the CERTIFICATE GENERAL PROVISIONS section, is amended to remove the phrase "or fraudulent misrepresentations" from the first sentence.

WASHINGTON

Residents of the state of Washington, the following provision is included to bring your Certificate into conformity with Washington state law:

Accelerated Death Benefit

When an ACCELERATED DEATH BENEFIT section is include in the Certificate of Coverage, the following Accelerated Death Benefit Notice is also included:

If you receive payment of accelerated death benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.

This Accelerated Death Benefit is not intended to qualify under section 101(g)(26 U.S.C. 101(g) or section 770B(26U.S.C. 7702B) of the Internal Revenue Code of 1986 as amended by Public Law 104-191

WASHINGTON (continued)

Accidental Death and Dismemberment Benefit

The first paragraph shown in the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED PERSON section is replaced by the following:

The Covered Person suffers a loss described below, We will pay the amount of insurance that applies. The Covered Person, or the Covered Person's beneficiary, must give Us proof that:

1. Injury occurred while the insurance was in force under this section;
2. loss occurred within 365 days after the Injury; and
3. loss was due to Injury independent of all other causes.

When dependent Accidental Death and Dismemberment coverage is included in the Certificate of Coverage, the first paragraph shown in the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT FOR COVERED DEPENDENT section is replaced by the following:

The Dependent suffers a loss described below, We will pay the amount of insurance that applies. The Covered Person, or the Covered Person's beneficiary, must give Us proof that:

1. Injury occurred while the insurance was in force under this section;
2. loss occurred within 365 days after the Injury; and
3. loss was due to Injury independent of all other causes.

United HealthCare Insurance Company

Notice of Privacy Policy and Practices

Purpose of this Notice

United HealthCare Insurance Company respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This Notice describes how we protect the confidentiality of the personal information we receive. Our practices apply to current and former members.

Types of Personal Information We Collect

We collect a variety of personal information to administer a member's life or health coverage. Some of this information is provided by members in enrollment forms, surveys and correspondence (such as address, Social Security number, and dependent information). We also receive personal information (such as eligibility and claims information) through transactions with our affiliates and members, employers, insurance agents, other insurers, and health care providers. We retain this information after a member's coverage ends. We limit the collection of personal information to that which is necessary to administer our business, provide quality service and meet regulatory requirements.

How We Protect Personal Information

We treat personal information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide our products or services to members (for example, our claims processors and care coordinators). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet strict physical, electronic and procedural security standards to protect personal information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal Information

We may share any of the personal information we collect (as described above) with our affiliates as permitted by law. We may also disclose this information to non-affiliated entities or individuals as permitted or required by law. Non-affiliates with whom we may disclose information as permitted by law include our attorneys, accountants and auditors, a member's authorized representative, health care providers, third party administrators, insurance agents and brokers, other insurers, consumer reporting agencies, and law enforcement or regulatory authorities. We may also disclose any of the personal information we collect (as described above) to companies that perform marketing services on our behalf or to other companies with whom we have joint marketing or disease management agreements. We do not disclose personal information to any other third parties without a member's request or authorization.

Individual Rights to Access and Correct Personal Information

We have procedures for a member to access the personal information we collect, and other than information we collect in connection with, or in anticipation of, a lawsuit or legal claim, we will make this information available to the member upon written request. Our goal is to keep our member information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal information we have about you is not accurate, please let us know by contacting our Compliance Officer at United HealthCare Specialty Benefits, Mail Route MN010-W115, 6300 Olson Memorial Highway, Golden Valley, MN 55427.

Further Information

We may amend our privacy policy from time to time. In accordance with applicable law, we will send our current customers a Notice describing our privacy policy and practices at least once a year. It will also be available upon request. This Notice is provided on behalf of the following United HealthCare Insurance Company affiliates:

For purposes of this Notice of Privacy Practices, “we” or “us” refers to the following UnitedHealthcare entities: All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Eyecare of North Carolina, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.