# Iron Workers District Council of New England Benefit Plans

## Health and Welfare Fund

Summary Plan Description 2016

# Iron Workers District Council of New England Health and Welfare Fund

## Summary Plan Description 2016

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# Welcome to Your Health and Welfare Plan

We are pleased to issue this 2016 Summary Plan Description of the Iron Workers District Council of New England Health and Welfare Fund. This booklet includes the changes in your Plan since the last booklet was printed and describes the current Plan of benefits for Eligible Members and their Dependents as of February 2016.

This comprehensive and easy-to-use booklet has been designed with you in mind. "Fast Facts" appear at the beginning of each section to give you a quick overview of what is contained within that section.

As a participant in the Plan, you are eligible for a comprehensive package of benefits. On pages 1 – 9, you can find the schedule of benefits, detailing how most services are covered.

We encourage you to read through this SPD to learn about your benefits. And if you have any questions, please reach out to the Fund Office by calling **617-265-3757** or the Iron Clad Insurance Claims Office at **617-436-3500**. The Office staff is happy to assist you.

***This booklet, which replaces and supersedes any prior Summary Plan Description, serves as the Plan's official rules and regulations that establish the Plan. The Trustees reserve the right to amend, modify, or terminate the Plan at any time to the extent permitted by law.***

### *Notice of Grandfathered Status*

The Board of Trustees represents that the group health plan coverage it provides is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("ACA"). A grandfathered health plan may preserve basic health coverage that was already in effect when the law was enacted. The Plan is not required to include certain consumer protections of the ACA that apply to other plans (for example, the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in ACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply or do not apply to a grandfathered health plan can be directed to the Fund Office at **617-265-3757** or toll free at **800-637-3736**. You may also contact the Employee Benefits Security Administration, U. S. Department of Labor at **866-444-3272** or **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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# Important Contact Information

| | |
|---|---|
| **Fund Office**<br>Iron Workers District Council of<br>New England Health and Welfare Fund | 161 Granite Avenue<br>Dorchester, MA 02124<br>617-265-3757 or 800-637-3736 |
| **Claims Office**<br>Iron Clad Insurance | 161 Granite Avenue, Suite 201<br>Dorchester, MA 02124<br>617-436-3500 or 866-229-4766 |
| **Employee Assistance Program**<br>Modern Assistance Programs (MAP) | 1400 Hancock Street, 2nd Floor<br>Quincy, MA 02169<br>617-774-0331 |
| **Pre-Certification for Continued Stay Review and Second Surgical Opinion**<br>CareAllies | 1777 Sentry Park West<br>Dublin Hall, 4th Floor<br>Bluebell, PA 19422<br>800-768-4695 |
| **Medical Plan**<br>Tufts Carelink | P.O. Box 9165<br>Watertown, MA 02471<br>www.tuftshealthplan.com/carelink/ironworkers |
| **Vision Care Plan**<br>Davis Vision | 159 Express Street<br>Plainview, NY 11803<br>800-999-5431 |
| **Long-Term Disability Plan**<br>Standard Insurance | Contact the Fund Office<br>617-265-3757 |
| **Hearing Care Benefit**<br>HearUsa | 800-442-8231 |

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# Schedule of Benefits

## Active Employees

| | In-Network/ Participating Provider | Out-of-Network/ Non-Participating Provider |
|---|---|---|
| Comprehensive Major Medical | | |
| **Your Annual Deductible** | | |
| Per Individual | $300 | $300 |
| Per Family | $600 | $600 |
| **Benefit Payable** (after deductible) | 90% of PPO rate | 60% of Reasonable and Customary charges |
| **Coinsurance for Covered Expenses** | | |
| You Pay | 10% of the PPO rate | 40% of Reasonable and Customary charges |
| Plan Pays | 90% of the PPO rate | 60% of Reasonable and Customary charges |
| **Maximum Out-of-Pocket Expense**[1] | | |
| Per Individual | $1,500 | $4,000 |
| Per Family Coverage | $3,000 | $6,250 |
| **Balance of Covered Charges** for the remainder of the calendar year (after maximum Out-of-Pocket) | 100% of PPO rate | 100% of Reasonable and Customary charges |
| **Annual Maximum** | None | |
| Hospitalization | | |
| Hospital Stay | 90% of PPO rate | 60% of Reasonable and Customary charges |
| If you or your eligible dependent does not obtain Pre-Admission Certification for an initial hospital admission, any benefits payable under this Plan for that hospitalization will be reduced by 10% (not to exceed $500). Thereafter, benefits will be reduced by 20% (not to exceed $1,000) for each time you do not obtain a Pre-Admission Certification. | | |
| If you or your dependents do not use the Hospital Pre-Admission Certification Program for a Hospital stay and it is determined the services would not have been approved, you (and your Dependents, if applicable) will be financially responsible for the charges. | | |
| Physician Services | | |
| Office Visits | You pay $20 copayment per visit then 100% of PPO rate; no deductible applies. | 60% of Reasonable and Customary charges, subject to deductible |
| Diagnostic tests, x-rays and imaging, routine pap tests and mammograms | 90% of PPO rate | 60% of Reasonable and Customary charges |
| Well Child Care, birth through age 6 | You pay $20 copayment per visit, no deductible | 60% of Reasonable and Customary charges |
| Annual Physical Examination (for anyone older than age 6), one exam per year | You pay $20 copayment per visit, Plan pays 100% of Reasonable and Customary charges, no deductible | |
| Gynecological Exam, one per year | 100% of Reasonable and Customary charges, no deductible, no copay | |
| For the above, for the Plan to pay at 100% and not be subject to a deductible, the services must be billed as a free-standing facility (non-hospital), and also, for office visits, tests, x-rays and imaging, and Well Child Care, by an in-network/participating provider. | | |
| Mental Health and Substance Abuse Treatment | | |
| Outpatient Treatment | You pay $5 copayment per visit then Plan pays100% of PPO rate; no deductible applies. | 60% of Reasonable and Customary charges |
| Contact Modern Assistance Programs (MAP) to assist you with services for mental health and substance abuse treatment. Call MAP at 617-774-0331. Benefit subject to Medical Necessity. | | |
| Inpatient Treatment | 90% of PPO rate | 60% of Reasonable and Customary charges |

[1] Does not include balance billing, copayments, the annual deductible, services excluded from out-of-pocket expenses, services not covered by the Plan and any penalties assessed for failure to obtain prior authorization for services.

| | In-Network/ Participating Provider | Out-of-Network/ Non-Participating Provider |
|---|---|---|
| Pre-certify admissions with MAP at 617-774-0331. If you or your eligible dependent does not obtain Pre-Admission Certification for an initial hospital admission, any benefits payable under this Plan for that hospitalization will be reduced by 10% (not to exceed $500). Benefits will be reduced by 20% (not to exceed $1,000) if you do not obtain a Pre-Admission Certification each subsequent time. Benefit subject to Medical Necessity.<br>If you or your dependents do not use the Hospital Pre-Admission Certification Program for a Hospital stay and it is determined the services would not have been approved, you (and your Dependents, if applicable) will be financially responsible for the charges. | | |
| Laser Vision Corrective Surgery | | |
| Surgical procedure(s) only | $1,500 per eye available once per lifetime | |
| Home Health Care Benefit | | |
| Up to 90 visits per year | 100% of PPO rate | 100% of Reasonable and Customary charges |
| Hearing Care Benefit | | |
| Hearing Exam<br>Plan pays one per two years for adults and one per year for children | 100% | Not covered |
| Hearing Aid (every three years) | $2,500 per ear | |
| Chiropractic Benefit | | |
| Chiropractor Visit | 80% of PPO rate | 80% of Reasonable and Customary charges |
| Annual Maximum | 26 visits per calendar year | 26 visits per calendar year |
| Alternative/Complementary Care Benefits | With MAP approval 617-774-0331 | Without MAP approval |
| | You pay $20 copayment per visit. Plan pays 100% of Reasonable and Customary charges. Maximum benefit of $1,500 per covered person per calendar year. | Not covered |
| Prescription Drug Benefit | | |
| Retail Pharmacy<br>You Pay (34-day supply) | $15 generic<br>$30 preferred brand<br>$45 non-preferred brand | You pay the full amount and apply for reimbursement |
| Mail-Order Pharmacy<br>You Pay (102-day supply) | $30 generic<br>$60 preferred brand<br>$90 non-preferred brand | |
| Specialty Drugs | $30 generic<br>$60 preferred brand<br>$90 non-preferred brand | Specialty and Biotechnology Drugs are available only through Express Script's Specialty Drug Pharmacy, Accredo |
| Dental | | |
| Part One Services—Preventive Services | 100% of Reasonable and Customary charges | |
| Maximum Amount (per calendar year):<br>For those age 19 and over:<br>For those under age 19: | <br>$600<br>Subject to Reasonable and Customary and to Medical Necessity | |
| Part Two Services—Major Services | Refer to Schedule of Dental Benefits on page 41 | |
| Maximum Amount (per calendar year):<br>For those age 19 and over:<br>For those under age 19: | <br>$2,500<br>Subject to Reasonable and Customary and to Medical Necessity | |

| | In-Network/ Participating Provider | Out-of-Network/ Non-Participating Provider |
|---|---|---|
| Part Three Services—Orthodontia | Refer to Schedule of Dental Benefits on page 43 | |
| Orthodontia Lifetime Maximum | $2,500<br>(Excluding Medically Necessary Orthodontia, as determined by the American Association of Orthodontists, but only for those under age 19.) | |
| Vision | | |
| Examination | Covered in full every 12 months | $30 allowance |
| Frames | Premiere Selection displayed on the Tower Collection, covered in full every 24 months for members or Dependents age 18 or older; once every 12 months for Dependents under age 18. | $30 allowance |
| Lenses | Covered in full once every 12 months with a qualifying prescription change of one half diopter or a 10% shift in axis; otherwise every 24 months. Dependents under age 18 are eligible every 12 months. | $30 allowance |
| Contact Lenses | Standard daily wear contacts are covered in full every 24 months in lieu of eyeglass lenses. Dependents under age 18 are eligible every 12 months in lieu of eyeglass lenses. | $60 allowance |
| Safety Glasses<br>(Active member only, no dependent coverage) | Lenses and fashion or designer frames covered in full every 12 months. Frame and optional lenses upgrades are subject to member copayments. | Not covered |

| Weekly Accident and Sickness | Benefit |
|---|---|
| If you become Totally Disabled due to a non-work related Illness or a non-work related injury and are unable to work while you are covered by this Plan, you are entitled to the following benefit, which will continue during your disability for a maximum of 26 weeks. | |
| | $250 per week up to 26 weeks |
| Accidental Death and Dismemberment | |
| Benefit Maximum | $30,000 |
| Both hands; both feet; sight of both eyes; one hand and one foot; one hand and sight of one eye; one foot and sight of one eye; third-degree burns covering 75% of body; quadriplegia | $30,000 |
| One hand; one foot; one eye; sight of one eye; loss of hearing; loss of speech; paraplegia; hemiplegia; third-degree burns covering 50%-75% of body | $15,000 |
| Loss of thumb and index finger; uniplegia | $7,500 |
| Long Term Disability | |
| Benefit Amount | $1,000 per month |
| Life Insurance | |
| Benefit Amount | $30,000 |

## Contributory Plan—Self-Pay Plan—COBRA (Core Only)

| | In-Network/ Participating Provider | Out-of-Network/ Non-Participating Provider |
|---|---|---|
| Comprehensive Major Medical | | |
| **Your Annual Deductible** | | |
| Per Individual | $300 | $300 |
| Per Family | $600 | $600 |
| **Benefit Payable** (after deductible) | 90% of PPO rate | 60% of Reasonable and Customary charges |
| **Coinsurance for Covered Expenses** | | |
| You Pay | 10% of the PPO rate | 40% of Reasonable and Customary charges |
| Plan Pays | 90% of the PPO rate | 60% of Reasonable and Customary charges |
| **Maximum Out-of-Pocket Expense**[2] | | |
| Per Individual | $1,500 | $4,000 |
| Per Family Coverage | $3,000 | $6,250 |
| **Balance of Covered Charges** for the remainder of the calendar year (after maximum Out-of-Pocket) | 100% of PPO rate | 100% of Reasonable and Customary charges |
| **Annual Maximum** | None | |
| Hospitalization | | |
| Hospital Stay | 90% of PPO rate | 60% of Reasonable and Customary charges |
| If you or your eligible dependent does not obtain Pre-Admission Certification for an initial hospital admission, any benefits payable under this Plan for that hospitalization will be reduced by 10% (not to exceed $500). Thereafter, benefits will be reduced by 20% (not to exceed $1,000) for each time you do not obtain a Pre-Admission Certification. | | |
| If you or your dependents do not use the Hospital Pre-Admission Certification Program for a Hospital stay and it is determined the services would not have been approved, you (and your dependents, if applicable) will be financially responsible for the charges. | | |
| Physician Services | | |
| Office Visits | You pay $20 copayment per visit then the Plan pays 100% of PPO rate; no deductible applies. | 60% of Reasonable and Customary charges, subject to deductible |
| Diagnostic tests, x-rays and imaging, routine pap tests and mammograms | 90% of PPO rate | 60% of Reasonable and Customary charges |
| Well Child Care, birth through age 6 | You pay $20 copayment per visit, no deductible | 60% of Reasonable and Customary charges |
| Annual Physical Examination (for anyone older than age 6), one exam per year | You pay $20 copayment per visit, Plan pays 100% of Reasonable and Customary charges, no deductible | |
| Gynecological exam, one per year | 100% of Reasonable and Customary Charges, no deductible, no copay | |
| For the above, for the Plan to pay at 100% and not be subject to a deductible, the services must be billed as a free-standing facility (non-hospital), and also, for office visits, tests, x-rays and imaging, and Well Child Care, by an in-network/participating provider. | | |

[2] Does not include balance billing, copayments, the annual deductible, services excluded from out-of-pocket expenses, services not covered by the Plan and any penalties assessed for failure to obtain prior authorization for services.

| | In-Network/ Participating Provider | Out-of-Network/ Non-Participating Provider |
|---|---|---|
| Mental Health and Substance Abuse Treatment | | |
| Outpatient Treatment | You pay $5 copayment per visit then the Plan pays 100% of PPO rate; no deductible applies. | 60% of Reasonable and Customary charges |
| Contact Modern Assistance Programs (MAP) to assist you with services for mental health and substance abuse treatment. Call MAP at 617-774-0331. Benefit subject to Medical Necessity. | | |
| Inpatient Treatment | 90% of PPO rate | 60% of Reasonable and Customary charges |
| Pre-certify admissions with MAP at 617-774-0331. If you or your eligible dependent does not obtain Pre-Admission Certification for an initial hospital admission, any benefits payable under this Plan for that hospitalization will be reduced by 10% (not to exceed $500). Benefits will be reduced by 20% (not to exceed $1,000) if you do not obtain a Pre-Admission Certification each subsequent time. Benefit subject to Medical Necessity.<br>If you or your dependents do not use the Hospital Pre-Admission Certification Program for a Hospital stay and it is determined the services would not have been approved, you (and your dependents, if applicable) will be financially responsible for the charges. | | |
| Laser Vision Corrective Surgery | | |
| Surgical Procedure(s) only | $1,500 per eye available once per lifetime | |
| Home Health Care Benefit | | |
| Up to 90 visits per year | 100% of PPO rate | 100% of Reasonable and Customary charges |
| Hearing Care Benefit | | |
| Hearing Exam<br>Plan pays one per two years for adults; and one per year for children | 100% | Not covered |
| Hearing Aid (every three years) | $2,500 per ear | |
| Chiropractic Benefit | | |
| Chiropractor visit | 80% of PPO rate | 80% of Reasonable and Customary charges |
| Annual Maximum | 26 visits per calendar year | 26 visits per calendar year |
| Alternative/Complementary Care Benefits | With MAP approval 617-774-0331 | Without MAP approval |
| | You pay $20 copayment per visit. Plan pays 100% of Reasonable and Customary charges. Maximum benefit of $1,500 per covered person per calendar year. | Not covered |
| Prescription Drug Benefit | | |
| Retail Pharmacy<br>You Pay (34-day supply) | $15 generic<br>$30 preferred brand<br>$45 non-preferred brand | You pay the full amount and apply for reimbursement. |
| Mail-Order Pharmacy<br>You Pay (102-day supply) | $30 generic<br>$60 preferred brand<br>$90 non-preferred brand | |
| Specialty Drugs | $30 generic<br>$60 preferred brand<br>$90 non-preferred brand | Specialty and Biotechnology Drugs are available only through Express Script's Specialty Drug Pharmacy, Accredo |

## Contributory Plan—Special Basic Buy-In Plan

| | In-Network/ Participating Provider | Out-of-Network/ Non-Participating Provider |
|---|---|---|
| Comprehensive Major Medical | | |
| **Your Annual Deductible** | | |
| Per Individual | $450 | $450 |
| Per Family | $750 | $750 |
| **Benefit Payable** (after deductible) | 70% of PPO rate | 50% of Reasonable and Customary charges |
| **Coinsurance for Covered Expenses** | | |
| You Pay | 30% of the PPO rate | 50% of Reasonable and Customary charges |
| Plan Pays | 70% of the PPO rate | 50% of Reasonable and Customary charges |
| **Maximum Out-of-Pocket Expense**[3] | | |
| Per Individual | $3,000 | $5,000 |
| Per Family Coverage | $5,000 | $7,500 |
| **Balance of Covered Charges** for the remainder of the calendar year (after maximum Out-of-Pocket) | 100% of PPO rate | 100% of Reasonable and Customary charges |
| **Annual Maximum** | None | |
| Hospitalization | | |
| Hospital Stay | 70% of PPO rate | 50% of Reasonable and Customary charges |
| If you or your eligible dependent does not obtain Pre-Admission Certification for an initial hospital admission, any benefits payable under this Plan for that hospitalization will be reduced by 10% (not to exceed $500). Thereafter, benefits will be reduced by 20% (not to exceed $1,000) for each time you do not obtain a Pre-Admission Certification. | | |
| If you or your dependents do not use the Hospital Pre-Admission Certification Program for a Hospital stay and it is determined the services would not have been approved, you (and your dependents, if applicable) will be financially responsible for the charges. | | |
| Physician Services | | |
| Office Visits | You pay $20 copayment per visit then the Plan pays100% of PPO rate; no deductible applies. | 50% of Reasonable and Customary charges, subject to deductible |
| Diagnostic tests, x-rays and imaging, routine pap tests and mammograms | 70% of PPO rate | 50% of Reasonable and Customary charges |
| Well Child Care, birth through age 6 | You pay $20 copayment per visit, no deductible | 50% of Reasonable and Customary charges |
| Annual physical examination (for anyone older than age 6), one exam per year | You pay $20 copayment per visit, Plan pays 100% of Reasonable and Customary charges, no deductible | |
| Gynecological exam, one per year | 100% of Reasonable and Customary Charges, no deductible, no copay | |
| For the above, for the Plan to pay at 100% and not be subject to a deductible, the services must be billed as a free-standing facility (non-hospital), and also, for office visits, tests, x-rays and imaging, and Well Child Care, by an in-network/participating provider. | | |

[3] Does not include balance billing, copayments, the annual deductible, services excluded from out-of-pocket expenses, services not covered by the Plan and any penalties assessed for failure to obtain prior authorization for services.

| | In-Network/ Participating Provider | Out-of-Network/ Non-Participating Provider |
|---|---|---|
| Mental Health and Substance Abuse Treatment | | |
| Outpatient Treatment | You pay $5 copayment per visit then the Plan pays 100% of PPO rate; no deductible applies. | 50% of Reasonable and Customary charges |
| Contact Modern Assistance Programs (MAP) to assist you with services for mental health and substance abuse treatment. Call MAP at 617-774-0331. Benefit subject to Medical Necessity. | | |
| Inpatient Treatment | 70% of PPO rate | 50% of Reasonable and Customary charges |
| Pre-certify admissions with MAP at 617-774-0331. If you or your eligible dependent does not obtain Pre-Admission Certification for an initial hospital admission, any benefits payable under this Plan for that hospitalization will be reduced by 10% (not to exceed $500). Benefits will be reduced by 20% (not to exceed $1,000) if you do not obtain a Pre-Admission Certification each subsequent time. Benefit subject to Medical Necessity.<br>If you or your dependents do not use the Hospital Pre-Admission Certification Program for a Hospital stay and it is determined the services would not have been approved, you (and your dependents, if applicable) will be financially responsible for the charges. | | |
| Home Health Care Benefit | | |
| Up to 90 visits per year | 100% of PPO rate | 100% of Reasonable and Customary Charges |
| Hearing Care Benefit | | |
| Hearing Exam<br>Plan pays one per two years for adults; and one per year for children | 100% | Not covered |
| Hearing Aid (every three years) | $2,500 per ear | |
| Chiropractic Benefit | | |
| Chiropractor visit | 80% of PPO rate | 80% of Reasonable and Customary charges |
| Annual Maximum | 26 visits per calendar year | 26 visits per calendar year |
| Prescription Drug Benefit | | |
| Retail Pharmacy<br>You Pay (34-day supply) | $15 generic<br>$30 preferred brand<br>$45 non-preferred brand | You pay the full amount and apply for reimbursement. |
| Mail-Order Pharmacy<br>You Pay (102-day supply) | $30 generic<br>$60 preferred brand<br>$90 non-preferred brand | |
| Specialty Drugs | $30 generic<br>$60 preferred brand<br>$90 non-preferred brand | Specialty and Biotechnology Drugs are available only through Express Script's Specialty Drug Pharmacy, Accredo |

## Retired Employees

| | In-Network/ Participating Provider | Out-of-Network/ Non-Participating Provider |
|---|---|---|
| Comprehensive Major Medical | | |
| **Your Annual Deductible** | | |
| Per Individual | $300 | $300 |
| Per Family | $600 | $600 |
| **Benefit Payable** (after deductible) | 80% of PPO rate | 60% of Reasonable and Customary charges |
| **Coinsurance for Covered Expenses** | | |
| You Pay | 20% of the PPO rate | 40% of Reasonable and Customary Charges |
| Plan Pays | 80% of the PPO rate | 60% of Reasonable and Customary charges |
| **Maximum Out-of-Pocket Expense**[4] | | |
| Per Individual | $1,500 | $4,000 |
| Per Family Coverage | $3,000 | $6,250 |
| **Balance of Covered Charges** for the remainder of the calendar year (after maximum Out-of-Pocket) | 100% of PPO rate | 100% of Reasonable and Customary charges |
| **Annual Maximum** | None | |
| Hospitalization | | |
| Hospital Stay | 80% of PPO rate | 60% of Reasonable and Customary charges |
| If you or your eligible dependent does not obtain Pre-Admission Certification for an initial hospital admission, any benefits payable under this Plan for that hospitalization will be reduced by 10% (not to exceed $500). Thereafter, benefits will be reduced by 20% (not to exceed $1,000) for each time you do not obtain a Pre-Admission Certification. | | |
| If you or your dependents do not use the Hospital Pre-Admission Certification Program for a Hospital stay and it is determined the services would not have been approved, you (and your dependents, if applicable) will be financially responsible for the charges. | | |
| Physician Services | | |
| Office Visits | You pay $20 copayment per visit then the Plan pays 100% of PPO rate; no deductible applies. | 60% of Reasonable and Customary charges, subject to deductible |
| Diagnostic tests, x-rays and imaging, routine pap tests and mammograms | 80% of PPO rate | 60% of Reasonable and Customary charges |
| Well Child Care, birth through age 6 | You pay $20 copayment per visit, no deductible | 60% of Reasonable and Customary charges |
| Annual physical examination (for anyone older than age 6), one exam per year | You pay $20 copayment per visit, Plan pays 100% of Reasonable and Customary charges, no deductible | |
| Gynecological exam, one per year | 100% of Reasonable and Customary Charges, no deductible, no copay | |
| For the above, for the Plan to pay at 100% and not be subject to a deductible, the services must be billed as a free-standing facility (non-hospital), and also, for office visits, tests, x-rays and imaging, and Well Child Care, by an in-network/participating provider. | | |
| Mental Health and Substance Abuse Treatment | | |
| Outpatient Treatment | You pay $5 copayment per visit then the Plan pays 100% of PPO rate; no deductible applies. | 60% of Reasonable and Customary charges |
| Contact Modern Assistance Programs (MAP) to assist you with services for mental health and substance abuse treatment. Call MAP at 617-774-0331. Subject to Medical Necessity. | | |

[4] Does not include balance billing, copayments, the annual deductible, services excluded from out-of-pocket expenses, services not covered by the Plan and any penalties assessed for failure to obtain prior authorization for services.

| | In-Network/ Participating Provider | Out-of-Network/ Non-Participating Provider |
|---|---|---|
| Inpatient Treatment | 80% of PPO rate | 60% of Reasonable and Customary charges |
| Pre-certify admissions with MAP at 617-774-0331. If you or your eligible dependent does not obtain Pre-Admission Certification for an initial hospital admission, any benefits payable under this Plan for that hospitalization will be reduced by 10% (not to exceed $500). Benefits will be reduced by 20% (not to exceed $1,000) if you do not obtain a Pre-Admission Certification each subsequent time. Benefit subject to Medical Necessity.<br>If you or your dependents do not use the Hospital Pre-Admission Certification Program for a Hospital stay and it is determined the services would not have been approved, you (and your Dependents, if applicable) will be financially responsible for the charges. | | |
| Laser Vision Corrective Surgery | | |
| Surgical procedure(s) only | $1,500 per eye available once per lifetime | |
| Home Health Care Benefit | | |
| Up to 90 visits per year | 100% of PPO rate | 100% of Reasonable and Customary charges |
| Hearing Care Benefit | | |
| Hearing Exam<br>Plan pays one per two years for adults; and one per year for children | 100% | Not covered |
| Hearing Aid (every three years) | $2,500 per year | |
| Chiropractic Benefit | | |
| Chiropractor Visit | 80% of PPO rate | 80% of Reasonable and Customary charges |
| Annual Maximum | 26 visits per calendar year | 26 visits per calendar year |
| Prescription Drug Benefit | | |
| Retail Pharmacy<br>You Pay (34-day supply) | $15 generic<br>$30 preferred brand<br>$45 non-preferred brand | You pay the full amount and apply for reimbursement. |
| Mail-Order Pharmacy<br>You Pay (102-day supply) | $30 generic<br>$60 preferred brand<br>$90 non-preferred brand | |
| Specialty Drugs | $30 generic<br>$60 preferred brand<br>$90 non-preferred brand | Specialty and Biotechnology Drugs are available only through Express Script's Specialty Drug Pharmacy, Accredo |
| Dental | | |
| Cleaning and Examination, Once Per Calendar Year | | 100% of Reasonable and Customary charges |
| For those under age 19 | | Subject to Reasonable and Customary and to Medical Necessity |

# Plan Participation

**FAST FACTS:**

- Your eligibility status is determined twice a year—February 1 and August 1.
- You may cover your lawful spouse under your health care coverage and applicable children up to age 26.

## Active Employees

### *Participating Employers*

Participating Employers contribute to the Plan pursuant to Collective Bargaining Agreements with Iron Workers Local Nos. 7 and 37 affiliated with the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers, AFL-CIO. The Fund Office will provide you, upon written request, with information as to whether a particular Employer is contributing to this Plan of behalf of participants working under the Collective Bargaining Agreements.

### *Initial Eligibility*

You may become eligible to participate in the Plan when you begin working in covered employment within the jurisdiction of the Iron Workers District Council of New England and you meet the initial hours requirement.

Your eligibility is determined twice a year:

- The first day of February; and
- The first day of August.

| For February 1 Eligibility | For August 1 Eligibility |
|---|---|
| The 6-month work period is August 1 – January 31 | The 6-month work period is February 1 – July 31 |
| The 12-month work period is February 1 – January 31 | The 12-month work period is August 1 – July 31 |

You become eligible by working:

- 600 hours in the 6-month work period; or
- 1,200 hours in the 12-month work period; or
- 2,400 hours in the 18-month work period.

### *Continuing Eligibility*

Once you become eligible to participate in the Plan, you remain eligible as long as you meet the work hours requirements outlined under "Initial Eligibility."

### *Reinstating Eligibility*

If you lose eligibility for Plan coverage, you must meet the initial eligibility requirements again before you are eligible for Plan coverage.

## Apprentices

If you are an apprentice working in covered employment, you may purchase medical insurance coverage for yourself and your eligible dependents at the COBRA continuation coverage rate as of the first of the month immediately after working a minimum of 600 hours within a six-month period.

## Retired Employees

Retirees and their families, if under age 65 and not eligible for Medicare, may enroll in the Retiree Plan. This coverage is not automatic; you must enroll and remit the monthly payments. If you choose to elect Individual coverage, you may not thereafter obtain Family coverage except under certain limited circumstances. Contact the Fund Office for details. Retirees do not receive the Alternative Care or any of the Disability and Death Benefits. Retirees do receive a benefit of one dental exam and one dental cleaning per year as noted in the schedule of benefits.

You have an **obligation to notify** the Plan if you, your spouse or your dependent becomes eligible for Medicare because of a disability. Your spouse or an adult dependent, respectively, also has such **obligation to notify** the Plan if either becomes eligible for Medicare because of a disability.

If the Plan pays benefits as the result of a failure to promptly notify Iron Clad, in writing, then you (and as may be applicable, your spouse and/or adult dependent) will be financially responsible to reimburse the Plan for such payments. This applies whether such individual became entitled to Medicare any time before or after enrollment in Retiree Coverage

**If you or your dependent is covered under the Retiree Plan and becomes eligible for Medicare**, such person's coverage is terminated as of the first day of the month in which such person attains Medicare eligibility. You should promptly apply for and elect Medicare Part B and Part D upon eligibility for Medicare. There is a penalty for delayed enrollment if you do not enroll in Medicare Part B and Part D during the seven-month period immediately following the date of eligibility for Medicare. Even if you may have enrolled in COBRA coverage, you will not avoid the penalty. Remember—it is your responsibility to enroll in Medicare Part B and Part D and pay its monthly premiums.

There are many individual Medicare Supplement Plans available which include drug coverage and we encourage you to research your options well in advance so that you do not have a lapse in coverage.

To be eligible for the Retiree Plan, you must have worked 10,000 hours in the 10 calendar years prior to your retirement, including 300 hours in the previous year, or continue from active service or COBRA coverage.

## When Active Employee Eligibility Ends

Eligibility for you and/or your dependents will end on the earliest of:

- The date this Plan terminates;
- The date you are no longer a member of an eligible class;
- The date a change is made in this Plan to terminate coverage for your class;
- The date premium payments on your behalf cease;
- The date you enter active military service; or
- The last day of a specific six-month eligibility period if you did not accumulate 600 hours of work in the preceding six-month work period, 1200 hours in the preceding 12-month work period, or 2400 hours in the preceding 18-month work period.

When your coverage ends, you may be eligible to continue coverage by electing COBRA Continuation Coverage and paying the monthly payments. For more information, refer to the COBRA Continuation Coverage section.

## Dependent Eligibility

Your dependents are eligible for Plan coverage on the same date you become eligible or the date you acquire the dependent, whichever is later, so long as you remain eligible and while the person remains a dependent as defined in this plan. You must supply the necessary documentation in a timely fashion. If you fail to do so, the coverage may not be retroactive.

Your eligible dependents include:

- Your spouse to whom you are legally married.
- Your child under age 26. "Child" includes the following:
  - Biological child, unless such child has been adopted, or for whom you do not have legal custody and a court has not ordered you to provide medical coverage;
  - Legally adopted child, from the date of the filing of a petition to adopt;
  - Foster children who are fully dependent on your support;
- Biological child of an unmarried, eligible dependent child up until the eligible dependent child attains age 26, but only so long as the child remains unmarried, lives in the same household as you and is chiefly dependent upon you for support;
- Your stepchild until age 19, who is the biological or adopted child of your spouse, only if you and your spouse remain married to each other and the stepchild lives in the same household as you and is chiefly dependent on you for support. A stepchild can continue to be covered up until the attainment of age 26 while you and the applicable parent of the stepchild remain married to each other, but only if you and the applicable parent of the stepchild had been married prior to the stepchild attaining age 19 and, as of age 19, the stepchild had been living in your household and had been chiefly dependent on you for support;
- Biological child of an unmarried, covered/eligible (as defined above) stepchild until the covered stepchild attains age 26, but only so long as the stepchild remains unmarried, remains eligible and covered, lives in the same household as you and is chiefly dependent upon you for support;
- A minor who is related to you by blood or adoption, who lives with you and for whom you are his/her court-appointed legal guardian. Coverage can continue up to age 26 if there was guardianship as of the date the minor attained age 18;
- Your unmarried, disabled child of any age, however, you must submit written evidence of the child's incapacity to the Claims Office within 31 days after he/she attains age 26. Proof of continued incapacity may also be required;

  The disabled child must:
  - Have become disabled due to a mental or physical disability before age 26;
  - Be incapable of self-sustaining employment and continue to be incapable of such employment; and
  - Be dependent on you for more than one-half of his/her financial support and maintenance.
- Your child covered under a Qualified Medical Child Support Order (QMCSO);
  - A QMCSO is a court order that directs a medical plan covering a parent to provide benefits to the parent's child. The Plan will provide benefits in accordance with such an order and will be treated as a dependent under the Plan if he/she meets the criteria specified in the law governing QMCSOs. A QMCSO cannot subject the Plan to provide benefits to a former stepchild.
  - A copy of the Plan's QMCSO procedures is available at the Fund Office. You may contact the Fund Office if you have questions about the Plan's QMCSO procedures.

If an individual's coverage is terminated as a result of a person's attainment of age 26, then the effective date for termination of coverage will be the last day of the calendar month in which such person attained age 26.

### *Verification of Dependents*

From time to time, Iron Clad may request documentation of newly and currently enrolled dependents to verify eligibility. Documentation includes, but is not limited to, government-issued marriage certificates and birth certificates.

## When Dependent Coverage Ends

Your dependent's coverage will end on the earliest of the following:

- The date this Plan terminates;
- The date your coverage terminates;
- The date a dependent no longer meets the Plan's definition of an eligible dependent;
- If COBRA is elected, the date your eligible dependent's COBRA Continuation Coverage ends;
- The date specified in a Qualified Medical Child Support Order (QMCSO);
- For your stepchild, the date that a divorce decree for you and your spouse becomes final. For more details, please see the "Becoming Divorced and Separated" section under "Life Events."

## COBRA Self-Pay

If you are an active employee and you lose eligibility for benefits, you may still receive certain benefits by making payments to the Fund each month under the COBRA Self-Pay Plan. The COBRA Self-Pay Plan does not include all of the benefits you had as an active employee. For more details, please see COBRA Continuation Coverage on page 19.

## Special Basic Buy-In Plan

You may elect the Special Basic Buy-In Plan if you prefer a less expensive plan with limited coverage. Your monthly cost for coverage will be less than the COBRA Self-Pay Plan; however, you will pay a higher annual deductible before benefits commence. The Special Basic Buy-In Plan does not include Dental, Vision, Weekly Accident and Sickness, Life and AD&D, and Alternative Care coverage.

## Special Enrollment Rights

If you have a life-changing event, you may request special enrollment. These events include acquiring a new dependent because of marriage, birth, adoption, or placement for adoption. You must submit government-issued certified documents for such enrollment. In some cases, payment of benefits may be delayed or benefits terminated if documentation is not presented when requested.

CHIPRA (the Children's Health Insurance Program Reauthorization Act of 2009) created other special enrollment events, which apply if you are eligible for the Plan but are not enrolled in the Plan.

First, if you or your dependents were covered under Medicaid or a state CHIP plan and lose that coverage, you or your dependents are entitled to a special enrollment period in this Plan.

Second, if you or your dependents become eligible for a state's health plan assistance program, you are entitled to a special enrollment period. You have 60 days to notify the Plan of the event, and 31 days to provide proof of eligibility and to enroll. To request Special CHIPRA Enrollment or obtain more information, contact the Fund Office.

To request special enrollment or obtain more information, contact Iron Clad.

# Life Events

**FAST FACTS:**

- Notify Iron Clad immediately when a major life event happens.
- Review your beneficiary designation forms to reflect the most up to date information.

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

- Getting married;
- Birth or adoption of a child;
- Becoming separated or divorced;
- Your child no longer meets the Plan's definition of a dependent;
- Taking a leave of absence;
- Taking military leave;
- Your spouse or dependent becomes covered under any other Plan;
- Retiring; and
- Death.

**When You Experience a Life Event**

Notify Iron Clad as soon as you experience one of the life events listed here. In case of your death, your spouse or dependent should notify both Iron Clad and the Fund Office. The Trustees may ask you to provide government-issued documentation verifying a life event. In some cases, payment of benefits may be delayed or benefits terminated if documentation is not presented when requested.

If you have a change of address or experience one of these life events, notify Iron Clad immediately. You will receive a new card to complete and return to Iron Clad to update your records.

## If You Marry

When you get married, promptly notify Iron Clad. You must complete a new data enrollment card and send Iron Clad relevant government-issued documents such as birth certificates, marriage certificates, any court decrees, orders, or any other document determined necessary by the Trustees to verify the eligibility of your dependents.

Once you provide the required information, coverage for your spouse begins on the date of your marriage. If you do not notify the Iron Clad Claims Office within 30 days, your spouse's Plan coverage will begin on the first day of the month following the date on which Iron Clad received the information. You must report to Iron Clad your spouse's coverage under any other group medical plan.

## If You Add a Dependent Child

Subject to the Dependent Eligibility section, the Plan will cover your new dependent child as of 12:01 a.m. on the date of birth, adoption, marriage, or date of the court order establishing financial responsibility for the child, so long as you promptly notify Iron Clad and submit government-issued documents such as birth certificates, marriage certificates, any court decrees, orders, or any other document determined necessary by the Trustees to verify the eligibility of your dependents. If you do not notify the Iron Clad Claims Office within 30 days, your dependent's Plan coverage will begin on the first day of the month following the date on which Iron Clad received the information. You must report to Iron Clad your dependent's coverage under any other group medical plan.

## If Your Spouse or Dependent Becomes Covered Under Any Other Plan

If your spouse or your dependent becomes covered under any other plan, you must promptly notify Iron Clad, in writing. If this Plan pays benefits as the result of a failure to so notify Iron Clad, then you (and, as may be applicable, your spouse and or adult dependent), will be financially responsible to reimburse this Plan for such payments. This Plan will also have the right to withhold future benefit payments as may be applicable, for you, your spouse, and/or your dependent, equal to such amount.

## If You Divorce or Legally Separate

If you divorce or legally separate, you must notify Iron Clad as soon as possible. You must provide Iron Clad with a copy of the judgment of divorce or separate support in order for your former spouse to remain eligible for coverage under this Plan provision.

Your ex-spouse may continue coverage under the Active Plan (unless the judgment provides that your ex-spouse is responsible for his or her own coverage) until the earliest of the following:

- The date your coverage under the Plan terminates;
- The date either you or your former spouse remarry. However, upon your remarriage, your former spouse may be eligible for COBRA continuation coverage; or
- The date the judgment provides that the former spouse is no longer eligible for coverage under this Plan.

**Note:** If you should lose eligibility in the Active Plan and thereafter re-gain eligibility, your former spouse **cannot** be enrolled in the Active Plan.

**Note:** Any coverage in the Retiree Plan of an ex-spouse is terminated upon the remarriage of you or your ex-spouse.

**Note:** Any coverage in the Retiree Plan of an ex-spouse will terminate three years from the date of the divorce.

If you or your ex-spouse fail to promptly notify Iron Clad, in writing, of your divorce, and the Plan pays benefits as a result of such failure (i.e. for the ex-spouse or for a stepchild), then you and your ex-spouse are, jointly and severally, financially responsible to reimburse the Plan. The Plan will also have the right to withhold future benefit payments for you (and, if any, for your ex-spouse and a stepchild) equal to such amount.

If you fail to promptly notify Iron Clad, in writing, of your remarriage, and the Plan pays benefits as a result of such failure, (i.e. for the ex-spouse), you will be financially responsible to reimburse the Plan. The Plan will also have the right to withhold future benefit payments for you (and, if any, for your ex-spouse) equal to such amount.

If your ex-spouse fails to properly notify Iron Clad, in writing, of his/her remarriage, and the Plan pays benefits as a result of such failure, (i.e. for the ex-spouse) then he/she will be financially responsible to reimburse the Plan. The Plan will also have the right to withhold future benefit payments, if any, for your ex-spouse equal to such amount.

## If Your Child Is No Longer Eligible for Coverage

Your dependent's eligibility for coverage will end on the earlier of the:

- First day of the month for which you do not meet the Plan's continuing eligibility requirements;
- Date a dependent no longer meets the Plan's definition of an eligible dependent;
- Date your eligible dependent's election period for COBRA Continuation Coverage ends (however, with attainment of age 26, see "Dependent Eligibility" section);
- Date specified in a Qualified Medical Child Support Order (QMCSO); or
- For a stepchild, the date the divorce for your and your spouse is final.

If your child loses Plan coverage because he/she ceases to meet the Plan's definition of a dependent, he/she may receive benefits through COBRA Continuation Coverage for up to 36 months. For more information about COBRA Continuation Coverage, contact the Fund Office.

## If Your Dependent Dies

If your spouse or child dies, you must notify Iron Clad as soon as possible. You may also want to review your beneficiary designation and determine whether any changes are necessary.

## If You Become Disabled

If you become Disabled and cannot work, there are several different benefit programs available through the Plan.

Your coverage under the **Weekly Accident and Sickness Benefit** entitles you to a weekly disability benefit of $250 per week if you become Totally Disabled due to a non-work-related illness or a non-work related injury and are unable to work while you are covered by this Plan. The benefit will continue for a maximum of 26 weeks for any one continuous period of disability based on the same initial illness or injury. The benefit is limited to a lifetime to a maximum of 52 weeks. See page 52 for more information.

You may be eligible for a benefit of up to $1,000 per month under the **Long-Term Disability Benefit** if you are unable to work due to an illness or injury. See page 53 for more information.

If you have a serious injury that is covered by the **Accidental Death and Dismemberment (AD&D) Plan Benefit**, you will be eligible for a cash payment through your AD&D coverage. See page 55 for more information.

If you become Totally and Permanently Disabled before you attain age 60, your **Life Insurance** will continue at no cost to you for at least 12 months from the date the premiums were paid on your behalf. Refer to page 57 for more information.

## If You Stop Working or Reduce Your Hours

You may elect to purchase COBRA Continuation Coverage for yourself and your dependents for up to 18 months if coverage ends due to your termination of employment or your reduction in hours. You must inform the Fund Office within 60 days after your reduction in hours or termination of employment or you will lose your right to elect COBRA Continuation Coverage.

If your employment is terminated or your hours are reduced, and at that time, or within 60 days, you or one of your dependents is disabled (as determined by Social Security), coverage may continue for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months beyond the initial 18 months, you must notify the Fund Office of your determination of disability by the Social Security Administration. For more information about COBRA Continuation Coverage, refer to page 19.

## If You Retire

If you retire before you reach age 65, you or your eligible dependents may elect to continue your medical coverage under COBRA Continuation Coverage or the Retiree Plan. These Plans require the payment of a monthly premium. Coverage of any person under the Retiree Plan terminates, at the earlier of, attaining age 65 or upon eligibility for Medicare before age 65 because of a disability.

## If You Become Eligible for Medicare

**If you are an Active employee** and you or your dependent is eligible for Medicare because of attaining age 65 or because of a disability, you will continue to be covered by the Fund Medical Plan at no cost to you. With active coverage, the Plan will usually be primary to Medicare. Medicare will consider whatever expenses remain after the Plan has paid its share. You should promptly apply for and elect Medicare Part B upon learning your active coverage will terminate. There is a penalty for delayed enrollment if you do not enroll in Medicare Part B during the seven-month period immediately following termination of active coverage in the Plan. Even if you have enrolled in COBRA coverage, you will not avoid the penalty. Remember—it is your responsibility to enroll in Medicare Part B and pay its monthly premiums.

**If you or your dependent is covered under the Retiree Plan** and becomes eligible for Medicare, such person's coverage is terminated as of the first day of the month in which such person attains Medicare eligibility. You should promptly apply for and elect Medicare Part B upon attainment of Medicare eligibility. There is a penalty for delayed enrollment if you do not enroll in Medicare Part B during the seven-month period immediately following attainment of Medicare eligibility. Even if you have enrolled in COBRA coverage, you will not avoid the penalty. Remember—it is your responsibility to enroll in Medicare Part B and pay its monthly premiums.

You have an **obligation to notify** the Plan if you, your spouse or your dependent becomes eligible for Medicare because of a disability. Your spouse or an adult dependent, respectively, also has such **obligation to notify** the Plan if either becomes eligible for Medicare because of a disability.

If the Plan pays benefits as the result of a failure to promptly notify Iron Clad, in writing, then you (and, jointly and severally, as may be applicable, your spouse and/or adult dependent) will be financially responsible to reimburse the Plan for such payments. This applies whether such individual became entitled to Medicare any time before or after enrollment in Retiree Coverage.

## If You Die

If you die from any cause while you are covered as an active employee, your life insurance benefit will be paid to your beneficiary. Depending on your cause of death, your beneficiary may also be entitled to Accidental Death and Dismemberment benefits. Your designated beneficiary must provide the Fund Office with proof of your death before benefits will be paid. For more information about the life insurance benefit, refer to page 57.

Your surviving dependents may be eligible to continue coverage under COBRA for up to 36 months. Coverage of a widowed spouse in the Retiree Plan will terminate upon, the earlier of, the remarriage of such spouse or his/her eligibility for Medicare. For more information about COBRA Continuation Coverage, refer to page 19.

If you die while covered under the Retiree Plan, your spouse and dependents may be able to continue coverage. Coverage of a widowed spouse in the Retiree Plan will terminate upon, the earlier of, the remarriage of such spouse or his/her eligibility for Medicare. For more information, contact the Fund Office.

## If You Take a Leave of Absence

If applicable for you and your employer, under the Family and Medical Leave Act (FMLA), you can take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth of a child or placement of a child with you for adoption;
- The care of a seriously ill spouse, parent, or child;
- Your serious illness; or
- You have an urgent need for leave because your spouse, child, or parent is on active duty in the armed services in support of a military operation.

In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must:

- Be your spouse, child, parent, or next of kin;
- Be undergoing medical treatment, recuperation, or therapy, for a serious illness or injury incurred in the line of duty while in military service; and
- Be an outpatient, or on the temporary Disability retired list of the armed services.

The FMLA requires certain employers to maintain health care coverage during the leave period. If you think that this law may apply to you, please contact your employer.

## If You Enter the Military

If you are called into active uniformed services, you may elect to continue your Plan coverage, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your health care coverage will continue under the Plan if you serve for up to 31 days.

If you are on active duty for less than 31 days, you will continue to receive full Fund health care coverage for up to 30 days. If you serve 31 days or more, your coverage will continue until the last day of the month that you enter active service. After that, to continue coverage, you or your dependent must make the required self-payment contribution for coverage.

**Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you are absent from employment because of active service in the United States Armed Forces, you and your eligible dependents may be eligible to continue medical coverage on a Self-Pay basis for the period of your military service (to a maximum of 24 months). Contact the Fund Office for more information.

You may elect and continue your coverage at your own expense until the earlier of:

- The period beginning when coverage ended and ending on the date on which you are eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after coverage ended.

You must give advance notice of your military service and provide a copy of your call to uniformed service orders to the Fund Office, unless you are unable to do so because of military necessity, advance notice is impossible, or it is unreasonable under the circumstances.

Coverage under USERRA will run concurrently with COBRA Continuation Coverage. The cost of continuation coverage under USERRA will be the same cost as COBRA Continuation Coverage. The procedures for electing coverage under USERRA will be the same procedures described in the COBRA Continuation Coverage section of this booklet, except that only the Employee has the right to elect USERRA coverage for himself or herself and his/her dependents, and that coverage will extend to a maximum of 24 months.

# COBRA Continuation Coverage

**FAST FACTS:**

- If you lose your eligibility for benefits, you may be able to elect COBRA benefits.
- Your children may be eligible to continue coverage under COBRA when they no longer satisfy the Plan's definition of "eligible dependent."
- To maintain your coverage under COBRA, you must pay monthly premiums on time beginning with the first month in which coverage under the Plan terminates.
- The length of your COBRA continuation coverage period depends on your specific qualifying event.
- You cannot receive Life Insurance or Accidental Death and Dismemberment Insurance or Weekly Accident and Sickness while under COBRA continuation coverage.

In certain situations where your coverage would otherwise terminate under the Plan, the Plan provides an opportunity for a temporary extension of health care coverage. After a qualifying event, COBRA continuation coverage is offered to each person who is a qualified beneficiary.

You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is terminated because of a qualifying event.

Health care coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) is called COBRA Continuation Coverage. It is offered to you, at rates set by the Trustees, in specific instances called qualifying events where coverage under the Plan would otherwise terminate. If you are eligible for continuing coverage under both USERRA and COBRA, USERRA continuing coverage will run concurrently with COBRA Continuation Coverage.

## Qualifying Events

If you are an employee and lose your coverage under the Plan because either one of the following qualifying events occurs:

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

If you are the spouse of an employee, you become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occur:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

**If you have a COBRA qualifying event, call the Fund Office at: 617-265-3757, or 800-637-3736.**

Your dependent children become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occurs:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare (under Part A, Part B, or both); or
- The child is no longer eligible for coverage under the Plan as a dependent child, e.g. because of age attainment
- Your dependent stepchild is no longer eligible for coverage under the Plan, e.g. because of age attainment or divorce from the stepchild's parent.

## Notifying the Fund Office/Electing COBRA

The Fund will offer COBRA Continuation Coverage to qualified beneficiaries only after it has been notified that a qualifying event has occurred. Within 60 days of the occurrence, you or your dependent must inform the Fund Office of a divorce, separation, or a child losing dependent status under the Plan. If you do not notify the Fund Office in a timely manner, you or your dependent will lose the right to elect COBRA Continuation Coverage.

By law, your employer is required to notify the Fund Office of your death, termination of employment or reduction in hours or entitlement to Medicare within 30 days of its occurrence. However, because employers contributing to multiemployer funds may not be aware of these events, we urge you or a family member to notify the Fund Office of any qualifying event as soon as it occurs.

When the Fund Office is notified that one of these events has occurred, and you lose coverage under the Plan, you and your eligible dependents will be notified within 14 days of your right to elect COBRA Continuation Coverage. Each qualified beneficiary has an independent right to COBRA—your eligible dependents have the option to elect COBRA coverage whether you elect COBRA coverage or not. In addition, covered members may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect this coverage on behalf of their children.

You must also notify the Fund within 60 days of a Social Security Disability award and before the normal COBRA expiration date. In addition, if you are eligible for the 29-month Disability extension of COBRA Continuation Coverage, and receive a notice that you are no longer eligible for the Social Security Disability award, you must notify the Fund within 30 days of receiving the notice that you are no longer eligible.

Once you receive a COBRA notice, you have 60 days to respond in writing (using the Fund's COBRA election notice) if you want to elect COBRA Continuation Coverage. As noted above, your eligible dependents each have the option to elect coverage independently from you if you choose not to elect COBRA Continuation Coverage.

If COBRA Continuation Coverage is elected, the Plan will provide coverage that is similar to the health coverage (excluding Sickness and Accident, Life Insurance, and AD&D Benefit) provided to similar employees and their dependents.

COBRA Continuation Coverage will be offered to you and all of your eligible dependents who were covered under the Plan on the day before the day of the qualifying event. If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA Continuation Coverage is in effect, you may add this child to your coverage, and that child will be treated as a qualified dependent under COBRA. You must notify the Fund Office, in writing, of the birth or placement for adoption to add the child to your coverage. However, children of your child are not qualified beneficiaries and cannot attain COBRA coverage while the COBRA continuation coverage is in effect.

## Periods of Coverage

The maximum period of COBRA Continuation Coverage is 36 months from the qualifying event.

- Coverage continues for a maximum of 18 months if your coverage ends due to your termination of employment or your reduction in hours.
- If you or anyone in your family covered under the Fund is determined by Social Security to be disabled and you notify the Fund in a timely manner, you and your entire family may be entitled to receive up to an additional 11 months (added to the original 18-month period) for a total of 29 months. Coverage will continue for a maximum of 29 months if you or an eligible dependent qualifies for a Social Security Disability Award at the time you lose eligibility, or within 60 days after that, provided you notify the Fund within 60 days of the award and before the normal COBRA expiration date. Other members of your family who have elected COBRA Continuation Coverage are also eligible to continue COBRA coverage for the extended 29-month period.

- Coverage continues for a maximum of 36 months for your spouse or other eligible dependents' (only) if their coverage would otherwise end because of your:
  - Death;
  - Legal separation or divorce;
  - Entitlement to Medicare; or
  - Dependent child no longer qualifying for dependent coverage under the Plan.
- In addition, after qualifying for COBRA Continuation Coverage due to your termination of employment or reduction in work hours, eligibility for COBRA Coverage can be extended for your spouse and eligible dependent(s) only for up to a maximum period of 36 months in total if your spouse or other eligible dependent experiences a second life event during an 18-month COBRA Continuation Coverage period because of your:
  - Death;
  - Legal separation or divorce;
  - Entitlement to Medicare; or
  - Dependent child no longer qualifying for dependent coverage under the Plan.

## Loss of Continued Coverage

COBRA Continuation Coverage for you or your eligible dependents may terminate if:

- You or your eligible dependents do not make the required self-payment contributions on a timely basis;
- You or your eligible dependents first become covered under any other group health care plan, including Medicare (provided such plan does not contain any exclusions or limitations with respect to any pre-existing conditions) after electing COBRA Continuation Coverage;
- The Fund ceases to provide any group health benefits;
- You or your dependent reaches the end of the 18-month, 29-month, or 36-month COBRA Continuation Coverage period and you are not eligible for additional continuation coverage under the rules described above;
- You become eligible for Medicare; or
- Your dependent becomes eligible for Medicare.

Once your COBRA Continuation Coverage terminates, it cannot be reinstated.

## Paying for COBRA

Once you notify the Fund Office, you will receive a form to elect your COBRA coverage and information on the monthly cost for coverage.

Your first payment for continuation coverage must include payments for any months retroactive to the day you and/or your dependents' coverage under the Plan terminated. This payment is due no later than 45 days after the date you or your dependent signed the election form and returned it to the Fund Office. After that, your premiums must be paid in monthly installments and are due the 15th of the month prior to the coverage month. If you do not pay your premiums within 30 days of the due date, your coverage will terminate.

## Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent child loses coverage under another group health plan, you may enroll the spouse or dependent child for coverage for the balance of the period of COBRA Continuation Coverage. The spouse and/or dependent child must have been eligible but not enrolled for coverage under the terms of this Plan and declined coverage when enrollment was previously offered under this Plan. In addition, the spouse and/or dependent child must have been covered under another group health plan or had other health insurance coverage during the period of unenrolled COBRA coverage.

You must enroll the spouse and/or dependent child within 31 days after the termination of the other coverage.

The loss of coverage under the other plan must be due to one of the following:

- Exhaustion of COBRA Continuation under another plan;
- Loss of eligibility; or
- Employer contributions towards the other plan decline or are eliminated.

Loss of eligibility does not include a loss due to failure of the individual or participant to pay on a timely basis or termination for cause. Also, if you obtain a new dependent while you are covered under COBRA, with certain limitations, you may enroll that dependent. Contact the Fund Office for details.

## Retiring

If you retire before you reach age 65, you or your eligible dependent may elect to continue your medical coverage under COBRA Continuation Coverage or the Retiree Plan. These Plans require the payment of a monthly premium.

Coverage of any person under the Retiree Plan terminates, at the earlier of, attainment of age 65 or upon eligibility for Medicare before age 65 because of a disability.

For limitations for coverage of an ex-spouse in the Retiree Plan, see the "If You Divorce or Legally Separate" section on page 15. For limitations for coverage in the Retiree Plan of a widowed spouse, see the "If You Die" section on page 17.

## If You Become Eligible for Medicare

You have an **obligation to notify** the Plan if you, your spouse or your dependent becomes eligible for Medicare because of a disability. Your spouse or an adult dependent also has such **obligation to notify** the Plan if either becomes eligible for Medicare because of a disability.

You should promptly elect Medicare Part B and Part D. There is a penalty for delayed enrollment if you do not enroll in Medicare during the seven-month period immediately following termination of active coverage in the Health and Welfare Plan. Enrollment in COBRA coverage will not avoid the penalty. Remember—it is **your** responsibility to enroll in Medicare Part B and Part D and pay its monthly premium. There are many individual Medicare Supplement Plans available which include Drug Coverage and we encourage you to research your options well in advance so that you do not have a lapse in coverage.

## For More Information

For questions, concerning your Plan or your COBRA continuation coverage rights should be directed to the Fund Office. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available on EBSA's website.)

# Your Medical Benefits

The Plan offers comprehensive health care coverage to help you and your family stay healthy. This coverage can provide financial protection against catastrophic health care bills. In addition, this benefit includes certain management provisions to help control costs and for the review as to whether the services you receive are appropriate. You and your family are also eligible for certain home health care benefits and an annual check-up to ensure your good health.

**FAST FACTS:**

- You save money when you use a participating provider from the PPO Network.
- You must use the Hospital Pre-Admission Certification Program (PAC) if your physician recommends a hospital stay.
- The Second Surgical Opinion option is covered at 100%.
- Modern Assistance Program can help you or your family with personal problems, drug and alcohol counseling, stress, and financial problems.
- Medical benefit coverage is for those services that are Medically Necessary.

## Benefit Management Provisions

Your medical plan contains certain Benefit Management Provisions to help control the cost of health care benefits, but also to review whether the health services you receive are appropriate. The key features of the Benefit Management Provisions are:

- Preferred Provider Organization
- Hospital Pre-Admission Certification
- Second Surgical Opinion
- Modern Assistance Program (MAP)

You must follow the requirements of utilization review, pre-admission review, discharge planning, individual case management and tiered (or step) therapies. If you do not do so, your benefits involving these programs may be reduced or denied. Specifically, you may still be responsible for the difference between any allowed charge, as determined by these programs, and the provider's actual charge.

## How to Use Your Medical Benefits

Simply present your ID card when you visit a provider so that the provider knows the correct location to contact for information, to bill, to pre-certify, etc. Certain services must be pre-certified in order to receive coverage. If you visit an out-of-network provider, you may have to file a claim to receive reimbursement.

## How Your Coverage Works

While you must meet your annual deductible in order for the Plan to pay for some services, the Plan may pay for some services before you do so.

### *Annual Deductible*

The annual deductible is the dollar amount you pay each year before the Plan pays benefits. The annual deductible for individual coverage is $300 per calendar year. The annual deductible for family coverage is $600 per calendar year. Your deductible does not count toward your out-of-pocket maximum.

## *Carryover Deducible*

If you incur expenses in the last three months of the calendar year toward your deductible, in part or in full, the amount will be "carried over" to reduce the deductible for the following calendar year.

## *Family Deductible*

Once the deductible amount per family has been satisfied by a combination of any number of covered family members in a calendar year, no further deductible will be required for the rest of that calendar year.

**Do not Forget Your ID Card**

It's important to present your Identification Card (ID Card) to medical care providers at the time of service, especially if you use the PPO. Your ID Card will identify you as a member of the Tufts CareLink and Cigna PPO, so providers will know the location to contact for information regarding pre-certification, billing, etc.

## *Coinsurance and Out-of-Pocket*

Once you meet your annual deductible, you and the Plan share in the cost of your medical expenses. For most services, you pay a percentage and the Plan pays a percentage. For example, in the Active Plan, you pay 10% and the Plan pays 90% of the costs when you visit a provider who participates in the PPO network. This is called your "coinsurance."

Your coinsurance payments for most services count toward the out-of-pocket maximum. If your in-network coinsurance totals $1,500 per individual or $3,000 per family, you have reached the out-of-pocket maximum for that calendar year and the Plan will pay 100% of your eligible medical expenses for the remainder of the calendar year.

However, your deductible, copayments, amounts over maximums and any penalties do not count toward your out-of-pocket maximum.

## *Preferred Provider Organization (PPO)*

The Plan offers benefits from a network of doctors and hospitals through Tufts CareLink and Cigna. A PPO network of physicians and hospitals agree to charge a negotiated dollar amount for medical services. You and your family always have the final say in determining which doctors and hospitals you select. When you use a PPO network provider, you save money for yourself and the Plan. If you select a non-participating provider, your out-of-pocket costs will be higher. To find out whether or not a certain provider participates in the PPO network, visit the online Provider Directory at **www.tuftshealthplan.com/carelink/ironworkers** or call 800-768-4695.

**Consult the PPO Provider Directory**

Sometimes medical care providers move into and out of the PPO. Check with your provider before making an appointment to verify that he or she participates in the PPO. The PPO Provider Directory is available online: **www.tuftshealthplan.com/carelink/ironworkers**

Non-PPO (or "out-of-network") providers can charge different rates for different services. The Plan will pay for out-of-network services, but at the "Reasonable and Customary" (R&C) rate only. The R&C rate is a "standard" fee charged by health care providers for a particular service in a particular geographic area. Generally, the Plan will pay 60% and you will pay 40% of the R&C rate for out-of-network services, although the amounts vary as indicated in the Schedule of Benefits. If the non-PPO provider charges more than the R&C rate, you must pay the difference between what the plan pays and what the provider charges. This is important to consider when selecting a provider.

The following example compares what Joe would pay if he goes to a PPO provider and a Non-PPO provider for an office visit for a routine illness, such as a sinus infection. For the purposes of this example, assume that Joe is an active employee and has met his deductible.

| | PPO Provider | Non-PPO Provider |
|---|---|---|
| Office Visit | Joe pays his $20 copayment at the time of his office visit. | Joe's out-of-network doctor requires payment up front; Joe must pay $100 at the time of the visit. |
| | The plan pays 100% of the PPO provider's charges. | The Reasonable and Customary charge for an office visit in Joe's area is $50. |
| | | Since Joe met his deductible, the Plan pays 60% of the Reasonable and Customary charges of $50, which equals $30. |
| Claim Forms | Provider files all claims for Joe. | Joe must file his own claim forms and wait for reimbursement. |
| Joe's Cost | Joe pays only the $20 copayment. | Joe's net cost after reimbursement is $70. |

## Hospital Pre-Admission Certification

Hospital Pre-Admission Certification (PAC) is a program that helps reduce Plan costs by determining whether a hospital stay is medically necessary. If your physician recommends a hospital stay, you must call the CareAllies unit at its toll-free number 800-768-4695 to obtain this review.

The CareAllies medical professional will consult with your physician, to determine whether hospitalization is medically necessary, or if equally effective treatment can be provided in an alternative setting. After the review, the CareAllies representative will notify you, your physician, and the hospital. If your hospital stay is approved, the CareAllies representative will assign an initial number of approved hospital days.

**Make Sure You Know the Plan Rules**

If your benefits are reduced because Plan rules were not followed, for example, failure to Pre-Certify a Hospital Admission, that reduction cannot be used to satisfy any deductible under this Plan.

If more days in the hospital are required, the CareAllies representative will discuss the Continued Stay Review process with your physician. If it is agreed that continued hospitalization is medically necessary, additional days will be approved.

### *Emergency Hospital Admissions*

If you or your dependent is admitted to the hospital for an emergency, you, a responsible family member, or the attending physician must call the CareAllies unit at 800-768-4695 within 48 hours of the emergency admission. When the CareAllies representative is notified, he or she will be able to assign an initial number of approved hospital days.

### *Mental Health or Substance Abuse Disorder Admissions*

If your physician recommends a hospital stay, you must call Modern Assistance Programs (MAP) at 617-774-0331 to obtain this review.

### *Benefit Reductions if Admissions are not Certified*

If you or your dependents do not use the Hospital Pre-Admission Certification Program for a hospital stay, and that stay is not retroactively approved, any benefits payable for charges made by the hospital in connection with the stay will be reduced by 10% up to $500.

If you or your dependent does not use the Hospital Pre-Admission Certification Program a second time, and that stay is not retroactively approved, any benefits payable for hospital charges will be reduced by 20% up to $1,000.

Any subsequent stay that is not certified and retroactively approved will also be subject to a 20% reduction not to exceed $1,000 per confinement.

If you or your dependents do not use the Hospital Pre-Admission Certification Program for a hospital stay and it is determined through retroactive review that the services would not have been approved, you (and your dependents, if applicable) will be financially responsible for the charges.

## Second Surgical Opinion

A second surgical opinion is an optional program that may help you and your eligible dependents determine whether to have an elective surgery that your doctor recommends.

The Plan will cover 100% of Reasonable and Customary charges for a second surgical opinion provided by a Participating Physician. The only requirement is that you must receive the results of the second surgical opinion physician's findings before deciding on the course of treatment.

**What is a Participating Physician?**

A Participating (or consulting) physician is a Board Certified physician who is on the Second Opinion Panel, contracted through CareAllies. The physician must be Board Certified in the field of the proposed surgery or in the field of medicine that applies to the medical condition.

The Plan will pay 100% of the Reasonable and Customary charges made for a second opinion consultation, including any additional tests and x-rays that the examining physician may feel are required to complete the second opinion review. If the second surgical opinion does not confirm the need for surgery, you or your dependents may request a third surgical opinion. The Plan will pay 100% of the Reasonable and Customary charges incurred for the third consultation by a Participating Physician.

### *Expenses Not Covered by Second Surgical Opinion*

- Consultation with a non-participating physician;
- More than two consultations in connection with the proposed surgery, after you or your dependent have received an initial recommendation for surgery;
- X-rays and tests not related to the proposed surgery;
- Failure to be examined in person by the physician who is rendering the opinion;
- Failure on the part of the physician to send a written report to Iron Clad;
- Surgery performed by the consulting physician; or
- Any consultation made in connection with an injury or illness that is not covered by this Plan.

## Employee Assistance Program (EAP)

EAP services are provided by Modern Assistance Programs (MAP). MAP will help identify and evaluate personal problems, facilitate mental health and substance abuse treatment, or make referrals. After a referral, the EAP counselor will monitor treatment. The services of the EAP are completely confidential and free of charge for you or your eligible dependents while you are a Plan participant.

Contact the EAP by calling 617-774-0331 or by writing to:

Modern Assistance Programs, Inc.
1400 Hancock Street
Second Floor
Quincy, MA 02169

# Expenses the Medical Plan Pays

**FAST FACTS:**

- Your Plan includes benefits for inpatient treatment, diagnostic tests and x-rays, treatment of infertility, routine pap tests and mammograms, chiropractic care and well-child care.
- The Plan pays for services and treatments that are medically necessary.

## Inpatient Treatment

The Plan will pay for charges made by a hospital for inpatient treatment. Covered room and board charges may not exceed the hospital's average rate for semiprivate rooms. If a hospital does not have semi-private rooms, the covered charges will not exceed the average rate for semiprivate rooms charged by hospitals in the surrounding geographical area. If intensive care accommodations are required for a critically and seriously ill or injured individual, the daily room and board charges for such accommodations are covered in full.

## Pre-Admission Testing

The Plan pays for diagnostic tests and x-rays ordered by a physician and conducted in the outpatient department of a hospital within seven days of an actual admission to a hospital. The Plan will pay for charges made by the hospital—as long as the person is scheduled for future admissions for treatment of the condition that made the tests necessary.

In the event the scheduled admission does not take place, the testing may still be covered, if the admission is postponed or cancelled for one or more of the following reasons:

- The tests show a condition requiring medical treatment prior to admission;
- A medical condition is developed that delays the admission;
- A hospital bed is not available on the scheduled date of admission; or
- The tests indicate that, contrary to the attending physician's expectations, the admission is not necessary.

## Diagnosis and Treatment of Infertility

Benefits will be payable for the medically necessary expenses for the diagnosis and treatment of infertility. Experimental procedures are not covered. The Plan covers the following:

- Artificial insemination (AI);
- In-vitro fertilization and embryo placement (IVI-EP);
- Any costs associated with the sperm, egg and/or inseminated egg procurement; processing and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any; and
- Gamete intra-fallopian transfer procedures (GIFT).

The Plan allows for a maximum of three (3) treatment cycles.

The Plan excludes any costs associated with surrogacy; reversal of voluntary sterilization; or cryopreservation of embryos, sperm, and/or eggs.

## Routine Pap Tests and Mammography

The Plan will pay for Pap tests and mammograms, as follows:

- Annual Pap test for women age 18 and older;
- A baseline mammogram for women between 35 and 40 years of age;
- Annual mammogram for women 40 years or older.

### *Women's Health and Cancer Rights Act*

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for mastectomy-related services in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Contact Iron Clad for more information regarding this benefit.

## Well Child Care

The Plan provides well-child care benefits for children from birth through age six. Benefits are payable for:

- Six visits from birth through one year of age;
- Three visits from age one through age two; and
- One visit annually from age two through age six.

Covered charges for children to age six include:

- Routine physical exams;
- Routine history;
- Routine measurements;
- Sensory screening;
- Neuropsychiatric screening; and
- Developmental screening.

When recommended by a physician, these charges are also covered:

- Hereditary and metabolic screening at birth;
- Immunizations and tuberculin tests; and
- Blood and urine tests.

## Routine Physical Exam

The Routine Physical Exam Benefit provides coverage for a routine physical examination performed by a physician. Routine physical examinations are paid at 100% of the PPO Allowance less a $20 copayment for in-network providers or 100% of the Reasonable and Customary charges of an out-of-network provider. Charges must be billed as a free-standing facility (non-hospital) in order to be reimbursed at the 100% level, otherwise, covered charges are subject to the deductible and coinsurance.

If diagnostic tests are conducted for a condition discovered in a routine physical examination, payment for the extra procedures may be covered under other plan provisions.

The Routine Physical Exam Benefit covers a check-up to ensure your good health. It is not for diagnosing an illness or injury—that is covered under your comprehensive major medical benefits. It is also not to be used for pre-employment screenings or continuing employment, or for obtaining life insurance coverage.

## Routine Annual Gynecological Exam

The Routine Annual Gynecological Exam Benefit covers one routine gynecological exam per year, at 100% of Reasonable and Customary charges. There is no deductible or copay. Charges must be billed as a free-standing facility (non-hospital) in order to be reimbursed at the 100% level, otherwise, covered charges are subject to the deductible and coinsurance.

### *Newborns' and Mothers' Health Protection Act*

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 a provider to obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

## Chiropractic Services

The Plan pays benefits for chiropractic services (spinal manipulation). If you use a PPO Provider, benefits will be paid at 80% of the PPO rate. Should you choose out-of-network, the Plan will pay 80% of Reasonable and Customary charges after the Deductible.

The calendar year maximum for chiropractic benefits is 26 visits.

# Other Included Benefits

The Plan will also pay benefits at the Reasonable and Customary rate for charges for:

- Outpatient treatment through a hospital;
- Diagnosis, treatment and surgery made by a physician or surgeon;
- Bariatric surgery (subject to prior approval);
- A registered graduate nurse (R.N.) for private duty nursing, other than a nurse who normally lives in your home or is a member of your or your spouse's immediate family;
- Artificial limbs or eyes for the initial replacement of natural limbs or eyes lost while insured;
- Initial trusses, braces or supports; casts, splints and crutches;
- Rental of durable medical equipment such as wheelchairs and hospital type beds. The maximum benefit for renting is the purchase cost;
- Oxygen and rental of equipment for its administration, and other mechanical equipment for the treatment of respiratory paralysis The maximum benefit limit for renting is the purchase cost;
- Local ambulance service;
- X-rays and laboratory tests, including diagnostic services rendered in conjunction with routine physical examinations;
- Radium, radioactive isotopes and x-ray therapy;
- Anesthesia and its administration;
- Blood and other fluids to be injected into the circulatory system;
- Physiotherapy by a licensed physiotherapist;
- Prescription drugs while hospital confined;
- Skilled Nursing Facility room and board and special service charges, for admission within 14 days of a covered hospital stay of at least three days' duration;
- Physical, speech and occupational therapy by a registered therapist;
- Services of a Visiting Nurse Association, for intermittent nursing services and physical therapy;
- Dental care involving the repair or replacement of teeth or the repair of dental prostheses when the teeth or prostheses are damaged due to an injury on or after the effective date of this Plan;
- Asbestos screening;
- Podiatrists' services, except for routine foot care such as trimming of corns or calluses;
- Enteral formulas, for home use when ordered in writing, by a physician as medically necessary for the treatment of Crohn's disease and ulcerative colitis;
- Screening for lead poisoning for children;
- Cardiac rehabilitation, including outpatient treatment initiated within 26 weeks after the diagnosis of the disease;
- Sterilization of the reproductive system;
- Medically necessary early intervention services including occupational, physical and speech therapy, nursing care and psychological counseling for children from birth to age three;
- Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g. Nicorette, Nicoderm, etc.) once per lifetime, to a maximum of $100; and

Please refer to General Exclusions section for medical expenses that are not covered.

- Bone marrow, tissue and organ transplants when a covered person in this Plan is a recipient, subject to pre-approval. Covered services typically include:
  - patient evaluation;
  - organ procurement or acquisition;
  - hospital care; and
  - physician care.

  Excluded services are:
  - transportation to and from the transplant center;
  - temporary lodging and meals for the recipient or for a companion;
  - air ambulance for visits to the transplant center;
  - search fees for donor match;
  - medical services for a covered person in this Plan who donates to a person who is not covered in this Plan; and
  - living donor expenses, except as specified below.

  When the recipient is a covered person in this Plan, but only to the extent that the donor is not covered by any other plan of health care coverage, the following services related to the procurement of bone marrow, tissue or an organ from a donor are covered:
  - evaluation and preparation of the donor; and
  - surgical intervention and recovery services which relate directly to donating the bone marrow, tissue or organ to the recipient.

The Plan will not pay for any medical charges for a potential donor who does not become the ultimate donor.

# Alternative Care — Active Employees

The Plan provides benefits for alternative/complementary therapies with the pre-approval from the Employee Assistance Program (EAP)—Modern Assistance Programs, Inc. (MAP). Benefits for covered alternative therapies are limited to a maximum of $1,500 per covered person per calendar year.

Alternative/complementary medicine focuses on the whole body and provides natural treatments to complement conventional medical care. The treatments are used for health maintenance, prevention and control of chronic conditions such as addiction and pain management.

Alternative/complementary therapies include but are not limited to the following:

- Acupuncture;
- Homeopathy;
- Acupressure;
- Nutritional Counseling;
- Therapeutic Massage (Body Work);
- Hypnotherapy;
- Traditional Chinese Medicine;
- Massage Therapy; and
- Naturopathy.

There are specific criteria for these Alternative Benefits to be covered. For more information, call MAP at 617-773-4288. No benefits will be paid without prior approval from MAP.

# Treatment for Mental Health and Substance Abuse

The Plan pays for the medically necessary Mental Health and Substance Abuse treatment. Contact the EAP, Modern Assistance Programs, Inc. (MAP) at 617-774-0331 to ensure that you obtain the full benefits.

**FAST FACTS:**

- You and your family are eligible to receive mental health and substance abuse benefits under the Major Medical Benefit.
- Active employees may be entitled to receive alternative or complementary care benefits up to $1,500 per covered person, per calendar year.

## Mental Health—Inpatient Treatment

The Plan pays for covered charges you or your eligible dependents incur for treatment as an inpatient, provided you receive treatment:

- As an inpatient in a hospital under the direction and supervision of the Department of Mental Health; or
- In a private hospital licensed by the Department of Health.

Partial Hospitalization benefits may also be available. "Partial Hospitalization" means continuous treatment of not less than four hours and not more than 12 hours. Two days of Partial Hospitalization equal one day of inpatient treatment.

## Substance Abuse Benefits—Inpatient Treatment

You and/or your family are eligible to receive inpatient treatment for alcohol and drug rehabilitation in a hospital or residential facility licensed by the Department of Public Health for treatment of alcoholism or drug abuse. The benefit is subject to Medical Necessity review by the EAP.

### *Limitations*

No benefits will be paid for court-ordered treatment for alcoholism or drug abuse, for treatment obtained in anticipation of court-ordered treatment, or for any treatment in conjunction with any criminal proceeding.

## Outpatient Treatment for Mental Health and Substance Abuse

The Plan also provides benefits for outpatient treatment of Mental Health and Substance Abuse.

Covered Charges will include only services provided by:

- A comprehensive health services organization;
- A licensed or accredited hospital;
- A community mental health center or other mental health clinic or day care center which provides mental health services, subject to the approval of the Department of Mental Health; or
- A licensed Physician, a licensed psychologist, a licensed independent clinical social worker, or a licensed psychotherapist who devotes a substantial portion of his time to the practice of psychiatry. Covered Charges include services only for consultations or diagnostic and treatment sessions.

## Emergency Treatment

In case of emergency, you or your dependents must be treated in the emergency room of the nearest general hospital for benefits to be payable. Maximum benefits will be payable as long as you notify the EAP within 48 hours of admission.

# Home Health Care

**FAST FACTS:**

- All treatment must be pre-approved by the Hospital Pre-Admission Certification Program. Call CareAllies at 800-768-4695.
- Your physician must approve your Home Health Care treatment in writing within 36 hours after your hospitalization as an inpatient is terminated.
- If you use a PPO Provider, covered charges are paid at 100% of the PPO rate up to 90 visits per calendar year with no deductible.

The Home Health Care Plan is a program developed for you or your dependents' care and treatment following a hospitalization.

## How to Use Your Home Health Care Benefits

To use home health care benefits, your physician must approve this treatment in writing within 36 hours after you or your dependents are released from the hospital. The attending physician must certify that proper treatment would require continued confinement as an inpatient in a hospital if you did not have access to the care and services the Home Health Care Plan provides. All treatment **must be pre-approved** by the Hospital Pre-Admission Certification Program. Call CareAllies at 800-768-4695.

For benefits to be payable, the treatment should be:

- Authorized by the Hospital Pre-Admission Certification Program;
- In accordance with the Home Health Care Plan; and
- Due to an injury or illness that is not employment-related.

## Your Cost for Coverage

Benefits are payable for charges that you or your dependents incur for home health care visits. If you use a PPO Provider, covered charges are paid at 100% of PPO rate, up to 90 visits per calendar year. You do not need to meet a deductible before the Plan pays benefits. If you use a non-PPO provider, 100% of the Reasonable and Customary charges will be paid for up to 90 visits per calendar year. No deductible applies.

A Home Health Care Agency is an agency or organization that:

- Primarily provides nursing and other therapeutic services; is federally certified and duly licensed, if required;
- Has established policies by a professional group associated with the agency, including at least one physician and at least one registered nurse, to govern the services provided;
- Provides for full-time supervision of services by a physician or by a registered nurse;
- Has its own administrator; and
- Maintains a complete medical record on each patient.

## *Home Health Care Expenses that Are Covered*

Benefits are payable for the Reasonable and Customary charges made by a Home Health Care Agency for the following necessary services or supplies provided by or for the Home Health Care Plan:

- Part-time or intermittent home nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available;
- Part-time or intermittent home health aide services that primarily consist of medical or therapeutic caring for the patient by someone other than a registered or licensed practical nurse;
  - Physical, occupational or speech therapy if provided by the home health care agency; and
  - Medical supplies, legend drugs and medications prescribed by a physician, and laboratory services by or for a Home Health Care Agency as long as these items would have been covered under the Plan if you had been hospitalized.

## *Home Health Care Expenses that Are Not Covered*

In addition to the General Exclusions, no benefits are payable under this section for any health care expense incurred for:

- Services or supplies of a Home Health Care Agency given to an individual eligible for Medicare;
- Services or supplies not included in the Home Health Care Plan;
- Services of a person who lives with you or is a member of your or your spouse's immediate family;
- Custodial care, except when ordered by a physician for intermittent Home Health Care during a period of recovery and billed by the Home Health Care Agency;
- Any period during which you or your dependent are not under the continuing care of a physician;
- Home visits made by the attending physician; or
- Routine maternity care.

For more information, contact the CareAllies representative at 800-768-4695.

# Prescription Drug Benefit

**FAST FACTS:**

- You have a $15 copayment for generic drugs when you use a participating pharmacy.
- Save money by using the mail-order service to fill prescriptions for maintenance medications and receive up to a 102-day supply per copayment.

Your Plan includes coverage for most prescription drugs utilizing Express Scripts as the Pharmacy Benefit Manager. You have the option of purchasing drugs from a retail pharmacy or, if you take medication on a regular basis for a condition (maintenance medication), you can take advantage of the mail-service program.

Express Scripts also provides a customer service line 866-544-2926.

You must follow the requirements of utilization review, individual case management, tiered (or step) therapies and any prior authorization from Express Scripts. If you do not do so, your benefits involving these programs may be reduced or denied. Specifically, you may still be responsible for the difference between any allowed charge, as determined by these programs, and the provider's actual charge.

## Retail Pharmacy

The Plan provides coverage for prescription medication that you purchase from a retail pharmacy. You may receive a 34-day supply. Your copayment is based on the type of drug prescribed:

- $15 copayment for generic drugs;
- $30 copayment for preferred brand-name drugs; and
- $45 copayment for non-preferred brand name drugs.

### Generic Drugs

Generic drugs are a less expensive alternative to brand name drugs. The generic version of any particular drug is the chemical equivalent of its brand name counterpart. It contains identical active chemical ingredients and must meet the same manufacturing standards and federal requirements for safety and effectiveness as a brand name drug.

## Mail-Service Prescription Program

The mail order program is a convenient way for you to receive any medication, particularly maintenance drugs or medications that you require on an ongoing basis. Examples of maintenance drugs include those you take for high blood pressure, heart conditions or diabetes. Because you know in advance that you will need this medication, it is easy to establish a routine of filling these prescriptions by mail.

You can receive up to a 102-day supply of maintenance medication at one time from the mail order service prescription program. When you use the Mail Order Program, your copayments are:

- $30 copayment for generic drugs;
- $60 copayment for preferred brand-name drugs; and
- $90 copayment for non-preferred brand-name drugs.

| Prescription Drug Benefit | Participating Provider | Non-Participating Provider |
|---|---|---|
| Retail Pharmacy | $15 generic/$30 preferred brand/ $45 non-preferred brand for a 34-day supply | You pay the full amount and apply for reimbursement through Express Scripts. |
| Mail Order | $30/generic/$60 preferred brand/ $90 non-preferred brand for a 102-day supply. | |
| Specialty Drugs | There may be certain restrictions and limitations on Specialty Drugs. Contact Express Scripts for details. | |

### *How to Use the Mail Service Prescription Program*

Be sure your written prescription provides all of the following information:

- Patient's full first and last name;
- Doctor's name;
- Exact strength, quantity and dosage; and
- Diagnosis, if required for that drug.

Send your profile card and your copayment to:

Express Scripts
Home Delivery Service
P. O. Box 747000
Cincinnati, OH 45274-7000

### *Delivery*

Your order will be processed within 48 hours of receipt of the prescription and will be shipped via UPS or First Class Mail. Please allow 7 to 10 working days for delivery.

### *Ordering Refills*

The profile information is only required with your first mail order. After your first order, you may phone in your refills by calling 866-544-2926. You may receive one refill per prescription.

## Prescription Drugs That Are Covered

- Legend drugs. Any drug whose label must bear the legend "Caution Federal Law Prohibits Dispensing Without a Prescription;"
- State restricted drugs. Any drug that can be dispensed in a state or jurisdiction by prescription only;
- Compound medications. Any drug mixture which contains at least one legend drug or state restricted drug;
- Injectable insulin and the following diabetic supplies:
- Insulin syringes and needles;
- Urine testing strips for glucose;
- Lancets;
- Alcohol swabs;
- Ketone testing strips;
- Lancet devices;
- Blood testing strips for glucose;
- Ketose tablets;
- Oral contraceptives;
- Tretinoin, all dosage forms (e.g. Retin-A), for acne only for participants or their dependents under age 26;
- Maintenance drugs;

- Prenatal vitamins, single entity vitamins and injectible vitamins;
- Infertility medications, including clompiphene (tablet) and Pergonal and Metrodin (injectible); and
- Self-administered injectibles.

## Prescription Drugs That Are Not Covered

In addition to the General Exclusions, no benefits are payable under this provision for:

- Non-federal Legend drugs, except injectable insulin;
- Therapeutic devices or appliances, including hypodermic needles, syringes (except those used for injectable insulin), syringes (except those used for covered injectable drugs or vitamins), support garments and other non-medical items, regardless of their intended use;
- Any charge for the administration of a Prescription Drug;
- Drugs labeled: "Caution—limited by federal law to investigational use" or experimental drugs, even if a charge is made to the insured;
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the date of the original prescription;
- Any drug dispensed during confinement in a hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which has on its premises a facility for dispensing pharmaceuticals;
- Any drug that is provided without charge under local, state or federal programs;
- Immunization agents, biological sera, blood or blood plasma;
- Drugs whose sole purpose is to promote or stimulate hair growth;
- Tretinoin, all dosage forms (e.g. Retin-A) for individuals age 26 or older;
- Growth hormones; or
- Appetite suppressants, except Desoxyn and Dexedrine when medically necessary for Attention Deficit Disorder (ADD) and Narcolepsy.
- Any drugs that are not medically necessary.

# Dental Benefit for Active Employees

**FAST FACTS:**

- Under the dental benefit you may visit any dentist you wish; however, by utilizing the Dental PPO network you may save out-of-pocket expenses.
- Dental procedures that cost more than $200 must be pre-approved by the Claims Office.
- The Maximum Benefit for all cosmetic orthodontic treatment combined during the lifetime for each family member is $2,500.

Iron Clad utilizes Cigna Dental PPO Shared Administration. To locate a network dentist go to **www.cignadentalsa.com** and select the network entitled Cigna Dental PPO Shared Administration, or call 800-797-3381.

## What's Covered

Your dental coverage consists of three parts.

- **Part One**— Preventive Care. Part One of your dental benefit covers basic care, including examinations and cleanings. Dental benefits for Part One Services are reimbursed to the Reasonable and Customary allowance, up to a calendar year maximum of $600.
- **Part Two**— Major Services. Part Two of your dental benefit covers major dental services such as fillings and extractions. These services are reimbursed according to scheduled allowances up to a calendar maximum of $2,500.
- **Part Three**—Orthodontia. Part Three of your dental benefit covers orthodontia procedures. The maximum benefit for all orthodontic treatment combined during the lifetime of each family member is $2,500, but this limitation excludes Medically Necessary Orthodontia for individuals under age 19.

  **NOTE:** The annual and lifetime dollar limits shown above (and in the chart below) do not apply to individuals under age 19. The lifetime maximum for non-Medically Necessary Orthodontia does apply regardless of age.

| Dental Services | Plan Pays |
|---|---|
| Part One Services—Preventive Services | |
| Benefit Payable | 100% of Reasonable and Customary charges. |
| Maximum Amount (per calendar year) | $600 |
| Part Two Services—Major Services | |
| As per Dental Schedule of Benefits | As per Dental Schedule of Benefits |
| Maximum Amount (per calendar year) | $2,500 |
| Part Three Services—Orthodontia | |
| Benefit Payable | As per Dental Schedule of Benefits |
| Maximum Amount (per lifetime) Excluding Medically Necessary Orthodontia | $2,500 |

## Predetermination of Benefits

If your dentist estimates that the cost of a proposed treatment will exceed $200, he/she should submit the treatment plan to Iron Clad to obtain approval.

Your dentist must submit the form to Iron Clad before your treatment begins (unless it's an emergency). If your dental office does not submit a treatment plan, the Fund reserves the right to make a determination of benefits payable, taking into account alternate procedures and courses of treatment based on accepted standard dental practices.

If an eligible member or dependent is referred from one dentist to another in the course of treatment, or if more than one dentist provides services on one dental procedure, the benefits will be determined as if one dentist had provided all treatment.

## Schedule of Dental Benefits

| Part One—Preventive Care |
|---|
| Examinations and Cleanings—Covered at 100% of Reasonable and Customary Charges |
| Oral Examination, diagnosis and charting, including Prophylaxis—two per Calendar Year |
| Emergency treatment of pain |
| Fluoride and Sealants Topical application of fluoride for claimants under the age of 19—two per Calendar Year |
| Stainless Steel crowns on primary teeth (baby teeth) |
| X-Rays—Plan covers 100% of Reasonable and Customary charges |
| Intraoral—complete series<br>▪ Full mouth series—14 standard X-Rays<br>▪ Once each 3-year period<br>▪ Intraoral—periapical<br>▪ Intraoral—occlusal view |
| Bitewing X-Rays Full series—4 bitewings<br>▪ Once each calendar year charges |
| Panorex film<br>▪ Cephalometric film once each 3-year period |
| Study Models |
| Prosthetic Repair—Plan covers 100% of Reasonable and Customary charges |
| Adjustments to Dentures<br>▪ Adjust complete upper denture<br>▪ Adjust complete lower denture<br>▪ Adjust partial upper denture<br>▪ Adjust partial lower denture |
| Repairs to Complete Dentures<br>▪ Repair broken complete denture base<br>▪ Replace missing or broken teeth |
| Repairs to Partial Dentures<br>▪ Repair resin denture base<br>▪ Repair cast framework<br>▪ Repair or replace broken clasp<br>▪ Replace broken teeth, per tooth |
| Denture Rebase Procedure<br>▪ Rebase complete upper dentures<br>▪ Rebase complete lower dentures<br>▪ Rebase partial upper dentures<br>▪ Rebase partial lower dentures |
| Denture Reline Procedures, maximum: one each 3-year period<br>▪ Reline complete upper, chairside<br>▪ Reline complete lower, chairside<br>▪ Reline partial upper, chairside<br>▪ Reline partial lower, chairside<br>▪ Reline complete upper, laboratory<br>▪ Reline complete lower, laboratory<br>▪ Reline partial upper, laboratory<br>▪ Reline partial lower, laboratory |
| Tissue Conditioning<br>▪ Upper<br>▪ Lower Prosthetic Repair is covered at 100% of Reasonable and Customary charges |

| Part Two—Major Services | |
|---|---|
| Restorations | Maximum Allowance |
| Silver Amalgam<br>▪ One surface primary tooth<br>▪ One surface permanent tooth<br>▪ Two surface primary tooth<br>▪ Two surface permanent tooth<br>▪ Three surface primary tooth<br>▪ Three surface permanent tooth<br>▪ Four or more surface primary tooth<br>▪ Four or more surface permanent tooth<br>▪ Reinforcement pins, once per tooth | <br>$61<br>$61<br>$75<br>$75<br>$88<br>$88<br>$107<br>$107<br>$30 |
| Synthetic porcelain or plastic Anterior teeth only Maximum per tooth | $40 |
| Composite Resin Anterior teeth only<br>▪ One surface<br>▪ Two surfaces<br>▪ Three surfaces<br>▪ Four or more surfaces | <br>$67<br>$83<br>$102<br>$127 |
| Restorations—For teeth not restorable by fillings | |
| Crowns—Single Restorations Only<br>▪ Porcelain fused to high noble metal<br>▪ Porcelain fused to noble metal<br>▪ Full Cast high metal<br>▪ Full Porcelain<br>▪ Labial Veneer | <br>$600<br>$600<br>$600<br>$600<br>$600 |
| Post and Core | $175 |
| Implants | $600 |
| Endodontics—Allowance includes necessary x-rays | |
| Pulp Capping | $32 |
| Vital Pulpotomy | $87 |
| Root Canal therapy<br>▪ One root<br>▪ Two roots<br>▪ Three roots<br>▪ Four roots | <br>$391<br>$447<br>$569<br>$569 |
| Apicoectomy | $150 |
| Periodontia | |
| Gingivectomy<br>1-3 Contiguous teeth<br>Per quadrant | <br>$125<br>$250 |
| Gingival Curettage per quadrant | $250 |
| Gingival flap procedure, per quadrant | $250 |
| Mucogingival surgery, per quadrant | $350 |
| Osseous surgery and flap, per quadrant | $584 |
| Pedicle soft tissue grafts | $521 |
| Free soft tissue graft and donor site | $521 |
| Periodontal scaling and root Planing, per quadrant | $115 |
| Occlusal Adjustment | $72 |
| Occlusal Guard[5] | $325 |

[5] Once per lifetime and only for treatment of occlusions. Limit does not apply to individuals under age 19. Mouth guards for sports are not covered.

| Simple Extractions | |
|---|---|
| Extraction single tooth | $77 |
| Each additional tooth | $67 |
| Space Maintainers<br>Passive Appliances designed to prevent tooth movement. Not for orthodontic purposes. | |
| Fixed Unilateral | $309 |
| Fixed Bilateral | $467 |
| Removable Unilateral | $150 |
| Removable Bilateral | $200 |
| Recementation of space maintainer | $25 |
| Oral Surgery | |
| Surgical removal of an erupted tooth | $128 |
| Soft tissue impaction | $170 |
| Partial bony impaction | $205 |
| Complete bony impaction | $246 |
| Removal of cyst | $140 |
| Incision and drainage of abscess | $105 |
| Alveolectomy | $75 |
| Biopsy | $390 |
| Closure of oral antral fistula | $75 |
| Removal of labial frenum | $75 |
| Surgical removal of retained root | $138 |
| Surgical exposure of unerupted or impacted tooth for orthodontic treatment including normal post-surgical care | $135 |
| Open reduction of fracture of maxilla | $563 |
| Open reduction of fracture of mandible | $723 |
| Closed reduction of fracture of maxilla | $426 |
| Closed reduction of fracture of mandible | $512 |
| Anesthesia<br>General Anesthesia in connection with a covered Part Two Service | |
| First 30 minutes | $163 |
| Each additional 15 minutes | $72 |
| Prosthetic Services<br>Supplying, fitting and inserting the listed appliances | |
| Dentures, Full and Partial (complete upper and lower)<br>Each except as provided in next item | $525 |
| Full, both immediate and permanent, with permanent dentures inserted within 12 months from date of insertion of immediate denture<br>Maximum each jaw | $1,050 |
| Partial, Upper or Lower full case, 2 clasps | $425 |
| Partial, bilateral, chrome cobalt alloy or gold base, 2 or more full cast claps with occlusal rests, acrylic attachments and porcelain or acrylic teeth, either jaw, each | $450 |
| Adding teeth to partial denture to replace natural teeth not part of existing denture<br>▪ First tooth<br>▪ Each additional tooth | <br>$75<br>$50 |

| | |
|---|---|
| Bridgework, fixed:<br>▪ Abutments<br>▪ 3/4 Crown<br>▪ Full cast<br>▪ Porcelain<br>▪ Porcelain fused to metal<br>▪ Inlay used as abutment<br>▪ 2-surface<br>▪ 3-surface | <br><br>$600<br>$600<br>$600<br>$600<br><br>$120<br>$180 |
| Pontic, cast with metal<br>Pontic, porcelain fused to metal<br>Pontic, resin with metal | $600<br>$600<br>$600 |
| Bridgework, removable<br>Steel with clasps and lugs (Nesbett):<br>▪ One tooth<br>▪ Two teeth<br>▪ Three teeth | <br><br>$150<br>$200<br>$225 |
| Bridge and denture replacements are limited to once in a 3-year period. | |
| **Part Three—Orthodontia** | |
| Treatment<br>Initial fee (fabrication and insertion of orthodontic appliances) | $580 |
| Monthly active orthodontic treatment, per month<br>Maximum active treatment = 24 months | $80 |
| The Maximum Benefit for all orthodontic treatment combined during the lifetime of each family member is $2,500, but excluding non-medically necessary Orthodontia | |

**Note:** If a procedure is recommended that is not listed above, your dentist must submit the alternative procedures, in writing to Iron Clad for approval before treatment begins. This applies to all dental services.

## Dental Expenses That Are Not Covered

No benefits will be payable for the following:

**What's Covered?**

Only the dental procedures described in the fee schedule are covered by this Plan.

- Any professional fees, other than the fees of the dentist performing the treatment or expenses, that are not recommended as necessary and approved by a dentist for the diagnosis, treatment or prevention on an injury or illness;
- Replacement of a lost, missing or stolen prosthetic device;
- Treatment due to an injury or illness that is employment-related or that is covered under the Workers' Compensation Law, Occupational Disease Laws, or similar laws, or due to any act of war or aggression;
- Any amount that is paid for, or provided by any government agency except Medicaid, and except for the Reasonable and Customary charges otherwise covered under this Plan, which were incurred by you or your dependent in a Veteran's Administration facility; or you, as an armed services retiree, or your dependent for services, treatment or supplies which are not related to military service;
- Services or supplies that are cosmetic in nature, (except Part Three services);
- Expenses and traveling time incurred by a dentist in the course of providing services;
- Services, treatment or supplies provided before the effective date of your or your dependent's coverage under this Plan; or
- Treatment, services or supplies incurred or rendered after the date this Plan is terminated.

# Vision Benefit

**FAST FACTS:**

- When you visit a Davis Vision participating provider, you and your eligible dependents are entitled to an eye exam every 12 months.
- Every 24 months, adults age 18 and over are entitled to eyeglass lenses or contact lenses instead of eyeglass lenses.
- Every 24 months, adults age 18 and over are entitled to eyeglass frames from the Davis Vision Premiere Selection.
- Children under age 18 may receive Premiere Selection frames and lenses for eyeglasses or contact lenses every 12 months.
- You must pay for services in full and file your own claims if you use a non-participating provider. Reimbursements are made according to a schedule.

## How the Vision Plan Works

When you or your dependents need vision care services, call the network provider of your choice and schedule an appointment. Identify yourself as an Iron Workers District Council of New England Health and Welfare Fund member, retiree, or dependent. You'll need to give the network provider your Social Security number and provide the year of birth for any covered children needing services. The provider's office will verify your eligibility for services. No claim forms, ID cards or vouchers are required. The Fund Office will handle all Davis Vision claims.

If you have any questions about your vision benefit, call Davis Vision at 800-999-5431 for assistance.

## Eye Exams

When you use a participating provider, you and your dependents are covered for an eye examination every 12 months.

| Vision Benefit | Participating Provider | Non-Participating Provider Allowance |
|---|---|---|
| Examination | Covered in full every 12 months. | $30 |
| Frames | Premiere Selection displayed on the Tower Collection, covered in full every 24 months for members or dependents age 18 or older; once every 12 months for dependents under age 18. | $30 |
| Lenses | Covered in full once every 12 months with a qualifying prescription change of one-half diopter or a 10% shift in axis; otherwise every 24 months. Dependents under age 18 are eligible every 12 months. | $30 |
| Contact Lenses | Standard daily wear contacts are covered in full every 24 months in lieu of eyeglass lenses. Dependents under age 18 are eligible every 12 months in lieu of eyeglass lenses. | $60 |

## Frames

Every 24 months, you may select a pair of eyeglass frames from the Davis Vision Premiere selection Tower Collection in most network provider offices. If you select eyewear outside the Tower Collection, you may pay more. Your dependent children under 18 years old may receive frames from the Tower Collection every 12 months.

## Lenses for Frames

No copayment is required when you select lenses for your eyeglass frames from the Davis Vision wide selection of lenses once every 12 months with a qualifying prescription change of one half diopter or a 10% shift in axis; otherwise every 24 months. The following lenses/coatings are included:

- Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range;
- Glass grey #3 prescription lenses;
- Oversize lenses;
- Post-cataract (lenticular) lenses;
- Fashion, sun or gradient tinted plastic lenses;
- Polycarbonate lenses;
- SuperShield® (scratch resistant) lens coating;
- Ultraviolet (UV) protective coating;
- Photogrey Extra® (sun-sensitive) glass lenses; and
- Progressive addition multifocals

Optional lens types or coatings are available at discounted fees. Contact Davis Vision at 800-999-5431 for more information.

## Contact Lenses

You may receive contact lenses once every 24 months (once every 12 months for dependents under age 18) instead of eyeglasses and frames. No copayment is required for standard, soft, daily-wear disposable or planned replacement contact lenses for most prescriptions. If provider-supplied toric/gas permeable contact lenses are required, a $300 allowance will be applied toward their cost.

## If You Do Not Use a Participating Provider

You do not have to receive services from a participating doctor. If you visit a non-participating doctor, you pay for services at the time of your appointment and reimbursement will be sent to you. You will be reimbursed for an examination and eyewear up to the following amounts:

| Item | Amount |
|---|---|
| Examination | $30 |
| Frames | $30 |
| Lenses | $30 |
| Contact Lenses | $60 |

## Vision Coverage Restrictions

- Coverage is only for routine eye examinations and corrective eyewear.
- Benefits for medical treatment of eye disease or injury are covered under the Medical Plan, not this Vision Care Plan.
- All parts of the benefit must be submitted at one time. You may not split the benefit between a participating and a non-participating doctor.

## Safety Glasses — Active Employees Only Benefits for Frames and Lenses

| In-Network Benefits | | Materials-Only Plan Design |
|---|---|---|
| | | Frequency |
| Spectacle Lenses | | Once Every 12 Months |
| Frame | | Once Every 12 Months |
| | | Copayments |
| Eyewear (Spectacle Lenses and Frame) | | $0 |
| Eyeglass Benefit—Frame | | |
| Davis Vision Safety Frame Collection[6] | | |
| Fashion level | | Included |
| Designer level | | Included |
| Premier level | | $20 |
| Eyeglass Benefit—Spectacle Lenses | | |
| Clear plastic single-vision, lined bifocal or trifocal lenses (any Rx) | | Included |
| Oversize Lenses | | Included |
| Tinting of Plastic Lenses | | Included |
| Scratch-Resistant Coating | | Included |
| Polycarbonate Lenses[7] | | Included |
| Ultraviolet Coating | | Included |
| Side-Shields (fixed or removable) | | Included |
| Additional Lens Options | Average Retail Price | Member Charges |
| Standard Progressive Lenses | $150-$195 | $50 |
| Premium Progressives (Varilux®, etc.) | $195-$300 | $90 |
| Intermediate-Vision Lenses | $150-$175 | $30 |
| Blended-Segment Lenses | $40-$50 | $20 |
| Polarized Lenses | $95-$110 | $75 |
| Plastic Photosensitive Lenses | $95-$150 | $65 |

[6] Davis Vision's Safety Frame Collection meets or exceeds the Z87.1 American National Standard and the requirements of the Occupational Safety and Health Administration (OSHA) for impact resistance.

[7] Polycarbonate lenses meet or exceed the Z87.1 American National Standard and the requirements of the Occupational Safety and Health Administration (OSHA) for impact resistance.

### Filing Claims

If you use a non-participating provider, you must pay the provider directly for all charges and submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, New York 12110

Claim forms are available from Davis Vision by calling 800-999-5431.

# Hearing Care Benefit

**FAST FACTS:**

- The Plan pays for a hearing examination once every two years for adults and one per year for children to age 18.
- The Plan pays up to $2,500 per ear for hearing aids, hearing aid repairs and ear molds, once every three years.
- Call 800-442-8231 for a directory of audiologists in your area.

## How the Hearing Plan Works

- Call 800-442-8231 for a directory of audiologists in your area.
- Choose an audiologist from the list and make an appointment.
- The audiologist will call Iron Clad to verify your eligibility.
- The provider will complete the claim and send it to HearUSA for processing.
- The Fund will pay the benefit amount directly to the network provider.
- You will be billed for the balance of the allowable charges above the benefit amount of $2,500.

There is no coverage if you use a provider outside of the Hear USA network. If you cannot locate a provider within your geographic area, contact Iron Clad for a review.

### *Benefits*

| | |
|---|---|
| Hearing Exam | Once every two years for adults<br>One per year for children to age 18 |
| Hearing Aids | $2,500 per ear for hearing aids per three-year period.<br>Batteries for hearing aids not included. |

## Filing Claims

Your HearUSA provider will file your claims for you. The Plan will pay the provider the discounted charges, up to the benefit maximum. You will receive an explanation of benefits from Iron Clad showing paid amounts and remaining allowable charges, if any.

You will be responsible for paying the provider the balance of allowable charges above the benefit amount for your hearing aid charges. Allowable charges vary according to the recommended hearing aid technology.

# General Exclusions

In addition to any limits described under the sections that describe health benefits, there are specific limitations and exclusions applicable to all benefits. No benefits are payable for:

- Any work-related injury or illness;
- Services, supplies, drugs or treatment that are not medically necessary, or that are not prescribed by a physician. This exclusion also applies to any hospital confinement (or any part of a confinement) that is not recommended or approved by a physician;
- Fees in excess of the Reasonable and Customary charges for services, supplies or treatments;
- Elective or cosmetic surgery, unless:
  - The surgery is required because of an accidental bodily injury, congenital deformity or disease, or when performed to correct a deformity due to a previous therapeutic process.
- Expenses incurred as a result of war or an act of war, declared or undeclared;
- Non-emergency care when traveling outside of the United States;
- Weight loss programs (Nutrition counseling is covered under the Alternative Care benefit for those plans with Alternative Care coverage.);
- Hospital, medical or surgical treatment provided by or paid for by the federal government unless there is a legal obligation to pay charges without regard to the existence of any insurance, or for Reasonable and Customary charges otherwise covered under this Plan which were incurred by:
  - You or your dependent at a Veteran's Administration facility; or
  - You, as an armed service retiree, or your dependent for services or supplies that are not related to military service;
- Any charges that you or your dependent are not legally obligated to pay;
- Custodial care, whether or not it is provided in a rehabilitation facility or a skilled nursing facility;
- Charges incurred for experimental procedures or research purposes;
- Charges incurred for recreational or leisure therapy;
- Charges incurred for services rendered by any provider who is your or your dependent's spouse, parent, child, grandchild, brother or sister, or who lives in your or your dependent's home;
- Charges for dental care or treatment, or dental x-rays, unless as specifically provided herein;
- Medical expenses incurred as a result of a third party's negligence or wrongful act. In certain circumstances, the Plan is authorized to advance an amount equal to the benefits that are payable if a third party is not liable. However, the advance is subject to reimbursement provisions as set forth in the General Information section;
- Transportation, other than local ambulance service;
- Any charges that would be payable under any available no-fault motor vehicle insurance coverage; and
- Genetic testing that does not meet the guidelines to satisfy Medical Necessity requirement.

# Extension of Health Benefits

If you or one of your dependents is Totally Disabled due to an illness or injury on the date coverage under this Plan terminates, your benefits may be extended for expenses incurred because of that disability if the following conditions are met:

- The expense would have been covered if the coverage had continued;
- You or your dependent remain disabled on the date the expense is incurred; and
- You or your dependent is not entitled to similar benefits under any other group plan when each expense is incurred.

## Benefits That Are Extended

Benefits will be extended and payable only for treatment of the illness or injury that caused the disability. Comprehensive Major Medical Benefits will be payable subject to the limitations and maximums that were in effect under this Plan at the time coverage terminated for charges incurred within 12 months after such date.

Benefits will continue until the earliest of:

- The date you or your dependent is no longer disabled;
- The date you or your dependent become covered under another insurance plan that provides similar benefits;
- The end of 12 consecutive months after coverage under this Plan for comprehensive major medical benefits terminates.

# Coordination of Benefits

Family members are often covered by more than one group health insurance plan. As a result, sometimes two or more plans end up paying for the same expense. To avoid this costly problem, your Health Plan provides a Coordination of Benefits provision.

**What is an allowable expense?**

An allowable expense is any necessary, Reasonable and Customary item of expense for health care, when the item is at least in part covered by one of the involved medical or dental plans.

Coordination of Benefits (COB) is an administrative method that health plans follow to allow you to receive coverage under more than one group insurance plan without receiving duplicate payments for the same expenses. If you and your spouse both work, and each of you are covered by each other's group medical plan, COB provides that the provisions of both plans are taken into account when benefits are paid.

The Coordination of Benefits provision only applies to your medical and dental coverage. It does not apply to Life Insurance or Accidental Death and Dismemberment coverage.

## How Coordination of Benefits Works

If you or your dependents are also covered under another group plan, the total amount paid from all plans will never be more than 100% of allowable expenses. In other words, if you and your spouse are covered by two plans, the benefit will not be more than what the health care provider charged. For example, if your spouse has a tooth removed and the dentist charges $70. The chart below shows how the expense will be coordinated by your spouse's plan, which is Primary, and the Iron Workers Plan, which is secondary.

| Allowable Expense | Other Plan (Primary) Pays | Iron Workers Health and Welfare Plan Pays | Total Reimbursement to You From Both Plans |
|---|---|---|---|
| $70 for a single tooth extraction | $55 (Scheduled amount under Primary Plan) | $15 if the scheduled amount of the service is $15 or more. The plan pays the difference between 100% of the eligible charge ($70) and what the Primary Plan pays ($55) up to the amount the Plan would have paid if it had been in the Primary position ($70). | $70 (100% of charge) |

When a plan provides benefits in the form of a service, the reasonable cash value of each service will be considered both as an allowable expense and as a benefit paid.

## Which Plan Pays First?

In order to apply this provision, one of the plans is called the Primary Plan. All other plans are called Secondary Plans. The Primary Plan pays first. The Secondary Plans then pay the remaining unpaid allowable expenses. No plan pays more than it would have without this provision.

**What is a Claims Determination Period?**

The Claims Determination Period is a calendar year—January 1 through December 31—or the portion of a calendar year during which you or your dependents are covered under this Plan.

In general, if you are the patient, this Plan is the Primary payer. If your spouse is the patient, his or her plan is the Primary, and this Plan is the secondary. When the child's parents reside together, whether married or not married to each other, this Plan follows the insurance industry standard known as the "birthday rule" when your child is the patient. This means that the plan of the parent whose birthday occurs earlier in the year (regardless of year of birth) is Primary for the child. If both parents have the same birthday, the plan that has covered a parent for the longer period of time is the Primary Plan.

If a dependent child's parents are not married to each other, a plan is Primary if:

- First, it is the plan of the biological or adoptive parent with custody;
- Second, it is the plan of the spouse of the biological or adoptive parent with custody;
- Third, it is the plan of the biological or adoptive parent without custody.

However, if court documents specify a parent has responsibility for medical coverage for the child, that party's plan is Primary.

If these items cannot determine which plan is Primary, the plan that has covered the dependent child the longest will be Primary.

**A Plan is Primary if it:**

- Does not have a coordination of benefits provision;
- Covers the claimant as an employee;
- Covers the claimant as an employee longer than the other Plan; or
- Covers the claimant as other than a laid-off employee or as a retiree.

## Filing Claims through COB

When you or your dependent are covered under more than one group plan, file the claim with the Primary Plan first. When that process is completed and you have received an Explanation of Benefits (EOB) from the Primary Plan, submit the claim with a copy of the itemized bill and a copy of the EOB to the Secondary Plan. The Secondary Plan cannot process the claim without the EOB from the Primary Plan. For most in-network services, providers often complete this process for you.

## Right of Recovery

The Plan has the right to recover excess payment from:

- Any person to whom payments were made;
- Any other insurance company; and
- Any other organization.

Whenever the plan is considered the Secondary Plan and a claim payment is reduced because of the COB provision, the amount of the reduction will be carried for the balance of the calendar year as a credit to the member of your family for whom the claim was made.

The credit may be used for other medical expenses, incurred by the same family member in the same calendar year. A claim record is maintained only for a calendar year, and a new record commences each January 1.

# Weekly Accident and Sickness Benefit for Active Employees

**FAST FACTS:**

- Benefits are payable for up to 26 weeks.
- You must be under a physician's care to receive this benefit.

A Disability Claim is any claim that requires a finding of total disability as a condition of eligibility to receive benefits.

For Disability Claims, the plan reserves the right to have a physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

Upon request, further claim procedure information will be sent to you.

The Plan pays a $250 weekly disability benefit if you become totally disabled due to a non-work-related illness or a non-work related injury and are unable to work while you are covered by this Plan. The benefit will continue during your disability for a maximum of 26 weeks for any one continuous period of disability.

You do not need to be confined to your home to collect benefits, but you must be under the care of a Legally Qualified Physician licensed to practice medicine.

This benefit is limited to a lifetime maximum of 52 weeks.

If you are totally disabled and cannot work because of a non-work related illness, your Weekly Accident and Sickness benefit is payable from the eighth day of disability. If you are totally disabled and cannot work because of a non-work related accident, your Weekly Accident and Sickness benefit is payable from the first day of disability.

There is one level of appeal for Disability claims. A decision will normally be made by the Board of Trustees within 45 days of receipt of the appeal by the Fund Office.

**What is "Totally Disabled"?**

You are considered totally disabled if you are an employee and you are completely unable to perform each and every duty pertaining to your occupation or employment as a result of an illness or injury.

## Taxable Benefit

The payments you collect under this benefit count as taxable income and must be reported on your income tax return. The Fund Office will arrange to have taxes withheld from your disability payments upon request. The Fund Office also deducts the FICA tax from your benefit on your behalf.

# Long Term Disability (LTD) Insurance for Active Employees

**FAST FACTS:**

- You are eligible for the Long-Term Disability benefit if you are a Plan participant eligible for medical benefits based on your hours of work.
- The LTD plan offers a comprehensive rehabilitation program.
- The Plan encourages you to stay at work or return to work when it is appropriate and receive partial benefits during your period of disability.

The Iron Workers District Council of New England Health and Welfare Plan automatically provides you with coverage of up to $1,000 per month if you become disabled due to an illness or injury and are unable to work. The Long-Term Disability (LTD) plan is administered by Standard Insurance Company.

## How the LTD Plan Works

If you are disabled and cannot work, the Plan will begin to pay benefits after a 180-day waiting period. The Health and Welfare Fund provides coverage of a flat benefit of up to $1,000 per month.

During the first 24 months you receive LTD benefits, you are considered disabled if:

- You are unable to perform the material and substantial duties of your regular occupation due to an illness or injury; and
- You have a 20% or more loss in your monthly earnings due to that illness or injury.

After 24 months of payments, you are considered disabled if you are unable to perform the material duties of any occupation for which you are reasonably suited by education, training or experience.

For purposes of this Plan, disabilities caused by pregnancy or complications from pregnancy are covered in the same way as any other illness.

## When LTD Benefits End

Benefits will continue as long as you remain disabled or up to age 65. If you become disabled at or after age 60, your benefit will decrease according to a schedule until you reach age 70. Benefits are payable for one year if you become disabled at or after age 70.

**Your benefit for a disability resulting from a mental illness or substance abuse is limited to 24 months unless you are hospitalized for that period**

## Pre-Existing Condition Limitation

The Plan excludes benefits for pre-existing conditions for the first 12 months you are covered under the Plan. If you have had treatment for a condition three months prior to your effective date for coverage, you will not be eligible for an LTD benefit unless you are treatment-free for 12 months after your effective date of coverage.

LTD payments are reduced by other sources of disability benefits such as work earnings, Social Security benefits, unemployment compensation, pension benefits or Weekly Accident and Sickness benefits and Workers' Compensation.

## Partial Disability Benefit

You may be eligible for a benefit under the Plan if you are partially disabled. You are considered "partially disabled" if you are unable to perform one or more of the functions of your regular job due to an illness or injury. For the first 12-month period you receive benefits, your benefits will only be reduced if your earnings and LTD payments when combined exceed your pre-disability earnings.

At the end of the 12-month period, benefits will be calculated using reduced benefits. Once your earnings exceed 80% of what you were earning prior to your disability, your benefit payments will stop.

## Recurrent Disability

Benefits may resume if you return to work for fewer than six months and are again disabled by the same or related cause. You do not need to meet the initial 180-day waiting period again.

Your benefit for a disability resulting from a mental illness or substance abuse is limited to 24 months unless you're hospitalized for that period.

LTD payments are reduced by other sources of disability benefits such as work earnings, Social Security benefits, unemployment compensation, pension benefits or Weekly Accident and Sickness benefits and Workers' Compensation.

## Survivor Benefit

If you die while receiving benefits under the Plan, a lump sum benefit equal to three times your gross monthly benefit is payable to an eligible survivor or estate (in the case of a minor) provided you had been disabled for six months at the time of your death.

This Disability Income Insurance Plan is underwritten by Standard Insurance Company, Portland, Oregon. Full details about this program are described in the insurance and legal documents that govern these benefits and any other documents that establish plan provisions. If there are discrepancies between the wording in this booklet and those documents, the language in those documents will govern.

# Accidental Death and Dismemberment (AD&D) Insurance for Active Employees

**FAST FACTS:**

- You may change your beneficiary by requesting a "Change of Beneficiary" form from the Fund Office.
- Your Accidental Death benefit is payable in addition to your Life Insurance benefit.

The Accidental Death and Dismemberment (AD&D) Insurance benefit is payable if, while you're insured, you sustain any of the losses listed in the chart below because of an accident. For benefits to be payable, the loss must take place within 180 days from the date of the injury. This benefit is in addition to any other benefits under the Plan.

The following AD&D benefits are payable under the Plan:

| Type of Loss | Amount Payable |
|---|---|
| Life | $30,000 |
| Both Hands | $30,000 |
| Both Feet | $30,000 |
| Sight of Both Eyes | $30,000 |
| One Hand and One Foot | $30,000 |
| One Hand and Sight of One Eye | $30,000 |
| One Foot and Sight of One Eye | $30,000 |
| Third-degree Burns Covering 75% of Body | $30,000 |
| Quadriplegia | $30,000 |
| One Hand or One Foot or One Eye | $15,000 |
| Sight of One Eye | $15,000 |
| Loss of Hearing or Speech | $15,000 |
| Paraplegia or Hemiplegia | $15,000 |
| Third-degree Burns Covering 50-75% of Body | $15,000 |
| Loss of Thumb and Index Finger | $7,500 |
| Uniplegia | $7,500 |

Loss of hand or foot means that the limb is severed at or above the wrist or ankle joint, respectively. Loss of sight means the total and irrecoverable loss of sight.

If you suffer more than one loss in any one accident, payment will be made only for the loss with the greatest amount payable.

**Who will receive benefits?**

If you die, benefits will be paid to the beneficiary you name. For any other eligible loss, the benefits will be paid to you.

## Losses that Are Not Covered

The purpose of this coverage is to provide benefits for losses due to accidents. Therefore, no benefits are paid because of a loss caused or contributed to by:

- Bodily or mental illness, or disease of any kind;
- Ptomaines or bacterial infections (except infections caused by pyogenic organisms that occur with and through an accidental cut or injury);
- Intentional self-destruction or self-inflicted injury;
- Participation in the commission of a felony;
- War or an act of war;
- Service in any military, naval or air force of any country while such country is engaged in war; or
- Police duty as a member of any military, naval or air organization.

## Naming a Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing a "Change of Beneficiary Form," available at the Fund Office. You do not need to obtain the beneficiary's consent to change your beneficiary. The change will be effective when the completed form is received at the Fund Office.

## Examinations

The Company/Plan will have the right and opportunity through its medical representatives to examine any living insured as often as necessary while a claim is pending.

The Company/Plan will also have the right to make an autopsy in case of death, where it is not prohibited by law.

## Legal Actions

No legal action can be brought until at least 60 days after written Proof of Loss to the Company. No legal action can be brought more than three years after the date written Proof of Loss is required.

This limitation and the time permitted for filing this Notice of Claim and Proof of Loss, is extended to comply with the minimum requirements of the state in which the claimant resides at the time his insurance under this Plan is in effect.

# Life Insurance for Active Employees

**FAST FACTS:**

- You can name anyone you wish as your beneficiary.
- If you become totally disabled before you reach age 60, your life insurance benefit may continue at no cost to you.
- If you no longer belong to an eligible insured class because you have terminated your employment, you may convert your Group Life Insurance to any form of individual life insurance usually offered by Aetna, except for term insurance.

If you die from any cause while you are insured, your designated beneficiary will be eligible for a benefit of $30,000. Your life insurance is underwritten by Aetna.

Before the benefit will be paid, your beneficiary must provide the Fund Office with proof of your death as soon as possible. ***Please contact the Fund Office, who will submit application—there is a 12 month deadline.***

## Naming a Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing a "Change of Beneficiary Form," available at the Fund Office. You do not need to obtain the beneficiary's consent to change your beneficiary. The change will be effective when the completed form is received at the Fund Office.

If you become divorced, it is your responsibility to change your beneficiary if your ex-spouse is named as a beneficiary and you wish to change that designation.

If you die, your beneficiary must notify the Fund Office as soon as possible in order for benefits to be paid.

If you name more than one beneficiary, the total amount will be shared equally between all surviving beneficiaries unless you designated how much each beneficiary should receive. If there is no living beneficiary when you die Aetna will make payment to your surviving spouse. If none, payment will be made to your surviving children in equal shares, and if you do not have any surviving children, to your parents in equal shares, if you do not have any surviving parents to your brothers and sisters in equal shares. However, Aetna has the option to make the payment to the fiduciary of your estate.

## Life Insurance if You Become Disabled

If you become totally disabled (completely unable to perform the duties of your occupation or employment as a result of an injury or illness) you will still be eligible for the life insurance benefit.

The amount of life insurance coverage that will be continued while you are Totally and Permanently Disabled is the amount that was in effect when you became Disabled.

## Premiums Waived if You Become Disabled

If you become totally and permanently disabled before you turn age 60, your life insurance will continue at no cost to you. Coverage will continue during your disability at no cost to you if:

- You send written proof of your disability to Aetna no later than 12 months after the start of your disability; and
- The proof shows that you were totally and permanently disabled for at least nine months, and that your disability will presumably continue to exist.

Each year, your premiums will continue to be waived if you submit proof of continuing total and permanent disability within three months of the anniversary of the date the Fund Office received the initial proof of your disability.

Your benefits will continue under this extension until the earliest of:

- 31 days after the date you are no longer totally and permanently disabled;
- The date you fail to provide Aetna Insurance and/or the Fund Office with proof of your continued disability (which must be within three months of the anniversary of the date the Fund Office received the initial proof of your disability); or
- The date you fail to be examined by a physician designated by Aetna, if that request is made. This examination will not be required more than once a year after your insurance has been continued under this extension for two full years.

The amount of life insurance coverage that will be continued while you are totally and permanently disabled will be the amount that was in effect when you became disabled.

If you die, and an individual is equitably entitled to compensation because he or she has incurred expenses on your behalf, or for your burial, Aetna may pay this individual up to $250 of your life insurance benefit. However, this payment will not be more than the amount due under the Plan. Payment made in good faith under this provision will fully discharge Aetna's obligation with respect to the amount paid.

## Conversion Privilege

If you no longer belong to an eligible insured class because you have terminated your employment, you may convert your group life insurance to any form of individual life insurance usually offered by Aetna except for term insurance. Contact Aetna at 866-825-6944.

You will not need a medical examination to convert to another form of life insurance, but you must complete the application form and send it with the first premium payment to Aetna no later than 31 days after your group life insurance has terminated. The face value of your new policy cannot be more than the amount you had under the group Plan. The rate you pay will depend upon:

- Your age (at the nearest birthday to the date of issue of the individual policy);
- Your age of risk at the time of your conversion; and
- The face amount of your new policy.

**Life Insurance Benefit**

If you die, and an individual is equitably entitled to compensation because he or she has incurred expenses on your behalf, or for your burial, Aetna may pay this individual up to $250 of your life insurance benefit. However, this payment will not be more than the amount due under the Plan. Payment made in good faith under this provision will fully discharge Aetna's obligation with respect to the amount paid.

You may also convert if your life insurance benefits terminate because the policy terminates, or because life insurance benefits for your class terminate. In this case, however, you must have been covered under the group Plan for at least five years. You may convert the lesser of the following amounts:

- The amount of life insurance you had under this Plan, less any new amount you may have or for which you may become eligible under another group Plan within 31 days of the termination; or
- $2,000.

If you die during the 31-day period following the termination of your group life insurance, Aetna will pay to your last-named beneficiary the amount of life insurance to which you could have converted whether or not you applied for an individual life insurance policy.

## Examinations

The Company/Plan will have the right and opportunity through its medical representatives to examine any living insured as often as necessary while a claim is pending.

The Company/Plan will also have the right to make an autopsy in case of death, where it is not prohibited by law.

## Legal Actions

No legal action can be brought until at least 60 days after written Proof of Loss to the Company. No legal action can be brought more than three years after the date written Proof of Loss is required.

This limitation and the time permitted for filing this Notice of Claim and Proof of Loss, is extended to comply with the minimum requirements of the state in which the claimant resides at the time his insurance under this Plan is in effect.

# General Information

## Payment of Health Benefits

All Medical and Hospital claims, except in-patient mental health and substance abuse claims, should be sent directly to Tufts Carelink, either electronically or by paper to:

Tufts Health Plan, Carelink Claims
Post Office Box 9165
Watertown, MA 02471-9165

All In-Patient mental health and substance abuse claims should be sent directly to:

Modern Assistance Programs, Inc.
1400 Hancock Street, 2nd Floor
Quincy, MA 02169

All Dental claims should be sent directly to Iron Clad:

Iron Clad Insurance
161 Granite Avenue, Suite 201
Dorchester, MA 02124

The necessary claim forms and instructions are available at the Fund Office, your Local Union Office and Iron Clad.

Benefits will be paid upon receipt of the properly completed claim forms. If you are out of work due to disability, do not wait until you return to work before making a claim for benefits—do it immediately.

All claims for benefits must be made within one year of the date of the injury or illness. However, a claim may be accepted beyond that period if there are exceptional reasons for failure to file.

An assignment is included on the claim form in order to assign benefits directly to the hospital or physician and thus avoid your paying all or a substantial part of these bills. Benefits are automatically assigned to Participating Providers in the PPO network.

For those providers on a PPO Fee Schedule, you are only responsible for the applicable copayments. For all other PPO providers, you are responsible for the balance due after the insurance payment but only at the PPO Network rate. For non-PPO providers you are responsible for the balance due after the insurance payment. Please contact Iron Clad if there are any questions.

No benefits are payable under this Plan for confinement in a U.S. Government hospital (except as mandated by law) or for any surgical, medical, or other treatment services, supplies received in or from such a hospital. No benefits are payable for confinement, services or supplies for which no charge is made and for which you or any of your dependents are required to pay.

No medical exam or age restriction is required of any employee to secure this insurance, and all new employees will be insured regardless of age.

## How to File a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you must submit a completed claim form, unless your hospital, doctor or other healthcare provider uses a standard billing form and files it directly with Iron Clad on your behalf. Simple inquiries or phone calls about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

A claim form may be obtained from Iron Clad by calling 617-436-3500.

Dental Claims should be mailed to:

Iron Clad Insurance
161 Granite Ave., Suite 201
Dorchester, MA 02124

Medical Claim submission options are as follows:

- EDI claims
  - Direct EDI claim submission via a HIPAA standard 837-I or 837-P claim transaction; or
  - EDI claim submission through a clearinghouse of your choice.

    If you are currently submitting electronically to Tufts Health Plan these claims should be included in your current transmission.

    If you are not currently submitting electronically to Tufts Health Plan but would like to you will need to contact EDI Operations at 888-880-8699 extension 4042 or via e-mail at **edi_operations@tufts-health.com**.
- Paper claims (standard UB-04 or CMS1500 red claim form) should be submitted to:

  CareLink℠ Claims
  P.O. Box 9165
  Watertown, MA 02471-9165

The following information must be completed in order for your request for benefits to be a claim, and for Iron Clad to be able to decide your claim:

- Participant name
- Patient name
- Patient Date of Birth
- SSN of participant or retiree
- Date of Service
- CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association)
- ICD-10 (the diagnosis code found in the International Classification of Diseases, 10th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Billing name and address
- If treatment is due to accident, accident details.

**Note**: Claims involving Urgent Care (defined below) must be submitted telephonically to 617-436-3500 if followed in writing within 24 hours with the information listed above.

When you present a prescription to a pharmacy to be filled under the terms of this plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

## When Claims Must Be Filed

Claims should be filed within 90 days following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than one year from the date the charges were incurred.

Your claim will be considered to have been filed as soon as it is received at the claims or fund office.

For Vision Claims, your claim will be considered to have been filed as soon as it is received by Davis Vision at the following address:

Davis Vision
159 Express Street
Plainview, NY 11803

## Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

## Comprehensive Medical Benefits

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

### *Pre-Service and Urgent Care Claims*

A **Pre-Service Claim** is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Under this Plan, prior approval of services is required for any hospitalization, certain mental and nervous or substance abuse benefits and certain cosmetic surgeries.

**Important**: If you fail to pre-certify these services, there are penalties involved which result in a significant reduction in benefits and in some cases, no Plan benefits will be payable for those services.

The Plan has a contract with CareAllies and Modern Assistance Programs to administer Pre-Service, Urgent Care and Concurrent Care Claims. If you improperly file a **Pre-Service Claim**, you will be notified as soon as possible.

For properly filed Pre-Service Claims, you will be notified of a decision within **15 days** from receipt of the claim unless additional time is needed. The time for response may be extended up to **15 days** if necessary due to matters beyond the control of CareAllies or MAP. If an extension is necessary, you will be notified before the end of the **15-day** period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because CareAllies or MAP needs additional information from you, CareAllies or MAP will notify you as soon as possible, but no later than **15 days** after receipt of the claim, of the specific information needed to

complete the claim. In that case you and/or your doctor will have **45 days** from receipt of the notification to supply the additional information. During the period in which you are allowed to supply additional information, the decision on the claim will be suspended. When 45 days have elapsed from the date of the extension notice or the date you respond to the request (whichever is earlier), CareAllies or MAP then has **15 days** to make a decision on the Pre-Service Claim and notify you of the determination. If the information is not provided within the **45 days** allowed, your claim will be denied.

An **Urgent Care Claim** is any claim for medical care or treatment in which the time periods for making Pre-Service Claim determinations:

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an Urgent Care Claim is determined by CareAllies or MAP applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

If you improperly file an Urgent Care Claim, CareAllies or MAP will notify you as soon as possible but not later than **24 hours** after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If you are requesting pre-certification of an Urgent Care Claim, the time deadlines are different. CareAllies or MAP will respond to you [and your doctor] with a determination by telephone as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of the claim by CareAllies or MAP. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, CareAllies or MAP will notify you and your doctor as soon as possible, but not later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. During the period in which you are allowed to supply the additional information, the normal period for making a decision on the claim is suspended. The deadline is suspended from the date of the extension notice until either two business days have passed or you respond to the request (whichever is earlier). You and/or your doctor must provide the specified information within the **two business days** allowed. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than **48 hours** after the plan receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

### *Concurrent Claims*

A **Concurrent Claim** is a claim that is reconsidered after an initial approval and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment. A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously-approved benefit (other than by plan amendment or termination) will be made by CareAllies or MAP as soon as possible, to enable you to have an appeal decided before the benefit is reduced or terminated. Any request by a claimant to extend an approved Urgent Care treatment will be acted upon by CareAllies or MAP within **24 hours** of receipt of the claim, provided the claim is received at least **24 hours** prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to Pre-Service or Post-Service Claim timeframes, whichever applies.

### *Post-Service Claim*

A **Post-Service Claim** is a claim submitted for payment after health services and/or treatment have been received. For example, a Pre-Service Claim would not qualify as a Post-Service Claim because services have not yet been rendered.

The following procedure applies to Post-Service Claims:

- Obtain a claim form.
- Complete the employee's portion of the claim form.
- Have your physician either complete the Attending Physician's Statement section of the claim form, submit a completed health insurance claim form, or submit a HIPAA-compliant electronic claims submission.
- Attach all itemized hospital bills or doctor's statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

You do not need to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any further bills or statements for any medical or hospital services covered by the Plan to Iron Clad as soon as you receive them.

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

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the required information. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the decision on the claim will be suspended. When 45 days have elapsed from the date of the extension notice or the date you respond to the request (whichever is earlier), the Plan then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

## Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on the absence of Medical Necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
- **For Urgent Care Claims**, the notice will describe the expedited review process applicable to Urgent Care Claims. For these claims, the required determination may be provided orally and followed by written notification.

For **Urgent Care** and **Pre-Service Claims**, you will receive notice of the determination even when the claim is approved.

## Request for Review of Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision on a claim, you may ask for a review. Your request for review must be made in writing to Iron Clad within **180 days** after you receive notice of denial. However, appeals involving Urgent Care Claims may be made orally by calling Care Allies or MAP.

## Review Process

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

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

A different person will review your claim other than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made based on the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

## Levels of Appeal and Timing of Notice of Decisions on Appeal

- **Pre-Service Claims:** There is one level of appeal for Pre-Service Claims. You will be sent a notice of decision on review within **30 days** of receipt of the appeal by the Fund Office.
- **Urgent Care Claims:** There is one level of appeal for Urgent Care Claims. You will be sent a notice of a decision on review within **72 hours** of receipt of the appeal by the Fund Office.
- **Post-Service Claims:** There are two levels of appeal for Post-Service Claims. For first-level appeals, a decision on the appeal will be made within **30 days** of receipt of the appeal by the Plan. If you disagree with this decision, you can file a second written appeal to the Board of Trustees. Ordinarily, for second level appeals, decisions will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within **30 days** of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five **(5) days** after the decision has been reached. If you disagree with this decision, you can file a second written appeal to the Board of Trustees for their next regularly scheduled meeting following receipt of your request for review.
- **Concurrent Claims:** Appeals involving a termination or reduction of benefits of previously approved care shall be completed before the termination or reduction. The claimant shall be given notice sufficiently in advance of the termination or reduction to allow the claimant to appeal before the benefit is terminated or reduced. Appeals of Concurrent Claims involving an extension of care shall be conducted within the procedures and timeframe for Pre-Service, Urgent, or Post-Service appeals, depending on which category applies to the appeal.

- **Accident and Sickness Claims:** There is one level of appeal for Disability claims. A decision will be made by the Board of Trustees within 45 days of receipt of the appeal by the Fund Office. If the Plan determines that special circumstances require an extension of time, you will receive a written notice of the extension before the end of the 45-day period. The notice will include the reasons required for the extension and the approximate date the Plan expects to make a decision. The final decision will be made within 45 days of the time the Plan notifies you of the extension.

## Notice of Decision on Review

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

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

## Lawsuit Limitations

You may not commence a lawsuit to obtain benefits until after you have:

- Exhausted all levels of appeal and final decisions have been determined; or
- The appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision.
- The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be commenced more than three years after the end of the year in which medical or dental services were provided, or, if the claim is for weekly accident and sickness benefits, more than three years after the start of the disability.
- The Plan grants its fiduciaries discretionary authority to determine eligibility for benefits and to construe the Plan's terms. Consequently, if you file a lawsuit, the issue will be limited to whether or not the Board of Trustees (or its delegate(s), as may apply) acted arbitrarily or capriciously in making a decision.

## Plan Change or Termination

The contents of the booklet contain only a brief summary of the benefits available to you under the Plan. For full and complete provisions of your insurance, refer to the Rules and Regulations of the Plan on file at the Fund Office.

Nothing in this Summary Plan Description is meant to interpret, extend, or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions warrant.

## No-Fault Coverage

If you or your dependent is involved in a motor vehicle accident covered by a policy with no-fault provisions, the motor vehicle insurance carrier is initially liable for medical, surgical, hospital and related charges up to the maximum amounts of the benefits. This applies to whatever insurance policies are subject to a no-fault claim. This also applies to whether the vehicle is owned by a member, spouse, dependent, dependent's parent, and/or any other individual.

## Reimbursement

If you or your dependent has a claim against any other party who may be responsible or liable for the cost of the benefits paid by the Fund, you must repay the Fund out of any proceeds you (or your dependent) receive from the other party. Benefits include all amounts paid as Weekly Accident and Sickness benefits.

Also, you must pay the Fund from the proceeds on any claim against any other party's insurance, or against your or your dependent's own insurance, including but not limited to, under/uninsured benefits. This includes the insurance proceeds from a parent's policy concerning a claim by a minor child. The Plan does not cover work-related injuries or illnesses. However, if the Plan does pay such expenses, you must reimburse the Plan from the proceeds of any Workers' Compensation claim.

Whether the proceeds are paid by way of settlement of the claim or by way of judgment, you or your dependent must pay the full amount due to the Fund without reduction for attorneys' fees or costs. The Fund will have a lien in the amount recovered by you or your dependent.

The Fund has the right to require that you or your dependent sign a reimbursement agreement on a form approved by the Board of Trustees. In the event the member or his dependent fails to reimburse the Fund from proceeds received from a third party, or from any insurance proceeds, the Fund will also have the right to withhold future benefits equal to the amount otherwise due to the Fund plus interest and the right to bring a lawsuit against a member or a dependent to obtain reimbursement.

The Fund may make an advance of an amount equal to Plan benefits pending a determination of third party liability or receipt of settlement proceeds. This advance is subject to the right of reimbursement by the Fund. As applicable, you or your dependent have an obligation for reimbursement to the Fund. See General Exclusions to Health Benefits, page 48.

The right of reimbursement to the Fund applies regardless of how the third-party recovery is characterized, or of the application of state law limits or prohibitions on reimbursements. The make-whole, the collateral source, double payment and the common fund rules do not apply to the Fund's right to reimbursement.

The Trustees and the Fund have an equitable lien which imposes a constructive trust upon the claim proceeds funds. The enforcement of the equitable lien does not require that any of these funds be "traced."

## Fraud and Abuse

This Plan is subject to federal laws that provide that criminal penalties may be imposed against those who receive or attempt to receive health care plan benefits by committing fraud or abuse against the Plan. State fraud and abuse laws may also apply. In addition, the Plan may bring a lawsuit against any member, beneficiary or provider who obtains services or payments to which he/she/it is not entitled. The Plan may also offset future benefit payments otherwise due to a member or beneficiary or a future reimbursement to a medical provider.

# Health Insurance Portability and Accountability Act (HIPAA)

The Plan is required to protect the confidentiality and security of your private health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

You may find a complete description of your rights under HIPAA in the Plan's Privacy Notice that describes the Plan's privacy policies and procedures and outlines your rights under the privacy rules and regulations.

Your rights under HIPAA include the right to:

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

Upon written request, the Plan Office will provide you with a copy of the full HIPAA Privacy Notice.

## The Plan's Protection of Your Protected Health Information (PHI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA is set forth in the Plan's privacy notice that was distributed to you upon eligibility in the Plan. The privacy notice is available from the Plan Administrator. The Plan will use and/or disclose Protected Health Information (PHI) only according to the provisions of the HIPAA Privacy Rules.

Some employees of the Plan have access to certain PHI in the course of the services they perform for the Plan and each of those who do, only have access to particular PHI commensurate with the services he/she performs. No member of the Board of Trustees has access to PHI held by the Plan. All Plan employees protect the privacy of individually identified health information that is received, created or maintained in the course of their employment, and use and/or disclose such information only according to the terms of the Notice of Privacy Practices. Some Plan functions which involve PHI are performed by vendors. Each has agreed, in writing, that it will use and/or disclose PHI only according to the HIPAA Privacy Rules.

If your unsecured PHI is breached, the Fund Office will promptly notify you, but in no event, later than 60 calendar days after discovery of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Plan up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Fund Office or the HHS Secretary should you so believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Fund Office has improperly followed the breach notification process.

# Your ERISA Rights

As a participant in the Iron Workers District Council of New England Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides certain entitlements to all Plan participants listed below.

## *Receive Information about Your Plan and Benefits*

- Examine, without charge, at the plan administrator's office and at other specified locations, such as 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 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 a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

## *Continue Group Health Plan Coverage*

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 documents governing the plan on the rules governing your COBRA continuation coverage rights.

## *Prudent Actions by Plan Fiduciaries*

In addition to creating rights for plan participants, ERISA imposes duties upon those who are responsible for the operation of the welfare benefit plan. Those 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 the reason, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time restrictions.

Under ERISA, there are steps you can take to enforce the above rights. For instances, 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 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 the Plan fiduciaries were to misuse the plan's money, or if you contend that you were 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 Pension and Welfare Benefits Administration, U.S. Department of Labor 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 Employee Benefits Security Administration.

# Important Plan Definitions

**Adult** means a person who has attained age 18 years of age.

**Coinsurance** means that portion of covered expenses that a covered individual is responsible for paying. In most cases, the covered individual is responsible for paying a percentage of the total covered expenses that are in excess of the deductible.

**Copayments** are fixed amounts you pay for covered health services, usually when you receive the service.

**Covered charges** are the Reasonable and Customary charges for Medically Necessary services and treatments that are covered under this Plan, are for medical conditions that are covered under this Plan, and are based on valid medical need according to accepted standards of medical practice.

**Custodial Care** refers to all services and supplies, (including room and board) that are provided to you or your dependent whether disabled or not, to assist in the activities of daily living, regardless of the practitioner or provider who prescribed, recommended, or performed , whether or not it is provided in a rehabilitation facility or a skilled nursing facility.

**Deductible** means a fixed dollar amount of covered expenses incurred in any calendar year that a covered individual is responsible for paying before the Plan begins to pay benefits. The deductible is usually in addition to any copayment amount and any coinsurance percentage of coverage that the covered individual is responsible for paying.

**Experimental Procedure**

- Any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is under investigation and is limited to research;
- Techniques that are restricted to use at centers that are capable of carrying out disciplined clinical efforts and scientific studies;
- Procedures that are not proven in an objective way to have therapeutic value or benefit; or
- Any procedure or treatment whose effectiveness is medically questionable.

**Hospital** is an institution that:

- Is primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic, and therapeutic services for the diagnosis, treatment and rehabilitation of Injured, Disabled or sick persons;
- Maintains clinical records on all patients;
- Has bylaws in effect with respect to its staff of physicians;
- Has a requirement that every patient be under the care of a physician;
- Provides 24-hour nursing service rendered or supervised by a registered professional nurse;
- Has in effect a hospital utilization review Plan;
- Is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and
- Has accreditation under one of the programs of the joint commission on accreditation of health care organizations.

Unless specified, the term "hospital" does not include any institution that is used principally as a rest facility, nursing facility, convalescent facility or facility for the aged. Also, it does not mean any institution that makes a charge that you or your dependent are not required to pay.

However, licensed institutions used principally for the care and treatment of drug addiction or alcoholism will be included under the definition of "hospital" with the applicable insurance coverage being provided. Licensed institutions used principally for the care and treatment of mental illness will be included under the definition of "hospital" with the applicable insurance coverage being provided for confinement in that institution.

**Illness** means a sickness, disorder or disease that is not employment-related. Pregnancy is treated in the same manner as an illness under this Plan for you or an eligible dependent.

**Injury** means physical damage to your or your dependent's body caused by an accident, independent of all other causes. Only injuries that are not employment-related are considered for benefits under this Plan, except under the Life and Accidental Death and Dismemberment Benefits.

**Medically Necessary** means any service, supply, drug, treatment, or hospital confinement (or part of a hospital confinement) that is:

- appropriate and effective for the diagnosis, treatment or care of the condition, disease, illness or injury for which it is prescribed or performed;
- appropriate with regard to generally accepted standards of medical practice within the medical community or scientific evidence;
- not primarily for the convenience of the member, the member's family or a provider; and
- the most appropriate in terms of type, amount, frequency, setting, duration, supplies or level of service that can safely be provided to the member, i.e., a less expensive professionally-acceptable alternative is available.

The fact that a physician may prescribe, order, recommend or approve a service or supply, does not make it medically necessary or make the expense a covered charge. Vendors for the Plan (e.g. Cigna, Tufts) and Iron Clad may review claims for Medical Necessity.

**Member** means a "participant" in the Plan as defined by the Employee Retirement Income Security Act (ERISA).

**Participating Employers** as used in this Plan means each employer who contributes to the Iron Workers District Council of New England Health and Welfare Fund for the purpose of providing insurance benefits for employees. These are employers in accordance with a collective bargaining agreement with Local Union Numbers 7 and 37 of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers, AFL-CIO and whose names are included on the records of the Trustees as participating employers.

**Physician** means a legally qualified doctor or surgeon who is licensed to perform the particular medical or surgical service. It also includes any other health care provider or allied practitioner, if and as mandated by state law. It will not include anyone who is your spouse, parent, child, grandchild, brother or sister.

**Qualifying Events** are events that make you eligible to elect to receive continuation of coverage (COBRA). Some examples are: termination of your employment, other than for gross misconduct; reduction of your work hours; your retirement; your death; or your divorce or legal separation.

**Reasonable and Customary charges** are the usual fees charged by health care providers for a particular service in a particular geographic area. The patient pays any amount that providers charge above Reasonable and Customary.

**Skilled Nursing Facility** means an institution, or part of one, approved by Medicare or meets all of the following requirements:

- Is licensed, if required, under the laws of the jurisdiction in which it is located;
- Is operated primarily for the skilled nursing care and rehabilitation of sick or injured persons as inpatients;
- Has a written agreement with a hospital to accept patients who no longer require hospital treatment but required continued skilled nursing care;
- Provides 24-hour nursing service under the direction of a full-time registered nurse (R.N.);
- Operates under the supervision of a doctor of medicine (M.D.) at all times; and
- Keeps complete medical records on each patient.

This term does not include institutions that provide only:

- Minimal care;
- Custodial care;
- Ambulatory care; or
- Part-time care services.

This term also does not include institutions for the care and treatment of:

- Mental and Nervous Disorders;
- Pulmonary tuberculosis;
- Drug abuse or addiction; or
- Alcohol abuse or alcoholism.

**Totally Disabled** refers to an employee who is completely unable to perform each and every duty pertaining to your occupation or employment as a result of an illness or injury. This definition does NOT apply to life insurance.

# Administrative Information

The chart below provides a quick reference for administrative information about the Iron Workers District Council of New England Health and Welfare Plan.

| | |
|---|---|
| Legal Name of the Plan | The Iron Workers District Council of New England Health and Welfare Plan |
| Plan Administrator | The Plan is administered by the Trustees. The Trustees have retained an Administrator to operate the Fund Office, to perform the routine day-to-day administration of the Plan. You may contact the Trustees at the following address:<br><br>Board of Trustees<br>Iron Workers District Council of New England<br>Health and Welfare Fund<br>161 Granite Avenue<br>Dorchester, MA 02124<br>Phone: 617-265-3757 |
| Plan Sponsor | The Board of Trustees |
| Plan Number | 501 |
| Employer Identification Number | 04-2163872 |
| Plan Type | This Plan is an ERISA welfare benefit plan. Group Medical, Dental, Vision, Prescription Drug and Weekly Income benefits are provided on a self-funded basis directly from the Plan. |
| Plan Year | The accounting records of the Plan are kept on a plan year basis beginning each January 1. |
| Agent for Service of Legal Process | The Board of Trustees of the Iron Workers District Council of New England Health and Welfare Fund. Process may be served at the Fund Office or upon any Trustee. |
| Source of Contributions to the Fund and Identity of Any Organization Through Which Benefits Are Provided | All contributions to the Plan are made by individual contributing employers in accordance with collective bargaining agreements or participation agreements. The assets are held by the Trustees, and the Trustees invest such assets or have delegated such investment to professional investment managers. |
| Insurance Carriers and Third Party Administrators | See “Important Contact Information” on page iv. |

## *Participating Employers*

You may make a written request to the Fund Office for information as to whether a particular employer or employee organization or union is a participating employer with respect to this Plan; and, if so, you may request the address of that participating employer.

## *Reference to Collective Bargaining Agreements*

This Plan is a welfare benefit plan, self-administered by a Board of Trustees, jointly by Union and employer representatives. The Plan is maintained pursuant to Collective Bargaining Agreements. All employer contributions to the Plan are made in accordance with these Collective Bargaining Agreements with Locals No. 7 and 37 of the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers, AFL-CIO. Copies of the Collective Bargaining Agreements may be obtained by the participants and beneficiaries upon written request to the Plan Administrator.

## Type of Administration of the Plan

The Trustees are the formal Plan Administrator; however, they have delegated important administrative responsibilities to third parties.

This Plan is maintained for the purpose of providing comprehensive medical, prescription drug, dental, vision, Life and Accidental Death and Dismemberment Insurance, and Weekly Income benefits for participants and their dependents who meet the eligibility requirements described in this booklet.

The Iron Workers District Council of New England Health and Welfare Fund is an ERISA welfare benefit plan. The plan provides group medical, vision, prescription drug and Weekly Income benefits on a self-funded basis directly from the Plan. Life and AD&D Insurance is provided through Aetna.

The Collective Bargaining Agreements require employer contributions to the Plan at fixed rates per hour worked.

All assets are held in trust by the Board of Trustees. Benefits and administrative expenses are paid from the Trust. Benefits are provided from the Fund's assets that are accumulated under the provision of the Collective Bargaining Agreement and the Trust Agreement. The assets are held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses.

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described earlier in this booklet.

The procedures to follow for filing a claim for benefits are also set forth elsewhere in this booklet.

Under the documents creating the Benefit Fund (and the terms of the Plan), the Trustees have sole discretionary authority to make final determinations regarding eligibility for benefits, the types and forms of benefits, any applications for benefits, and the interpretation of the Plan and any administrative rules adopted by the Trustees. Benefits under this Plan will be paid only if and when the Board of Trustees or persons to whom such decision making authority has been delegated by the Trustees, in their sole discretion, decide the participant or covered dependent is entitled to benefits under the terms of the Plan.

The decision of the Trustees is final and binding and will receive judicial deference to the extent that it does not constitute an abuse of discretion. If a decision of the Trustees is challenged in court, the decision will be upheld unless the court finds that it is arbitrary and capricious. Individual Trustees, Employers, or Union representatives do not have the authority to interpret the Plan on behalf of the Board of Trustees or to act as agents of the Board with respect to interpretation of the Plan. You may only rely on information regarding the Plan that is communicated to you in writing and signed on behalf of the full Board of Trustees either by the Trustees or, if authorized by the Trustees, signed by the Board's designated representative.

You must follow the Plan's claims and appeals procedures before you bring any legal action under ERISA to obtain Plan benefits. You or any other claimant may not begin any such legal action, including proceedings before administrative agencies, until you have followed and fully exhausted the Plan's claims and review procedures described in this booklet. You may have, at your own expense, legal representation at any stage of the review process.