IRON WORKERS WELFARE PLAN *of* WESTERN PENNSYLVANIA

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DEAR ACTIVE PARTICIPANTS:

The Board of Trustees is pleased to present this revised Summary Plan Description (SPD) that replaces all prior SPD booklets. This SPD, which also serves as the official Plan Document, describes the eligibility requirements of the Welfare Plan and includes the procedures you must follow when filing a claim. The SPD also includes information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA).

There have been improvements and changes made to the Plan since the last booklet was printed in 1997. The following is a summary of the most important changes:

- **The Plan has entered into a contract with Express Scripts to provide prescription drug coverage. Generic drugs require no co-payment. Brand name drugs require a $10.00 co-payment per prescription or refill. It is imperative for all participants to utilize generic drugs when they are prescribed.**

- **The Life and Accidental Dismemberment benefits are now insured through the United of Omaha Life Insurance Company.**

- **The Plan has entered into a contract with the Membership Assistance Program (MAP) to provide you and your family with confidential help in dealing with personal problems. The MAP staff will help you and your family with the following kinds of problems: marital or family problems, financial or legal difficulties, emotional or stress-related problems, drug or alcohol abuse or problems related to work. For confidential help, call: 1-888-877-8997. This program is also available to apprentices upon successful completion of their orientation class.**

- **A voluntary self-pay dental plan through United Concordia is available.**

We urge you to read this SPD carefully and to keep it in a convenient place for future reference. The Welfare Plan is designed to help you and your family in meeting the rising costs of medical care as well as providing a measure of protection in the event of your death or disability. If the benefits provided under this Plan are used wisely, and only when needed, the Plan will continue to provide security and the sense of well being for which it is intended.

If you have any questions about the Plan or how to apply for benefits, do not hesitate to contact the Plan Office.

The Board of Trustees

IMPORTANT

It is important that you notify the Plan Office whenever you have a change in any one of the following:

- **Home Address and Phone Number.** Advise the Welfare Plan Office promptly so that their records will be up to date if they should need to communicate with you about any matter concerning your coverage.

- **Beneficiary Designation.** Contact the Welfare Plan Office to obtain the necessary form if you want to change the beneficiary for your Life Insurance and Accidental Dismemberment Insurance.

- **Family composition.** Give prompt written notice to the Welfare Plan Office about any change in your family status such as marriage or divorce, birth of a child, the marriage of any of your enrolled children, or death of any dependent.

Notify the Plan Office whenever you have a change in Home Address, Phone Number, Beneficiary Designation or Family Composition.

The Trustees reserve the right and have the full authority and right to amend, alter, modify, terminate and interpret all provisions concerning the nature, amount and duration of benefits to be provided. All benefits provided must always be within the financial limits of the Plan and must be consistent with a prudent funding policy established by the Trustees. The Trustees have the full authority and right to determine eligibility requirements for participation in this program.

The Plan may be terminated by the Trustees or in certain circumstances, for example, if future collective bargaining agreements do not require employer contributions to the Plan. In the event of Plan termination, benefits for covered expenses incurred prior to the termination date fixed by the Trustees will be paid to eligible individuals as long as the Plan's assets exceed its liabilities. Full benefits may not be paid if the Plan's liabilities exceed its assets. Excess assets, if any, then remaining after the payment of all Plan liabilities will be utilized for purposes similar to the Plan's present purposes. You will be notified in writing if the Plan is amended or terminated.

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SCHEDULE *of* BENEFITS

LIFE INSURANCE BENEFIT

(For Active Members in the Full Plan of Coverage)

Covered continuously by the Welfare Plan for 12 months or longer $50,000
During the first 12 months of coverage under the Welfare Plan $25,000

ACCIDENTAL DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

(For Active Members in the Full Plan of Coverage)

Maximum Benefit $20,000

WEEKLY ACCIDENT AND SICKNESS BENEFIT

(For Active Members in the Full Plan of Coverage)

Maximum Weekly Benefit . . . . . $ 375

RETIREE DEATH BENEFIT

(See Page 67 for Eligibility Requirements)

Eligible Members Under Local Union No. 3 . . . . . .$ 6,000
Eligible Members Under Local Union No. 772 . . . . . .$ 9,000

RETIREE HEALTH INSURANCE REIMBURSEMENT BENEFIT

(See Page 68 for Eligibility Requirements and Explanation)

Individual Coverage-Local Union No. 3 . . . . . up to $260 per month
Family Coverage-Local Union No. 3 . . . . . up to $520 per month
Individual Coverage-Local Union No. 772 . . . . . up to $220 per month
Family Coverage-Local Union No. 772 . . . . . up to $440 per month

MEDICAL BENEFITS UNDER DIRECTBLUE

(SELECTBLUE FOR OUT-OF-AREA MEMBERS) (Active Members and Their Eligible Dependents)

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Deductible		
Individual	None	$250
Family	None	$500
Coinsurance	100%	70% after deductible
Out-of-Pocket Limit	Not Applicable	$2,000 Individual $4,000 Family
Lifetime Maximum	Unlimited	$300,000
Primary Care Physician Office Visits	100% after $10 Co-payment	70% after Deductible
Specialist Office Visits	100% after $10 Co-payment	70% after Deductible
Preventive Care		
Adult		
Routine Physical Exams	100% after $10 Co-payment	Not Covered
Routine GYN Exams Including PAP Tests	100% after $10 Co-payment	70%; deductibles & maximums do not apply
Mammograms as Required	100%	70% after deductible
Pediatric		
Routine Physical Exams	100% after $10 Co-payment	Not Covered
Pediatric Immunizations	100%	70%; deductibles & maximums do not apply
Hospital Services		
(Inpatient & Outpatient)	100%	70% after Deductible
Emergency Room Services		
Emergency Accident/ Emergency Medical Care	100% after $20 Co-payment (Co-payment waived if admitted)	70% after Deductible
Surgical/Medical Services	100%	70% after Deductible
Maternity Services	100%	70% after Deductible
Family Planning & Infertility Services ①	100%	70% after Deductible

MEDICAL BENEFITS UNDER DIRECTBLUE

(SELECTBLUE FOR OUT-OF-AREA MEMBERS) (Active Members and Their Eligible Dependents)

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Assisted Fertilization Procedures	100% Limit $5,000 lifetime Maximum	70% after deductible Limit $5,000 lifetime Maximum
Diagnostic Services (Lab, X-ray and other tests)	100%	70% after Deductible
Outpatient Physical Therapy	100%	70% after Deductible
Outpatient Speech & Occupational Therapy	100%	70% after Deductible
Spinal Manipulation	100% after $10 Co-payment	70%; deductible does not apply Limit: 20 visits per calendar year
Ambulance Service	100%	70% after Deductible
Private Duty Nursing	100%	70% after Deductible
Skilled Nursing Facility Services	100%	70% after Deductible
Home Health Care	100%	70% after Deductible
Hospice	100%	70% after Deductible
Durable Medical Equipment	100%	70% after Deductible
Mental Health Services ②		
Inpatient	100%	70% after Deductible
Outpatient	100%	50% after Deductible
Substance Abuse Services ③		
Inpatient	100%	70% after Deductible
Detoxification	7 days / admission; 4 admissions / lifetime	
Rehabilitation	100%	70% after Deductible
	30 days / year; 90 days / lifetime	
Outpatient	100%	50% after Deductible
Detoxification	60 visits / year; 120 visits / lifetime	
Precertification Requirements ④	Performed by Network Medical Management	Required for inpatient admission to non-network hospital

MEDICAL BENEFITS

The term "Member", "Active Member" and "Participant" are used interchangeably throughout this booklet.

1. Treatment includes coverage for the correction of a physical or medical problem associated with infertility.

2. State mandated benefits (30 inpatient days and 60 outpatient visits annually, with the right to exchange inpatient days for outpatient visits on a one-for-two basis) ***may*** apply to serious diagnosis. Serious diagnosis includes: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder.

   To obtain mental health and substance abuse services at the maximum benefits level you must contact Highmark's Mental Health and Substance Abuse Unit before seeking treatment.

3. First instance or course of treatment reimbursed at 70% after deductible for out-of-network care.

4. If Blue Cross Blue Shield is not contacted prior to a non-emergency inpatient admission the patient will be responsible for the entire precertification penalty. If it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

ELIGIBILITY RULES

These eligibility rules provide a means by which a member covered under a collective bargaining agreement requiring contributions to the Welfare Plan can maintain health coverage during periods of:

- **active employment;**
- **temporary, total or partial disability,**
- **involuntary or voluntary unemployment (including vacation); and**
- **time prior to actual voluntary retirement.**

The eligibility rules do not provide extended coverage if you voluntarily leave covered employment to work in another industry or to become self-employed. By covered employment, the Plan means work for which a collective bargaining agreement requires contributions to be made to this Welfare Plan on your behalf.

If you voluntarily leave covered employment to work in another industry or to become self-employed (including ironwork not covered by the collective bargaining agreement), your coverage (if eligible under the full plan of coverage) will terminate at the end of the third (3rd) month after you last worked in covered employment, provided your Hour Bank is sufficient to continue eligibility. If a new member eligible under the "Special Eligibility" rules quits the apprentice program or the special organization program terminates, eligibility for coverage will terminate at the end of the following month. After that, you will be eligible for COBRA Continuation Coverage explained on page 70. You should promptly notify the Plan Office if this occurs so that your coverage may be properly terminated and COBRA Continuation Coverage offered.

INITIAL ELIGIBILITY

Full Plan of Coverage

New members must work 540 hours in a period of six (6) consecutive months to become initially eligible under the Welfare Plan. The rules require that you:

- Work at least 40 hours in four (4) of the six (6) months; and
- Have hours during the first (1st) and sixth (6th) month of the six-month period used to determine your eligibility.

Any hours you work over the first 540 hours during this six month initial eligibility period will be credited to your Hour Bank.

ELIGIBILITY RULES

Special Eligibility Rule

The following rules provide limited medical coverage for the following:

- A new member participating in the apprentice program or brought in under a special organization program in the jurisdiction of Local No. 3 or Local No. 772.
- Former active participants who were covered under the Welfare Plan and were credited with 6,000 hours of contributions within the prior five (5) calendar years.
- Retirees returning to work who were previously eligible for the retiree reimbursement coverage. Retirees who have never taken advantage of the retiree reimbursement coverage, even though eligible, must notify the Welfare Plan Office if they would like to take advantage of the "Special Eligibility" rule.

The following rules also apply under this ***"Special Eligibility"*** *rule:*

- If a new member meets the initial eligibility rules for the full plan of coverage, he will be placed in that plan.
- A new member is entitled to gain eligibility under this "Special Eligibility" rule once in three (3) calendar years including the year in which he returns to work in covered employment.
- A former participant shall only be allowed to take advantage of this "Special Eligibility" rule once in three (3) calendar years including the year in which he returns to work in covered employment.
- A participant cannot self-pay to gain eligibility in the full active employee benefit program, or have that program reinstated.

ELIGIBILITY RULES

Initial "Special Eligibility" Rule

DirectBlue coverage (or SelectBlue for members who live out-of-the-area) will begin the first (1st) day of the calendar month following the month after the member completes at least 180 hours of work in a period not to exceed two (2) consecutive months, for which contributions have been made to this Welfare Plan.

> **For example:** *A member works 100 hours in January and 80 hours in February. His coverage will commence April 1 (See "lag month") below.*

This "Special Eligibility" will only include DirectBlue coverage (or SelectBlue for members who live out-of-the-area). It will not include life insurance, sickness and accident benefits, prescription drug benefits or any other plan benefits.

Termination of Eligibility for Those Members Eligible Under the "Special Eligibility" Rules

If a new eligible member quits the apprentice program, or the "special" organization program terminates, eligibility will terminate at the end of the following month. This assumes that he has not worked sufficient hours to satisfy the initial eligibility rule for the full plan of coverage.

Lag Month

In order that there is sufficient time for employer contribution reports to be received and processed by the Welfare Plan Office, a **lag month** will be used in determining your initial eligibility. The lag month is one (1) calendar month between the six-month period (or two-month for special eligibility) for which the hours are reported and the month coverage is actually provided.

Therefore, your eligibility will begin on the first (1st) day of your eighth (8th) month of employment (or the 1st day of your 4th month for special eligibility) if you meet the requirements.

> **For example**, *if you worked in covered employment from January 1 through June 30 and accumulated the required 540 hours (and meet the requirements of working in January and June) your eligibility will start August 1st. In this case July is the lag month.*

Benefits **will not** be paid for days of hospitalization, medical or surgical services received before the initial eligibility date. This includes expenses incurred during the lag month.

ELIGIBILITY RULES

Continued Eligibility

You will remain eligible as long as your employer(s) make contributions for at least 90 hours each month. Any excess contributions made on your behalf will be credited to your Hour Bank. You may accumulate up to 1,080 hours in your Hour Bank.

As your coverage continues, the lag month between the time you earn the contributions and the actual coverage remains.

> **For example**, *the 90 hours you work during the month of July are used to determine eligibility for September. In this case, August is the lag month.*

Hour Bank and/or Self-Pay

If less than 90 hours are contributed on your behalf during any month, the number of hours needed to total 90 will be deducted from your Hour Bank.

> **For example,** *suppose only 70 hours are contributed on your behalf for the month of February. Also, suppose you have 1,000 hours in your Hour Bank. 20 hours will be deducted from the Hour Bank to make the required 90 hours. Your Hour Bank balance will be reduced to 980 hours.*

If, at the beginning of any month, you do not have a total of 90 hours contributed on your behalf and/or remaining in your Hour Bank, you may self-pay, at the Welfare Plan hourly rate, the remaining amount needed to make the required 90 hours.

> **For example,** *if you have 40 hours contributed on your behalf for August and 25 hours remaining in your Hour Bank, you would have 65 hours. Therefore, you will have to self-pay for 25 hours to continue your eligibility for October (40+25+25=90).*

This use of the Hour Bank and/or the self-pay rules is only available if you are actively seeking and available for full-time employment under a collective bargaining agreement requiring contributions to this Welfare Plan, except as outlined for disabled members under **Continued Eligibility During Disability Periods**. You may not use the Hour Bank and/or self-pay if you voluntarily leave covered employment to seek employment in another industry or become self-employed. Your right to self-pay and/or use your Hour Bank terminates the first day of the month following three (3) consecutive months during which you fail to work 270 hours in the previous twelve (12) consecutive month period, or earlier if you fail to make the required monthly self-payment.

ELIGIBILITY RULES

Once your right to self-pay terminates you will be eligible for COBRA continuation coverage. You may also reinstate your eligibility through covered employment under the **Reinstatement of Eligibility** rules explained below.

You cannot self-pay if other group health coverage is available as a result of your and/or your spouse's employment. However, if you are employed by a political subdivision such as a municipality, water authority, board of education, or other public entity, within the geographic jurisdiction of the union for the type covered under a collective bargaining agreement with a contributing employer or in a capacity directly involved with the industry, unions or political subdivision or government position through elective office, you may use your accrued Hour Bank to continue eligibility.

For retirees over age 60, the following rules apply:

- **If a retiree's pension is not suspended, the hours accrued do not count towards the Hour Bank.**
- **If a retiree's pension is suspended, the hours do count towards the Hour Bank.**

Reinstatement of Eligibility

A member will be entitled to reinstate his/her eligibility within 24 months of termination if he/she is reemployed in covered employment for 270 hours in a period not to exceed three (3) months. You will be entitled to at least two (2) months of eligibility.

If you are not covered by the Welfare Plan for 24 consecutive months, you will be required to regain coverage under the **Initial Eligibility** rules. However, retirees who return to work in covered employment will become covered again by having 270 hours of contributions made on their behalf in a three (3) month period. Coverage will begin no later than the first (1st) day of the fifth (5th) month following his/her return to covered employment.

For example, *if you return to covered employment in May and have 270 hours of contributions made on your behalf for the period May 1st through July 31st, your eligibility will be reinstated September 1st. August will be the lag month and your coverage will continue until at least October 31st.*

ELIGIBILITY RULES

If a former active plan member was covered under this Welfare Plan and was credited with 6,000 hours of contributions within the prior five (5) calendar years, he will have the right to reinstate under the "Special Eligibility" rules. Retirees returning to work who were previously eligible for the retiree reimbursement coverage, can also reinstate under the "Special Eligibility" rules.

Reciprocal Contributions

The Iron Workers Welfare Plan of Western Pennsylvania is signatory to the International Reciprocal Agreement for Welfare Plans. To the extent that contributions are received from a plan that is also signatory to the International Reciprocal Agreement, the contributions will be adjusted to provide the equivalent number of hours at the negotiated contribution rate provided in collective bargaining agreements to this Welfare Plan.

The Plan has also entered into a number of agreements where this Plan will accept or transfer contributions on a member's behalf.

If you become eligible under another Welfare Plan that is not signatory to the International Reciprocal Agreement for Welfare Plans or if the other Welfare Plan does not have an agreement to transfer contributions, your Hour Bank under this Welfare Plan will be frozen. Your coverage may be reinstated when you lose eligibility under the other plan.

Participation Agreements

If you are not covered by a collective bargaining agreement requiring contributions to the Welfare Plan, you are eligible for coverage under the Plan if your employer has entered into a written participation agreement with the Trustees requiring your employer to make contributions to the Plan on your behalf for 40 hours per week and 52 weeks per year.

Limitation on Participation for Owners and Management Employees

If you have any type of direct or indirect financial interest in an employer, or if you perform any type of work or service for an employer in the ironworker industry that is not covered by the collective bargaining agreement, whether as an employee, owner or independent contractor, you will not be eligible for any coverage under the Welfare Plan for work with that employer, unless that employer enters into a written participation agreement with the Trustees requiring the employer to make contributions to the Plan on your behalf for 40 hours per week and 52 weeks per year (referred to as a "40/52 agreement"). This limitation applies even if you work sufficient hours for the employer under the collective bargaining agreement to be otherwise eligible for coverage under the Plan.

ELIGIBILITY RULES

The determination of whether you have a direct or indirect financial interest in an employer is made by applying constructive ownership of stock rules from the Internal Revenue Code (§ 318) modified for non-corporate employers to apply to ownership of capital or profits interests of such an employer (and to reduce the 50% stock threshold to 5%). Under these rules, for example, you are deemed to own the stock owned by your spouse. Thus, if you work for an employer owned by your spouse, this limitation will apply, and you will not eligible for coverage for work with this employer unless the employer enters into a 40/52 agreement on your behalf.

Employer for this purpose includes any related employer (i.e., the parent company of the employer, any subsidiary company of the employer, and any trade or business under common control with the employer as determined by applying the controlled group and affiliated service group rules from the Internal Revenue Code (§414(b), (c), (m) and (o)). Thus, for example, if you work for a subsidiary controlled by a corporation you own, this limitation will apply, and you will not be eligible for coverage for work with this employer unless the employer enters into a 40/52 agreement on your behalf.

Employer, however, does not include any employer if its securities are listed on the New York Stock Exchange, the American Stock Exchange or a regional stock exchange with daily price quotations or if its securities are traded on NASDAQ. This includes most publicly traded companies. Thus, your ownership of stock of such an employer will not trigger the application of this limitation, and your eligibility for coverage under the Welfare Plan for work for such an employer will be determined under the regular eligibility rules.

Also, this limitation does not apply to your work for an employer that is not related to the employer in which you have a financial interest or for which you perform non-bargaining work or service. Thus, if you work sufficient hours for the unrelated employer, you will be provided with coverage under the Plan if otherwise eligible, even if you also work for an employer in which you have a financial interest or for which you perform non-bargaining work or service.

Continued Eligibility During Disability Periods (For Members Eligible Under the Full Plan of Coverage)

After you become eligible for the full plan of coverage, if you are unable to work because of a certified disability, you will be credited with 22-1/2 disability hours for each full week of disability to be used toward maintaining your eligibility.

A **certified disability** is one for which the member:

- is being paid Weekly Accident and Sickness Benefits through the Welfare Plan; or
- submits evidence of receiving Workers' Compensation benefits as the result of a disability incurred while performing work normally under the jurisdiction of Iron Workers Local Unions.

You can receive disability hours for a maximum of 52 weeks per illness or accident in a 24-month period up to a lifetime maximum of 104 weeks of benefits for a recurring disability.

If you return to work after recovering from a disability, but do not have 90 hours between the disability hours and the hours contributed on your behalf by your employer(s), the number of hours needed to total 90 will be deducted from your Hour Bank.

For example, *if you were disabled for the first two weeks of September, you would be credited with 45 hours. If an additional 30 hours were contributed on your behalf for work you actually did during the last two weeks of September, you would have a total of 75 hours. 15 hours would then be deducted from your Hour Bank to continue your eligibility for the month of November (45+30+15=90).*

However, as discussed in the Weekly Accident & Sickness Benefit section, no disability hours will be credited if it is determined that you fraudulently applied for the Weekly Accident & Sickness Benefit or misrepresented your entitlement to the benefit, or if it is determined that you received Weekly Accident & Sickness Benefit payments as the result of your fraud or misrepresentation.

Certificate of Creditable Coverage

When your coverage ends, you and/or your covered dependents are entitled by law to, and will be provided with, a certificate of creditable coverage (from Highmark Blue Cross Blue Shield). Certificates of creditable coverage indicate the period of time you and/or your dependent(s) were covered under the Plan (including, if applicable, COBRA Continuation Coverage), as well as certain additional information required by law. This certificate may be necessary if you and/or your dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered dependents a health insurance policy within 63 days after your coverage under this Plan ends. The certificate is necessary because it may reduce any exclusion for pre-existing conditions that may apply to you and/or your covered dependents under the new group health plan or health insurance policy.

This certificate will be provided to you shortly after this Plan knows, or has reason to know, that coverage (including COBRA Continuation Coverage) for you and/or your covered dependents(s) has ended. This certificate will also be provided once the Welfare Plan Office receives a request for this certificate, provided that the Welfare Plan Office receives the request within two years after the later of the date your coverage under this Plan ended or the date your COBRA Continuation Coverage ended.

The certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your coverage ends under this Plan. If you (or any of your covered dependents) elect COBRA Continuation coverage, another certificate will be sent to you (or them if COBRA Continuation Coverage is provided only to them) by first class mail shortly after the COBRA Continuation Coverage ends for any reason.

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) creates a right for certain members to take up to twelve (12) weeks of unpaid leave for their own serious illness, after the birth or adoption of a child or to care for their seriously ill spouse, parent or child. The Family and Medical Leave Act requires certain employers to maintain health care coverage during the leave period. Your benefits are protected and your Hour Bank is frozen if your employer approves your family and medical leave. Contact the Welfare Plan Office for more information concerning the requirements for an FMLA leave.

Members in Military Service

If you are on active duty for 90 days or less, your dependents will continue to receive health care coverage for up to 90 days. Member coverage is to be provided by the military under the health care system for members of U.S. Armed Forces (TRICARE).

At the end of this three-month period, the Trustees may again review the situation in order to determine whether to further extend dependents' benefits.

If you return to covered employment from active duty within three months, your hour bank will be reinstated at the same number of hours as when you were called to active duty. Essentially, all this means is that all of your hours to determine your eligibility will be as they were when you were called to active duty. If your military service extends beyond three months, the Trustees may again review your status.

If you are on active duty for more than 90 days, USERRA (Uniformed Services Employment and Reemployment Rights Act of 1994) permits you to continue medical coverage for you and your dependents at your own expense for up to 18 months. This continuation right operates in the same way as COBRA Continuation Coverage. See page 70 for a full explanation of the COBRA Continuation Coverage, which will allow you to continue your medical coverage. In addition, your dependent(s) may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

ELIGIBILITY RULES

Definition of Eligible Dependents

With respect to all benefits provided by the Welfare Plan except the Supplemental Medical Benefit, **Eligible Dependents** are your spouse, and each unmarried child who has not reached his/her 23rd birthday. Such children include:

- Natural children and product of a legal marriage
- Your children or those children of your current spouse who qualify as your dependent under the IRS Code who you have claimed as a dependent the previous year. You must provide proof acceptable to the Board of Trustees that you claim this person as your dependent on your Federal Income Tax return
- Your natural children, although not the product of a legal marriage, which a court of competent jurisdiction has held you to be responsible for that child's support
- Legally adopted children or children legally placed for adoption
- Stepchildren legally dependent upon you for your support
- Your child named in a Qualified Medical Child Support Order (QMCSO) - contact the Plan Office for the rules and procedures for children named under a QMCSO

You may be required to provide proof to the Welfare Plan Office that the dependent meets the definition of an Eligible Dependent.

Eligible Dependents under the Supplemental Medical Benefit are those persons who qualify as your dependents under the IRS Code. You must provide acceptable certification to the Board of Trustees that you claim this person as your dependent on your federal income tax return.

If your unmarried dependent child is incapable of self-sustaining employment because of physical handicap or mental retardation and he/she is dependent upon you for support and maintenance, his/her coverage will continue provided his/her incapability began prior to attaining age 19. You must submit proof of the dependent child's incapability to the Welfare Plan Office within the 31-day period following the day he/she attains age 19. You may be requested to provide proof of the continued existence of such incapability to the Welfare Plan Office from time to time.

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. A QMCSO requires the Fund to cover an alternate recipient who might not otherwise be eligible for coverage. This Plan provides benefits according to the requirements of the QMCSO. The Fund Office will notify affected participants and alternate recipients if a QMCSO is received. You may request a copy of the Fund's QMCSO procedures, free of charge, if you need additional information.

Benefits for Dependents of Deceased Members

If a member dies while eligible under the Welfare Plan, the Plan will provide a minimum of twelve (12) months of continued eligibility for the surviving spouse and eligible dependent children, if other health coverage is not available as a result of the spouse's own employment. The maximum amount of extended coverage is equal to the deceased member's full Hour Bank plus six (6) additional months.

> **For example**, *if your Hour Bank had 900 hours, coverage for your spouse and children would continue for ten (10) months (990 hours ÷ 90 = 10 months) plus an additional six (6) months for a total of 16 months.*

LIFE INSURANCE BENEFIT

(Provided through United of Omaha Life Insurance Company)
For Active Members Eligible in the Full Plan of Coverage ONLY

If you die from any cause - on the job or off - while you are insured for this Life Insurance Benefit, your named beneficiary will receive the applicable benefit amount.

Benefit Amount

The amount payable to beneficiaries of active members who were insured under this Life Insurance Benefit for twelve (12) consecutive months or more is $50,000. The amount payable to beneficiaries of active members who were insured under this Life Insurance Benefit for less than twelve (12) consecutive months is $25,000.

Beneficiary

You may name anyone you wish as your beneficiary for life insurance and you may change your beneficiary at any time by filling out the proper form obtained from/and returned to the Welfare Plan Office.

If you have not designated a beneficiary or if your beneficiary predeceases you, payment of the Life Insurance Benefit will be made equally to the members of the first (1st) of the following categories that applies:

- spouse
- children
- parents
- brothers and sisters
- executors or administrators

The Life Insurance Benefit will be paid to your beneficiary or beneficiaries as a single lump sum. Your beneficiary must submit a certified copy of the death certificate. However, if your beneficiary is a minor, the benefit will be paid to the beneficiary's legal guardian or otherwise distributed in accordance with applicable law.

LIFE INSURANCE BENEFIT

Total and Permanent Disability

If prior to attaining age 62, while insured under the group policy, you become permanently and totally disabled from any gainful employment, the Welfare Plan will pay the premiums necessary to provide you with life insurance coverage. You will be required to provide proof that you obtained a Social Security disability award showing that you were totally disabled from any gainful employment. The Life Insurance Benefit will be continued until you:

- **attain age 62; or, if sooner,**
- **are no longer considered to be permanently and totally disabled.**

If you die during the time your life insurance is continued by the Welfare Plan, your beneficiaries will be paid the appropriate benefit amount.

If Social Security does not determine that you are totally and permanently disabled from gainful employment, you will be offered the opportunity to convert your life insurance.

Conversion Privilege Feature

If your Life Insurance Benefit terminates, you may convert to an individual life insurance policy within 31 days of termination. No medical examination is required. The benefit amount of the converted policy cannot exceed the amount provided under the group plan. You may choose any type of individual policy being written by United of Omaha Life Insurance Company, except term insurance or any insurance that provides disability or other supplemental benefits. Your premium cost for the conversion policy will be based on your class of risk and attained age at the time of conversion.

If you die within the 31-day period following termination, your beneficiary will receive the Life Insurance Benefit amount as though you were still insured under the Group Policy.

ACCIDENTAL DISMEMBERMENT & LOSS *of* SIGHT INSURANCE BENEFIT

(Provided through United of Omaha Life Insurance Company)
For Active Members Eligible in the Full Plan of Coverage ONLY

If you sustain any of the losses described below solely through external, violent and accidental means — on the job or off — the Accidental Dismemberment and Loss of Sight Insurance Benefit will be paid in addition to any other benefits payable under the Welfare Plan.

Benefit Amount

The amount payable if you sustain any of the following losses is:

Two Limbs	$20,000
Sight of Both Eyes	$20,000
One Limb and Sight of One Eye	$20,000
One Limb	$10,000
Sight of One Eye	$10,000

Loss of limb means dismemberment by severance at or above the wrist or ankle joint, or loss of the use of the limb. **Loss of sight** means the total and irrecoverable loss of sight.

Even if more than one of the covered losses is suffered as the result of any one accident, this Accidental Dismemberment and Loss of Sight Insurance Benefit will only pay $20,000.

General Exclusions and Limitations
These General Exclusions and Limitations do not apply to any Life Insurance Benefits provisions.

We do not pay under the Accidental Dismemberment Benefits provisions for any loss which:

a. is not permanent;

b. occurs more than 365 days after the Injury;

   This 365 day limit will not apply if you are in a coma or being kept alive by an artificial support system at the end of the 365 days.

c. does not result from an accident;

d. results from Injuries you receive in any aircraft other than while riding as a passenger in a commercial aircraft on a regularly scheduled flight; or while:
   1. operating;
   2. riding as a passenger in; or
   3. boarding or leaving;

   any aircraft while you are traveling on business of the policyholder, provided the aircraft:
   1. has a current and valid FAA (Federal Aviation Administration of the United States) standard air worthiness certificate; and
   2. is operated by a person holding a current and valid FAA pilot's certificate of rating authorizing him or her to operate the aircraft;

e. results from injuries you receive while riding in any aircraft engaged in:
   1. racing;
   2. endurance tests; or
   3. acrobatic or stunt flying;

f. is caused by you, and is a result of injuries you receive, while under the influence of any controlled drug, unless administered on the advice of a physician;

Note: Controlled Drug *means any drug having the capacity to affect behavior and regulated by law with regard to possession and use.*

g. is caused by you, and is a result of injuries you receive, while intoxicated;

Note: Intoxicated *means Your blood alcohol level at dismemberment equals or exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the loss occurs.*

h. results, whether you are sane or insane, from:
   1. an intentionally self-inflicted Injury; or
   2. suicide or attempted suicide;

i. results from your participation in a riot or in the commission of a felony;

j. results from an act of declared or undeclared war or armed aggression; or

k. which is incurred while you are on active duty or training in the Armed Forces, National Guard or Reserves of any state or country, and for which any governmental body or its agencies are liable.

WEEKLY ACCIDENT & SICKNESS BENEFIT (LOSS OF WAGES)

For Active Members Eligible in the Full Plan of Coverage ONLY

The Weekly Accident and Sickness Benefit provides benefits as a partial replacement for lost wages if a member is totally and temporarily disabled from work due to a non-occupational accident or sickness. This benefit is not available if you would not be available for work in Covered Employment for some reason other than the fact that you are disabled. The benefit is not payable to any claimant who continues to receive hourly wages, including paid vacation, salary, or when collecting unemployment compensation during a disability period.

On the first (1st) day of the month following the onset of total and permanent disability, you may choose to receive an immediate disability pension as opposed to drawing this Weekly Accident and Sickness Benefit from the Welfare Plan.

The weekly benefit begins on the first (1st) day of the disability resulting from an accident and the eighth (8th) day of disability caused by a sickness. However, if you are hospital confined for a sickness, this Weekly Accident and Sickness Benefit will begin on the first (1st) day of hospital confinement due to a sickness if sooner than the eighth (8th) day of the sickness. You must be under the care of a legally qualified physician. If your disability due to sickness lasts for a period of at least 15 consecutive days, benefits will be paid for the first seven (7) days of the disability. **Remember**, the Welfare Plan reserves the right to request physical examinations for any claim under this Weekly Accident and Sickness Benefit. However, all initial claims for benefits that are retroactive for more than five (5) weeks will require an examination by a physician selected by the Welfare Plan. Claims must be submitted within 90 days of the onset of the disability.

You do not need to be confined to your home to collect benefits, but you must be under the care of a medical doctor (M.D.) or doctor of osteopathy (O.D.). Such care must be professional medical care received on a regular basis, in the hospital, a physician's office or in your home.

IMPORTANT: If it is determined that you fraudulently applied for the Weekly Accident and Sickness Benefit or misrepresented your entitlement to the Benefit, or if it is determined that you received Weekly Accident and Sickness Benefit payments as the result of your fraud or misrepresentation, you will lose all eligibility to receive the Weekly Accident and Sickness Benefit during the 24-month period that begins on the date of the determination. Also, you will be responsible for the repayment of all Weekly Accident and Sickness Benefit payments you received as the result of your fraud or misrepresentation, you will not be entitled to the 22-1/2 hour weekly disability credit used to determine your eligibility under the Welfare Plan (and your vesting, eligibility and benefits under the Pension Plan) for those weeks of payment.

This determination will be made by the Trustees (or their designee). You should note that if you receive Weekly Accident and Sickness Benefit payments and unemployment compensation payments (or wages and salary) for the same week or weeks, it will be presumed that you have received the Weekly Accident and Sickness Benefit payments as the result of your fraud or misrepresentation.

A determination under these provisions can be reviewed under the claims and appeal procedures for a denied Weekly Accident and Sickness Benefit.

You are limited to a lifetime maximum of 104 weeks of benefits for recurring disabilities combined, regardless of how often you become temporarily disabled.

WEEKLY ACCIDENT & SICKNESS BENEFIT (LOSS OF WAGES)

Non-Occupational Injury or Sickness

If you are unable to work due to a non-occupational injury or sickness, this Weekly Accident and Sickness Benefit will pay $375 per week for a maximum period of 52 weeks in any 24-month period for all related disabilities. You are limited to a lifetime maximum of 104 weeks of benefits for **recurring** disabilities combined, regardless of how often you become temporarily disabled.

You are not entitled to benefits if you continue to receive hourly wages, salary, paid vacation or unemployment compensation while disabled or during the period you are receiving payments.

If you recover from a disability for which benefits have been paid and again become disabled for the same or related cause within 24 months, both disabilities will be considered one period of disability.

A claim for a new period of disability for a claim not related to the previous disability cannot begin until you have recovered from your current total disability and returned to work for at least full two (2) weeks, with a minimum of 80 hours in covered employment. This is true whether benefits have been paid to you for the full 52-week period or not.

Occupational Injury

If you are unable to work due to an occupational injury, you must apply for Workers' Compensation. The Plan will pay benefits for the first seven (7) days of your disability if you recover before completing the waiting period for payment of the first week of Workers' Compensation benefits.

Exclusions

You are not entitled to Weekly Accident and Sickness Benefit if:

1. you continue to receive hourly wages, salary, Workers' Compensation or unemployment compensation while disabled;
2. you would not be available for work for any reason other than your disability;
3. you are not under the care of a legally qualified physician;
4. your disability started before you became covered for this benefit.

MEMBERSHIP ASSISTANCE PROGRAM (LYTLE BEHAVIORAL HEALTH)

The Plan, through Lytle Behavioral Health, provides the Membership Assistance Program (MAP). This program provides you and your family with confidential help in dealing with personal problems. The MAP staff will help you and your family with the following kinds of problems:

- Marital or family problems;
- Financial or legal difficulties;
- Emotional or stress-related problems;
- Drug or alcohol abuse; or
- Problems related to work.

For confidential help call: 1-888-877-8997.

MEDICAL BENEFITS UNDER DIRECTBLUE (SELECTBLUE FOR MEMBERS OUT-OF-THE-AREA)

For Eligible Members and Their Eligible Dependents

HOW YOUR BENEFITS ARE APPLIED

Before you can fully understand how your benefits are processed and paid, you should be familiar with how your benefits are applied and the meaning of a few important terms you will see throughout this booklet.

Benefit Period

Your benefit period is a 12-month period beginning each January 1. The benefit period may also be referred to as "calendar year."

Cost Sharing Provisions

Cost sharing is a policy that requires you, as the member and your covered dependents to pay part of your covered expenses or services. The terms copayment, deductible and coinsurance describe methods that may require you to pay part of your medical expenses. Cost sharing keeps your health insurance affordable.

MEDICAL BENEFITS UNDER DIRECTBLUE (SELECTBLUE FOR MEMBERS OUT-OF-THE-AREA)

Copayment

The copayment is the up-front dollar amount you must pay for services such as, but not limited to, physician and specialist office visits, emergency room visits and any medication covered under the prescription drug benefit. (See your Benefits Chart for the Copayment amount(s).)

The copayment paid does not vary with the cost of the service and does not apply toward the out-of-pocket limit. You are expected to pay the provider at the time of service.

Deductible

The deductible is the amount you must pay for medically necessary health care each year before the program begins to pay all or part of the remaining expenses. See your Benefits Chart for the Deductible amount.

To help employees with several covered dependents, the deductible you pay for the entire family, regardless of its size, is specified under "Family" deductible. To reach this total, you can count the expenses incurred by two or more family members. However, the deductible contributed towards the total by any one family member cannot be more than the amount of the individual deductible. If one family member meets the individual deductible and again needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family had not been met.

When two or more family members are injured in the same accident, the program begins to pay benefits after only one family member meets the deductible.

Coinsurance

The coinsurance is the specific percentage of the provider's reasonable charge you must pay for certain eligible expenses after your deductible limit, if applicable, has been met. Refer to your Benefits Chart for the percentage amounts paid by the program. The remaining coinsurance amounts are your responsibility.

Out-of-Pocket Limit

The out-of-pocket limit refers to the amount of money you pay out of your pocket for eligible health care expenses before your program begins to pay 100% for additional eligible expenses. See your Benefits Chart for the Out-of-Pocket limit. The out-of-pocket limit does not include copayments, deductibles, mental health/substance abuse expenses, prescription drug expenses or amounts in excess of the provider's reasonable charge. Your individual out-of-pocket limit applies to each covered person per calendar year. The family out-of-pocket limit refers to the amount you have paid out of your own pocket for total covered services your family received during the calendar year.

MEDICAL BENEFITS UNDER DIRECTBLUE (SELECTBLUE FOR MEMBERS OUT-OF-THE-AREA)

Lifetime Maximum

The maximum benefit that the program will provide for any covered individual during his or her lifetime is specified in your Benefits Chart.

The amount paid for covered services for any individual covered under this program will be added to any amount paid for benefits for that same individual under any other group health care expense plan between the Plan and Highmark Blue Cross Blue Shield, for the purpose of calculating the benefit period or lifetime maximum applicable to each individual.

BlueCard Program

The calculation of Participant liability for covered services for claims incurred outside the service area served by the Participant's Home (Highmark) Blue Cross and/or Blue Shield Plan and processed through the BlueCard Program will be, unless applicable state law provides otherwise, the lower of the Provider's billed charge for the covered service or the negotiated price for the covered service that the Host Blue Cross and/or Blue Shield Plan passes to the Home (Highmark) Blue Cross and/or Blue Shield Plan.

The negotiated price paid by the Participant's Home (Highmark) Blue Cross and/or Blue Shield Plan to the Host Blue Cross and/or Blue Shield Plan for covered services provided through the BlueCard Program will reflect:

- **Actual prices that reflect the final negotiated price on a claim;**
- **Estimated prices that factor in settlements or other non-claim transactions with health care providers; or**
- **Average discounts developed to pass a uniform rate of BlueCard Program savings to members.**

The Host Blue Cross and/or Blue Shield Plans may adjust their future estimated prices or average discounts if the estimates or averages used in the past were either too high or too low.

In addition, statutes may require Blue Cross and/or Blue Shield Plans in a small number of states to use a basis for calculating Participant liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim. Thus, when the covered Participants receive covered services in these states, the Participant's liability for covered services will be calculated using these states' statutory methods.

Precertification through Healthcare Management Services

For benefits to be paid at either the in-network or out-of-network level, services and supplies must be considered medically necessary and appropriate.

- ***Inpatient Admission Precertification***

Healthcare Management Services (HMS) is responsible for ensuring that quality care is delivered to members within the proper setting. An HMS Care Manager will review your request for an inpatient admission to ensure it is:

1. Appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury;
2. Provided for your diagnosis or the direct care and treatment of your condition, illness, disease or injury;
3. In accordance with standards of good medical practice;
4. Not primarily for the convenience of you, your physician, hospital or health care provider; and
5. The most appropriate service that can safely be provided.

Where precertification is a requirement in this Healthcare Management Services section and you are to receive Covered Services, it is your responsibility to obtain the required precertification or ensure that your provider obtains the required precertification. For purposes of the precertification requirement, you will be subject to the out-of-network care provisions described below.

1. In-Network Care
   When you use an in-network provider within the local service area for inpatient care, the provider will typically contact HMS for you to receive authorization for your care.
2. Out-of-Network Care
   When you are admitted to an out-of-network facility or require services outside the local area, you are responsible for contacting HMS for authorization for your care.

MEDICAL BENEFITS UNDER DIRECTBLUE (SELECTBLUE FOR MEMBERS OUT-OF-THE-AREA)

Your call to HMS prior to your admission to an out-of-network facility provider will help you know what your financial responsibility may be. You should call 7 to 10 days prior to your planned admission. For emergency or maternity-related admissions, call HMS within 48 hours of the admission or as soon as reasonably possible. You can contact HMS via the toll-free Member Service number on the back of your ID card.

If you do not call to certify your admission, you will be responsible for the entire cost of the precertification penalty.

IMPORTANT: Out-of-network providers and providers out of the area who do not directly contract with Highmark Blue Cross Blue Shield are not obligated to contact HMS or to abide by any determination of medical necessity or appropriateness rendered by HMS. You may, therefore, receive services that are not medically necessary and appropriate for which you will be responsible. Please contact HMS to avoid unnecessary out-of-pocket costs. HMS will notify you if the admission/service does not meet their criteria of medical necessity.

Discharge Planning Through Healthcare Management Services

Discharge planning is a review of the case to identify the member's discharge needs. The process begins prior to admission and extends throughout the member's stay in a facility. Discharge planning ensures continuous, quality care and is coordinated with input from the member's physician. To plan effectively, the HMS care manager assesses the member's:

1. Level of function pre- and post-admission;
2. Ability to perform self-care;
3. Primary caregiver and support system;
4. Living arrangements pre- and post-admission;
5. Special equipment, medication and dietary needs;
6. Obstacles to care;
7. Need for referral to case management or disease management; and
8. Availability of benefits or need for benefit adjustments.

Out-of-network providers and providers out of the area who do not directly contract with Highmark Blue Cross Blue Shield are not obligated to contact HMS or to abide by any determination of medical necessity or appropriateness rendered by HMS.

MEDICAL BENEFITS UNDER DIRECTBLUE (SELECTBLUE FOR MEMBERS OUT-OF-THE-AREA)

Case Management Services Through Highmark Blue Cross Blue Shield

Should you or a covered family member fall victim to a serious injury or chronic illness, Highmark Blue Cross Blue Shield's Case Management Services can provide critical care support to:

1. Coordinate a treatment plan to enable you to reach optimum recovery in a timely manner;
2. Identify alternatives to an acute care setting such as rehabilitative therapies or specialized home care services when appropriate; and
3. Work with you to obtain the maximum level of health care coverage.

Continued Stay Review Through Healthcare Management Services

While you or your covered dependent are in a facility as an inpatient, HMS will be in contact with facility personnel familiar with the case to make certain that continued hospitalization is appropriate. Determination of the need for continued inpatient coverage will be made in consultation with the patient's physician. Either HMS or the facility will notify the patient if the inpatient stay is determined to be no longer medically necessary and appropriate. This process is also referred to as concurrent care review. If you or your covered dependent elect to remain in the facility after such notification, no further benefits will be provided for the remainder of the stay.

Decisions About Precertification and Pre-Service Claims

• *Decisions on Inpatient Admission Precertification and Other Pre-Service Claims*

Requests for precertification of a planned inpatient admission are treated as "pre-service claims." HMS decides pre-service claims and will notify you in writing of its determination, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date HMS receives the claim. This 15-day period of time, however, may be extended one time by HMS for an additional 15 days, provided HMS determines that the additional time is necessary due to matters outside its control and notifies you of the extension prior to the expiration of the initial 15-day pre-service claim determination period and the date by which it expects to decide the claim.

If an extension is necessary because you have failed to submit information necessary for HMS to make a decision on your pre-service claim, the notice of extension sent to you by HMS will specifically describe the information that you must submit and will afford you at least 45 days in which to submit that information. In that case, HMS will decide your claim within a reasonable period of time after the earlier of the date you submit the required information or the date the period to submit the information ends, but not later than 15 days after that date.

• *Decisions on Claims Involving Urgent Care*

If your request for approval of an inpatient admission involves urgent care, HMS will make a decision on your request as soon as possible, taking into account the medical urgency involved, not to exceed 72 hours following receipt of the claim. A request for precertification of an inpatient admission or other pre-service claim involves urgent care if the time it would ordinarily take HMS to make a decision on the pre-service claim could result in seriously jeopardizing the patient's life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of the patient's medical condition, subject the patient to severe pain that cannot be adequately managed without the care or treatment requested.

If you do not submit sufficient information for HMS to make a decision on your urgent care claim, HMS will notify you of the required information as soon as possible, but not later than 24 hours after receipt of your claim, and you will be provided with at least 48 hours to submit that information. In that case, HMS will decide your claim as soon as possible after the earlier of that date you submit the required information or the date the period to submit the information ends, but not later than 48 hours after that date.

- ***Decisions on Claims Involving Continued Stay/Concurrent Care Review***

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

A reconsideration of a benefit with respect to a Concurrent Claim that involves the *termination* or *reduction* of a previously-approved benefit (other than by plan amendment or termination) will be made by Highmark Blue Cross Blue Shield as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved Urgent Care treatment will be acted upon by Highmark Blue Cross Blue Shield 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. If not received at least 24 hours prior to the expiration of the approved treatment, a request to extend approved Urgent Care treatment will be decided as a new Urgent Care claim. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

Notice of Determinations on Inpatient Admission Precertification and Other Pre-Service Claims

Any time your request for inpatient admission precertification or other pre-service claim is approved, you will be notified in writing that the claim has been approved.

Any time your request for precertification is denied, you will receive written notice of that denial which will include:

1. The specific reason or reasons for the denial;
2. A reference to the provision of your program upon which the decision was made;
3. A description of any additional information necessary to complete or perfect your claim and why such information is necessary;
4. A description of the review procedures and time limits applicable to those procedures and your right to initiate legal action under ERISA if the decision on review is adverse;
5. Any internal rule, guideline, protocol or other similar criterion relied upon in deciding your claim or a statement of your right to request a copy of the same, free of charge; and
6. An explanation of the scientific or clinical judgment used in deciding your claim in cases where medical necessity, experimental treatment or a similar exclusion or limit has been applied or a statement of your right to request a copy of the same, free of charge.

For a description of your right to appeal an adverse benefit determination of an inpatient admission precertification or any other pre-service claim, see the Appeal Procedure provisions set forth in the *General Information* section of this booklet.

Any time your request for precertification is denied, you will receive written notice of that denial.

COVERED SERVICES UNDER DIRECTBLUE (SELECTBLUE FOR MEMBERS OUT-OF-THE-AREA)

The program provides benefits for the following services you receive from a provider only when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and co-payment amounts are described in the Benefits Chart. In-network care is covered at a higher level of benefits than out-of-network care.

You may receive a copy of a directory that lists in-network PPO providers, free of charge, if you contact the Plan Office at 412-227-6740 or toll-free at 1-800-927-3199 or contact the Member Services Department toll-free at 1-800-241-5704.

Blues On Call 1-888-258-3428

This toll-free health care information and support service number connects you to a specially trained registered nurse. If you call about an illness or injury, the nurse listens to your symptoms, makes a comprehensive health assessment, and helps determine the level of care needed. Depending upon the evaluation, you may be advised to seek emergency care or call your network provider. In some cases, you may be given home health care instructions and the nurse may call you back to check your progress.

You can also call for general health inquiries and health care assistance on any health care topic.

Physician Visits

- ***Outpatient Medical Services***

Outpatient medical care is care that is not related to surgery, pregnancy or mental illness and includes the following:

1. Medical care visits and consultations to examine, diagnose and treat an injury or illness.
2. Immunizations and therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness.
3. Allergy Extract/Injections.

- ***Emergency Accident and Medical Care***

Treatment of accidental bodily injuries, or initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity to require immediate medical attention.

Preventive Care

- ***Routine Physical Examinations***

Examinations, regardless of their medical necessity and appropriateness, including a complete medical history and necessary diagnostic services needed because of your sex, age and medical background.

- ***Prostate Blood Tests (PSA)***

Covered benefits include coverage for Prostate Blood Tests (PSA) as part of the routine preventive care. The test is eligible when ordered by a PCP as part of the routine physical exam.

- ***Gynecological Visits***

Covered benefits include one routine gynecological examination and one Pap test per calendar year. Benefits are not subject to the program deductibles or maximums.

- ***Mammographic Screening***

1. An annual routine mammographic screening if 40 years of age or older.
2. Mammographic examinations regardless of age when such services are physician recommended.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.

- ***Pediatric Care and Immunizations***

1. Pediatric care including routine physical examinations and diagnostic services regardless of medical necessity and appropriateness.
2. Pediatric immunizations when performed and billed by a hospital, facility, physician or other professional provider. Benefits are provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or maximums.

Hospital Services

The program covers the following services you receive in a hospital or other facility provider. Benefits will be covered only when and so long as they are determined to be medically necessary and appropriate for the proper treatment of the patient's condition.

- ***Bed, Board and General Nursing Service in:***

1. A semi-private room.
2. A private room. Private room allowance is the average semi-private room charge.
3. A bed in a Special Care Unit, which gives intensive care to the critically ill.

- ***Other Services:***

1. Operating, delivery and treatment rooms and equipment.
2. Drugs and medicines provided to you while you are an inpatient in a hospital or other facility provider.
3. Whole blood, administration of blood, blood processing and blood derivatives.
4. Anesthesia, anesthesia supplies and services rendered in a hospital or other facility provider by an employee of the hospital or other facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery.
5. Medical and surgical dressings, supplies, casts and splints.
6. Diagnostic services.
7. Therapy services.

- ***Emergency Accident Care***

Outpatient emergency hospital services and supplies to treat injuries caused by an accident.

Emergency Medical Care

The initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity to require immediate medical attention.

- ***Surgery***

Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the hospital or other facility provider other than the surgeon or assistant at surgery.

- ***Pre-Admission Testing***

Outpatient tests and studies required for your scheduled admission as an inpatient.

Surgical/Medical Services

The program covers the following services you receive from a professional provider or other professional provider. If you use an Out-of-Network Professional Provider and an inpatient hospital admission is required, you must contact Healthcare Management Services prior to your admission.

- ***Surgical Services***

1. Surgery performed by a professional provider. Payment includes visits before and after surgery.
2. If more than one surgical procedure is performed through the same incision or body opening during one operation, you are covered only for the primary procedure. No benefits will be payable for any of the other procedures performed at the same time.

3. If more than one surgical procedure is performed during the same operation through more than one route of access, the total benefits payable will be calculated as follows:
   a. The amount payable for the primary procedure, plus
   b. 50% of the amount payable for each of the next three procedures
   c. No more than four procedures are covered per operation.
4. Sterilization and its reversal, regardless of medical necessity.
5. Oral surgical services limited to:
   a. Surgical removal of impacted teeth partially or totally covered by bone;
   b. Extraction of teeth in preparation for radiation therapy;
   c. Facility provider and anesthesia services rendered in connection with non-covered dental procedures when determined by Highmark Blue Cross Blue Shield or its designated agent to be medically necessary and appropriate due to the age and/or medical condition of the member;
   d. Accidental injury to the jaw or structures contiguous to the jaw;
   e. Mandibular staple implant when not done to prepare the mouth for dentures;
   f. Maxillary or mandibular frenectomy;
   g. The correction of a non-dental physiological condition which has resulted in a severe functional impairment;
   h. Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of mouth;
   i. Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

- ***Assistant At Surgery***

Services of a physician who actively assists the operating surgeon in the performance of a covered surgery if a house staff member, intern or resident is not available.

- ***Anesthesia***

Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or the assistant-at-surgery. Benefits will also be provided for the administration of anesthesia ordered by the attending professional provider and rendered by a professional provider for outpatient oral surgical procedures.

- ***Second Surgical Opinion***

A second physician's opinion and related diagnostic services to help confirm the need for elective covered surgery recommended by your first physician.

Keep in mind that:

1. Your second opinion must be from someone other than your first physician who recommended the surgery.
2. Elective surgery means non-emergency surgery.
3. Getting a second opinion is your choice.
4. A third opinion is covered if the first and second opinions conflict.
5. You are covered for surgery even when the physicians' opinions conflict.
6. If the consulting opinion is against elective surgery and the member decides to have the elective surgery, the surgery is a covered service. In such instance, the member will be eligible for a maximum of two such consultations involving the elective surgery, but limited to one consultation per consultant.

- ***Inpatient Medical Services***

The program covers the following services you receive from a professional provider when you are an inpatient for a condition not related to surgery, pregnancy, or mental illness:

1. Medical Care Visits
2. Intensive Medical Care
    a. Constant attendance and treatment when your condition requires it for a prolonged time.
3. Concurrent Care
    a. Care rendered concurrently with surgery during one hospital stay by a professional provider who is not your surgeon, for treatment of a medical condition separate from the condition for which surgery was performed.
    b. Care by two or more professional providers rendered concurrently during one hospital stay when the nature or severity of your condition requires their services.

- ***Consultation***

Consultation rendered to a hospital inpatient by another professional provider when requested by the attending professional provider. Staff consultations required by hospital rules are excluded.

- ***Newborn Care***

Professional provider visits to examine the newborn infant while the mother is an inpatient.

Diagnostic Services

The program covers the following services when ordered by a professional provider:

1. Diagnostic x-ray, consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine.
2. Diagnostic pathology, consisting of laboratory and pathology tests.
3. Diagnostic medical procedures, consisting of electrocardiogram, electroencephalogram, and other electronic diagnostic medical procedures and physiological medical testing approved by Blue Cross Blue Shield.
4. Allergy testing, consisting of percutaneous, intracutaneous, and patch tests.

Therapy Services

The program covers the following services you receive from a professional provider or other professional provider:

1. Radiation therapy
2. Chemotherapy
3. Dialysis treatment
4. Physical therapy
5. Respiration therapy
6. Occupational therapy
7. Speech therapy
8. Infusion therapy
9. Cardiac rehabilitation

Home Infusion Therapy Services

The program covers the following services you receive from a home infusion therapy provider in a home setting:

1. Pharmaceuticals
2. Pharmacy services
3. Intravenous solutions
4. Medical/surgical supplies
5. Nursing services associated with home infusion therapy
6. Specific adjunct non-intravenous therapies are included when administered only in conjunction with home infusion therapy

Mastectomy and Breast Cancer Reconstruction

The program covers a mastectomy performed on an inpatient or outpatient basis, as well as surgery to reestablish symmetry or alleviate functional impairment. This includes, but is not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Also covered is the use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof. Physical complications of all stages of mastectomy are also covered, including lymphedemas. The plan covers one home health care visit, as determined by your physician, within 48 hours after discharge if discharge occurred within 48 hours after your admission for a mastectomy.

Family Planning and Infertility Services

The plan covers correction of a physical or medical problem, diagnostic services, counseling, and sterilization procedures such as tubal ligation or vasectomy.

Maternity Services

Hospital services and surgical/medical services from a provider for:

1. Normal pregnancy
2. Complications of pregnancy
3. Nursery care

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

Maternity Home Health Care Visit

If you are discharged from inpatient care prior to 48 hours following a normal vaginal delivery or 96 hours following a caesarean delivery, you are entitled to one maternity home health care visit within 48 hours of discharge. A licensed network health care provider who offers post partum care may provide you with parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and any necessary maternal and neonatal physical assessments. At your discretion, the visit may occur at your provider's facility. Benefits are not subject to the program copayment, coinsurance or deductible amounts, if applicable.

Spinal Manipulations

Spinal manipulations for the detection and correction, by manual or mechanical means, of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Ambulance Service

1. Local transportation by a vehicle designed, equipped and used only to transport the sick and injured:
   a. from your home, scene of accident or medical emergency to a hospital;
   b. between hospitals;
   c. between hospital and skilled nursing facility.

Trips must be to the closest local facility that can give covered services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area.

2. Local transportation by a vehicle designed, equipped and used only to transport the sick and injured:
   a. from a hospital to your home, or
   b. from a skilled nursing facility to your home.

Private Duty Nursing Services

Services of a practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in your home or is not a member of your immediate family.

1. For a member who is an inpatient in a hospital or other facility provider only when Highmark Blue Cross Blue Shield determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.
2. For a member at home only when Highmark Blue Cross Blue Shield determines that the nursing services require the skills of an RN or an LPN.

Skilled Nursing Facility Services

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

No benefits are payable:

1. After the member has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care;
2. When confinement is intended solely to assist the member with the activities of daily living or to provide an institutional environment for the convenience of a member;
3. For treatment of alcohol abuse, drug abuse or mental illness.

Home Health Care/Hospice Care Services

The program covers the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care.

1. Skilled nursing services of an RN or LPN, excluding private duty nursing services.
2. Physical therapy, occupational therapy and speech therapy.
3. Medical and surgical supplies.
4. Oxygen and its administration.
5. Medical social service consultations.
6. Health aide services when you are also receiving covered nursing or therapy services.
7. Respite care
8. Family counseling related to the member's terminal condition.

No home health care benefits will be provided for:

1. dietician services
2. homemaker services
3. maintenance therapy
4. dialysis treatment
5. custodial care
6. food or home delivered meals

Dental Services Related to Accidental Injury

Dental services rendered by a physician or dentist which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face that occurs on or after your effective date. Injury caused by chewing or biting will not be considered accidental injury.

Durable Medical Equipment

The rental or, at the option of Blue Cross Blue Shield, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use prescribed by a professional provider. Rental costs must not be more than purchase price.

Prosthetic Appliances

Purchase, fitting, necessary adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. **Replace all or part of a missing body organ and its adjoining tissues;**
2. **Replace all or part of the function of a permanently inoperative or malfunctioning body organ.**

Dental appliances and the replacement of cataract lenses are not covered.

Orthotic Devices

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Transplant Services

Benefits will be provided for covered services furnished by a hospital which are directly and specifically related to transplantation of organs, bones, tissue or blood stem cells.

If a human organ or tissue transplant is provided from a living donor to a human transplant recipient:

1. When both the recipient and the donor are members, each is entitled to the benefits of this plan;
2. When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this plan subject to the following additional limitations: 1) the donor benefits are limited to only those provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or other Blue Cross or Blue Shield coverage or any government program, and 2) Benefits provided to the donor will be charged against the recipient's coverage under this plan;
3. When only the donor is a member, the donor is entitled to the benefits of this plan, subject to the following additional limitations: 1) The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this plan, and 2) No benefits will be provided to the non-member transplant recipient.
4. If any organ or tissue is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the member recipient's plan limit.

Enteral Formulae

Enteral Formulae is a liquid source of nutrition administered under the direction of a physician which may contain some or all the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube. Coverage is provided for Enteral Formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits for such Enteral Formulae are exempt from any applicable deductible requirements.

Additional coverage for Enteral Formulae is provided when administered on an outpatient basis, when Medically Necessary and Appropriate for your medical condition, when considered to be the sole source of nutrition and:

1. When provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized, instead of regular shelf food or regular infant formulas; or
2. When provided orally, and identified as one of the following types of defined formula:
    a. With hydrolyzed (pre-digested) protein or amino acids; or
    b. With specialized content for special metabolic needs; or
    c. With modular components; or
    d. With standardized nutrients.

These additional benefits are subject to the program deductible, copayments and maximums.

Once it is determined that you meet the above criteria, coverage for Enteral Formulae will continue as long as the Formulae represents at least 50% of your daily caloric requirement.

Additional coverage for Enteral Formulae **excludes the following**:

1. Blenderized food, baby food, or regular shelf food when used with an enteral system;
2. Milk or soy based infant formulae with intact proteins:
3. Any formulae, when used for the convenience of you or your family members;
4. Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance;
5. The following formulae when provided orally; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates;
6. Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Diabetes Treatment

Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

1. **Equipment and Supplies:** Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices.
2. **Orthotic Devices:** Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive orthotic device which restricts or eliminates motion of a weak or diseased body part.
3. **Outpatient Diabetes Education:** * When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an Outpatient Diabetes Education Program:
   - Visits Medically Necessary and Appropriate upon the diagnosis of diabetes; and
   - Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in self-management, or b) identifies as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

***OUTPATIENT DIABETES EDUCATION PROGRAM** means a program of self-management training and education, including medical nutrition therapy, for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient Diabetes Education services will be covered subject to the criteria of Highmark Blue Cross Blue Shield. These criteria are based on the certification programs for Outpatient Diabetes Education developed by the American Diabetes Association (ADA) and the Pennsylvania Department of Health (DOH).

Disease State Management Program

Through the Disease State Management Program, the plan identifies Members at risk for certain health problems and provides specific programs of care. You may receive assistance in self-management of health conditions such as but not limited to diabetes, congestive heart failure or chronic obstructive pulmonary disease. Such services may include:

1. An evaluation of your physical and psychosocial status;
2. Development of an individualized treatment plan by a nurse in conjunction with your physician;
3. Education and training, such as symptom monitoring, medication dosages and compliance, appropriate diet and nutrition, smoking cessation, and exercise; and
4. Ongoing monitoring and treatment modifications.

Mental Health Services

The program covers the following services you receive from a provider to treat mental illness.

1. ***Inpatient Facility Services***
   Covered inpatient hospital services provided by a hospital or other facility provider.
2. ***Inpatient/Outpatient Medical Services***
   Covered inpatient/outpatient medical services provided by a professional provider.
   a. Individual psychotherapy.
   b. Group psychotherapy.
   c. Psychological testing.
   d. Counseling with family members to aid your diagnosis and treatment.
   e. Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider.
3. ***Partial Hospitalization Mental Health Services***
   Partial hospitalization mental health care services provided by a partial hospitalization program that has been approved by Blue Cross Blue Shield. Such programs are subject to periodic review by Blue Cross Blue Shield.
4. ***Outpatient Mental Health Services***
   Covered services (except room and board) provided by a hospital, other facility provider or professional provider when you are an outpatient.

Substance Abuse Services

The program covers the following services you receive in a hospital or other facility provider:

1. **Inpatient Detoxification** - Up to seven days per admission. The lifetime maximum is four admissions.
2. **Inpatient Non-Hospital Rehabilitation** - Up to 30 days per calendar year. The lifetime maximum is 90 days.
3. **Outpatient Rehabilitation** - Up to 60 full session visits or equivalent partial visits per calendar year. The lifetime maximum is 120 visits. A maximum of 30 of these visits may be exchanged on a two-for-one basis to secure up to 15 additional days per calendar year for inpatient non-hospital rehabilitation services beyond the 30-day limit as referred to above. The additional exchange days are subject to the lifetime limits.

ELIGIBLE PROVIDERS

Eligible providers include hospitals, facility other providers, professional providers and professional other providers licensed where required and performing within the scope of such license.

Eligible providers include *(just to name a few)*:

Hospitals

Facility Other Providers:

- Alcohol Abuse Treatment Facility
- Ambulance Service
- Ambulatory Surgical Facility
- Birthing Facility
- Day/Night Psychiatric Facility
- Drug Abuse Treatment Facility
- Freestanding Dialysis Facility
- Freestanding Nuclear Magnetic Resonance Facility/ Magnetic Resonance Imaging Facility
- Home Health Care Agency
- Home Infusion Therapy Provider
- Hospice Facility
- Outpatient Alcohol Abuse Treatment Facility
- Outpatient Drug Abuse Treatment Facility
- Outpatient Physical Rehabilitative Facility
- Outpatient Psychiatric Facility
- Pharmacy Provider
- Rehabilitation Hospital
- Skilled Nursing Facility

ELIGIBLE PROVIDERS

Professional Providers:

Audiologist

Certified Registered Nurse*

Chiropractor

Clinical Laboratory

Dentist

Nurse-Midwife

Optometrist

Physical Therapist

Physician

Podiatrist

Psychologist

Speech-Language Pathologist

Teacher of the Hearing Impaired

Other Professional Providers:

Occupational Therapist

Respiratory Therapist

*** Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.**

The list of providers in the provider network is furnished to you automatically, without charge, in a separate booklet. You may contact the Welfare Plan Office if you need another copy.

WHAT IS NOT COVERED UNDER THE PLAN

Your program will not provide benefits for services, supplies or charges:

1. Which are not medically necessary and appropriate as determined by Blue Cross Blue Shield or the Plan.

   Medically Necessary and Appropriate is defined as:
   Services or supplies provided by a Hospital, Facility Other Provider, Professional Provider or Professional Other Provider that Blue Cross Blue Shield or the Plan determines are: appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and provided for the diagnosis, or the direct care and treatment of your condition, illness, disease or injury; and in accordance with standards of good medical practice; and not primarily for your convenience, or the Provider's; and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered or your condition, and you cannot receive safe or adequate care as an outpatient.

2. Which are not prescribed by or performed by or upon the direction of a professional provider.

3. Rendered by other than hospitals, other facility providers, professional providers, or other professional providers or suppliers who are certified and approved.

4. Which are experimental/investigative in nature. However, Blue Cross Blue Shield and the Plan recognize that situations occur when you elect to pursue experimental/investigative treatment. If you are to receive a service which Blue Cross Blue Shield or the Plan may consider to be experimental/investigative you or the hospital and/or professional provider may contact Blue Cross Blue Shield's Member Services or the Plan Office to determine whether Blue Cross Blue Shield or the Plan considers a service to be experimental/investigative.

   Experimental/Investigative is defined as: the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by Blue Cross Blue Shield or the Plan or its designated agent to be medically effective for the condition being treated.

Blue Cross Blue Shield and the Plan will consider an intervention to be experimental/investigative if; the intervention does not have FDA approval to be marketed for the specific relevant indication(s); or available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or the intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or the intervention does not improve health outcomes; or the intervention is not proven to be applicable outside the research setting. If an intervention as defined above is determined to be experimental/investigative at the time of service, it will not receive retroactive coverage even if it is found to be in accordance with the above criteria at a later date.

5. Rendered prior to your effective date.

6. Incurred after the date of termination of your coverage except as provided herein.

7. For any illness or injury suffered after your effective date as a result of any act of war.

8. For which you would have no legal obligation to pay.

9. Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.

10. To the extent payment has been made under Medicare when Medicare is primary or would have been made if you had applied for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary.

11. For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplement coverage.

12. For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state or local government's Workers' Compensation, occupational disease or similar type legislation. This exclusion applies whether or not you file a claim for the benefits or compensation.

13. To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to pay.

14. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.

15. For prescription drugs. (except as through Express Scripts)

16. Which are submitted by a certified registered nurse and another professional provider or other professional provider for the same services performed on the same date for the same patient.

17. Rendered by a provider who is a member of your immediate family.

18. Performed by a professional provider or other professional provider enrolled in an education or training program when such services are related to the education or training program.

19. For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident which occurs while you are covered by a Blue Cross Blue Shield plan or program or the Plan, provided that you are enrolled, without interruption, from the date of the accident to the date of the surgery; and b) surgery to correct functional impairment which results from a covered disease, injury or congenital birth defect.

20. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

21. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider or other professional provider.

22. For inpatient admissions which are primarily for diagnostic studies.

23. For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.

24. Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided herein. However, certain dental surgeries are covered by the Plan, as provided in the section entitled Other Covered Services.

25. For oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face.

26. For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

27. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

28. For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.

29. For any treatment leading to or in connection with transsexual surgery; except for sickness or injury resulting from such surgery.

30. For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury.

31. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services.

32. For nutritional counseling and services intended to produce weight loss.

33. For dietary or food supplements except as provided herein.

34. For preventive care services, wellness services or programs, except as provided herein or as mandated by law.

35. For well baby care visits, except as provided herein or as mandated by law.

36. For routine or periodic physical examinations, the completion of forms and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate except as provided herein or as mandated by law.

37. For immunizations required for foreign travel.

38. For allergy testing except as provided herein or as mandated by law.

39. For treatment of sexual dysfunction not related to organic disease or injury.

40. For any care primarily related to autistic disease of childhood, learning disabilities or mental retardation, which extends beyond traditional medical management or for services provided for environmental change.

41. For ambulance services, except as provided herein.

42. For care, treatment or services that have been disallowed under the provisions of the managed care program.

43. For any other medical or dental service or treatment, except as provided herein.

Out-of-Area Coverage

Medical Treatment Away From Home:

- If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room, or clinic. If the illness or injury is a true emergency, it will be paid at the in-network benefit level. If the treatment results in an admission, you have certain responsibilities under Healthcare Management Services.
- If the illness or injury is not a true emergency and you receive care from a provider who does not belong to the network, benefits will be provided at the lower, out-of-network level.

Services provided for a student while away at school:

- Care provided by the school's medical center is usually included in the tuition and therefore, not normally filed under the parent's health insurance plan.
- For emergency care to be reimbursed at the higher in-network level, the condition must be a true emergency situation.
- If other medical care is needed and is not provided by the school's medical center, the student is required to use network providers to receive the higher level of benefits.

Benefits After Termination of Coverage

If you are an inpatient on the day your coverage terminates, inpatient benefits will be continued as follows:

- **Until the maximum amount of benefits has been paid; or**
- **Until the inpatient stay ends; or**
- **Until you become covered under another group program; whichever occurs first.**
- **Your benefits will not be continued if your coverage is terminated because you failed to pay any required premium.**

Coordination of Benefits

Most health care programs, including your program, contain a coordination of benefits provision. This provision is used when you, your spouse or your covered dependents are eligible for payment under more than one group or individual health program. The object of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments.

Here is how the coordination of benefits provision in your Blue Cross Blue Shield coverage and your Plan coverage works:

When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional benefit payments can be made under your program.

When the person who received care is covered as an employee (or retired employee) under one contract, and as a dependent under another, then the employee coverage pays first.

When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the program that covered the parent longer will be the primary program. If the dependent child's parents are separated or divorced, the following applies:

1. If the parent with custody of the child has ***not*** remarried, the coverage of the parent with custody pays first.
2. When a divorced parent with custody has remarried, the coverage of the parent with custody pays first but the stepparent's coverage pays before the coverage of the parent who does not have custody.
3. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

The object of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments.

When none of the above circumstances applies, the coverage you have had for the longest time pays first; provided that:

1. If there are two plans that simultaneously provide benefits to the member, the benefits of a program covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a program covering the person as a laid-off or retired employee or as a dependent of such person; and
2. If the other program does not have a provision regarding laid-off or retired employees, and, as a result, the benefits of each program are determined after the other, then the provisions of (1) above shall not apply.

   If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment.

Coordination of benefits prevents duplication and works to the advantage of all members of the group.

If you are an active employee over the age of 65, the Plan has primary responsibility for your claims. If you are entitled for Medicare solely because of an end stage renal disease (ESRD), this Plan has primary responsibility for your claims for the first 30 months and Medicare is secondary. After 30 months, Medicare has primary responsibility and this Plan is secondary. Medicare also has primary responsibility for your claims if you are an eligible employee who is disabled and you have received Social Security Disability Income for 24 consecutive months.

Subrogation and Reimbursement Rights

The Plan has the right, through subrogation and reimbursement, to recover all of the benefits (including medical benefits and Weekly Accident and Sickness benefits) it has paid to you or on your behalf to the extent a third party has caused the condition for which the benefits are paid or is responsible for the payment of the benefits. The Plan may recover the benefits from the responsible third party and/or insurance carrier or from you if you have received a payment directly. Throughout this section, the term "you" refers to you and your spouse, dependent or beneficiary and an insurance carrier includes, without limitation, an insurance carrier providing medical payments, uninsured/underinsured motor vehicle insurance or workers' compensation.

For example, *if you are in an automobile accident, you may receive a payment for your injuries or damages from an automobile insurance company or from a third party that was at fault in the accident. If the Plan paid for your medical expenses incurred as the result of the automobile accident, the Plan has the right to recover those benefits from you.*

The Plan is subrogated to all rights of recovery you have now or in the future against any third party that caused the condition for which Plan benefits are paid or any third party and/or insurance carrier that is responsible for the payment of the benefits. If you do not pursue a lawsuit or take other legal action against the third party and/or insurance carrier, the Plan may do so in your name. If you pursue a lawsuit or other legal action, the Plan may intervene and participate in that action and you give your consent for the Plan to do so.

The Plan has an equitable lien - or claim - on any payment that is due you now or in the future to the extent it has paid benefits to you or on your behalf. A constructive trust applies to any payment you receive from a third party or insurance company. If you receive payment from a third party or insurance company, you are obligated to hold that payment for the benefit of the Plan and immediately reimburse the Plan for the amount of benefits the Plan paid to you or on your behalf, up to the full amount of the payment you receive. You may not transfer or otherwise dispose of the payment. The Plan's claim applies to any payment you receive, whether it is by lawsuit, settlement, compromise and release or other means. This includes, but is not limited to, medical payments, uninsured or underinsured motor vehicle insurance or workers' compensation insurance. The Plan has the right to recover the dollar amount of the benefits it has paid from any payment you receive from a third party and/or insurance company, no matter how the payment is allocated among co-claimants for the payment and no matter how the payment is characterized.

Unless the Plan agrees otherwise, the Plan is not responsible for any costs you may incur in recovering a payment from a third party and/or insurance company, such as attorneys' fees, experts' fees, legal costs or other out-of-pocket expenses, and the Plan's right to recover the benefits it has paid will not be reduced by any such costs. The Plan has the right to recover all of the benefits paid to you or on your behalf, whether or not you have been fully paid or made whole for your treatment, injuries, damages or other expenses related to the condition for which benefits are paid.

The Plan may designate an agent to pursue the Plan's rights to subrogation and reimbursement for benefits it pays to you or on your behalf. You are required to take any action and sign and deliver any documents the Plan needs to recover benefits and to notify the Plan and its agents of any recovery you receive. You must not do anything that would release, discharge or otherwise compromise the Plan's right to recover benefits it paid to you or on your behalf.

Disclosure

Your health benefits are entirely funded by employer contributions held in a Trust Fund. Highmark Blue Cross Blue Shield provides administrative and claims payment services only.

You are hereby notified:

Your health care benefit program is provided through Highmark Blue Cross Blue Shield. Highmark Blue Cross Blue Shield is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Highmark Blue Cross Blue Shield to use the familiar Blue Cross and Blue Shield words and symbols.

For Members Eligible in the Full Plan of Coverage ONLY

Covered Drugs

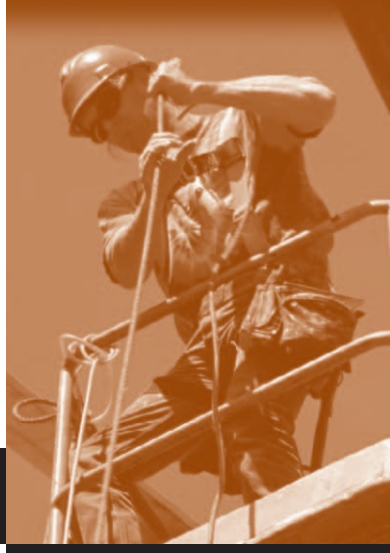
Covered drugs are those which, under Federal Law are required to bear the legend: Caution: Federal Law prohibits dispensing without prescription or which are specifically designated by the Iron Workers Welfare Plan of Western Pennsylvania. Covered drugs include injectable insulin (which do not always require a prescription) and diabetic supplies such as needles, syringes, lancets and monitoring machines.

Express Scripts Network

You must purchase drugs from an Express Scripts network pharmacy or mail order program to be eligible for benefits under this Plan. *No benefits are available if drugs are purchased from a pharmacy that is not in the Express Scripts Network.*

Express Scripts has an arrangement with the Iron Workers Welfare Plan of Western Pennsylvania to provide prescription drugs to active members and their eligible dependents at an agreed upon price. Call the Plan Office or Express Scripts for a list of network pharmacies or instructions for obtaining prescriptions through the mail order program.

Prescription Drug benefits are not subject to a deductible, coinsurance or maximum. There is no co-payment for generic drugs. You must pay a $10 co-payment for a brand name prescription or refill. You may receive up to a 90-day supply for this co-payment for a maintenance drug. A new prescription will only be filled for up to a 30-day supply.



SUPPLEMENTAL HOME HEALTH CARE BENEFITS PROVIDED UNDER THE WELFARE PLAN

For Members Eligible in the Full Plan of Coverage ONLY

If you or your eligible dependent can be treated for an illness or injury under a Home Health Care Plan which is designed by your doctor as an alternative to hospital confinement, and you have exhausted your Highmark Blue Cross Blue Shield benefit, or your claim is denied by Highmark Blue Cross Blue Shield, the Plan will pay the reasonable and customary charges for necessary medical services and supplies provided under the Home Health Care Plan up to the following limits:

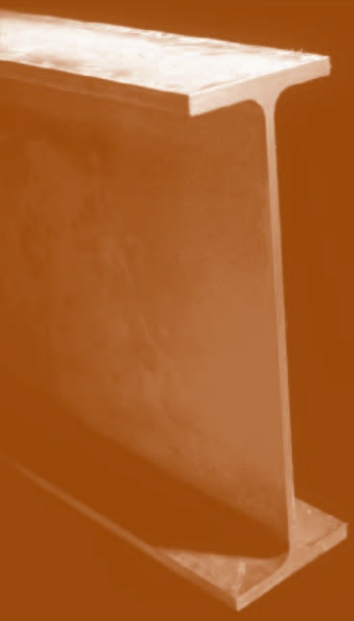
- **$60 per visit/per day (limited to one visit per day);**
- **$6,000 calendar year maximum; and**
- **$30,000 lifetime maximum (while covered by this Plan).**

A Home Health Care Plan is a program for continued care and treatment in a private residence (not necessarily your home) for an injury or illness that would otherwise require hospital confinement as an inpatient.

In order to be covered under this benefit, the Home Health Care Plan must be established and approved in writing by the eligible person's physician, and the physician must certify that proper treatment of the injury or illness would require confinement as a hospital inpatient in the absence of the services and supplies provided as part of the home health care plan.

The following services are covered under the benefit:

1. **Following hospitalization, up to 100 visits of the cost of a licensed practical nurse or another approved party;**
2. **Physical therapy, occupational therapy, and speech therapy provided by the home health care agency; and**
3. **Medical supplies, drugs and medications, prescribed by a physician and laboratory services by or on behalf of a hospital, to the extent such items would have been covered under the Plan if the individual were an inpatient.**



SUPPLEMENTAL HOME HEALTH CARE BENEFITS PROVIDED UNDER THE WELFARE PLAN

No payment will be made for:

1. Services provided by an immediate relative or a person who ordinarily resides in the household;
2. Custodial care;
3. Charges made by the owner of the residence;
4. Transportation service;
5. Charges for housekeeping services or maid services, unless they are necessary in conjunction with services to provide medical treatment to the eligible person;
6. Charges incurred for services that exceed the per visit, calendar year or lifetime maximums;
7. Services or supplies furnished due to sickness resulting from occupational disease, or for occupational injuries;
8. Services or supplies not included in the Home Health Care Plan; or
9. Any period during which the individual is not under the continuing care of a physician.

OTHER COVERED SERVICES PROVIDED UNDER THE WELFARE PLAN

For Members Eligible in the Full Plan of Coverage ONLY

The following services are covered under the Plan, although they are not covered under the DirectBlue Program (SelectBlue for members out-of-the-area):

1. Dental surgeries including:
   a. Alveolectomy;
   b. Osseous surgery; and
   c. Gingevectomy / curretage
2. Hair prosthesis for hair loss caused by chemotherapy or radiation, up to a lifetime maximum of $500 per person.
3. Corrective work boots, up to an annual maximum of $400 per person.

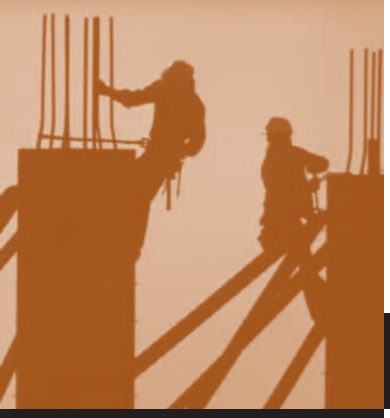
SUPPLEMENTAL MEDICAL BENEFIT

THIS BENEFIT IS BASED UPON THE HOURLY RATE SPECIFIED IN THE COLLECTIVE BARGAINING AGREEMENT FOR LOCAL NO. 772. THE LOCAL UNION NO. 3 AGREEMENT CURRENTLY DOES NOT PROVIDE FOR A CONTRIBUTION TO THE SUPPLEMENTAL MEDICAL BENEFIT.

The Supplemental Medical Benefit: or **Cash Bank**, based on a member's actual hours of contributions, is an additional benefit provided by the Iron Workers Welfare Plan of Western Pennsylvania to reimburse out-of-pocket medical expenses and premiums not reimbursed under your medical benefits. This benefit is designed to assist active members in paying health care expenses for themselves and their dependents. For purposes of this Supplemental Medical Benefit only, **Eligible Dependents** include any person that you are legally allowed to declare as your dependent on your federal income tax return.

The Cash Bank can be used to pay for certain eligible health care expenses not reimbursed by your medical plan or any other benefit or insurance plan. Among the eligible items are:

1. Medical and dental expenses over those covered by any medical plan covering you or your dependents;
2. Deductibles;
3. Co-payments;
4. COBRA Continuation Coverage premium;
5. Other health insurance premiums; and
6. Self-payment for extension of eligibility if a lack of work causes ineligibility.



SUPPLEMENTAL MEDICAL BENEFIT

Coverage under the Supplemental Medical Benefit will end when an active employee permanently leaves the trade and is not available for future work. If you have no hours credited for 36 months, it will be presumed that you have permanently left the trade and are no longer available for future work unless you become employed by a political subdivision such as a municipality, water authority, board of education, or other public entity, within the geographic jurisdiction of the Union, in employment of the type covered under a collective bargaining agreement with a contributing employer.

Expenses paid or incurred after you leave the trade will not be reimbursed. Retirees who have funds in their cash bank are:

1. **Exempt from the termination rule; and**
2. **Will have no further benefits when the benefit has been exhausted.**

The surviving spouse or dependent children of a deceased member can be provided with any remaining benefits under the Supplemental Medical Benefit.

Call the Plan Office if you have any questions concerning this benefit

VOLUNTARY DENTAL PROGRAM

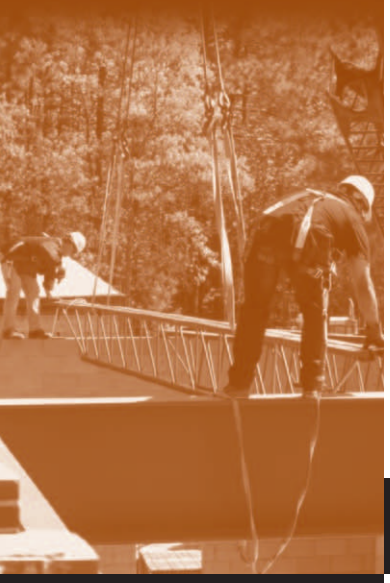
United Concordia

The Welfare Plan offers a voluntary dental expense program through United Concordia, a subsidiary of Highmark Blue Cross Blue Shield. Open enrollment to this program is available to all active participant members and their eligible dependents as well as retirees each January 1st. New members are offered enrollment at the time they become eligible for medical coverage.

This program is a Dental Maintenance Organization program similar to an HMO. The Board of Trustees will act as the intermediary, collecting an annual self-payment and making premium payments to United Concordia.

THIS PROGRAM IS PURELY VOLUNTARY. United Concordia establishes participation rules. Detailed information is available through the Plan Office regarding this program, the dentists who participate, and the benefits that are available. As this is a personally purchased insured program, the Board of Trustees has not negotiated a contract nor is the Board of Trustees responsible for claims payments, limitations and exclusions from dental care or a participant's right to appeal.

United Concordia establishes renewal rates. Any individual who is participating will have the right at that time to continue at the new premium rate.



RETIREE DEATH BENEFITS

If you are a Retired Member, you will be eligible for the Death Benefit if:

- Your employment has been primarily in the jurisdiction of a local union which has specifically negotiated the contribution necessary to support this coverage (Local Union #3 or Local Union #772), and;
- You retired in accordance with the Rules and Regulations of the Iron Workers Pension Plan of Western Pennsylvania, based on employment primarily in the jurisdiction of the local union where employers are contributing a sum necessary to support this coverage; and
- You are eligible to retire from the Iron Workers Pension Plan of Western Pennsylvania without the benefit of the provisions of the International Pro-Rata Agreement. You must have earned at least ten (10) pension credits under the Pension Plan if you retire at age 65 or older, or at least 15 pension credits, if you retire before age 65. If you are disabled, you must have at least ten (10) pension credits. If you retire with less than 15 pension credits, you must have earned at least ten (10) full pension credits based on actual contributions.

As previously noted, the Board of Trustees reserves the right to amend all benefits under the Plan at any time, including decreasing or eliminating this Death Benefit.

Benefit Amount

Upon submission of due proof of death of an eligible Retired Member covered as a result of employment in the jurisdiction of Local Union No. 772, the Trustees will pay a $9,000 Death Benefit to the eligible beneficiary(ies). A $6,000 Death Benefit will be paid to eligible beneficiary(ies) of a Retired Member covered as a result of employment in the jurisdiction of Local Union No. 3.

Beneficiary

A Retired Member may name whoever they want as their beneficiary(ies). If no beneficiary is named, or if such beneficiary has predeceased the Retired Member or is not entitled, by law or otherwise, for any other reason, the Trustees will pay the Death Benefit, equally to the members of the first category that applies, who survive the Retired Member:

- spouse
- children
- parents
- brothers and sisters

If none of the above persons survives the Retired Member, the Board of Trustees will set aside an amount not to exceed the amount of the Death Benefit for payment of funeral, burial and gravesite expenses (collectively called Funeral Services). The Trustees will pay such amount to any one or more of the following persons:

- **the Retired Member's personal representative;**
- **the Provider(s) of the Funeral Services (i.e., funeral director, cemetery company or association or gravemarker company); or**
- **any other such person(s) who will have paid the Funeral Services.**

Payment under such circumstances will be made upon presentation of the original receipt bill or bills to the Trustees. The Trustees will not pay the difference between the Death Benefit and the amount paid for Funeral to the Retired Members estate or to any other person.

If the Trustees, in good faith, pay the Death Benefit or the Funeral Services as described above, the Trustees will be released from any liability whatsoever to any person whose interest is or may be affected by such payment. Any person to whom payment is made will be answerable to anyone prejudiced by an improper distribution.

RETIREE HEALTH INSURANCE REIMBURSEMENT BENEFIT

The Welfare Plan provides a partial reimbursement to eligible Retired Members who purchase their own medical coverage. Reimbursement is currently your cost for coverage up to a maximum of $520 per month toward family coverage and $260 per month for individual coverage for Local Union No. 3 members, and $440 per month toward family coverage and $220 per month for individual coverage for Local Union No. 772 members.

If you are purchasing insurance through an outside carrier, you must submit a paid receipt for your health coverage before receiving the reimbursement. This reimbursement is then made on a quarterly basis.

If you are purchasing insurance under the COBRA Continuation Coverage or under the special early retiree group coverage, this reimbursement will be applied towards your premium(s) due each month.

For Early Retirees

In order to be entitled to this monthly reimbursement, you must have at least 5,000 hours of employer contributions made on your behalf in a period of five (5) consecutive years (60 consecutive months) within the seven (7) year period (84 months) immediately prior to your pension effective date. Further, you must be entitled to an early retirement pension from the Iron Workers Pension Plan of Western Pennsylvania on the basis of employment in the jurisdiction of the Unions participating in this Welfare Plan.

If you do not meet the above requirements because you do not have sufficient employment (5,000 hours) with the 60 consecutive month period, you may still be eligible for reimbursement if the Welfare Plan determines you had been eligible for at least 24 consecutive months immediately prior to retirement and had been eligible for at least 60 months as an active employee during the past 84 months.

If you leave Covered Employment when you are eligible for Early Retirement and meet the requirements above, but choose to wait until a later date to begin your pension, you will be entitled to the reimbursement once you start receiving your pension.

This reimbursement is only available until you become entitled to Medicare (age 65). This reimbursement will continue to your spouse for a minimum of five years, unless she becomes age 65 prior to those five years. If the spouse is younger than the member, she will be provided with this reimbursement for as long as the member, but no less than five years.

For Retirees Eligible for the 48-Month Extended Disability Benefit

If you become eligible for the 48-Month Extended Disability Benefit from the Iron Workers Pension Plan of Western Pennsylvania and are under the age of 55, you will be entitled to the retiree health insurance reimbursement for a maximum of 24 months if you meet a requirement above. The reimbursement will end before 24 months if you become entitled to Medicare.

As previously noted, there is no guarantee that any benefits under the plan will be maintained in the future. The Board of Trustees reserves the right to amend or eliminate any benefit, including this benefit, at any time.

CONTINUATION *of* HEALTH COVERAGE *for* CERTAIN DISABLED MEMBERS (AND THEIR DEPENDENTS) WHO HAVE BEEN AWARDED A DISABILITY PENSION FROM THE IRON WORKERS PENSION PLAN *of* WESTERN PENNSYLVANIA

If you are awarded a disability pension from the Iron Workers Pension Plan of Western Pennsylvania, you may be entitled to continuation of health coverage. The eligibility rules and description of this coverage are defined in a separate booklet. Please contact the Plan Office for further information.

COBRA CONTINUATION COVERAGE

Federal Law requires the Plan to offer covered employees and their families the opportunity for a temporary extension of health coverage (called COBRA Continuation Coverage) at group rates in certain instances where coverage under the Plan would otherwise end. You do not have to show that you are in good health to choose COBRA Continuation Coverage.

This section summarizes your rights and obligations under the continuation coverage provisions of the law. You, your spouse and your dependent child(ren) should take the time to read this information carefully.

Qualifying Events

If you are a covered member under the Iron Workers Welfare Plan, you have the right to choose COBRA Continuation Coverage if you lose health coverage for a **qualifying event**.

A qualifying event for a member occurs when group health coverage under the Plan is lost because of:

1. Reduction of hours;
2. The termination of employment; or
3. Retirement

COBRA CONTINUATION COVERAGE

If you do not elect to continue this group health coverage for your spouse or eligible dependents, they each have an individual right to elect to continue coverage under the Plan on their own.

IT IS IMPORTANT THAT YOU, YOUR SPOUSE AND ALL OF YOUR ELIGIBLE DEPENDENTS ARE AWARE OF THESE RULES.

Your spouse has the right to choose COBRA Continuation Coverage if he/she loses group health coverage under the Plan for any of the following reasons:

1. Your death;
2. Your reduction of hours;
3. Your termination of your employment, including your retirement or military service;
4. Divorce or legal separation from you; or
5. Your termination of coverage because of entitlement to Medicare.

PLEASE NOTE: Entitlement to Medicare does not necessarily mean that your coverage under this Welfare Plan is lost. You are only eligible for COBRA Continuation coverage if you lose your coverage under this Welfare Plan.

Your dependent child has the right to elect COBRA Continuation Coverage if he/she loses group health coverage under the Plan for any of the following reasons:

1. Your death;
2. Your reduction of hours;
3. Your termination of your employment including your retirement;
4. Your divorce or legal separation;
5. Your coverage under the Welfare Plan terminates; or
6. He/she ceases to be a dependent child as defined in the Plan.

COBRA CONTINUATION COVERAGE

Notice Requirements

Under the law, you or a member of your family has the responsibility of informing the Welfare Plan Office, in writing, of a divorce (including a copy of your divorce decree), legal separation, or a child losing dependent status under the Plan within 60 days of the later of:

1. The date of the event; or
2. The date coverage would be lost because of the event.

If written notice of the qualifying event is not given within the 60-day period, your spouse and/or dependent (as applicable) will not be eligible to elect COBRA Continuation Coverage.

Although the Welfare Plan will determine if one of the following qualifying events has occurred:

1. Your death;
2. Your reduction of hours;
3. Your termination of your employment; or
4. Loss of coverage because of Medicare entitlement,

you or a member of your family should also notify the Welfare Plan Office (in writing) of any of these qualifying events. This will assure timely notification of eligibility for COBRA Continuation Coverage and for processing COBRA Continuation Coverage election forms.

When the Welfare Plan Office is notified in writing that a qualifying event has occurred, you (or spouse or dependent) will be notified of the right to elect COBRA Continuation Coverage. Under the law, you must elect COBRA Continuation Coverage by filing the COBRA election form with the Plan Office within 60 days from the later of:

1. The date your Plan coverage terminated (or will terminate); or
2. The date of the notice advising you of your rights to COBRA Continuation Coverage.

COBRA Continuation Coverage

If you or your spouse or your dependent do not file the COBRA election form with the Welfare Plan Office within this 60-day period, you, your spouse and dependents will not be eligible to elect COBRA Continuation Coverage for that qualifying event.

COBRA CONTINUATION COVERAGE

If you choose COBRA Continuation Coverage, the Plan is required to give you group health coverage which, at the time coverage is being provided, is identical to the coverage provided to covered members and their families under the Plan. This coverage does not include:

1. Life Insurance;
2. Accidental Dismemberment and Loss of Sight Insurance; or
3. Weekly Accident and Sickness Benefits.

SEE THE LIFE INSURANCE SECTION ABOUT CONVERTING TO AN INDIVIDUAL LIFE INSURANCE POLICY.

Premium Cost

You, your spouse and/or your dependents must pay the entire cost of COBRA Continuation Coverage at group rates. At the time your election is required to be made, the Welfare Plan Office will advise you of the cost of single and/or family coverage.

Length of COBRA Continuation Coverage

You may continue COBRA Continuation Coverage for up to eighteen (18) months for you and/or your dependents if your group health coverage terminates because of your:

1. Reduction of hours;
2. Termination of employment; or
3. Retirement.

The 18-month period may be extended to 36 months if a second qualifying event occurs (i.e. divorce, legal separation, death, or Medicare entitlement) during the 18-month period and if you have notified the Welfare Plan Office in writing of the second qualifying event. In addition, the 18-month period may be extended to 29 months for you and your dependents if:

1. You, your spouse, or one of your dependents were disabled at the time of the qualifying event or within the first 60 days after the qualifying event; and
2. You, your spouse or one of your dependents met the Social Security disability requirements; and
3. You have notified the Welfare Plan Office (in writing) of that determination within 60 days of the determination, and before the end of the 18-month period of COBRA Continuation Coverage.

Please note that if Social Security determines that you or your dependent has recovered from the disability before the end of the 29 months, you must notify the Welfare Plan Office within 30 days of such determination.

To enroll your new dependent for COBRA Continuation Coverage, you must notify the Welfare Plan Office within 31 days of acquiring the new dependent.

Adding New Dependents to Your COBRA Continuation Coverage

If you acquire a new dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA Continuation Coverage, you may add that dependent to your coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA Continuation coverage left and you get married, you can enroll your new spouse for five months of COBRA Continuation Coverage. To enroll your new dependent for COBRA Continuation Coverage, you must notify the Welfare Plan Office **within 31 days** of acquiring the new dependent. If you are paying the family rate for coverage, there will be no change in your COBRA premium amount. If you are paying for single coverage, adding your dependent will increase your COBRA premium amount.

If COBRA Continuation Coverage ceases for you before the end of the maximum 18, 29, or 36 month COBRA Continuation Coverage period, COBRA Continuation Coverage will also end for your newly added spouse. However, COBRA Continuation Coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA Continuation Coverage period if the required premiums are paid on time. Check with the Welfare Plan Office for more details on how long COBRA Continuation Coverage can last.

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

You may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage if your spouse or dependent loses coverage under another group health plan. The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the plan when enrollment was previously offered under the plan and declined. The spouse or dependent is only eligible if they were covered under another group health plan or had other health insurance coverage.

You must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a spouse or dependent child will cause an increase in the amount you must pay for COBRA Continuation Coverage if you are paying at a single rate. If you are paying the family rate, there will be no change in your COBRA premium amount.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage may be cut short for any of the following five reasons:

1. The Iron Workers Welfare Plan no longer provides group health coverage;
2. Your payment for COBRA Continuation Coverage is not paid on time;
3. The individual becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition the individual may have;
4. The individual becomes entitled to Medicare; or
5. The individual was entitled to extended coverage for up to 29 months due to Social Security disability, and there has been a final determination that the individual is no longer disabled.

Conversion Privilege

If you do not elect to pay for COBRA Continuation Coverage or if the maximum continuation period (18, 29 or 36 months) has been reached, you may apply for conversion of your coverage to an individual policy directly through the medical insurance carrier. You will not be required to provide evidence of good health. You may not convert if:

1. You are eligible for another group health care benefits program through your place of employment; or
2. The medical program that had been offered by the Plan is replaced by another health care benefits program immediately upon termination of the medical program.

Please note that conversion coverage is not the same as COBRA Continuation Coverage. Conversion coverage usually costs more because coverage is provided at individual rates. The coverage provided is usually at a reduced level.

You should note that if you enroll in an individual conversion policy, you lose your rights under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations after your conversion policy coverage ends.

If you have any questions concerning your rights, election or obligations relating to COBRA Continuation Coverage or the conversion privilege, please contact the Plan Office.

Claims Procedures and Appeal Procedures for Health Care Benefits

FOR THIS TYPE OF CLAIM	YOU SHOULD
Precertification of your benefits	Call Healthcare Management Services at the number listed on you Identification Card and follow the procedures discussed on page 22 of this booklet.
For benefits provided by **Highmark Blue Cross Blue Shield - DirectBlue (SelectBlue for members out-of-the-area)**	Generally, your provider will file a claim for you. If your provider does not file a claim form for you, call Highmark Blue Cross Blue Shield Member Services at 1-800-241-5704 for information about filing a claim form.
For **Supplemental Home Health Care** benefits, provided under Other Covered Services	Call the Welfare Plan Office at 412-227-6740 or toll free at 1-800-927-3199 to obtain a claim form and for information about these benefits.
For **Prescription Drug** benefits	Present your Express Scripts I.D. card to a participating pharmacy.
For **Weekly Accident** and **Sickness** Claims	Call the Welfare Plan Office at 412-227-6740 or toll free at 1-800-927-3199 to obtain a claim form and for information about these benefits.
For **Life Insurance** benefits or **Dismemberment** benefits	Call the Welfare Plan Office at 412-227-6740 or toll free at 1-800-927-3199 to obtain a United of Omaha Life Insurance Company claim form and for information about these benefits.

Member Inquiries

You should contact the Highmark Blue Cross Blue Shield Member Services Department at 1-800-241-5704 for all member inquiries about benefits provided through Highmark Blue Cross Blue Shield, including questions concerning your eligibility for coverage and benefits available to you through your Highmark Blue Cross Blue Shield program. The Highmark Blue Cross Blue Shield Member Services Department telephone number is also shown on your Identification Card.

You should contact the Welfare Plan Office at 412-227-6740 or toll free at 1-800-927-3199 for all member inquiries about benefits that are provided directly by the Fund and not through Highmark Blue Cross Blue Shield, including questions concerning your eligibility for coverage and benefits available to you through the Plan.

Filing Benefit Claims

This section describes the procedures for filing claims for benefits from the Plan that are provided through Highmark Blue Cross Blue Shield and directly by the Plan. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

If You Need to File a Claim Form

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures.

If you use the services of a Highmark Blue Cross Blue Shield network provider, the provider will generally file your claims for you. If your provider does not file a claim form for you for benefits offered under this Plan, you must submit a completed claim form. 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.

You may obtain a benefit claim form from the Welfare Plan Office by calling 412-227-6740 or toll free at 1-800-927-3199 or the Highmark Blue Cross Blue Shield Member Services Department at 1-800-241-5704. You may contact the Welfare Plan Office about how to file a claim for life insurance or accidental death and dismemberment benefits from United of Omaha Life Insurance Company.

The following information must be completed in order for your request for healthcare benefits to be a claim, and for Highmark Blue Cross Blue Shield or the Welfare Plan Office to be able to decide your claim.

1. Participant name;
2. Patient name;
3. Patient Date of Birth;
4. Social Security Number of participant or retiree;
5. Date of Service;
6. 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);
7. ICD-9 (the diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
8. Billed charge;

9. Number of Units (for anesthesia and certain other claims);
10. Federal taxpayer identification number (TIN) of the provider;
11. Billing name and address; and
12. If treatment is due to accident, accident details.

When you present a prescription to an Express Scripts participating pharmacy or through the mail order program to be filled under the terms of this Plan, your prescription request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures. See the section entitled Claim and Appeal Procedures for Healthcare Benefits Not Covered Under DirectBlue (SelectBlue for Members Out-of-the-Area).

Inpatient Admission Precertification and Other Pre-Service Claims

For a description of how to file inpatient admission precertification and other pre-service claims, see the section entitled ***Decisions About Precertification and Pre-Service Claims*** beginning on page 25 of this booklet.

Reimbursement and Other Post-Service Claims for Benefits Provided Through Highmark Blue Cross Blue Shield

In most instances, the hospitals and physicians that have provided services to you will submit their own reimbursement claim directly to Highmark Blue Cross Blue Shield or to the local Blue Cross or Blue Shield Plan serving your network area. When a provider does not submit a reimbursement claim to Highmark Blue Cross Blue Shield or to the local Blue Cross or Blue Shield Plan serving your network area, you may file a claim form. There are no filing fees or costs associated with filing a claim. To file a claim, you must submit itemized bills for the services you received along with a completed claim form. Claim forms can be obtained from the Welfare Plan Office or directly from Highmark Blue Cross Blue Shield. Please follow the instructions on the claim form so that your claim will not be delayed.

When a hospital or physician submits its own reimbursement claim, the amount that will be paid to that provider will be determined in accordance with the provider's agreement with Highmark Blue Cross Blue Shield or the local Blue Cross or Blue Shield Plan serving your network area. Highmark Blue Cross Blue Shield will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in that notice. If you believe that the copayment, coinsurance or deductible amount identified in that notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with Highmark Blue Cross Blue Shield. For instructions on how to file such claims, you should contact the Member Services Department using the telephone number shown on your Identification Card.

To be eligible for coverage, you must submit all reimbursement and other post-service claims within one year from the date of service.

Determinations on Highmark Blue Cross Blue Shield (DirectBlue and SelectBlue) Benefit Claims

Notice of Determinations on Inpatient Admission Precertification and Other Pre-Service Claims for Benefits Provided Through Highmark Blue Cross Blue Shield

For a description of the timeframes in which inpatient admission precertification and other pre-service claims will be determined by Highmark Blue Cross Blue Shield, see the section entitled *Decisions About Precertification and Pre-Service Claims* beginning on page 25 of this booklet.

Notice of Adverse Benefit Determinations on Reimbursement and Other Post-Service Claims

Highmark Blue Cross Blue Shield will notify you in writing of its determination on your reimbursement or other post-service claim within a reasonable period of time following receipt of your claim. That period of time will not exceed 30 days from the date your claim was received. This 30-day period of time, however, may be extended one time by Highmark Blue Cross Blue Shield for an additional 15 days, provided Highmark Blue Cross Blue Shield determines that the additional time is necessary due to matters outside its control and notifies you of the extension prior to the expiration of the initial 30-day post-service claim determination period and the date by which it expects to decide the claim. If an extension of time is necessary because you have failed to submit information necessary for Highmark Blue Cross Blue Shield to make a decision on your post-service claim, the notice of extension sent to you by Highmark Blue Cross Blue Shield will specifically describe the information that you must submit and will afford you at least 45 days in which to submit that information. In that case, Highmark Blue Cross Blue Shield will decide your claim within a reasonable period of time after the earlier of the date you submit the required information or the date the period to submit the information ends, but not later than 15 days after that date.

If your request for reimbursement or other post-service claim is denied, you will receive written notification of that denial which will include:

1. The specific reason or reasons for the denial;
2. A reference to the provision of your program upon which the decision was made;
3. A description of any additional information necessary to complete or perfect your claim and why such information is necessary;
4. A description of the review procedures and time limits applicable to those procedures and your right to initiate legal action under ERISA if the decision on review is adverse;
5. Any internal rule, guideline, protocol or other similar criterion relied upon in deciding your claim or a statement of your right to request a copy of the same, free of charge; and
6. An explanation of the scientific or clinical judgment used in deciding your claim in cases where medical necessity, experimental treatment or a similar exclusion or limit has been applied or a statement of your right to request a copy of the same, free of charge.

Appeal Procedure for Benefits Provided by Highmark Blue Cross Blue Shield

You have the right to appeal any determination made by Highmark Blue Cross Blue Shield, or its designated agent(s) with which you disagree. Your appeal should be directed to the Member Services Department and must be made in writing (or communicated orally under special circumstances) within the 180-day period following receipt of the notice of an adverse benefit determination, which is the subject of the appeal.

Your appeal will be reviewed by the Appeal Review Department and will not involve any individual that participated in any prior decision concerning the claim that is the subject of your appeal. If a decision on your appeal is based in whole or in part on medical judgment, the Appeal Review Department will consult with a licensed physician or, where appropriate, an approved licensed psychologist in the same or similar specialty that typically manages or consults on the health care service involved prior to making a decision on your appeal. The health care professional providing the consultation will not have participated in or be the subordinate of any individual that participated in any prior decision to deny the claim that is the subject of your appeal.

You may, upon request, review all documents, records and other information that may be relevant to your appeal. Upon request, copies of all such materials will be made available to you free of charge. In addition, the identity of any physician or medical expert whose advice was obtained in connection with the initial determination to deny your claim, whether or not that advice was relied upon, will be made available to you upon request and free of charge. You also have the right to submit any written data, comments, documents, records and other information that you wish to have the Appeal Review Department consider prior to rendering a decision on your appeal (whether or not previously submitted).

NOTE: In cases where an appeal relates to a claim involving urgent care, Highmark Blue Cross Blue Shield has established an expedited appeal process. This process makes it possible for both you and Highmark Blue Cross Blue Shield to transmit necessary information, including the decision that has been made on your appeal, by telephone, facsimile or other similarly expeditious methods of transmission.

Your appeal will be promptly investigated and decided. The Appeal Review Department will consider all of the comments, documents, records, reports and other information that have been made available and will not afford deference to any prior decision that has been made to deny your claim. You will be notified of the decision that has been made on your appeal as follows:

1. If your appeal relates to an adverse benefit determination on an inpatient admission precertification or other pre-service claim not involving urgent care, written notification of the decision will be provided within a reasonable period of time appropriate to the medical circumstances, not to exceed 30 days following receipt of your appeal;
2. If your appeal relates to an adverse benefit determination on an inpatient admission precertification or other pre-service claim involving urgent care, notification of the decision will be provided as soon as possible taking into account the medical urgency involved, not to exceed 72 hours following receipt of your appeal; and
3. If your appeal relates to an adverse benefit determination on a reimbursement or other post-service claim, written notification of the decision will be provided within a reasonable period of time not to exceed 60 days following receipt of your appeal.

The notification will include, among other items, the reasons for the decision and your right to pursue legal action, if necessary.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. If you do so, you must notify Highmark Blue Cross Blue Shield and the Welfare Plan Office in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number and a statement indicating the extent to which he or she is authorized to pursue the claim and/or file an appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

If a claim for benefits or the appeal of a denied claim involves Urgent Care, a health care professional with knowledge of your medical condition may act as your authorized representative without your written designation.

PLEASE NOTE: While this booklet describes the principal feature of the Highmark Blue Cross Blue Shield DirectBlue (SelectBlue) Plan, it is not to be considered the contract of benefits and provisions. The complete set of terms of coverage are set forth in the Group Agreement issued by Highmark Blue Cross Blue Shield.

Claim and Appeal Procedures for Healthcare Benefits Not Covered Under DirectBlue (SelectBlue for Members Out-of-the-Area)

When you fill your prescription at an Express Scripts network pharmacy or through the mail order program, you may be denied a prescription, for instance if you are not eligible for benefits or if the drug is not covered by the program. To challenge that decision, you should file a written claim with the Welfare Plan Office for Prescription Drug benefits within 90 days from the date of the denial of benefits by a retail pharmacy or through the mail order program. In no event will claims be honored that are filed later than one year after the date of the denial of Prescription Drug benefits.

When you have a claim for Supplemental Home Health Care Benefits or benefits provided by the Plan under Other Covered Services, you should file a written claim with the Welfare Plan Office for those benefits within 90 days from the date you receive the services. In no event will claims be honored that are filed later than one year after the date you receive the covered services.

The Trustees must provide you with a notice of their initial determination about your claim within certain timeframes after they receive your claim. For benefit claims filed on or after January 1, 2003, the Plan will make a decision on the claim and notify you of the decision within 30 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan may extend the 30 day period for an additional 15 days. You will be notified of the reason for the extension and when the decision will be made. This notification will occur before the expiration of the 30-day period. If an extension of time is necessary because you have failed to submit information necessary for the Trustees to make a decision on your benefit claim, the notice of extension sent to you by the Welfare Plan Office will specifically describe the information that you must submit and will give you at least 45 days in which to submit that information. In that case, the Trustees will decide your claim within a reasonable period of time after the earlier of the date you submit the required information or the date the period to submit the information ends, but not later than 15 days after that date.

If your request for benefits is denied, you will receive written notification of that denial which will include:

1. The specific reason or reasons for the denial of benefits or other adverse benefit determination;
2. A specific reference to the pertinent provisions of the Plan upon which the decision is based;
3. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
4. A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;
5. A copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request;
6. A copy of the scientific or clinical judgment or statement that it is available to you at no cost upon request for benefit claims that are denied due to:
    a. Medical necessity;
    b. Experimental treatment; or
    c. Similar exclusion or limit.

Your Right to Request a Review of a Denied Healthcare Benefit Claim

You have the right to a full and fair review if your claim for healthcare benefits not covered by DirectBlue (SelectBlue) is denied by the Plan. You must file your appeal in writing. You must make your request to the Welfare Plan Office within 180 days after you receive notice of denial. Your application for appeal must be in writing and it must include the specific reasons you feel denial was improper. You may submit any document you feel appropriate, as well as submitting your written issues and comments.

Review Process for Healthcare Benefit Claims

The review process works for healthcare benefits not covered by DirectBlue (SlelectBlue) as follows:

You have the right to review documents relevant to your claim and receive copies free of charge. A document, record or other information is relevant if:

1. It was relied upon by the Plan in making the decision;
2. It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
3. It demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or
4. 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 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 on the basis of 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 services or prescription drugs were not Medically Necessary, or were investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

You have the right to review documents relevant to your claim and receive copies free of charge.

Timing of Notice of Decision on Appeal of Healthcare Benefit Claims

Ordinarily, decisions on appeals involving healthcare benefit claims not covered by DirectBlue (SelectBlue) 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 no later than the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Claim and Appeal Procedures for Weekly Accident and Sickness Benefits

You should file your claim for Weekly Accident and Sickness benefits within 90 days from the date of the accident or the date of onset of the sickness. In no event will claims be honored that are filed later than one year after the date of the accident or the date of onset of the sickness.

The Trustees must provide you with a notice of their initial determination about your claim within certain timeframes after they receive your claim. For Weekly Sickness and Accident claims filed on or after January 1, 2002, the Plan will make a decision on the claim and notify you of the decision within 45 days. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan may extend the 45-day period for an additional 30 days. You will be notified of the reason for the extension and when the decision will be made. This notification will occur before the expiration of the 45-day period. The period for making a decision may be delayed an additional 30 days, provided the Plan administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If your claim for Weekly Accident and Sickness Benefit is denied, your denial notice must provide you with the following information:

1. The specific reason or reasons for the denial of benefits or other adverse benefit determination;
2. A specific reference to the pertinent provisions of the Plan upon which the decision is based;
3. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed;
4. A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim;
5. A copy of any internal rule, guideline, protocol or similar criteria that was relied on or a statement that a copy is available to you at no cost upon request;
6. A copy of the scientific or clinical judgment or statement that it is available to you at no cost upon request for group health Plan and weekly sickness and accident claims that are denied due to:
   a. Medical necessity;
   b. Experimental treatment; or
   c. Similar exclusion or limit.

Your Right to Request a Review of a Denied Weekly Accident and Sickness Claim

You have the right to a full and fair review if your claim for benefits is denied by the Plan. You must file your appeal in writing. You must make your request to the Fund Office within 180 days after you receive notice of denial. Your application for appeal must be in writing and it must include the specific reasons you feel the denial was improper. You may submit any document you feel appropriate, as well as submitting your written issues and comments.

Review Process for Weekly Accident and Sickness Claims

The review process works as follows:

You have the right to review documents relevant to your claim and receive copies free of charge. A document, record or other information is relevant if:

1. It was relied upon by the Plan in making the decision;
2. It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
3. It demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or
4. 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 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 on the basis of 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.

Timing of Notice of Decision on Appeal of Weekly Accident and Sickness Claims

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

Claim Review and Appeal Procedures for Benefits Under United of Omaha Life Insurance Company

Claims for life insurance or dismemberment benefits should be filed within 90 days from the date of death or loss. In no event will claims be honored that are filed later than one year after the date of death or loss.

Claim Review Procedures

Once United of Omaha Life Insurance Company receives the information necessary to evaluate the claim, a decision will be made within the time periods set forth below.

In the event an extension is necessary due to matters beyond control of United of Omaha Life Insurance Company, the Company will notify the person submitting the claim of the extension, the circumstances requiring the extension, and the date by which it expects to decide the claim. Extensions are limited as set forth below.

If an extension is necessary due to failure to submit complete information, United of Omaha Life Insurance Company will notify the person submitting the claim of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for United of Omaha Life Insurance Company to continue processing the claim, the missing information must be provided within the time periods set forth below.

United of Omaha Life Insurance Company may contact the person submitting the claim at any time for additional details about the processing of the claim.

Claim Review Decisions

a. **Initial review:** United of Omaha Life insurance Company will notify the person submitting the claim of their decision within 45 days after their receipt of the claim, unless additional information is requested as set forth below;
b. **Extension period:** 30 days; and
c. **Maximum number of extensions:** two

If additional information is needed, United of Omaha Life Insurance Company will notify the person submitting the claim within 30 days of receipt of the claim. Once the request for additional information is received, the person submitting the claim will have 45 days to submit the additional information to them. United of Omaha Life Insurance Company will have a total of 105 days (which includes an additional 30-day extension, if necessary, due to circumstances beyond the control of the Company) to process the claim. If they do not receive the additional information within the specified time period, they will make a determination based on the available information.

Claim Denials

If a claim is denied or partially denied, the person submitting the claim will receive a written or electronic notice of the denial that will include:

a. the specific reason(s) for the denial;
b. reference to the specific Policy provisions on which the denial was based;
c. if applicable, a description of any additional material or information necessary to complete the claim and the reason they need the material or information;
d. a description of the appeal procedures; including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
e. any other information that may be required under state or federal laws and regulations.

Opportunity to Request an Appeal

The person submitting the claim may appeal United of Omaha's decision in accordance with this Claim Review and Appeal Procedures provision. As part of the appeal, they will perform a full and fair review of their decision.

The request for an appeal can be submitted in writing, electronically or orally to United of Omaha Life Insurance Company and should include any additional information that the person submitting the claim believes should be considered by them.

The request for an appeal should include:

a. the name of the person for whom the claim has been submitted;
b. the name of the person filing the claim;
c. the policy number (GLUG-63T2); and
d. the nature of the appeal.

United of Omaha Life Insurance Company will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification of the claim review decision will include instructions on how and where to submit an appeal.

The person submitting the claim will:

a. have 180 days from receipt of notification to submit a request for an appeal;
b be provided the opportunity to submit written comments, documents, records and other information relating to the claim; and
c. be provided upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim.

In reviewing the appeal, the Company will consider all comments, documents, records and other information submitted by the person submitting the claim relating to the claim, without regard to whether such information was submitted or considered in the claim decision.

A request for an appeal authorizes United of Omaha Life Insurance Company, or anyone designated by them, to review records relevant to the claim.

Response to an Appeal

Once United of Omaha receives a request for an appeal, they will respond within 45 days, unless additional information is requested. If additional information is requested, the following extensions apply:

a. extension period: 45 days; and
b. maximum number of extension: one.

The Company will have a total of 90 days to process the appeal.

When the decision is made, the person submitting the claim will be provided with:

a. information regarding the decision; and
b. information regarding other internal or external appeal or dispute resolution alternatives, if available, including any required state mandated appeal rights.

Exhaustion of Remedies

You must follow all of the claims and appeals procedures described in this booklet before you may bring any action for benefits in a court of law or before an administrative agency.

Overpayments or Mistaken Payments

The Plan has the right to recover directly from you any overpayments or mistaken benefit payments it has made to you or on your behalf. Overpayments and mistaken payments include payments that the Plan makes while you are waiting for approval or settlement of your workers' compensation benefits, Plan payments resulting from any failure to provide accurate information to the Plan and Plan payments not otherwise provided for by its terms. Throughout this section, the term "you" refers to you or your spouse, dependent or beneficiary.

The Plan may appoint an agent to act on its behalf to recover overpayments or mistaken payments.

You are required to give any necessary authorization for the Plan's recovery of overpayments or mistaken payments. This includes your permission for the Plan to deduct the amount of the overpayments or mistaken payments from any future amounts due to you under this Plan.

The Plan has the option of recovering overpayments or mistaken payments by:

1. Reducing future payments due to you under the Plan; and/or
2. Bringing a legal action against you.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The original plan of benefits provided by the Welfare Plan became effective June 1, 1953. This booklet sets forth the plan of benefits, as well as the Eligibility and Termination Rules currently in effect.

Name of Plan. This Plan is known as the Iron Workers Welfare Plan of Western Pennsylvania.

Board of Trustees. A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of equal representation by the employers and the unions who have entered into collective bargaining agreements, which relate to this Plan. If you wish to contact the Board of Trustees, you may use the address and telephone number below (also listed in the front of this booklet):

Board of Trustees
Iron Workers Welfare Plan of Western PA
2201 Liberty Avenue
Pittsburgh, PA 15222
412-227-6740

Plan Administrator. The Board of Trustees is the Plan Administrator. The Plan Administrator has the absolute discretion and authority to determine eligibility for benefits, make legal and factual determinations and interpret Plan provisions. The decision of the Plan Administrator will be given judicial deference in any court proceeding.

Plan Sponsors. The Board of Trustees is the Plan Sponsor.

Participating Employers. Plan participants and beneficiaries may write to the Board of Trustees to find out if a particular employer is participating in this Plan. Iron Workers Local Union Nos. 3 and 772 are the unions participating in the Plan.

Identification Numbers. The number assigned to the Board of Trustees by the Internal Revenue Service is 25-6181473. The number assigned to the Plan by the Board of Trustees is 001.

Agent for Service of Legal Process. If legal disputes involving the Plan arise, any legal documents should be served on any of the Plan Trustees, at the following address: 2201 Liberty Avenue, Pittsburgh, Pennsylvania 15222.

Collective Bargaining Agreements. This Plan is maintained pursuant to collective bargaining agreements. Plan participants and beneficiaries may examine these collective bargaining agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees at the address listed in the front of this booklet.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Source of Contributions. The Plan's benefits for eligible employees are provided through employer contributions. The provisions of collective bargaining agreements determine the amount of the employer contributions. Under certain circumstances employee contributions are received by the Plan.

Insurance Companies. Medical benefits are provided under a group contract issued by Highmark Blue Cross Blue Shield. Prescription benefits are provided by Express Scripts. Life Insurance and Accidental Dismemberment benefits are provided under group policies issued by the United of Omaha Life Insurance Company. Membership Assistance Program benefits are provided by Lytle Behavioral Health. The Weekly Accident and Sickness benefit is self-insured by the Plan. United Concordia provides the voluntary dental program.

Trust Fund. All Plan assets are held in a Trust Fund. Professional asset managers hired by the Board of Trustees manage the Trust assets. Insurance premiums are paid from the Trust Fund and the Trust Fund pays the self-insured benefits of the Plan.

Fiscal Year. The fiscal records of the Plan are kept on a calendar year basis.

Type of Plan. This Plan is maintained for the purpose of providing life insurance, accidental dismemberment and loss of sight benefit, weekly disability benefit, prescription benefits, hospitalization, medical service and other health care benefits.

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

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

Type of Plan Administration. The staff of individuals who are hired by the Board of Trustees handles the Administrative operations of this Plan.

Procedure for Obtaining Additional Plan Documents. If you wish to inspect or receive copies of additional documents relating to this Plan, contact the Plan Administrative Office at the address or phone number listed in the front of this booklet. You will be charged a reasonable fee to cover the cost of any materials you wish to receive.

Rights of Plan Participants. As a participant in this Plan, you are entitled to certain rights and protections under ERISA. Although these rights and protections first became a part of federal law with the passage of ERISA, the Trustees have always considered the fair management of this Plan as their primary objective. The Trustees, therefore, intend to encourage you to first seek assistance from the Plan Administrator when you have questions or problems that involve the Plan.

STATEMENT *of* ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan's administrative office and at other specified locations, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing 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.
3. 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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay 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 it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

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