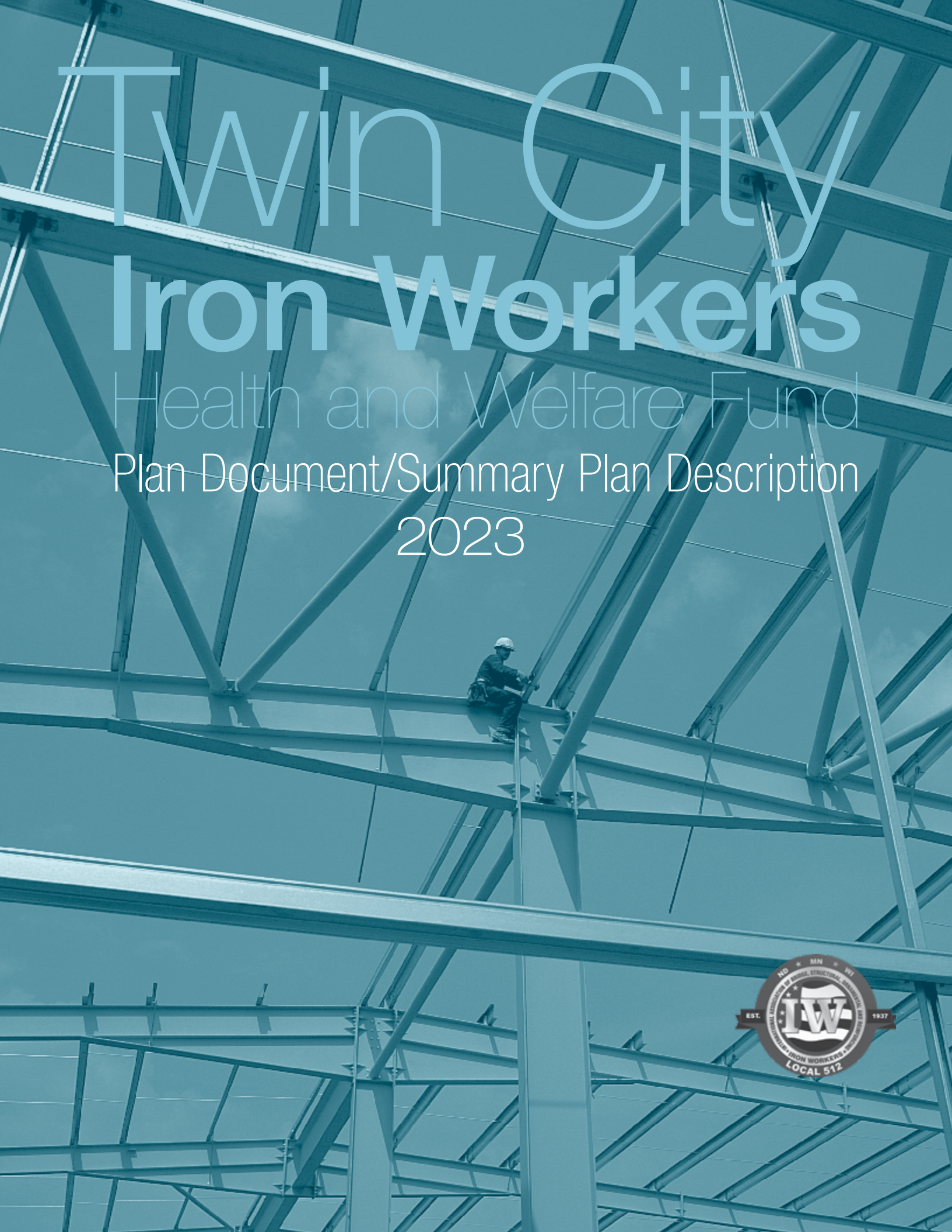

Twin City Iron Workers Health and Welfare Fund

Plan Document/Summary Plan Description

2023

The Twin City Ironworkers Health and Welfare Fund believes this Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding the protections that apply and that do not apply to a grandfathered health plan and what might cause a plan to lose grandfathered health plan status can be directed to the Plan Administrator at (952) 854 0795. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Twin City Ironworkers Health and Welfare Fund

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 854-0795
Toll-free: (800) 535-6373
Fax: (952) 854-1632
tcironworkersbenefits.com

Board of Trustees

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Plan Administrator

Wilson-McShane Corporation

Fund Counsel

McGrann Shea Carnival Straughn & Lamb, Chartered

Consultant

Segal

To All Eligible Participants:

We are pleased to provide you with this updated Summary Plan Description (SPD) booklet, which describes the provisions of the Fund's Health and Welfare Plan (the Plan) as of January 1, 2023, including the current Plan Eligibility rules and benefits for Employees, Owner-Operators, Disabled Employees, Retirees, surviving Spouses, and Dependents. This SPD also serves as the Plan Document, and replaces and supersedes any prior booklets about the Plan. If you terminated your employment before January 1, 2023, this Plan Document/SPD does not apply to you. The provisions of the Plan as they were on the last day of your employment for which Employer Contributions were made to the Fund will determine your benefits.

There have been several changes made to the Plan since the last SPD was printed. These include changes to the:

- Eligibility Period for Initial Eligibility;
- Definition of a Dependent;
- Opt-out coverage for Retirees;
- Dental benefit;
- Tobacco cessation benefit;
- Hearing aid benefit;
- Medical plan coverage and exclusions; and
- Claims and appeals procedures.

In addition, FDA-approved COVID-19 vaccines are covered at 100% of the allowable cost, which means such vaccines are free for you. No deductible applies, regardless of where the vaccine is administered.

Also, in response to the spread of COVID-19 and the enactment by Congress of the Families First Coronavirus Response Act (FFCRA), we have amended the Plan to provide temporary coverage for COVID-19 testing.

COVID-19 testing will cease automatically on the day the federal government declares an end to the Public Health Emergency:

- The Plan will cover 100% of the cost of in vitro diagnostic testing for the COVID-19 virus that is either:
  a. Authorized by the FDA; or
  b. Otherwise specifically authorized by federal law or regulation.
- Coverage refers to:
  a. Evaluation by a health care provider to determine whether you need a COVID-19 test; and
  b. Services to administer a COVID-19 test.

Before you are tested for COVID-19, be sure to confirm with your health care provider that the recommended test is authorized. If you receive a test that is not authorized, it may not be covered. You can find a list of FDA-authorized COVID-19 tests at fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations-medical-devices.

Coverage applies when a COVID-19 test is provided either in-network or out-of-network. For out-of-network charges, the Plan will cover the full billed amount regardless of whether the amount exceeds the reasonable and customary amount. No prior authorization or medical management requirements apply. Also note that coverage applies without regard to the site of care (e.g., in a physician's office, urgent care facility, emergency room, or via an e-visit). The coverage does not apply to any items and services you receive during a visit to a health care provider other than those expressly described above.

Please read this booklet in its entirety and keep it in a safe place for future reference. If you are married, please share this information with your Spouse.

The Plan is designed to assist you in meeting the cost of treatment for health care. The Trustees are proud of the benefits provided.

If you have any questions regarding Eligibility for Plan benefits, please contact the Administrative Office:

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 854-0795
Toll-free: (800) 535-6373
Fax: (952) 854-1632
tcironworkersbenefits.com

Sincerely,

Board of Trustees

Important Message

The Health and Welfare Fund is a legal Trust set up to provide benefits for participants. The Fund was established according to an Agreement and Declaration of Trust. The Trust Agreement and this Plan Document/SPD were adopted by the Trustees of the Fund to govern the Plan's operation.

The Plan is administered by a Board of Trustees that serves without any compensation and that acts on behalf of all participants when managing the Plan's operations. The Board includes Employer and Union representatives whose powers and duties are defined in the Trust Agreement.

The Trustees have discretion to determine whether a person is entitled to benefits under the Plan and will exercise these powers in a uniform and nondiscriminatory manner consistent with the Plan. The Trustees are, subject to the requirements of law, the sole judges of the facts and the standard of proof required in any case and of the application and interpretation of the Plan Document and Trust Agreement. Their decisions will be final and binding. The Plan will not discriminate on the basis of race, color, national origin, sex (including gender identity), age or disability.

The Plan and the Trust Agreement may be amended at the sole discretion of the Trustees at any time, upon approval by a majority of the Trustees at a meeting of the Trustees, duly noticed and held in accordance with the requirements of the Trust Agreement, or may be amended in writing by unanimous consent. In view of this right of amendment, you do not have a vested interest in the Eligibility rights or the Plan's benefits, because they and other Plan provisions may be changed as the Trustees deem necessary or appropriate.

All questions or controversies that arise in any manner or that arise between any persons in connection with the Plan or the Fund's operation, whether as a claim for benefits, dispute regarding the construction of language, or regarding any writing, decision, instrument, or account in connection with the operation of the Plan or otherwise, must be submitted to the Trustees for decision. If a claim for benefits is denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for a review under the review procedures provided for under the Plan's claims and appeals procedures. The decision on review will be binding upon all persons dealing with the Plan or claiming any benefit, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator that has jurisdiction over such matters.

The entire cost of the Plan's operations is paid by participating Employers who are required to contribute to the Fund in accordance with their collective bargaining or participation agreements, except to the extent that participant contributions are required or specifically permitted by the Plan.

Table of Contents

Active Plan

These benefits, except as specifically limited, are for: 1) Employees, Owner-Operators and Dependents covered under the Active Plan; and 2) Retirees, Totally Disabled Employees, surviving Spouses and Dependents covered under the Active Plan.

EMPLOYEES AND OWNER-OPERATORS ONLY	BENEFIT
Life Insurance	$50,000
Accidental Death and Dismemberment Insurance Principal sum	 $50,000
Weekly Disability Maximum number of weeks payable per period of Total Disability	$350 26
COMPREHENSIVE MEDICAL BENEFITS FOR EMPLOYEES AND DEPENDENTS	
Lifetime/Annual Maximum	Unlimited
Calendar Year Deductible Family maximum (number of deductibles)	$200 per Family Member 3
Out-of-Pocket Maximum per Calendar Year (this is in addition to the Calendar Year deductible) Per individual Per family (Does not apply toward orthotics and chiropractic expenses)	 $1,500 $4,500

ALL PERCENTAGES ARE APPLIED TO ALLOWABLE CHARGES FOR EACH COVERED SERVICE.	PLAN PAYS
Coinsurance (unless stated otherwise)	80% after you pay deductible
Preventive Physical Exam	First $500, no deductible; then 80% after you pay deductible
Emergency Room Copayment: you pay	$100 per visit, waived if admitted
Home Health Care	
Maximum number of visits per Calendar Year	120
Skilled Nursing Care Facility	
Percentage of daily Room and Board Charges paid by Fund	100%
Maximum period of confinement	60 days
Hospice Care	
Lifetime maximum days	185
Artificially Assisted Conception Lifetime Limit	$7,500
Physical Therapy, Occupational Therapy, and Speech Therapy	
Maximum combined lifetime visits	Unlimited
Chiropractic (including acupuncture)	
Maximum visits per Calendar Year	26
Mental Health and Chemical Dependency	80% after you pay deductible
Inpatient and outpatient treatment	
We recommend that you use the case management services provided by T.E.A.M., Inc.; however, you are not required to do so.	
Tobacco Cessation	
The Blue Cross Quit Coach counseling program	100%
Prescription drugs and over-the-Counter tobacco cessation aids – copayment you pay per prescription	20% (minimum $5)

SUPPLEMENTAL MEDICAL BENEFITS: THERE IS NO DEDUCTIBLE OR COPAYMENT REQUIRED FOR ANY OF THE SUPPLEMENTAL MEDICAL BENEFITS. THE FUND PAYS UP TO THE LISTED AMOUNTS FIRST, AND THEN YOU ARE RESPONSIBLE FOR THE REMAINING BALANCE.	
Doctor On Demand	100%
Hearing Aids	
Maximum benefit – once every five years	$4,000
Maximum benefit – once every three years	$2,000 for children 18 and under
Vision (including LASIK)	
Maximum benefit per two-year period (effective the first day of every even year):	$700
January 1, 2022 – December 31, 2023	This does not apply to routine pediatric up to age 19 vision care.
January 1, 2024 – December 31, 2025	
Breast Pumps (including tubing)	
Maximum benefit - one per lifetime	$500
Orthotics	
Maximum benefit (in a 12-consecutive-month period)	$200
PRESCRIPTION DRUG BENEFITS: NOT SUBJECT TO MEDICAL DEDUCTIBLE OR OUT-OF-POCKET LIMIT	
Copayment you pay per prescription	20% (minimum $5)
Calendar Year out-of-pocket limit	$3,000 per person

You may receive a 90-day supply of a prescription drug or a specialty drug through a Sav-Rx network retail pharmacy, mail order facility or specialty drug pharmacy. Some medications may require prior authorization to determine coverage, such as specialty medications, continuous glucose monitors, daily dose erectile dysfunction medications, etc.

DENTAL BENEFITS	PLAN PAYS
Deductible every two Calendar Years	$70 per Family Member
Percentage of Covered Expenses paid by the Fund	
Type A dental services	100% (no deductible)
Type B dental services	90%
Type C dental services	80%
Type D dental services	80%
Two-year maximum for types A, B, and C services combined	$3,000
January 1, 2021 – December 31, 2022	This does not apply to routine pediatric up to age 19 dental care.
January 1, 2023 – December 31, 2024	
Lifetime maximum for type D dental services	$3,000
Orthodontia Benefit – lifetime maximum per individual	$3,000

1. *The Plan does not cover inpatient expenses incurred at out-of-network facilities, except as otherwise required by the No Surprises Act.*
2. *The Plan covers Emergency Medical Conditions as defined in the SPD.*

Regular Retiree Plan

These benefits, except as specifically limited, are for Retirees, Totally Disabled Employees, surviving Spouses and Dependents covered under the Regular Retiree Plan. All percentages are applied to Allowable Charges for each covered service.

COMPREHENSIVE MEDICAL BENEFITS	PLAN PAYS
Lifetime Maximum	Unlimited
Calendar Year Deductible – you pay	$200 per Family Member
Family maximum (number of deductibles)	3
Copayment Limit per Calendar Year (This is in addition to the Calendar Year deductible.)	100% for most covered services after you reach this copayment limit
Per individual	$1,500
Per family	$4,500
(Does not apply toward orthotics and chiropractic expenses.)	
Coinsurance (unless stated otherwise)	80%, after deductible
Preventive Physical Exam	First $500, no deductible; then 80% after you pay deductible
Emergency Room Copayment	$100 per visit, waived if admitted
Home Health Care	
Maximum number of visits per Calendar Year	120
Skilled Nursing Care Facility expenses	
Percentage of Daily Room and Board Charges paid by Fund	100%
Maximum period of confinement	60 days
Hospice Care	
Lifetime maximum days	185
Artificially Assisted Conception Lifetime Limit	$7,500
Physical Therapy, Occupational Therapy, and Speech Therapy	
Maximum combined lifetime visits	Unlimited
Chiropractic (including acupuncture)	
Maximum visits per Calendar Year	26
Mental Health and Chemical Dependency	
Inpatient and outpatient treatment	80% after you pay deductible
We recommend that you use the case management services provided by T.E.A.M., Inc.; however, you are not required to do so.	

SUPPLEMENTAL MEDICAL BENEFITS: THERE IS NO DEDUCTIBLE OR COPAYMENT REQUIRED FOR ANY OF THE SUPPLEMENTAL MEDICAL BENEFITS. THE FUND PAYS UP TO THE LISTED AMOUNTS FIRST, AND THEN YOU ARE RESPONSIBLE FOR THE REMAINING BALANCE.	
Doctor On Demand	100%
Hearing Aids	
Maximum benefit – once every five years	$4,000
Breast Pumps (including tubing)	
Maximum benefit – one per lifetime	$500
Orthotics	
Maximum benefit (in a 12-consecutive-month period)	$200
PRESCRIPTION DRUG BENEFITS: NOT SUBJECT TO MEDICAL DEDUCTIBLE OR OUT-OF-POCKET LIMIT	
Copayment you pay per prescription	20% (minimum $5)
Calendar Year out-of-pocket limit	$3,000 per person
You may receive a 90-day supply of a prescription drug or a specialty drug through a Sav-Rx network retail pharmacy, mail order facility or specialty drug pharmacy. Some medications may require prior authorization to determine coverage, such as specialty medications, continuous glucose monitors, daily dose erectile dysfunction medications, etc.	
OPTIONAL VISION AND DENTAL BENEFITS	
Optional vision and dental benefits are offered together. You must choose both options.	
Vision (including LASIK)	
Maximum benefit per two-year period (effective the first day of every even year):	$700
January 1, 2022 – December 31, 2023	This does not apply to routine pediatric up to age 19 vision care.
January 1, 2024 – December 31, 2025	
Dental	
Deductible every two Calendar Years	$70 per Family Member
Percentage of Covered Expenses paid by the Fund	
Type A dental services	100% (no deductible)
Type B dental services	90%
Type C dental services	80%
Type D dental services	80%
Calendar Year maximum for types A, B, and C services combined	$1,500
Lifetime maximum for type D dental services	$2,000
Two-year maximum for types A, B, and C services combined	$3,000
January 1, 2021 – December 31, 2022	This does not apply to routine pediatric up to age 19 dental care.
January 1, 2023 – December 31, 2024	
Lifetime maximum for type D dental services	$3,000
Orthodontia – Lifetime Maximum per Individual	$3,000

1. *The Plan does not cover inpatient expenses incurred at out-of-network facilities.*
2. *The Plan covers Emergency Medical Conditions as defined in the SPD.*

Contact Information

6 Contact Information

The following table provides contact information if you ever need information or assistance.

IF YOU HAVE A QUESTION OR NEED INFORMATION ABOUT:	CONTACT:	CALL:	VISIT:
Eligibility, Updating Personal Information, Life Insurance, Accidental Death and Dismemberment, Weekly Disability, Medicare Advantage Prescription Drug Plan	Fund Office	(952) 854-0795 (800) 535-6373	tcironworkersbenefits.com
Medical PPO (Aware) Network	Blue Cross and Blue Shield of Minnesota	(800) 810-2583	bluecrossmn.com
Doctor On Demand	Fund Office	(952) 854-0795 (800) 535-6373	doctorondemand.com/ bluecrossmn
Prescription Drug Benefits (Retail and Mail Order)	Sav-Rx Prescription Service	(800) 228-3108	savrx.com
Employee Assistance Program	T.E.A.M., Inc.	(651) 642-0182 (800) 634-7710	team-mn.com
Vision Benefits	Fund Office	(952) 854-0795 (800) 535-6373	tcironworkersbenefits.com
Dental Benefits	Delta Dental	(800) 448-3815	deltadental.com
Hearing Benefits	Fund Office	(952) 854-0795 (800) 535-6373	tcironworkersbenefits.com

If any of these events occur, be sure to let the Fund Office know so that your benefits are updated for your situation.

Your benefits are designed to meet your needs at different stages of your life. Since different life events can affect your benefit coverage, it is very important that you keep the Fund Office informed when any of the following changes occur:

If any of these events occur, be sure to let the Fund Office know so that your benefits are updated for your situation.

- You change your home/mailing address;
- You wish to change your beneficiary;
- You are receiving workers' compensation benefits;
- You become disabled or return to work after a disability ends;
- You enter the military service of the United States;
- You acquire a new Dependent. Proper verification such as a marriage certificate or birth certificate, whichever is appropriate, must be submitted to the Fund Office when enrolling a new Dependent. In the event of the birth of a Dependent, a state-issued birth certificate must be submitted to the Fund Office. If the birth or marriage certificate is received by the Fund Office within 90 days, your Dependent's eligibility will begin retroactively to the date of birth or marriage. If the birth or marriage certificate is not received by the Fund Office within 90 days, your Dependents' eligibility will begin the first day of the month following the date the certificate is received;
- You have a change in marital status;
- You have a Dependent who no longer meets the Plan's definition of a Dependent (to ensure that you receive proper COBRA notice); or
- You become Eligible for Medicare.

You should contact the Fund's Administrative Office whenever you experience a life-changing event. Having an up-to-date enrollment form and beneficiary card on file will assist the Plan Administrator in verifying your Dependents and your Eligibility for Plan benefits, and ensure that your claims will be handled efficiently.

Limiting Age

Under the Plan, the limiting age for your Dependent child is age 26, except for a grandchild, in which case it is:

- Age 19; or
- Age 23, if your grandchild is a full-time student at an accredited school and Dependent on you for support and maintenance.

Adding a Dependent

This Plan complies with the federal law regarding special enrollment procedures, because all Eligible Employees and their Eligible Dependents are automatically enrolled in this Plan as soon as they meet the Plan's Eligibility requirements (if appropriate documentation to show Eligibility is provided, as stated below). There is no option to decline coverage.

To enroll your Dependent, call the Fund Office for an enrollment form. You must submit the completed enrollment form with the appropriate documentation to the Fund Office within 90 days of the event, for example, your marriage or the birth of a child. If you do not enroll your Dependent within 90 days, claims will be denied until you submit the required information.

Getting Married

When you marry, your Spouse is Eligible for health care coverage as of the date of your marriage. However, the Fund will not pay benefits on behalf of your Spouse until you enroll your Spouse for coverage. To enroll your Spouse, send a copy of your marriage certificate to the Fund Office as soon as it is available and complete the appropriate enrollment form. Once your Spouse is enrolled, benefits will be paid retroactively to the date of your marriage.

Adding a Child

Your natural child is Eligible for coverage on the date of his or her birth. If you adopt a child, have a child placed with you for adoption, or acquire a stepchild through marriage, he or she will be Eligible for coverage on the date of placement or marriage, as long as you are responsible for health care coverage and your child meets the Plan's definition of a Dependent child (see page 83).

You must enroll your child for coverage before the Fund pays benefits. To enroll your child, you must provide any required documentation, such as a birth certificate or adoption papers or a divorce decree for stepchildren, as soon as it is available. Once your child is enrolled, benefits will be paid retroactively to the date of the birth, placement for adoption, or marriage.

Adding a Dependent on Medicaid

Federal and state laws require an Eligible Employee to enroll any Dependents who are receiving health insurance coverage through Medicaid. If you do not enroll your Eligible Dependents who are receiving health insurance through Medicaid, you will be responsible for any penalties assessed on the Plan by Medicaid due to your failure to follow these rules.

Getting Divorced or Legally Separated

If you and your Spouse get a divorce or legal separation, your Spouse will no longer be Eligible for coverage. Your Spouse may elect to continue coverage under COBRA for up to 36 months upon divorce or legal separation. For your Spouse to obtain COBRA continuation coverage, you or your Spouse must notify the Fund Office within 60 days of the divorce or separation date. You must submit a divorce decree to the Fund Office.

Qualified Medical Child Support Order (QMCSO)

This Plan will recognize Qualified Medical Child Support Orders (QMCSOs) that require the Plan to provide medical, dental or vision benefits to children of Active or Totally Disabled Employees or Owner-Operators. A QMCSO is a court order or decree that provides for a child's coverage under a welfare benefit program.

A child of an Employee or Owner-Operator for whom coverage must be provided because of a QMCSO is also a Dependent.

Upon receipt of a QMCSO, the Plan Administrator will promptly notify you and each alternate recipient, as that term is defined in ERISA Section 609(a), of the receipt of such an Order and the Plan's procedures for determining whether the Order is a QMCSO.

Please notify the Fund Office if your situation involves a QMCSO. You or your Dependent may request a free copy of the Fund's procedures for handling these orders.

If a Dependent Child Loses Eligibility

In general, your child is no longer Eligible for coverage when he or she enters the military on a full-time basis or reaches the limiting age. You should notify the Fund Office if one of these events occurs.

Your child may elect to continue coverage under COBRA for up to 36 months after he or she loses Eligibility. To obtain COBRA continuation coverage, you or your child must notify the Fund Office within 60 days of the date your child no longer meets the definition of a Dependent.

If, because of a disability, your child is not capable of self-supporting employment upon reaching the limiting age, you may continue coverage for that child for as long as your own coverage continues and the child meets the definition of a disabled Dependent child. To qualify, your child's disability must begin before his or her coverage would otherwise end.

Taking a Family and Medical Leave of Absence

See page 15 for information about Eligibility for coverage during a leave under the Family and Medical Leave Act (FMLA).

Taking a Military Leave

See page 16 for information about continuing coverage while you serve in the uniformed services of the United States under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

In the Event of Your Death While an Active Participant

If you die while Eligible for coverage under the Plan, your beneficiary will receive a life insurance benefit (and an accidental death and dismemberment (AD&D) insurance benefit if your death is caused by an accident). These benefits apply to Employees and Owner-Operators only (not Dependents). Refer to the *Life Insurance Benefits and Accidental Death and Dismemberment Insurance Benefits* sections for further details.

In the event of your death, your Spouse or beneficiary must:

- Notify the Third Party Administrator;
- Provide the Third Party Administrator with a copy of your death certificate; and
- Apply for your death benefit (and AD&D insurance benefit, if applicable).

In addition, if you die while covered under the Plan, your Dependents (Eligible Spouse and children) may continue to be Eligible for benefits as long as your Individual Record System contains hours sufficient to continue this coverage. When your Individual Record System is depleted or canceled, your surviving Spouse may elect to continue his or her coverage by electing coverage through either the Regular Retiree Plan, the Medicare Advantage Prescription Drug Plan (if Eligible for Medicare), or COBRA continuation coverage. Your survivors will need to make the required Self-Contributions for this coverage.

When You Stop Working or Retire

Coverage for you and your Dependents will end if Contributions are no longer made to the Fund on your behalf. When your Individual Record System is depleted or canceled, you may be Eligible to continue coverage by electing COBRA continuation coverage and making the necessary Self-Contributions for such coverage by the due date.

If you retire, you may be Eligible for Regular Retiree Plan or Medicare Advantage Prescription Drug Plan coverage. You should refer to page 27 for additional information about Retiree Eligibility. Contact the Fund Office with any questions about Retiree Eligibility.

In the Event of Your Death While Retired

Your Dependents (Eligible Spouse and children) may elect to continue their coverage by electing coverage through either the Regular Retiree Plan, the Medicare Advantage Prescription Drug Plan (if Eligible for Medicare), or COBRA continuation coverage. Refer to the *Eligibility Provisions for Retirees* section for further details.

Initial Eligibility

Eligibility Period:

Any three or six-consecutive-month period that begins on the first day of any month, used to determine Eligibility for Plan benefits.

Employees

You become Eligible for Plan benefits on the first of any month after you:

- Have not been eligible for benefits provided by the Fund in the preceding 36-month period and work at least 360 hours in Covered Work for which contributions were required to be paid to the Fund on your behalf by an Employer or Employers in any six-consecutive-month period that begins on the first day of any month; or
- Have been eligible for benefits provided by the Fund in the preceding 36-month period and work at least 360 hours in Covered Work for which contributions were required to be paid to the Fund on your behalf by an Employer or Employers in any three-consecutive-month period that begins on the first day of any month; and
- Satisfy a one-month Lag Period.

If you are not actively at work due to a Total Disability on the date on which the coverage becomes effective, you will not be Eligible for the weekly disability benefits until you return to active employment in Covered Work. All other benefits will become effective on the Eligibility date.

Owner-Operators

You become Eligible for Plan benefits on the first of any month after you:

For Owner-Operators who employ five or fewer Plan participants:

- Work at least 390 hours in Covered Work for which contributions were required to be paid to the Fund on your behalf by an Employer or Employers in any six-consecutive-month period that begins on the first day of any month; and
- Satisfy a one-month Lag Period.

For Owner-Operators who employ at least six Plan participants:

- Work at least 480 hours in Covered Work for which contributions were required to be paid to the Fund on your behalf by an Employer or Employers in any six-consecutive-month period that begins on the first day of any month; and
- Satisfy a one-month Lag Period.

If an Owner-Operator is not actively at work due to a Total Disability on the date coverage becomes effective, he or she will not be Eligible for weekly disability benefits until he or she returns to active Covered Employment.

Contributions may not be made for self-employed individuals or partners of a partnership.

Continuing Eligibility

Once Eligible, you will remain covered for at least three months. You will also continue to remain covered for succeeding three-month intervals if you have the required hours of contributions made on your behalf.

Persons who cease to be Owner-Operators may continue to be treated as Owner-Operators for coverage purposes under the Plan for up to six calendar quarters. For more details, see the definition of Owner-Operator.

For example, an Employee who works 360 hours in the three-month period running from February 1 through April 30 is Eligible to participate in the Plan on June 1. An Owner-Operator who works 480 hours in the three-month period running from March 1 through May 31 is Eligible to participate on July 1.

Termination of Coverage

Employees

Your coverage will terminate on the last day of the month when the following two conditions are met:

- You do not have the required Employer Contributions, as follows:
  a. 360 hours in a rolling three-month look-back period; or
  b. 720 hours in a rolling six-month look-back period; or
  c. 1,080 hours in a rolling nine-month look-back period; or
  d. 1,440 hours in a rolling twelve-month look-back period.

  AND

You lack sufficient hours in your Individual Record System, when combined with your hours of Employer Contributions, to satisfy the hours required as described above.

EXAMPLE:

Bob's coverage will terminate on November 30 if Bob does not have:

Sufficient Employer Contributions hours, as follows:

- 360 hours of Employer Contributions between August 1 and October 31; or
- 720 hours of Employer Contributions between May 1 and October 31; or
- 1,080 hours of Employer Contributions between February 1 and October 31; or
- 1,440 hours of Employer Contributions between the previous November 1 and October 31;

OR

- Sufficient hours in his Individual Record System to make up for his lack of the required Employer Contribution hours.

Owner-Operators

There are two sets of criteria, depending on the number of Employees (including Owner-Operators) who work for the Owner-Operator and participate in the Fund:

- For six or more participants; and
- For five or fewer participants.

If the Owner-Operator's coverage category changes, the new hours requirement will apply, beginning with the first Eligibility Period following the change in category.

Six or More Participants

Your coverage will terminate on the last day of the month when the following two conditions are met:

- You do not have the required Employer Contributions, as follows:
  a. 480 hours in a rolling three-month look-back period; or
  b. 960 hours in a rolling six-month look-back period; or
  c. 1,440 hours in a rolling nine-month look-back period; or
  d. 1,920 hours in a rolling twelve-month look-back period;

AND

- You lack sufficient hours in your Individual Record System, when combined with your hours of Employer Contributions, to satisfy the hours required as described above.

Five or Fewer Participants

Your coverage will terminate on the last day of the month when the following two conditions are met:

- You do not have the required Employer Contributions, as follows:
  a. 390 hours in a rolling three-month look-back period; or
  b. 780 hours in a rolling six-month look-back period; or
  c. 1,170 hours in a rolling nine-month look-back period; or
  d. 1,560 hours in a rolling twelve-month look-back period;

AND

- You lack sufficient hours in your Individual Record System, when combined with your hours of Employer Contributions, to satisfy the hours required as described above.

If your coverage would have terminated because of an insufficient number of contribution hours, the number of hours needed to maintain your Eligibility will be withdrawn from your Individual Record System.

Individual Record System

The Individual Record System was established January 1, 1979. The Fund Office records regarding Employer Contributions made on your behalf during the period from November 30, 1977, through November 30, 1978, were reviewed, and hours received in excess of 1,600 hours during this period were posted to your Individual Record System as of January 1, 1979. On and after that date, an Individual Record System is established for each Employee or Owner-Operator as they become Eligible for benefits.

Any hours of Covered Work for which contributions are received on your behalf in excess of 1,600 in a 12-month period are added to your Individual Record System. The Fund reviews the hours of contributions received during the 12-month period from December 1 through November 30, and on the next January 1, the hours of contributions in excess of the first 1,600 hours are posted to your Individual Record System. The maximum hours allowed in your Individual Record System is 6,000.

Your hours in excess of 1,600 per year are added into your Individual Record System to be used if you need help to continue your Eligibility.

Employer Contributions records are reviewed on each of the termination dates listed in the Termination of Coverage section, beginning on page 12. If there has not been a sufficient number of hours of contributions submitted to continue your Eligibility, hours will be drawn from your Individual Record System to make up the deficiency and continue your coverage, provided there is a sufficient number of hours in your Individual Record System.

If you stop working in the jurisdiction of the Union before you retire on a pension, you and your Dependents will continue to be Eligible until your Individual Record System is depleted or canceled, unless coverage is continued by quarterly Self-Contributions or monthly COBRA payments.

Your Individual Record System will be canceled:

- At the end of a 12-month period during which no Employer Contributions are paid to this Fund, if you are an Employee and there are less than 360 hours in your Individual Record System;
- At the end of a 12-month period during which no Employer Contributions are paid to this Fund, if you are an Owner-Operator and there are less than 390 hours (five or fewer participants) or 480 hours (at least six participants) in your Individual Record System;
- If you become Eligible for coverage under another group benefit plan, either through employment or as a Dependent of a working Spouse; or
- If you enter the armed forces and fail to meet the requirements of the *Service in the Armed Forces* section of this booklet (see page 16).

If Employer Contributions are once again paid to this Fund within 12 months from the date of cancellation, your Individual Record System will be reinstated with the number of hours it contained before cancellation.

Self-Contribution Continuation

Also, if your coverage is going to terminate because you do not have enough contribution hours, you may elect Self-Contribution continuation coverage for six consecutive quarters with premiums paid each month. The Self-Contribution amounts will be determined by the Trustees and they differ between Employees and Owner-Operators. The Trustees reserve the right to modify and change these Self-Contribution rules and amounts at their sole discretion. If you elect to make Self-Contributions, you are waiving your right to COBRA continuation coverage.

Continued Eligibility During Disability Periods

If, after you become covered, you are unable to perform work because you are Totally Disabled, your Individual Record System will be credited, for maintaining Eligibility, with 28 disability hours for each full week of such disability. In no event, however, will more than 360 of such disability hours of credit be granted during any continuous 12-month period, or more than 720 hours for any continuous period of disability. To be credited with disability hours, you must either be drawing weekly disability benefits through the Fund, submit evidence that you are receiving income replacement benefits from your automobile insurance carrier, or submit evidence that you are drawing weekly workers' compensation benefits as the result of a disability incurred within the jurisdiction of the Union.

If you are still Totally Disabled on the date your coverage would normally terminate due to the depletion of your Individual Record System, you may continue to maintain your Eligibility by paying the amount of Self-Contribution prescribed by the Trustees, or you may continue coverage under COBRA for up to 29 months (18 months of COBRA plus 11 months Disability Extension) (refer to the *Termination of Coverage* section).

Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act of 1993, you may qualify to take up to 12 weeks of unpaid leave if you have a Serious Health Condition that makes you unable to perform the essential functions of your job or if you need to care for:

- A newborn child or newly adopted child;
- A seriously ill Spouse, parent or child; or
- A Spouse, parent or child who is notified of an impending call to active duty.

You may also qualify to take up to 26 weeks of unpaid leave to care for a Spouse, parent, child, or nearest blood relative who is recovering from an Injury or Illness sustained while on active duty.

If the FMLA applies to your Employer (small Employers are exempt), it requires your Employer to maintain your health coverage for the length of your leave (up to 12 weeks) as if you were actively at work. The Act also states that if you take a family or medical leave, you cannot lose any benefits accrued before the leave.

The Fund will grant Eligibility for a family or medical leave and will maintain your current Eligibility status for the duration of the leave, provided your Employer properly grants the leave of absence under the FMLA and makes the required contributions to the Fund on your behalf. Each Employer informs the Fund of how it calculates the 12-month period. FMLA leave may be taken intermittently or through a reduced work schedule:

- When Medically Necessary for a leave to care for a Family Member or for your own Serious Health Condition; or
- At the Employer's approval for parenting leave.

The Fund will credit your Individual Record System with sufficient hours of contributions to maintain coverage for you while on FMLA leave. The costs of crediting you with hours of contributions while you are on FMLA leave will be paid out of the Fund's general assets; no Employers will be responsible for these costs.

If you do not return to work from the FMLA leave or if you advise your Employer that you do not intend to return to work after the FMLA leave or if FMLA leave otherwise ends, the Fund will cease crediting the required hours of contributions to your Individual Record System and will cease maintaining coverage for you. You will continue to be Eligible until your Individual Record System is depleted or canceled, at which point you may continue coverage by making quarterly Self-Contributions or monthly COBRA payments, as set forth in this booklet. You will also be required to repay the Fund for its cost of providing the required hours of contribution during the FMLA leave, unless you fail to return to work for reasons beyond your control.

If you do not return to work after your leave and you are no longer Eligible to continue health coverage under the Plan, coverage under COBRA may be available.

Note that not all Employers are required to provide FMLA leave. Your Employer is required to comply with FMLA if it is a nongovernmental Employer that employs 50 or more Employees within a 75-mile radius for each working day during each of 20 or more calendar workweeks in the current or preceding Calendar Year.

Notice of Need for Leave

An Employer must immediately notify the Fund when it receives notice from an Employee of the need for FMLA leave. Notice should be given to the Plan Administrator.

"Uniformed services" means the:

- United States armed forces;
- Army National Guard;
- Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty;
- Commissioned Corps of the U.S. Public Health Service; and
- Any other category of persons designated by the president in time of war or emergency.

Individual Record System

If you do not wish to use your Individual Record System hours, you must notify the Fund Office within 30 days after entering the armed forces to freeze your Individual Record System until you return. Once you return to covered employment within the USERRA time frames, your Individual Record System balance will be restored. If you do not return to covered employment within the USERRA time frames, the balance in your Individual Record System will be forfeited.

COBRA and USERRA

Note that COBRA and USERRA run concurrently. This means that if you are simultaneously eligible for COBRA and USERRA, you will be entitled to the more generous benefit provisions under each law for periods in which you remain eligible for both forms of continuation coverage. If you fail to follow the COBRA rules when electing and paying for USERRA coverage, you may lose the right to continue coverage under USERRA.

Furthermore, to be Eligible for FMLA leave, you must satisfy the following requirements:

- You have been employed for at least 12 months (not necessarily consecutive) by the Employer participating in the Fund;
- You worked at least 1,250 hours during the previous 12 months for the Employer participating in the Fund; and
- You must work at a site employing at least 50 Employees or that is located such that there is a total of at least 50 Employees at that site and all the other worksites of the Employer within a 75-mile radius.

The Employer must immediately notify the Plan Administrator when FMLA leave ends or if it determines that leave was incorrectly characterized as FMLA leave.

See your Employer if you believe you may be entitled to a leave under the FMLA.

Service in the Armed Forces

If you are called into the uniformed services, you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Health coverage means medical, prescription drug, dental, vision and hearing coverage provided under the Plan.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Inactive duty training;
- Full-time National Guard duty; and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

If you elect to continue coverage and you are in the uniformed services for less than 31 days, you will continue to receive coverage in accordance with USERRA for up to 31 days. If your service continues for more than 31 days, you may elect to continue coverage under the Plan by making monthly Self-Contributions or using your Individual Record System hours. To continue coverage, you or your Dependent must pay the required Self-Contributions or have sufficient hours available in your Individual Record System. Payments will be made in the same manner and in the same amount as COBRA continuation coverage payments.

Your coverage will continue until the earlier of:

- The end of the period during which you are Eligible to apply for reemployment in accordance with USERRA; or
- 24 consecutive months after your coverage would have otherwise ended.

Your coverage will end on the earliest day in which:

- Your coverage would otherwise end as described above;
- Your former Employer ceases to provide any health plan coverage to any Employee;
- Your Self-Contribution is due and unpaid; or
- You again become covered under the Plan.

Your coverage will also end on the first day of the month following the date you enter the uniformed services and elect not to continue coverage. Your Dependents may continue coverage under the Plan by electing and making payments for COBRA continuation coverage.

You need to notify the Fund Office when you enter the military and when you return to covered employment. For more information about continuing coverage under USERRA, contact the Fund Office.

Reinstating Your Coverage

Following discharge from military service, you may apply for reemployment with your former Employer in accordance with USERRA. Reemployment includes the right to reinstatement in the existing health coverage provided by your Employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

When you are discharged or released from military service that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a contributing Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a contributing Employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for a contributing Employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred or aggregated during your military service, you have two years to return to work for a contributing employer. If you do not return to work within the required time frames, you must again meet the Initial Eligibility requirements to be Eligible for coverage.

Opt Out for Participation in High Deductible Plan with Health Savings Arrangement

An Eligible Spouse and/or Dependent(s) may opt out of this Plan on an annual basis if he or she participates in another plan with a Health Savings Arrangement (HSA). Exercising the right to this opt-out does not change the hourly contribution rate for the participant and any Dependents who remain in this Plan. A Spouse or Dependent who opts out of this Plan may return to this Plan in the month immediately following termination of coverage in the plan with the Health Savings Arrangement.

Dependent Eligibility

Dependents of Employees or Owner-Operators who meet the definition of a Dependent will be Eligible.

Your Dependents (except for Dependents of deceased Employees or Owner-Operators) cannot become covered under the Plan unless you are also covered. Your Dependent's coverage will begin on the date you become Eligible, or on the date you first acquire the Dependent, whichever is later.

No individual may be Eligible for benefits both as an Employee, Retiree or Owner-Operator and as a Dependent, or as a Dependent of more than one Employee, Retiree or Owner-Operator.

Reemployment

Following your discharge from service, you may be Eligible to apply for reemployment with your former Employer in accordance with USERRA. Such reemployment includes your reinstatement of health care coverage provided by your Employer.

A surviving Spouse of an Employee or Owner-Operator will be Eligible for coverage under the Plan available to Employees and Owner-Operators until the Employee's or Owner-Operator's Individual Record System is depleted. Thereafter, the surviving Spouse may choose to become Eligible for coverage under the:

- Regular Retiree Plan, if he or she is not 65 or older or if Eligible for Medicare on the basis of disability and has Dependents covered under the Fund's Plan; or
- Medicare Advantage Prescription Drug Plan, if he or she is Age 65 or is Eligible for Medicare based on disability and has no Dependents covered under the Fund's Plan.

If a Retiree and Spouse have opted out of the Plan (Retiree Opt-Out option) and the Retiree dies, the surviving Spouse is not Eligible for coverage under the Plan.

If the surviving Spouse elects one of the options above, he or she waives COBRA coverage. Eligibility for surviving Spouses, as long as they continue to make Self-Contributions in a timely manner, will terminate if the surviving Spouse remarries or obtains coverage under another group health plan.

Termination of Dependent Eligibility

Eligibility for your Dependents, other than a surviving Spouse, terminates as specifically provided in the Plan.

Eligibility for your surviving Spouse, provided he or she makes Self-Contributions in a timely manner, terminates upon the earlier of his or her remarriage or coverage under another group health plan.

Continuation of Coverage for Disabled Children

If on December 31, 1993, you had an unmarried child who is Totally Disabled and that child was Eligible under this Plan at the time he or she reached the maximum age for coverage of children as Dependents, the child's coverage under the Plan will be continued until the first of the following dates:

- The date he or she is no longer Totally Disabled;
- The date your Dependent coverage under this Plan is terminated; or
- The date he or she no longer meets this Plan's definition of a Dependent for any reason except age.

You must submit proof that your child is Totally Disabled no later than 31 days after he or she would have ceased to be covered as a Dependent under this Plan. This Fund also has the right to require, at reasonable intervals, proof that your child has been Totally Disabled continuously since the last proof was submitted. After your child's coverage has been continued under this section for two years, this Fund will not require proof more than once a year. If you fail to submit any required proof or refuse to permit medical or psychiatric examination of your child, the child will no longer be considered Totally Disabled.

Eligibility under this section is not available to those who were not Eligible as described above on December 31, 1993. In addition, if a Dependent qualifying under this section loses Eligibility for whatever reason, after the December 31, 1993 date, he or she will not be able to qualify under this section again.

Coverage for an Eligible Employee's or Eligible Retiree's unmarried child age 26 or **older who is disabled due to a mental or physical condition** will be continued for as long as the Employee or Retiree is covered under the Plan, provided that all of the following requirements are met:

- The child must have been Eligible for coverage on and continuously since December 31, 1993;
- The child must meet the definition of a child;
- The child must have become so disabled and incapable while a Dependent;
- The child must remain disabled due to mental or physical condition;
- The child must be incapable of self-sustaining employment and continue to be incapable of such employment;
- The child must have been covered under the Plan prior to reaching age 26;
- The child must be dependent upon the Eligible Employee or Eligible Retiree for the major portion of the child's support and maintenance (except to the extent the child is supported by another parent, is receiving governmental aid or assistance, or is the beneficiary of another Trust) and must be domiciled with the parent;
- At the time the first claim is filed on behalf of the child, the Eligible Employee or Eligible Retiree must furnish proof that the child was Totally Disabled while a Dependent. If the required proof is not received by the Plan, the child will not be considered an Eligible Dependent beyond the date he or she reaches age 26, even though such child continues to be Totally Disabled;
- Such disability due to a mental or physical condition will be considered to have been established only if proof of such incapacity is furnished at least 31 days prior to the date coverage would otherwise terminate. The Plan Administrator or its designee may require, at reasonable intervals, subsequent proof of the child's disability and dependency. The Plan Administrator will have the right to have a Physician of its choice examine the child periodically as a condition of continuing such child's status as an Eligible child; and
- The child must be Eligible to be claimed as a Dependent on the Eligible Employee's or Eligible Retiree's federal income tax return.

Rescission of Coverage

The Plan may rescind your coverage for fraud, intentional misrepresentation of a material fact, or material omission after the Plan provides you with 30 days' advance written notice of that rescission of coverage. The Trustees have the right to determine, in their sole discretion, whether there has been fraud, an intentional misrepresentation of a material fact, or a material omission. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective retroactively to the date when you would have lost coverage under the Plan. However, the following situations are not considered rescissions of coverage and do not require the Plan to give you 30 days' advance written notice:

- The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment;
- The Plan retroactively terminates your coverage because of your failure to timely pay required premiums or contributions for your coverage; or
- The Plan retroactively terminates your former Spouse's coverage back to the date of your divorce.

For any other unintentional mistakes or errors under which you and your Dependents were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively – for the future – once the mistake is identified. A prospective cancellation is not a rescission of coverage and the Plan is not required to give you 30 days' advance written notice.

Change of Eligibility Rules

The Trustees have broad discretion at any time to change or amend the Eligibility rules summarized in this booklet. No benefits are deemed vested nor is Eligibility guaranteed in any way.

Special Enrollment

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption occurs.

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

COBRA Continuation Coverage

COBRA allows you to continue coverage from 18 to 36 months, depending on the qualifying event that triggers COBRA continuation coverage.

The Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, is a federal law that requires this Plan and others like it to offer a temporary extension of Plan benefits to any Employee or Dependent who loses coverage under the Plan. You do not have to show that you are insurable for COBRA continuation coverage. It is offered to you and your Dependents at group rates in specific instances, called qualifying events, where coverage under the Plan would otherwise end. Depending on the type of qualifying event, "qualified beneficiaries" can include the Employee (or retired Employee) covered under the Plan, the Employee's Spouse and/or Dependent children.

You may have other options available to you when you lose group health coverage. For example, you may be Eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are Eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

COBRA continuation coverage applies to medical, dental and vision benefits. In addition to the continuation of health coverage offered by COBRA, the state of Minnesota requires that a similar continuation of life insurance be offered to Employees whose coverage terminates. If your coverage terminates, you will also receive information concerning your rights under this law.

Qualifying Events

In order to qualify for COBRA continuation coverage, you or your Dependent must experience a qualifying event that causes a loss of your Plan coverage. A qualifying event for you is:

- A reduction in your hours (and the depletion of the Individual Record System); or
- The termination of your employment (including retirement) for any reason other than gross misconduct.

For an Eligible Dependent, a qualifying event may be:

- Your death;
- A reduction in the number of hours you work;
- Termination of your employment (including retirement) for any reason other than gross misconduct;
- Your divorce or legal separation;
- Their loss of Dependent status; or
- Your entitlement to Medicare.

Notices of COBRA Continuation Coverage

General COBRA Notices. When you become covered under the Plan, you and each of your Dependents will receive information from the Fund Office concerning your rights under this law. A COBRA notice will also be sent within 14 days when your Individual Record System is depleted, if your Dependent reaches limiting age, or if you divorce (for your Spouse).

This general notice will be provided no later than 90 days after you become covered under the Plan. If, on the basis of the most recent information available to the Fund Office, you and your Spouse reside at the same location and your Spouse becomes covered under the Plan on or after the date you become covered, the Fund Office may mail you and your Spouse a single notice.

Once a qualifying event occurs, you or your beneficiary must notify the Fund Office.

Notice of Qualifying Events. If the qualifying event that occurs is the termination of employment or reduction of hours of employment, your death, or entitlement to Medicare Benefits, your Employer must notify the Fund Office of the qualifying event. However, you or another Family Member should also notify the Fund Office if any of these qualifying events occurs to ensure that you receive COBRA election materials as soon as possible.

You must promptly notify the Fund Office if you and your Spouse divorce or legally separate. If you fail to do so and your former Spouse continues to claim or receive benefits under the Plan, you and your Spouse can be subject to lawsuits, criminal charges, and loss of benefits. In addition, it is your responsibility to understand your marital status and to inform the Fund Office when a qualifying event has occurred.

You must also notify the Fund Office if your child ceases to be a Dependent, including by aging out of coverage.

The notice of a qualifying event or disability determination must be in writing and must include sufficient information to enable the Plan Administrator to determine the following information:

- The Plan;
- The covered participant and qualified beneficiaries;
- The type of qualifying event or disability determination; and
- The date on which the qualifying event occurred or the disability determination was made.

A notice that does not contain all of the required information will not be considered notice of a qualifying event. If you do not provide all of the information necessary to meet the content requirements in a timely manner, you will lose the right to elect or extend continuation coverage.

Keep Your Address Current

To protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of Family Members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Length of COBRA Continuation Coverage

In the case of losses of coverage due to your death, divorce, legal separation, becoming entitled to Medicare Benefits (under Part A, Part B, or both), or a child ceasing to be a Dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of your hours of employment, coverage may be continued for up to a total of 18 months. When the qualifying event is the end of employment or reduction of your hours of employment and you became entitled to Medicare Benefits less than 18 months before the qualifying event, COBRA continuation coverage for your qualified beneficiaries will last until 36 months after the date of your Medicare entitlement.

COBRA continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full and on time;
- You become entitled to Medicare Benefits (under Part A, Part B, or both) after electing COBRA continuation coverage; or
- Your Employer ceases to provide any group health plans for its Employees.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

Extended Coverage

If you elect COBRA continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. To extend the period of COBRA continuation coverage, you must notify the Plan Administrator, Wilson-McShane Corporation, of a disability or a second qualifying event. Failure to provide notice of a disability or second qualifying event may affect your right to extend the period of COBRA continuation coverage.

Disability

An 11-month extension of coverage may be available to any qualified beneficiary that the Social Security Administration (SSA) determines is disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To take advantage of the 11-month extension of coverage, *you must notify the Plan Administrator within 60 days of the SSA's determination of your or your Dependent's disability, and you must provide a copy of the SSA disability determination*. If the qualified beneficiary is determined by the SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after the SSA's determination.

Second Qualifying Event

If a second qualifying event occurs during the first 18 months of COBRA continuation coverage, an 18 month extension of coverage will be available to Spouses and Dependent children who elect COBRA continuation coverage. The maximum amount of COBRA continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include your death, divorce, legal separation, becoming entitled to Medicare Benefits (under Part A, Part B, or both), or a child ceasing to be Eligible for coverage as a Dependent under the Plan. These events can be second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. *To take advantage of the 18-month extension of coverage, you must notify the Plan Administrator within 60 days after a second qualifying event occurs, and you must provide documented evidence of*

the occurrence of the qualifying event (a copy of the divorce decree in case of a divorce, for example, or documented evidence of a loss of Dependent status, in case such a loss occurs).

Electing COBRA Continuation Coverage

Once notified, the Fund Office will mail you the necessary election form. When you receive the form, you will have 60 days from the date of the Fund Office's notification letter in which to elect or decline COBRA continuation coverage. You or your Eligible Dependent will be ineligible for COBRA continuation coverage if you do not elect coverage within 60 days.

You must complete the election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect COBRA continuation coverage. For example, your Spouse, if you have one, may elect COBRA continuation coverage even if you do not. COBRA continuation coverage may be elected for only one, several, or all Dependent children who are qualified beneficiaries. Therefore, you or your Spouse can elect COBRA continuation coverage on behalf of all of your qualified beneficiaries. If you elect COBRA continuation coverage, you cannot make Self-Contributions after your COBRA continuation coverage ends. See information about COBRA payments on page 24.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You may be able to get coverage through other health coverage options, including Medicaid, your Spouse's coverage, or the Health Insurance Marketplace, that costs less than COBRA continuation coverage. For the Health Insurance Marketplace, go to **HealthCare.gov** or call (800) 318-2596 to look into your options. You should take into account that you have special enrollment rights in any other group health plan for which you are otherwise Eligible (such as a plan sponsored by your Spouse's Employer), as long as you enroll within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment rights at the end of the COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA Payments

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or 150% in the case of an extension of COBRA continuation coverage due to a disability) of the cost to the Plan for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA continuation coverage. The required payment for each COBRA continuation coverage period for each option is determined by the Trustees each year.

First Payment for COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. This is the date the election notice is postmarked, if mailed. If you do not make your first payment for COBRA continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator, Wilson-McShane Corporation, at (952) 854-0795 for further payment information.

The Plan will not provide monthly billing statements or payment coupons. You will be responsible for making the first payment and all subsequent monthly payments within the due dates.

Continuation Credits

If you have any hours remaining in your Individual Record System that are available to you, they will be applied against your first monthly Self-Contribution for COBRA continuation coverage and you will have to self-pay the difference. Thereafter, you will have to make the full monthly payment to continue your coverage. If you do not have any hours available, you will have to make the full monthly payment to continue your coverage.

Periodic Payments for Continuation Coverage

After you make your first payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in your COBRA notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for COBRA continuation coverage is due on the dates indicated on the election form. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any breaks.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown on the notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan. Your first payment and all periodic payments for COBRA continuation coverage should be sent to the Plan Administrator, Wilson-McShane Corporation, at 3001 Metro Drive, Suite 500, Bloomington, MN 55425.

Continuation of Life Insurance Benefits

If an Employee or Owner-Operator loses Eligibility for life insurance benefits due to his or her failure to work the required number of hours or due to termination of employment, he or she is entitled to continue coverage for up to 18 months. Coverage begins on the first day of the month following the month in which the termination of Eligibility occurred. Coverage will terminate if he or she obtains coverage under another group life insurance policy or if he or she fails to pay the monthly premium on time. Once the 18 months have ended, the Employee or Owner-Operator will be offered an individual insurance policy offering the same or similar benefits, but at his or her own cost.

Enrolling in Medicare vs. COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **medicare.gov/medicare-and-you**.

You are Eligible for Regular Retiree Plan or Medicare Advantage Prescription Drug Plan benefits only as long as you are receiving monthly pension checks from the Twin City Iron Workers Pension Fund and you are making the required Self-Contribution. To be Eligible for the Medicare Advantage Prescription Drug Plan, you and your Dependents must be Eligible for Medicare.

If you become Eligible for Medicare and were Eligible for Retiree coverage on or after February 14, 2013, you are Eligible for the fully insured Medicare Advantage Prescription Drug Plan (currently through a major insurance company). If you were already covered under the self-funded Medicare Supplement Plan prior to February 14, 2013, you may remain covered under that plan.

Medicare-Eligible participants may opt out of coverage if they have other medical coverage, for example through their Spouse or the Veterans Administration.

Retiree Dollar Bank

When you retire and begin receiving monthly retirement benefits from the Twin City Iron Workers Pension Fund, your Individual Record System hours will be converted to a dollar bank as follows:

1. Divide your hour bank by 120 to determine the months of active coverage you have available due to banked hours;
2. Determine the applicable monthly Retiree premium for medical and ancillary benefits (single or family rate); and
3. Multiply the results of 1 and 2 above, which will be used to pay your portion of the cost of Retiree coverage.

Upon conversion, your coverage under the Active Plan will cease and you will become covered under the Retiree Plan. When your dollar bank has less than the amount required for a month of coverage, you will be billed for the remainder. Once your dollar bank is zero, you will be responsible to pay your monthly Self Contributions.

Regular Retiree Plan

The Fund provides a Regular Retiree Plan. You are Eligible when the following applies:

- If you are retired or disabled and receiving a monthly pension benefit from the Twin City Iron Workers Pension Fund, you will be covered if you enrolled at that time and have made the required Self Contributions.
- If you die while covered under the Plan as an active or retired member, your surviving Spouse and your Dependent children can elect coverage under the Regular Retiree Plan as long as they make the required Self-Contributions and continue to be Eligible under the Plan.
- Benefits will normally become effective the first day of the month for which a pension benefit is issued by the Twin City Iron Workers Pension Fund to retired or disabled members, or the first day of the month following the member's death for surviving Spouses and Dependents, provided you or your survivors have made the required Self-Contributions.
- A Retiree will continue to be Eligible for benefits under the Retiree Plan as long as the Retiree's dollar bank has sufficient funds to pay for the applicable monthly Retiree Plan premium or, once the dollar bank is depleted, the Retiree pays the premium on a timely basis.

Medicare Advantage Prescription Drug Plan

The Fund provides a Medicare Advantage Prescription Drug Plan through a contract with a major insurance company. A copy of that contract is available by request from the Fund Office. The insurance company that provides this benefit may change from time to time. The Medicare Advantage Prescription Drug Plan offers complete national coverage and fills in the gaps between original Medicare Benefits and required deductibles, coinsurance and copayments, and provides a Medicare drug benefit.

Coverage and Benefits

Retirees, retired Owner-Operators, surviving Spouses of Employees, Totally Disabled Employees, Totally Disabled Owner-Operators, and the Dependents of each are Eligible for the Regular Retiree Plan or the Medicare Advantage Prescription Drug Plan, subject to the specific rules contained in the Plan.

Under each Retiree plan, you have the option of purchasing coverage as follows:

- For yourself only;
- For yourself and your Spouse; or
- For yourself, your Spouse, and/or Dependent children who meet the Plan's Eligibility rules.

You must be covered before adding coverage for Dependents. If you do not elect coverage for your Dependents when first Eligible for Retiree coverage, you cannot add them later. However, you may drop any Dependent from coverage at the beginning of any calendar quarter. Such Dependent may not be added again at any time in the future.

You must purchase the same level of coverage and the same optional benefits for yourself and Dependents. Under the Regular Retiree Plan, dental and vision benefits are optional and are offered together. If these benefits are chosen, they can be dropped at the beginning of any calendar quarter. However, if these benefits are not elected, they cannot be added later.

Opt Out of Coverage

You and/or your Dependent may opt out of coverage under this Plan for one of the circumstances described in this section.

A Retiree who wishes to exercise any of the Fund's opt-out provisions, as described below, may freeze his or her Retiree dollar bank. The dollar bank balance in effect upon opting out of coverage will remain for future use, contingent upon the Retiree adhering to the requirements for opting out and opting back in to coverage under this Plan. Failure to adhere to these requirements will result in forfeiture of the dollar bank balance.

A Retiree may not access the Retiree dollar bank balance for any reason while he or she is in opt-out status.

If a Retiree and Spouse have opted out of the Plan and the Retiree dies, the surviving Spouse is not Eligible for coverage under the Plan.

Opt Out for Participation in High Deductible Plan with Health Savings Arrangement

An Eligible Spouse and/or Dependent(s) may opt out of this Plan on an annual basis if he or she participates in another plan with a Health Savings Arrangement (HSA). A Spouse or Dependent who opts out of this Plan may return to this Plan in the month immediately following termination of coverage in the plan with the Health Savings Arrangement.

Opt Out of a Retired Participant with Other Employer-Sponsored Coverage

A Retiree and his or her Eligible Spouse and/or Dependents may opt out if there is other Employer-sponsored coverage available, such as through a Spouse's Employer. Once you opt out of Plan coverage, you and your Spouse will have limited rights to reenroll. In order to opt out, you must complete the Opt Out Application form and provide the Fund Office with the following documentation of the other health insurance at least 30 days prior to the effective date of the opt-out:

- The effective date of the other coverage;
- The names of those enrolled for the other coverage; and
- Any other documentation requested by the Fund Office.

You may reenroll in the Plan if you provide documentation of any of the following qualifying events within 30 days of the event:

- If the other coverage is provided through your Spouse's Employer and your Spouse loses coverage due to termination, retirement or a reduction in hours; or
- If the cost to you of the other coverage increases by more than 50%; or
- If the other coverage is provided through your Spouse's plan and you lose coverage due to a divorce or legal separation.

You and your Spouse each must reenroll in the Plan upon becoming Eligible for Medicare. If your Spouse continues coverage as an Active Employee, you and your Spouse may wait to reenroll until your Spouse retires or has another qualifying event.

If you and your Spouse drop coverage but do not follow the opt-out procedures, you and your Spouse will not be allowed to reenroll in the Plan, regardless of the circumstances.

If you reenroll and your Spouse regains access to other health coverage through an Employer, you can opt out again and reenroll later, subject to the opt-out and reentry rules.

Opt Out to Participate in a Federal or State Marketplace Plan

A Retiree, or his or her covered Spouse and Dependents, may opt out of this Plan to participate in a health plan offered on either the federal or state Marketplace (the exchange). Participants or Dependents who opt out of this Plan for Marketplace coverage may return during the next year's Marketplace open enrollment period. Participants or Dependents who opt out must be able to show proof of coverage during the opt-out period. If a participant or Dependent opts out for more than four years, he or she may not return to this Plan until the time at which he or she attains Medicare Eligibility.

Opt Out for Coverage Through the Veterans Administration (VA)

If your Spouse has VA coverage, you may maintain Plan coverage for yourself and your Dependent children. If you and/or your Spouse have VA coverage and opt out of the Plan, you and/or your Spouse may only reenroll upon attainment of Medicare Eligibility. If you and/or your Spouse reenroll in Plan coverage and then leave the Plan again, you and/or your Spouse will lose Plan coverage permanently.

When You Opt Out

Once you opt out of Plan coverage, you and your Spouse will have limited rights to reenroll. In order to opt out, you must complete the Opt-Out Application form and provide the Fund Office with the following documentation of the other health insurance coverage at least 30 days prior to the effective date of the opt-out:

- The effective date of the other coverage;
- The names of those enrolled for the other coverage; and
- Any other documentation requested by the Fund Office.

You may reenroll in the Plan if you provide documentation of any of the following qualifying events:

- If the other coverage is provided through your Spouse's Employer and your Spouse loses coverage due to termination, retirement or a reduction in hours; or
- If the cost to you of the other coverage increases by more than 50%; or
- If the other coverage is provided through your Spouse's plan and you lose coverage due to a divorce or legal separation.

You must reenroll within 30 days of the qualifying event. If you do not reenroll within the 30 days, you and your Spouse will not be able to reenroll at any time in the future.

You and your Spouse each must reenroll in the Plan upon becoming Eligible for Medicare. If your Spouse continues coverage as an Active Employee, you and your Spouse may wait to reenroll until your Spouse retires or has another qualifying event.

If you and your Spouse drop coverage but do not follow the opt-out procedures, you and your Spouse will not be allowed to reenroll in the Plan, regardless of the circumstances.

If you reenroll and your Spouse regains access to other health coverage through an Employer, you can opt out again and reenroll later, subject to the opt-out and reentry rules.

Termination of Retiree Eligibility

Coverage will terminate when you are no longer recognized as a pensioner under the Twin City Iron Workers Pension Fund or when you fail to make the Self-Contributions as required. Coverage will not be reinstated without reestablishing Eligibility under the Plan's Initial Eligibility rules for Active Employees. When you become Eligible for Medicare and if you elect prescription drug coverage under Medicare, you and your Dependents will lose prescription drug coverage under the Plan. If you and/or your Spouse opt out of coverage and do not satisfy the conditions for opt-out or reenrollment, you and/or your Spouse will lose the right to reenroll in the Plan.

Termination of Benefits for Dependents of Deceased Retirees

In the event of a Retiree's death while Eligible for benefits under Regular Retiree Plan coverage, any Dependents' health benefits will continue if the required Self-Contributions are made. The surviving Spouse's coverage will continue until the Spouse remarries or becomes covered under another group health plan. Coverage for Dependent children will continue until the Dependent child no longer meets the definition of Dependent and is subject to the surviving Spouse maintaining coverage. If the surviving Spouse becomes ineligible, the only continuation of coverage available to the Dependent children is COBRA continuation coverage.

32 Life Insurance Benefits

The Fund provides life insurance benefits to Employees and Owner-Operators only (but not Dependents) through a contract with an insurance company. A copy of that contract is available by request from the Fund Office. The insurance company that provides this benefit may change from time to time. The terms and conditions of the insurance contract govern benefits available under this insured arrangement.

Benefits Payable

The maximum benefit amount is shown in the *Summary of Benefits*. This benefit will be paid to your beneficiary if you die while Eligible for benefits. A death certificate must be submitted to the insurance company before payment can be made. You may change your beneficiary at any time.

Contact the Fund Office for details about filing a claim, identifying the current insurance company, and changing your beneficiary.

Beneficiary Designation

The Plan will pay benefits to the beneficiary you designated in writing on the form provided by the Fund Office. If you name more than one beneficiary but do not say how much each beneficiary should receive, the total amount will be shared equally by all surviving beneficiaries.

If you have not designated a beneficiary or if your beneficiary dies before you do, benefits will be paid equally to the survivors in the first applicable category and upon evidence acceptable to the Plan of their status and priority:

- Spouse;
- Children;
- Parents;
- Brothers or sisters; or
- Your estate.

If your beneficiary is a minor child, the Fund must be provided with information about the child's guardian or Trust (if applicable). Payment will be made through the guardian or Trust.

Continuation of Insurance After Coverage Terminates

The Fund's group life insurance policy contains a provision that permits Employees who are becoming ineligible to elect continuation coverage under most conditions.

You are responsible for paying the cost of the continued coverage on a monthly basis.

The Fund Office will inform you of your rights to continue life insurance coverage, and the amount and manner in which the premium is to be paid when your Eligibility is due to terminate.

If you are Eligible to continue this coverage, you have 60 days from the date coverage would otherwise end to elect continued coverage. You are Eligible to continue the coverage until you obtain coverage under another group policy or for a period of 18 months after termination or layoff from Covered Work, whichever is shorter.

34 Accidental Death and Dismemberment Insurance Benefits

The Fund provides accidental death and dismemberment (AD&D) insurance benefits for Employees and Owner-Operators (but not Dependents) through a contract with an insurance company. A copy of the contract is available by request from the Fund Office. The terms and conditions of the insurance contract govern benefits available under this insured arrangement.

Benefits Payable

Benefits for loss of life are payable to your beneficiary. See page 32 for information on beneficiaries. Benefits other than for loss of life are payable to you.

The scheduled amounts are as follows (and as shown in the *Summary of Benefits*):

FOR LOSS OF:	BENEFIT AMOUNT IS:
Life	$50,000
Two hands	$50,000
Two feet	$50,000
Sight of two eyes	$50,000
One hand and one foot	$50,000
One hand and sight of one eye	$50,000
One foot and sight of one eye	$50,000
Speech and hearing	$50,000
One arm or leg	$37,500
One hand or one foot	$25,000
Sight of one eye	$25,000
Speech or hearing	$25,000
Thumb and index finger of same hand	$12,500
FOR PARALYSIS OF:	
Both arms and legs	$50,000
Both legs	$25,000
One arm and one leg on either side	$25,000
One arm or leg	$12,500

FOR LOSS OF:	BENEFIT AMOUNT IS:
BRAIN DAMAGE	$50,000
COMA	$500 MONTHLY BEGINNING ON THE 7TH DAY OF THE COMA FOR THE DURATION OF THE COMA TO A MAXIMUM OF 60 MONTHS ($30,000)

In addition, the Plan provides the following benefits:

SITUATION:	BENEFIT AMOUNT:
Accidental death while using a seat belt	$5,000*
Accidental death with air bag use	$2,500*
Hospital confinement following accidental Injury	$500*
Accidental death while traveling in a common carrier	$50,000*
Child care following accidental death of parent	$5,000 per year, $6,000 maximum
Child education following accidental death of parent	$10,000
Spouse education following accidental death of employee	$1,500

**For each participant who died, only the highest of these benefits is payable.*

The total amount payable for all losses resulting from Injuries sustained in any one accident will not be more than the maximum benefit shown in the *Summary of Benefits*.

This benefit may or may not be converted to an individual policy, depending upon the insurance policy in force when you cease to be Eligible for benefits. Contact the Fund Office for further details.

Exclusions

No benefits will be paid for losses resulting from:

- Suicide or attempted suicide, and intentional self-inflicted Injury;
- Travel, flight in, or descent from any kind of aircraft except as a fare-paying passenger of a commercial airline or chartered flight; or travel in any aircraft not holding a current airworthiness certificate;
- Taking part in a riot;
- Military service;
- The commission of or attempt to commit a felony or to which a contributing cause was your being engaged in an illegal occupation;
- Voluntary use of any controlled substance. This exclusion will not apply if the controlled substance is prescribed for you by a Physician; or
- Bodily infirmity or disease from bacterial infections (except accidental ingestion of contaminated foods) – other than infections caused from an Injury covered under this coverage

36 Weekly Disability Benefits

If, due to a Total Disability, you are not actively at work on the date on which the coverage becomes effective, you will not be Eligible for weekly disability benefits until you return to active employment in Covered Work.

A weekly benefit will be paid to Employees and Owner-Operators (but not Dependents) if you:

- Have become Totally Disabled as a result of a Non-Occupational Injury or Disease;
- Are prevented from working at your regular occupation;
- Require the regular care of a Physician; and
- Are not receiving salary, wages, unemployment or any retirement benefits.

Written proof of disability must be submitted to the Fund Office.

Benefits Payable

The weekly benefit paid is shown in the *Summary of Benefits*. You must not be receiving benefits under workers' compensation law (or other law of similar purpose). Any absence from work that starts while you are Eligible for this benefit is considered a disability absence if, during all of the absence, you are prevented from working solely because of Injury or disease.

The Plan pays benefits during a period of Total Disability for non-Work-Related Illness or Injury.

This benefit will be payable to you beginning the first day of a Total Disability due to an accidental Non-Occupational Injury or the eighth day of a Total Disability due to a Non-Occupational Disease. The maximum number of weeks of payment for all absences occurring during a single disability period is 26. Payment up to the maximum number of weeks will be made for as many separate and distinct disability periods as may occur.

During partial weeks of Total Disability, you will be paid a daily rate of one-seventh of the weekly benefit amount shown in the *Summary of Benefits*.

Once you begin receiving a pension benefit from the Twin City Iron Workers Pension Plan, your weekly disability benefits will stop.

Total Disability Period

In determining when one Total Disability period ends and a new one begins, all disability absences due to the same or related causes and separated by less than two consecutive weeks of full-time active work will be considered as occurring in a single Total Disability period.

If a new Total Disability period is due to a cause different from the causes of any prior Total Disability, it need only be separated from the prior Total Disability by one day of full-time active work. You will be Eligible for payment for up to the maximum number of weeks for that new Total Disability period.

It is not necessary to be confined to your home to collect benefits, but you must have been seen and treated personally by a Physician. All certifications of Total Disability must be made by a Physician and not a chiropractor. Benefits are not payable for any day on which you are no longer considered Totally Disabled.

In the event an Injury or disease is, in the opinion of the Trustees, Work-Related and the workers' compensation insurance carrier(s) or self-insured Employer(s) involved deny the claim, the Fund will provide the weekly disability benefits, subject to the other requirements being satisfied.

38 Comprehensive Medical Benefits

If you or your Dependent incurs medical Covered Expenses as a result of a Non-Occupational Injury or Non-Occupational Disease, benefits will be paid up to the maximum shown in the Summary of Benefits, according to the provisions summarized in this section.

In the event your Injury or disease is, in the opinion of the Trustees, Work-Related, the Fund will not provide comprehensive medical benefits even if the workers' compensation insurance carrier(s) or self-insured Employer(s) involved deny the claim. If you have requested and been denied benefits according to workers' compensation law or other similar laws, you will be considered to have a Work-Related Injury or disease until:

- You, for a legitimate reason, irrevocably withdraw the request for workers' compensation or similar benefits;
- A court finally determines that you are not entitled to workers' compensation or similar benefits; or
- The Fund executes a stipulation resolving your request for workers' compensation or similar benefits or acknowledges that the Injury or disease is not Work-Related.

Calendar Year Deductible

The Calendar Year deductible is the amount of Covered Expenses that must be paid before comprehensive medical benefits are payable. The amount of the Calendar Year deductible is shown in the *Summary of Benefits*.

The Calendar Year deductible applies separately to each Family Member once a year except as follows:

- Covered Expenses incurred during the last three months of a Calendar Year that are applied toward the deductible may be used to satisfy the deductible for the following year;
- At any time during a Calendar Year when three or more Family Members satisfy their individual deductibles, the deductibles for all remaining Family Members will be considered satisfied for the remainder of that Calendar Year; and
- Each Family Member may not contribute more than the amount of his or her own deductible toward satisfaction of the family deductible amount. The percentage of Covered Expenses that the Family Member is required to pay may not be used to satisfy the family deductible amount.

Copayment Limit

If you or your Dependent incur Covered Expenses up to the copayment limit after the deductible shown in the *Summary of Benefits* during a Calendar Year, benefits are then payable for 100% of the Family Member's Covered Expenses in excess of the copayment limit for the balance of that Calendar Year. The copayment limit does not apply to comprehensive medical benefits incurred for orthotics and chiropractic treatment, supplemental medical benefits, or dental benefits.

Preferred Provider Organization (PPO)

The Fund has entered into an agreement with Blue Cross and Blue Shield of Minnesota to use their Aware network. You may still use the Physician or provider of your choice. By using a PPO provider, the charges will usually be discounted. This should result in savings to the Fund and to you as well. To find a PPO provider, visit the Blue Cross and Blue Shield of Minnesota website (**bluecrossmn.com**) and search the Aware network, or call (800) 810-2583.

The Fund may change this agreement at any time.

Lifetime Maximum Benefit

There is no overall lifetime maximum on benefits that may be paid by the Plan.

Covered Expenses

Covered Expenses are the Medically Necessary Hospital and other medical expenses listed below.

Hospital Expenses

Expenses incurred for the following Hospital services that are recommended by the attending Physician:

- Room and Board Charges up to the average semiprivate room charge; and
- Hospital services and supplies.

Under federal law, a plan may not restrict the Hospital stay for childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section delivery. 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 newborn earlier than 48 hours (or 96 hours as applicable). A plan may not require, under federal law, that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you or your Dependent is admitted to a Hospital or any other facility for any reason, including for an Emergency Medical Condition (as defined in the Definitions section), be sure to confirm that the facility is a participating provider in the Blue Cross and Blue Shield network of providers. Please note that confirmation that a provider accepts Blue Cross and Blue Shield insurance does not necessarily mean that the provider is a Blue Cross and Blue Shield *participating provider.* A provider may accept payment from Blue Cross and Blue Shield without agreeing to the contracting and credentialing requirements to participate in the network. **Hospital services billed by a provider that is not a participating provider in the Blue Cross and Blue Shield network of providers will not be covered by the Plan**, unless subject to the No Surprises Act.

Family Member includes the Employee or Owner-Operator and any of his or her Eligible Dependents.

Whenever you or your Dependent will receive treatment for which an overnight stay is anticipated, you should call the number on the back of your card for assistance with finding an in-network provider.

Other Covered Medical Expenses

Charges for the following services and supplies are considered other covered medical expenses, provided they have not been considered as Hospital expenses:

- Services performed by a Physician;
- Services performed by a registered graduate nurse, other than a nurse who ordinarily resides in the Family Member's home, or who is a member of the Family Member's family or is a Family Member of the Spouse's family; and
- Emergency Medical Conditions, as defined in the Definitions section.

The following medical services and supplies:

- Drugs and medicines obtainable only upon the prescription of a Physician are covered through the Plan's prescription drug benefits (for exclusions, see page 51). Only drugs and medicines provided while an inpatient in a Hospital are covered under comprehensive medical benefits;
- Diagnostic laboratory and X-ray examinations;
- X-ray, radium and radioactive isotope therapy;
- Anesthetics and oxygen;
- Breast pumps (including tubing);
- Rental of durable medical or surgical equipment;
- Prosthetic devices designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, artificial eyes, breast prostheses, cochlear implants, and intraocular lenses needed after cataract surgery;
- Professional ambulance service when used to transport an Eligible individual to the first Hospital where treatment is given and to a subsequent Hospital if such transfer is Medically Necessary for the care of that individual. No other charges in connection with travel are included;
- Services performed by an assistant surgeon;
- Physical, occupational and speech therapy as recommended by a Physician, but not including services or supplies provided by a Skilled Nursing Care Facility or chiropractor (within the scope of his or her license);
- Skilled Nursing Care Confinement for the following services and supplies when incurred as the result of a Non-Occupational Injury or Disease:
  a. Room and Board Charges up to the Skilled Nursing Care Facility's daily room charge but not to exceed the maximum number of days payable as stated in the Summary of Benefits for each period of Skilled Nursing Care Confinement;
  b. Skilled Nursing Care Facility miscellaneous charges not to exceed the maximum allowance for miscellaneous charges as stated in the Summary of Benefits; and
  c. Successive periods of Skilled Nursing Care Confinement are considered one period of Skilled Nursing Care Confinement unless the subsequent confinement commences after a period of 60 days or more during which time the Family Member was not confined in either a Hospital or Skilled Nursing Care Facility;

- Private Duty Nursing (PDN) is covered without any day limit under the following conditions:
  a. Participant has skilled nursing needs and the participant's condition is unstable, requiring frequent nursing assessments and changes in the plan of care;
  b. Placement of the nurse is done to meet the skilled nursing needs of the participant only and not for the convenience of the family; and
  c. PDN care must be approved by the participant's treating Physician, with a written treatment plan that includes long- and short-term goals;

  The Plan's definition of Private Duty Nursing can be found on page 91.
- Services and supplies furnished by a Home Health Care Agency to a Family Member in his or her home and in accordance with a Home Health Care Plan. The Home Health Care must commence within seven days following termination of a Hospital confinement as a resident inpatient and must be for the same or related condition for which the Family Member was hospitalized. These services and supplies include:
  a. Part-time or intermittent nursing care by a registered graduate nurse or by a licensed practical nurse, if the services of a registered graduate nurse are not available;
  b. Part-time or intermittent home health aide services that consist primarily of caring for the patient;
  c. Physical, occupational and speech therapy; and
  d. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that such expenses would have been covered if the Family Member had remained in the Hospital.

  The maximum number of Home Health Care visits per Calendar Year is shown in the *Summary of Benefits*. Each visit by a registered graduate nurse or licensed practical nurse to provide physical, occupational or speech therapy, and each visit of up to four hours of home health aide services are considered as one Home Health Care visit.

  Expenses for Home Health Care will not be included as Covered Expenses if they are for:
  a. Services or supplies not specified in the Home Health Care Plan;
  b. Services of a member of your family, your Spouse's family, or your household;
  c. Services of any social worker; or
  d. Transportation services;
- Hospice care services for you or a covered Dependent diagnosed as terminally ill, up to the lifetime maximum number of days as shown in the Summary of Benefits. Charges must be incurred during a confinement in a hospice or a facility operating under the direction of a Hospice Agency following a Hospice Plan. Covered Expenses include counseling of the patient and the Eligible Family Members, and bereavement counseling of the Eligible Family Members.
- Counseling and bereavement counseling, which must be rendered by a:
  a. Psychiatrist;
  b. Licensed psychologist; or
  c. Licensed social worker;
- Inpatient hospice benefits are payable when:
  a. There are no suitable Caregivers available to provide hospice benefits;
  b. It is determined by the Hospice Agency that home hospice is impractical because the persons that regularly assist with home care find the patient is unmanageable;

c. Respite care is needed;
d. Payment will not be made for:

i. Hospice services and supplies that are not part of a Hospice Plan;
ii. Services of a Caregiver or a person who lives in the participant's home or is a member of his or her family;
iii. Domestic or housekeeping services that are unrelated to the patient's care;
iv. Services that provide a protective environment when no skilled service is required, including companionship or sitter services other than respite care; or
v. Services that are not directly related to a participant's medical condition, including, but not limited to:

– Estate planning, drafting of wills or other legal services;
– Pastoral counseling or funeral arrangement or services;
– Nutritional guidance or food services such as "meals on wheels"; or
– Transportation services;

- Inpatient and outpatient treatment of alcoholism or drug abuse as stated in the *Summary of Benefits*;
- Inpatient and outpatient treatment of Mental Disorders as stated in the *Summary of Benefits*;
- Developmental Delay Therapy, which includes:
  a. Any charge for speech therapy unless it is required to restore functions lost due to a disease or Injury or to treat developmental delay;
  b. Expenses incurred for physical therapy, occupational therapy and speech therapy as recommended by a Physician and provided by an appropriately licensed therapist, except that:

  i. No benefits will be payable for any such therapy provided in a Skilled Nursing Care Facility; and
  ii. No benefits will be payable for any such therapy provided by a chiropractor;

- Dental work or oral surgery only if they are incurred for the prompt repair of natural teeth, or other body tissues, required as a result of a Non-Occupational Injury. Dental services for children up to age 6 that are provided in a medical setting are also covered;
- Expenses incurred in connection with reconstructive surgery to:
  a. Rebuild or correct a body part when such surgery is incidental to or following surgery resulting from Injury, Sickness or disease;
  b. Rebuild or correct a functional defect determined by a Physician to have been present at birth and that adversely affects the ability to perform routine activities of daily living; or
  c. Reconstruct the breast on which a mastectomy was performed and reconstruct the other breast to produce a symmetrical appearance;
- Smoking cessation programs;
- Prescription and over-the-counter tobacco cessation drugs with a doctor's prescription. Tobacco cessation drugs are provided pursuant to the Sav-Rx Prescription Service's formulary and subject to the Plan's Prescription Drug benefit copayment requirements. Covered tobacco cessation drugs include generic nicotine replacement products (nicotine patch, gum and lozenges), brand Nicotrol (inhaler system), brand Nicotrol NS (nasal spray), brand Chantix, and generic Zyban;
- Artificially assisted conception subject to the limitations described on page 47;

- Organ and bone marrow transplants, and related organ tissue acquisition, including the removal, preservation and transportation of the donated part, but excluding any financial consideration to the donor other than for a Covered Expense that is incurred in the performance of or in relation to transplant surgery;
- Services performed by a chiropractor (within the scope of his or her license to services performed);
- Preventive inoculations;
- Routine well-baby care through age 4;
- Routine preventive physical examinations performed by a Physician, subject to the provisions shown in the *Summary of Benefits*;
- One wig per year when required to replace hair lost as a result of chemotherapy;
- Prophylactic mastectomies and post-mastectomy reconstructive surgery will be covered when one or more of the following risk factors are present in the Family Member:
    a. A strong family history of breast cancer. A "strong family history of breast cancer" means that two or more first-degree relatives of the Family Member have been diagnosed with breast cancer or three or more first- or second-degree relatives of the Family Member have been diagnosed with breast cancer;
    b. Cancer in one breast and a first-degree relative with a history of breast cancer;
    c. A first-degree relative with bilateral premenopausal breast cancer;
    d. A biopsy diagnosis of lobular carcinoma or atypical hyperplasia and either a first-degree relative with breast cancer or breast tissue density, scarring or calcification that precludes follow-up mammographies and physical examinations;
    e. A family history of hereditary cancer, defined as Cowden's disease, SBLA syndrome, ovarian/breast cancer syndrome, and documented by family pedigree;
    f. A positive test for BRCA1 or BRCA2 mutant genes (expenses for genetic testing are not, however, Covered Expenses);
    g. A significant risk of breast cancer due to prior medical treatment, as demonstrated by competent medical evidence and opinion of the Family Member's Physician;
    h. Family Members are required to submit proposed procedures to the Plan in advance for authorization; or
    i. "First-degree relatives" are defined as a Family Member's mother or sisters. "Second-degree relatives" are defined as a Family Member's first cousins, aunts and natural grandmothers.

Note: Women's Health and Cancer Rights Act of 1998. Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. If you or a Dependent is receiving benefits under the Plan in connection with a mastectomy and elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending doctor and the patient for:

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

- Charges for services provided at retail clinics, including, but not limited to, Minute Clinic and Target Clinic;

- Gene therapy when performed by an in-network provider, where the therapy has been approved by the U.S. Food and Drug Administration (FDA), and the Plan's medical management service provider has determined that the therapy is Medically Necessary. Gene therapy typically involves 1) replacing a gene that causes a medical problem with one that does not; 2) adding genes to help the body fight or treat disease; or 3) turning off genes that cause medical problems. Examples of gene therapy include, but are not limited to, chimeric antigen receptor T-cell (CAR-T) therapies, such as Kymriah and Yescarta, and other therapies like Luxturna and Zolgensma. Coverage will not be provided for gene therapy that is considered Experimental or Investigational by the Plan; and
- Medical formula used in enteral feedings.

Expenses for No Surprises Act Services

- Air Ambulance Services

  Air ambulance services are medical transport for patients by a rotary wing air ambulance, as defined in 42 CFR § 414.605, or fixed wing air ambulance, as defined in 42 CFR § 414.605. The No Surprises Act requires Air Ambulance Services, to the extent covered by the Plan, to be covered as follows:

  a. Air ambulance services from an out-of-network provider are covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider;
  b. The cost-sharing amount will be calculated as if the total amount that would have been charged for the services by an in-network provider of air ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services;
  c. Any cost-sharing payments the Participant or Dependent makes with respect to covered Air Ambulance Services will count toward your network Deductible and network out-of-pocket maximum in the same manner as those received from an in-network provider; and
  d. In general, a Participant or Dependent cannot be balance billed for these Air Ambulance Services.

- Continuing Care Patients

  If a Participant or Dependent is a Continuing Care Patient and the Plan terminates its contract with an in-network provider or an in-network Health Care Facility or Hospital, or benefits are terminated because of a change in terms of providers' and/or facilities' participation in the Plan, the Plan will do the following:

  a. Provide notice of the Plan's termination of its contracts with the in-network provider or facility and inform the patient or their representative of the patient's right to elect continued transitional care from the provider or facility; and
  b. Allow the Patient (90) days of continued coverage at the network cost sharing to allow for a transition of care to an in-network provider or facility.

A Continuing Care Patient is an individual who is: (a) receiving a course of treatment for a Serious and Complex Condition; (b) scheduled to undergo non-elective surgery (including any post-operative care); (c) pregnant and undergoing a course of treatment for the pregnancy; (d) determined to be terminally ill and receiving treatment for the illness; or (e) undergoing a course of institutional or inpatient care from the provider or facility.

In the case of an acute illness, a Serious and Complex Condition is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness or condition, a Serious and Complex Condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

- Emergency Services

  The No Surprises Act requires Emergency Services to be covered as follows:

  a. Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;
  b. Without regard to whether the health care provider furnishing the Emergency Services is an in-network provider or an in-network facility, as applicable, with respect to the services;
  c. Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from in-network providers and in-network facilities;
  d. Without imposing cost-sharing requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by an in-network provider or an in-network facility;
  e. By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services;
  f. By counting cost-sharing payments you make with respect to out-of-network Emergency Services toward your in-network provider Deductible and in-network provider out-of-pocket maximum in the same manner as those received from an in-network provider; and
  g. In general, Participants and Beneficiaries cannot be balance billed for these Emergency Services.

- Non-Emergency Services

  The No Surprises Act requires non-Emergency Services performed by an out-of-network provider at an in-network Health Care Facility to be covered as follows:

  With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider;

  By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such in-network provider were equal to the recognized amount for the items and services; and

  By counting any cost-sharing payments made toward any in-network provider deductible and in-network provider out-of-pocket maximums applied under the Plan (and the in-network provider Deductible and out-of-pocket maximums must be applied) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by an in-network Provider.

  In general, Participant and Beneficiaries cannot be balance billed for these items or services.

- Notice and Consent Exception

  Non-emergency items or services provided or performed by an out-of-network provider at an in-network Health Care Facility will be covered based on the Plan's out-of-network provider benefits and forgo the financial protections of the No Surprises Act if:

  At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the patient (or their representative) is provided with a written notice, as required by federal law, that the Provider is an out-of-network provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on treatment, the names of any in-network providers at the facility who are able to provide treatment, and that the patient may elect to be referred to one of the in-network providers listed; and

- The patient gives written informed consent to continued treatment by the out-of-network provider acknowledging that the patient understands that continued treatment by the out-of-network provider may result in greater expenses.
- The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the out-of-network provider satisfied the notice and consent criteria and, therefore, these services will be covered as follows:
  a. With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by an in-network provider;
  b. With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services; and
  c. By counting any in-network provider Deductible and in-network provider out-of-pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by an in-network provider.
  d. In general, Participants and Beneficiaries cannot be balance billed for these items or services.
- Choice of Health Care Professional

  The Plan does not require the selection or designation of a primary care provider (PCP) or pediatrician. You have the ability to visit any in-network or out-of-network health care provider; however, payment by the Plan may be less for the use of an out-of-network provider.
- Access to Obstetrical and Gynecological Care

  You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Cross Blue Shield of Minnesota at (800) 810-2583 or **bluecrossmn.com**.
- External Review Process

  The External Review Procedures of this Plan shall apply to No Surprise Act service claims.
- Provider Directory

  The provider directory will be updated at least every ninety (90) days. If a Participant or Dependent is informed by the Plan through a telephone, electronic, or internet-based inquiry, or receives information from a print or electronic provider directory that a provider is an in-network Provider, but, in fact, the provider is an out-of-network provider and services are furnished by the out-of-network provider, the Plan will:
  a. Apply a cost-sharing amount that is no greater than the cost-sharing amount that would have been assessed if the provider was an in-network provider; and
  b. Apply the out-of-pocket limit, if any, as if the services were provided by an in-network provider.

Limitations and Exclusions

Benefits will not be payable under comprehensive medical benefits for:

- Expenses that are payable under any other provision of the Plan;
- Any of the circumstances described in the *General Plan Exclusions* section beginning on page 57; or
- Hospital expenses incurred at facilities not participating in any Blue Cross and Blue Shield Association affiliate or Blue Card network of preferred providers, except as otherwise required by the No Surprises Act.

Also note that covered medical expenses for artificially assisted conception are subject to a lifetime benefit payment of $7,500. Such services are limited to artificial insemination, in vitro fertilization, gamete intrafallopian transfer, or similar fertility promotion procedures or techniques, which are only covered under the artificially assisted conception benefit. Artificially assisted conception does not include procedures for the medical treatment of infertility due to Sickness, Injury or bodily defect.

48 Supplemental Medical Benefits

The Plan provides supplemental medical benefits for hearing aid, vision and orthotic expenses.

These benefits are payable only to Employees, Owner-Operators and their Dependents, including those covered under the Active Plan and Regular Retiree Plan. No deductible is required for these supplemental medical benefits. Charges in excess of the maximum benefit shown in the *Summary of Benefits* for supplemental medical benefits will not be considered under any other provision of this Plan. The Fund pays the copayment percentage shown in the *Summary of Benefits*. The Family Member's share of these expenses does not count toward the comprehensive medical benefits copayment limit.

If an Injury or disease is, in the opinion of the Trustees, Work-Related, the Fund will not provide supplemental medical benefits even if the workers' compensation insurance carrier(s) or self-insured Employer(s) involved denies the claims. An individual who has requested and been denied benefits according to a workers' compensation law or other similar law is considered to have a Work-Related Injury or disease until:

- The individual, for a legitimate reason, irrevocably withdraws the request for workers' compensation or similar benefits;
- A court finally determines that the individual is not entitled to workers' compensation or similar benefits; or
- The Fund executes a stipulation resolving the individual's request for workers' compensation or similar benefits or acknowledges that the Injury or disease is not Work-Related.

Doctor On Demand

The Plan offers a convenient way for you and your covered Dependents to access care through virtual appointments with a doctor (medical, psychologist, or Psychiatrist). The online service, accessed through a computer, tablet or smartphone, is provided in partnership with Blue Cross and Blue Shield of Minnesota and is called Doctor On Demand.

If you or a Dependent is under the weather, getting a private, secure and convenient online medical visit through Doctor On Demand is a great option. Taking advantage of this benefit is especially helpful when you are away from home or your doctor is unavailable. Doctor On Demand doctors can answer medical questions, make a diagnosis and even prescribe medication for you in some instances, if needed. They can help with minor injuries and common medical ailments like colds, flu symptoms, fevers, allergies, infections, headaches, sore throats, minor rashes and earaches. Doctor On Demand also provides support for mental health through appointments with psychologists and Psychiatrists.

You can save time and get the care you need without having to schedule a doctor's appointment or be exposed to other sick people while sitting in a doctor's waiting room. It is also faster and cheaper than going to an emergency room or urgent care facility.

The Plan covers 100% of the cost each time you visit a doctor through Doctor On Demand. The deductible will not apply to Doctor On Demand visits.

To learn more, visit **doctorondemand.com/bluecrossmn**. If you have any questions, please contact the Fund Office at (952) 854-0795.

Hearing Aid Benefits

Hearing aid benefits are payable up to the maximum shown in the *Summary of Benefits* in any five-year period for participants and Dependents age 19 and older, and in any three-year period for Dependents under age 19.

The hearing aid must be prescribed by an audiologist who is operating within the scope of his or her license. The Family Member does not have to obtain the hearing aid from the audiologist who prescribed it. This benefit does not cover the cost of hearing aid batteries.

The cost of the audiological exam is Eligible for reimbursement under the Plan's comprehensive medical benefits. No reimbursement related to the hearing aid will be made under any other provision of this Plan.

Vision Benefits

Vision benefits are payable up to the maximum benefit per two-year period shown in the *Summary of Benefits* for the following expenses:

- Professional examinations by an ophthalmologist (M.D.) or optometrist licensed under the applicable state law;
- Lenses prescribed by a licensed ophthalmologist (M.D.) or optometrist;
- Frames purchased in conjunction with lenses newly prescribed by a licensed ophthalmologist (M.D.) or optometrist. This includes safety lenses that are Medically Necessary and prescribed to correct a vision problem or condition; and
- Those applied toward the cost of LASIK corrective surgery.

Charges in excess of the maximum benefit shown in the Summary of Benefits for this benefit will not be considered under any other provision of this Plan.

Note that the vision benefit is a two-year benefit that resets every even year.

Vision Expenses Not Covered

Benefits will not be payable for the following:

- Sunglasses, unless they are prescribed, for medical purposes, to be worn substantially at all times;
- Routine yearly examinations required by an Employer in connection with the occupation of the Family Member;
- Vision expenses resulting from an accidental bodily Injury arising out of or in the course of employment or from a disease compensable under any workers' compensation or similar law;

- Vision expenses for examinations in a Hospital owned or operated by the federal government or for any examination for which the individual is not required to pay; or
- Any expenses for circumstances described in the General Plan Exclusions section.

Orthotics Benefits

Orthotics benefits are payable up to the amount and time restrictions shown in the *Summary of Benefits*.

Charges in excess of the maximum benefit shown in the *Summary of Benefits* for this benefit will not be considered under any other provision of this Plan.

Prescription Drug Benefits

Using generic drugs will lower your and the Fund's costs. Always ask your Physician if generic medications are appropriate for you.

Prescription drug benefits are provided through a retail pharmacy program and through the Sav-Rx Prescription Service (Sav-Rx) Mail Order Pharmacy program. Benefits are not subject to a deductible. However, you must pay 20% ($5 minimum payment) of the cost of each prescription at the time of purchase. Once you reach the $3,000 per person out-of-pocket limit for the Calendar Year, the Plan will pay 100% for any other covered prescriptions for the rest of the year.

Covered Expenses

To be covered, the drug or medication must be obtainable by prescription only.

The following supplies, when authorized by a Physician, are considered Covered Expenses under this prescription drug benefit:

- Legend drugs that are lawfully obtainable only from an individual licensed to dispense drugs upon the Physician's prescription, including oral contraceptives;
- Injectable insulin;
- Prescribed syringes, hypodermic needles, test strips and other Medically Necessary supplies used for the administration of injectable insulin;
- Compound medication of which at least one ingredient is a prescription legend drug; and
- Specialty drugs are covered only when you use Sav-Rx Specialty Pharmacy suppliers.

Limitations and Exclusions

The following drugs or medications are not covered under the Plan's prescription drug benefits:

- Contraceptives that may lawfully be sold without a prescription;
- Drugs or medicines (except insulin) that may lawfully be sold without a prescription;
- Therapeutic devices or appliances, support garments, and other nonmedical substances, regardless of their intended uses;

- Experimental and/or Investigational drugs not approved for general sale and marketing in the United States. However, a drug will not be considered Experimental and/or Investigational if it is:
  a. Approved by the FDA as an "Investigational new drug for treatment use";
  b. Classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease," as that term is defined in FDA regulations; or
  c. Approved by the FDA for the treatment of cancer, but has been prescribed for the individual to treat a type of cancer for which the drug has not been approved for general use, provided that the FDA has not determined that such drug should not be prescribed for that individual's type of cancer;
- Refilling of a prescription in excess of the number of refills specified by the Physician or Dentist, or any refill dispensed after one year from the prescription of a Physician or Dentist;
- Prescribed drugs that may be properly received without charge under local, state or federal programs, including workers' compensation;
- Viagra in excess of 12 pills per month; or
- Any drugs or products that are partially or wholly cosmetic in nature.

Generally, prescriptions and refills can be filled up to a 34-day supply through the retail pharmacy program and up to a 90-day supply through the Sav-Rx Mail Order Pharmacy. Contact the Fund Office for mail order forms and envelopes.

The Plan provides access to a dental network through Delta Dental, and only covers dental expenses incurred in connection with a Non-Occupational Disease or Non-Occupational Injury. Charges in excess of the maximum benefit shown in the *Summary of Benefits* will not be considered under any other provision of this Plan.

If an Injury or disease is Work-Related in the opinion of the Trustees, the Fund will not provide dental benefits even if the workers' compensation insurance carrier(s) or self-insured Employer(s) involved denies the claims. An individual who has requested and been denied benefits according to a workers' compensation or other similar law is considered to have a Work-Related Injury or disease until:

- The individual, for a legitimate reason, irrevocably withdraws the request for workers' compensation or similar benefits;
- A court finally determines that the individual is not entitled to workers' compensation or similar benefits; or
- The Fund executes a stipulation resolving the individual's request for workers' compensation or similar benefits or acknowledges that the Injury or disease is not Work-Related.

Benefits Payable

The maximum benefit payable for all dental Covered Expenses incurred by any one Family Member will not exceed the maximum benefit period shown in the Summary of Benefits.

Covered Expenses

Covered Expenses are the charges made by a Dentist for the four types of services listed below. Items listed either in the following Limitations and Exclusions section or in the General Plan Exclusions section will not be considered Covered Expenses. The following sections describe covered dental services.

Type A Dental Services

Type A dental services are paid at 100% of the Allowable Charges without any deductible having to be paid. However, these benefits are subject to the limit shown in the *Summary of Benefits*. This limit covers the combined benefits paid for Types A, B and C dental services.

Covered Type A dental services include oral examinations, which include scaling and cleaning of teeth, but not more than four examinations or scalings and cleanings in any Calendar Year. Other covered services include:

- Dental X-rays, limited to:
  a. One full-mouth X-ray (of at least 14 films) in any period of 60 consecutive months;
  b. One supplementary bitewing X-ray in any period of 12 consecutive months for Dependents younger than age 19 or in any period of 24 consecutive months for all Family Members age 18 and older; and
  c. Dental X-rays required in connection with the diagnosis of a specified condition requiring treatment;
- One topical application of sodium or stannous fluoride in each period of 12 consecutive months for Dependents younger than age 19;
- Dental sealants for Dependents younger than age 19; and
- Space maintainers.

Type B Dental Services

Type B dental services are paid at 90% of the Allowable Charges after the deductible shown in the Summary of Benefits has been satisfied. However, these benefits are subject to the limit shown in the Summary of Benefits. This limit covers the combined benefits paid for Types A, B and C dental services. Covered Expenses for Type B dental services include:

- Restorative services (fillings only) using amalgam, synthetic porcelain, and plastic filling materials, and crowns and jackets when teeth cannot be restored with a filling material;
- Oral surgery, including the excision of impacted teeth and all oral surgery in connection with diseases of the gums or tissues of the mouth;
- Administration of general and local anesthetics in connection with oral surgery and/or other covered dental services;
- Injection of antibiotic drugs by a Dentist;
- Treatment of periodontal and other diseases of the gums and tissues of the mouth;
- Endodontic treatment, including root canal therapy; and
- Extractions, except when incurred as a result of orthodontic care.

Type C Dental Services

Type C dental services are paid at 80% of the Allowable Charges after the deductible shown in the *Summary of Benefits* has been satisfied. However, these benefits are subject to the limit shown in the *Summary of Benefits*. This limit covers the combined benefits paid for Types A, B and C dental services. Covered Expenses for Type C dental services include:

- Initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework;
- Replacement or alteration of full or partial dentures or fixed bridgework that is necessary because of oral surgery;
- Replacement of a full denture where the requirements in the Limitations and Exclusions section are met;
- Replacement or addition of teeth to an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework so long as the requirements in the Limitations and Exclusions section are met;
- Replacement of a crown restoration, provided the original crown was installed more than two years before the replacement;

- Repair or recementing of crowns, inlays, bridgework or dentures, or relining of dentures; and
- Dental implants and services in conjunction with an implant, including grafts, sinus lift surgery, and barrier membrane replacement.

Type D Dental Services

Type D dental services are orthodontic care. Orthodontic care is care that is corrective in nature and includes braces for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Type D dental services are paid at 80% of the Allowable Charges after the deductible shown in the *Summary of Benefits* has been satisfied. In addition, these benefits are subject to the limit shown in the *Summary of Benefits*.

Limitations and Exclusions

Dental benefits are not payable under the Plan for the following:

- Dental services or supplies that are included as Covered Expenses under the Plan's comprehensive medical or supplemental medical benefits or under any other plan sponsored by your Employer;
- Treatment by anyone except a Dentist. However, charges for cleaning or scaling of teeth performed by a licensed dental hygienist under the supervision and direction of a Dentist will be covered;
- First installation of dentures and bridgework (including crowns and inlays forming the abutments) when the charges are for the replacement of congenitally missing teeth or for replacement of natural teeth, except for cases where replacement of natural teeth is required;
- Replacement of a removable denture (partial or full) or fixed bridgework by a new denture or new bridgework, as well as charges for the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth. However, this exclusion will not apply if evidence satisfactory to the Fund is presented showing that one of the following is applicable to the specific charges for which a claim is made:
  a. The replacement or addition of teeth is required to replace one or more natural teeth that were extracted;
  b. The existing denture or bridgework was installed at least five years before its replacement and the existing denture or bridgework cannot be made serviceable; or
  c. The existing denture is an immediate temporary denture and replacement by a permanent denture is required and is done within 12 months after the date of installation of the immediate temporary denture;
- Services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures;
- Installation of prosthetic devices (including bridges and crowns) that either were ordered while the Family Member was not Eligible for this benefit or which were ordered while the Family Member was Eligible for this benefit but are finally installed or delivered to the Family Member more than 30 days after termination of his or her coverage;
- Replacement of a lost or stolen prosthetic device;
- Replacement of a crown restoration that was installed less than two years before the replacement; and
- Circumstances described in the General Plan Exclusions section beginning on page 57.

56 Employee Assistance Program

The Employee Assistance Program offers confidential counseling for a broad spectrum of personal problems including marital, legal, financial, family, relationships, alcoholism and/or drug abuse, emotional or psychological, spiritual, occupational/vocational, and workers' compensation/rehabilitation.

The Program is administered by Total Employee Assistance Management, Inc. (T.E.A.M., Inc.).

Several key points about this service:

- All counseling by T.E.A.M., Inc. has been prepaid by the Fund. However, when a referral is made to another care provider, the cost will be handled according to the rules of the Plan's comprehensive medical benefits;
- **Every consultation is confidential. No information will be given to either your Employer or the Union unless you specifically request it;**
- This counseling is available to Employees, Owner-Operators, Retirees and Dependents; and
- There is no preauthorization required for mental health and chemical dependency treatment. However, we recommend that you use T.E.A.M. to help coordinate your care.

T.E.A.M., Inc. offices are located throughout the Twin Cities, and confidential assistance is available 24 hours a day by calling (651) 642-0182 or (800) 634-7710.

If you live outside the Twin Cities Area, T.E.A.M., Inc. will arrange for either themselves or another provider in your area to assist you. Please call T.E.A.M., Inc. for further information.

General Plan Exclusions

Comprehensive medical benefits are not provided under this Plan for the following:

1. Inpatient expenses incurred at out-of-network facilities, except as otherwise required by the No Surprises Act;
2. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical emergency or when on temporary work assignment at a location outside the United States;
3. Charges in excess of the Allowable Charge limits established for this Plan, except as otherwise required by the No Surprises Act;
4. Services or supplies not recommended by a Physician, or not Medically Necessary in treating the Injury or Sickness. A Physician's recommendation is not required for chiropractic services that are Medically Necessary in treating the Injury or Sickness;
5. Services for which a Family Member is not legally obligated to pay;
6. Services provided by a member of an Employee's or Owner-Operator's household or by anyone related to the Employee or Owner-Operator;
7. Charges resulting from a Family Member's participation in a riot or in the commission of a felony, except cases involving domestic violence are covered;
8. Services or supplies that are:
   a. Not provided in accordance with generally accepted professional medical standards; or
   b. For Experimental and/or Investigational treatment;
9. Injury, Sickness or dental treatment that arises out of or in the course of any employment or work for pay or profit;
10. Expenses incurred after the termination of coverage, except as provided under any extension of coverage provisions included in the Plan;
11. Expenses incurred before Eligibility for Plan coverage;
12. Charges that would not have been made if no Plan coverage existed;
13. Services or supplies that are furnished, paid for, or otherwise provided for:
    a. By reason of the past or present service of any person in the armed forces of a government; or
    b. Under any law of a government (national or otherwise), except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees or their dependents;

14. Custodial care, which includes services and supplies including room and board and other institutional services that are provided to an individual, whether disabled or not, primarily to assist him or her in activities of daily living;
15. Any loss, expense or charge which results from cosmetic, plastic or reconstructive surgery except for surgery to:
    a. Rebuild or correct a body part when such surgery is incidental to or following surgery resulting from Injury, Sickness or disease of the involved body part;
    b. Rebuild or correct a functional defect determined by a Physician to have been present at birth and that adversely affects the ability to perform routine activities of daily living; or
    c. Reconstruct the breast on which a mastectomy was performed and reconstruct the other breast to produce a symmetrical appearance;
16. Charges for failure to appear for an appointment as scheduled or for the completion of claim forms;
17. Charges that result from an act of declared or undeclared war or armed aggression;
18. Supplies or equipment for personal hygiene, comfort or convenience, such as air conditioning, air purifiers, whirlpools, swimming pools, dehumidifiers, allergy-free pillows, blankets, mattress covers, electric heating units, orthopedic mattresses, lumbar gravity-reduction chairs, elevators or stair lifts, humidifiers, physical fitness and exercise equipment, waterbeds, or articles of clothing and shoes;
19. Special home construction to accommodate a disabled individual;
20. Charges for a Dependent for any medical expense for which he or she is entitled to benefits as an Employee, former Employee, Owner-Operator or former Owner-Operator of a contributing Employer;
21. Education, training, and room and board while a Family Member is confined in an institution that is primarily a school or other institution for training, a place of rest, a place for the aged, or a nursing home;
22. Nutritional consultations, instructions or treatments, except for in conjunction with the treatment of diabetes. Medical formulas used in enteral feedings are covered;
23. Weight control or treatment of obesity;
24. Eye exercises or vision training;
25. Artificially assisted conception, except as specifically stated in the Covered Medical Expenses section;
26. Vasectomy and tubal ligation reversals;
27. Speech therapy, unless it is required because of a physical impairment caused by a disease or Injury;
28. Medical expenses incurred in an automobile accident if automobile insurance was not obtained by the Family Member as required by state law. Payment will be considered on the amount that exceeds no fault coverage;
29. Vitamins, food supplements, special formula, and food substitutes, except medical formulas used in enteral feedings are covered;
30. Chelation therapy, except for acute arsenic, gold mercury, or lead poisoning;
31. Hypnosis;
32. Charges for services for the treatment of compulsive gambling;

33. Allergy food drops, sublingual allergy drops, or oral immunotherapy;

34. Orthodontics, except as specified in the Dental Benefits section;

35. Routine foot care; and

36. Any loss, expense or charge incurred as a result of any Injury, occurrence, condition or circumstance for which the injured Family Member or individual:

    a. Has the right to recover payment from a third party. At the discretion of the Trustees, losses, expenses and charges excluded by this general exclusion may be paid subject to the Fund's right of subrogation and reimbursement;
    b. Has recovered from a third party; or
    c. Has not submitted a claim for such loss, expense or charge prior to resolution of the third-party claim.

    This exclusion applies to any recovery received by a Family Member or individual regardless of how it is characterized, including, but not limited to, any apportionment to a Spouse for loss of consortium.

    The term "third party" as used in this section includes any individual, insurer, entity, or federal, state or local government agency that is or may be in any way legally obligated to reimburse, compensate or pay for an individual's losses, damages, injuries or claims relating in any way to the Injury, Sickness, occurrence, condition or circumstance for which the Fund has paid medical, dental or disability benefits. This includes but is not limited to insurers providing liability, medical expense, wage loss, no fault, uninsured motorist, underinsured motorist, and workers' compensation coverage.

60 Claims and Appeals

Claims Administrator

The entity, individual or committee of individuals designated by the Trustees to consider and respond to claims.

Informal Inquiries

The Claims Administrator will follow the guidelines below for dealing with informal inquiries regarding benefit claims.

Responsibility to Review Information

You are responsible for promptly reviewing any information you receive regarding the Plan.

60-Day Deadline for Notifying the Claims Administrator of Incorrect Information

You must notify the Claims Administrator within 60 days after receiving the information you believe is incorrect. The Plan is not responsible for any mistakes or losses unless you bring them to the Plan's attention within the 60 days.

60-Day Period to Challenge Answer to Informal Inquiries

In most cases, the Claims Administrator will consider the initial inquiry to be an informal claim, as opposed to a formal claim, under the terms of the Plan. The Claims Administrator will inform you that if the response to the inquiry does not resolve the matter to your satisfaction, you must, within 60 days after the decision on the inquiry, file a formal written claim for benefits in accordance with these claims procedures.

Physical and Dental Examination and Autopsy

The Trustees have the right, at the Fund's expense, to have their designated Physician or Dentist examine the Family Member whose Injury or Sickness is the basis of a claim for Plan benefits, as often as they may reasonably require, and to make an autopsy in case of death, where it is not forbidden by law.

Initial Claims

If you do not receive a benefit to which you believe you are entitled, you (or your authorized representative) must file a formal written claim to pursue the matter further. The procedures for filing a formal written claim are set forth below.

Filing a Claim

When filing a formal written claim for benefits, you should specifically designate the claim as a "Claim for Benefits" and should send it to the Claims Administrator at:

Twin City Ironworkers Health and Welfare Fund
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Contents of the Formal Written Claim

The claim should explain what you want and why you believe you are entitled to it and should include copies of any relevant documents.

Proof of Loss

Written proof of loss under any weekly disability benefit coverage must be given to the Fund by the Eligible individual within 60 days after the end of the period for which the Fund is liable. Written proof of loss under any other coverage must be given to the Fund by the Eligible individual within 60 days after the loss.

Proof of loss must cover the occurrence, the character, and the extent of the loss.

Late proof may be accepted only if, under the particular circumstances, it was furnished as soon as was reasonably possible and, in any event except in the absence of the Employee's or Dependent's legal capacity, within one year after the time it was otherwise required.

No action at law or in equity may be brought to recover from the Fund after two years from the time the claimant first receives information that constitutes a clear repudiation of the rights that the claimant is seeking to assert. This two-year limitation period will not run during the period of time, if any, when the claimant's claim is in the claims procedure process. Once that process is completed, however, the two-year period will continue running where it left off.

Submission of Falsified or Fraudulent Claims

All claims, enrollment forms, and any other information submitted or provided to the Plan must be accurate and complete. If the Board of Trustees finds that false or inaccurate information in support of a claim has been provided to the Plan, whether directly or indirectly, the claim will be denied. Further, the Plan will offset any amount improperly paid and/or terminate future coverage for the Participant and covered Family Members.

Deadline for Submitting the Claim

Different deadlines apply based on the circumstances surrounding the claim:

- If the claim follows an informal inquiry that was not resolved to your satisfaction, it must be filed within 60 days after you receive a response to the inquiry; and
- Any other claim must be filed within 60 days after you first receive the information on which the claim is based.

Claims Administrator's Response to the Claim

Health Care Claims

The Claims Administrator will ordinarily respond to the claim within 30 days after receiving it. The Claims Administrator may, however, extend this period once for an additional 15 days due to matters beyond the Plan's control. For example, the Claims Administrator may extend the time period if you do not provide enough information to decide the claim. If an extension is necessary, the Claims Administrator will notify you (prior to the end of the 30 days) of the extension, the reason for the extension, and the date by which the Claims Administrator expects to decide the claim.

If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the missing information. The period for deciding your claim will be suspended until you provide the missing information. Once the Claims Administrator receives the information, the Claims Administrator will respond to the claim within 15 days. If you do not provide the missing information within the specified period, the Claims Administrator will decide the claim without that information.

For No Surprises Act Services Claims, the out-of-network provider will receive an initial payment or denial of payment from the Plan for No Surprises Act Services within 30 days of receipt of all information necessary to adjudicate the Claim.

If a Claim is subject to the No Surprises Act, the Participant or Dependent cannot be required to pay more than the cost-sharing amount under the network Plan and the provider or facility is prohibited from billing the Participant or Dependent in excess of the required cost-sharing amount.

The Plan will pay a total plan payment directly to the out-of-network provider that is equal to the amount by which the Out-of-Network Rate for these services exceeds the cost-sharing amount for the services, less any initial payment amount.

Weekly Disability Benefit Claims

If the Fund denies your claim for weekly disability benefits, it will do so within 45 days of the date it receives the claim. In certain situations, the Fund may extend this by an additional 30 days if the Fund notifies you in writing before the end of the initial 45 day period of the reasons for the extension and provides information about when the Fund expects to make a decision on your claim. The Fund may further extend this by an additional 30 days if the Fund notifies you in writing before the end of the 75 day period, giving the same information required for the first extension. If the extension is needed because you did not submit the necessary information to the Fund, the Fund will tell you of the information it needs and will give you 45 days to provide the needed information to the Fund. If you do not provide the information within the 45 day period, the Fund will decide your claim on the basis of the information it has, and your claim may be denied.

Life and AD&D Insurance Claims

Life insurance benefits are payable in the event of your death. Payment to your designated beneficiary will be made immediately upon receipt of a certified copy of the death certificate.

Accidental death and dismemberment (AD&D) insurance benefits are payable in addition to the life insurance benefit. All accidental death claims will be investigated by the Board of Trustees. Therefore, a minimum period will elapse between the time the complete proof of loss has been received at the Fund Office and the payment of benefits.

Notice of Benefit Determination

The Claims Administrator will provide you with a written decision on the claim. If the claim is approved, you will receive a written notice of the approval. If the claim is denied in whole or in part, the denial will include the following information:

- Inform you of the specific reasons your claim was denied;
- Reference to the specific Plan provision(s) on which the determination was based;
- A description of any additional material or information for you to complete the claim and an explanation of why the material or information is necessary;
- A description of the Plan's review procedures and the time limits for these procedures (which are also stated below), plus include a statement concerning your rights under federal law if your claim is denied;
- If an internal rule was relied upon by the Plan in making the decision, either a description of the rule or a notice that you can request a copy of the rule from the Plan;
- If the claim decision was based on a Medical Necessity or Experimental treatment exclusion, either an explanation of the scientific or clinical judgment for the determination or a statement that the explanation will be provided to you upon your request;
- If the claim is an urgent care claim, a description of the review process applicable to urgent claims; and
- If the claim is a disability claim, a description of the review process applicable to disability claims and a discussion of the decision, including an explanation, if applicable, of the basis for disagreeing with or not following:
  a. The views presented by your health care and vocational professionals;
  b. The views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination; and
  c. Your disability determination from the Social Security Administration.

Deemed Denial

If you do not receive a decision on your claim within the time frame set out above, the claim is deemed to be denied and you can proceed to the appeal phase.

Appeal of Denied Claim

If all or part of your claim is denied after the Plan has received all necessary claim information, you have the right to appeal the decision and request a review of the claim. The procedures for appealing a claim decision are:

- Compose a claim appeal, which explains why you believe your claim should be reviewed;
- Attach any additional information you think will help a favorable decision to be made on your claim; and
- Return your completed appeal, along with any additional information you are submitting, to the Claims Administrator at:

Twin City Ironworkers Health and Welfare Fund
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Your claim appeal must be filed in writing at the Claims Administrator's office within 180 days of the date the claim denial was mailed to you.

When appealing a claim, you have certain rights under federal law. These include:

- You will have the opportunity to submit written comments, documents, records and other information relating to the claim;
- You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- The review by the Plan will take into account all comments, documents, records and other information submitted by you related to your claim, whether or not the information was submitted or considered in the initial benefit determination; and
- If your appeal is for disability benefits, the Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, and further, will provide you with such rationale as soon as possible and sufficiently in advance of the date of review of the denial by the Plan so as to give you a reasonable opportunity to respond prior to that date.

Contents of the Written Appeal

The written appeal should describe all of the reasons you believe the claim denial was in error, and should include copies of any documents you want considered in support of the appeal. The appeal will be decided based on the information submitted.

Applicable Time Frames for Deciding Claim Appeals

- **Urgent care claims.** If your appeal is for an urgent care claim, the Plan will review your appeal and notify you of its decision with 72 hours of the time you file the appeal with the Plan.
- **Preauthorization (pre-service) claims.** If your appeal is for a denial of a claim requiring preauthorization, the Plan will notify you of its decision on appeal within 30 days of the Plan's receipt of your appeal.
- **All other claims.** For all other claims, the Board of Trustees will review your appeal at its next regularly scheduled meeting. However, if your appeal was received by the Plan within 30 days of the Board of Trustees' meeting, your appeal will be reviewed at the Board's second regularly scheduled meeting following the Plan's receipt of your claim appeal. If special circumstances are required, such as the need to hold a hearing, the review of your appeal may be delayed until the Board's third meeting following your request for an appeal. If this extension is required, the Plan will notify you of the extension and of the special circumstances requiring the extension.

After a decision is made concerning your appeal, you will be notified of the decision by the Plan within five days of the decision being made.

Appeals Involving Claims Based on Medical Judgment

When reviewing an appeal on a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional with appropriate training and experience in the field of medicine. The health care professional providing the consultation will not be the same individual consulted on the initial determination, or a subordinate of such an individual. If you request, the identification of any medical or vocational experts whose advice was sought in connection with the denied claim, notwithstanding whether the advice was actually relied upon, will be provided.

Notice of Decision on Appeal

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

- The specific reason(s) for the determination;
- Reference to the specific Fund provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge; and
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge. If the determination was based on Medical Necessity, or because the treatment was Experimental or Investigative, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.

If the decision involved disability benefits, you will receive a written explanation providing for the basis for disagreeing with or not following (1) the views presented by your health care and vocational professionals; (2) the views of medical and/or vocational experts whose advice was obtained by the Plan in connection with this adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination; and (3) your disability determination from the Social Security Administration.

External Review of Claims for No Surprises Act Services

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of the claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if the denial involves surprise billing or cost-sharing issues that are protected under the No Surprises Act for Emergency Services, Air Ambulance Services, and non-Emergency Services provided by an out-of-network provider at an in-network Health Care Facility.

A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or Dependent fails to meet the requirements for eligibility under the Plan is not eligible for external review.

In general, the you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal claims and appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete the Plan's internal claims and appeals process first.

- In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while waiting for a decision on their internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal process is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must be made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within five (5) business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided;
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage;
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows the Claimant to proceed to external review before that process is completed); and
- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review;
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).); or
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that the request is not complete.)

Review of a Standard (Not Urgent Care) Claim by the IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding the claim. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information submitted after the ten (10)-business day deadline; and
- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial;
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon;
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law;
- A statement that judicial review may be available to you.

- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review of an Urgent Care Claim

You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding their initial claim that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize the ability to regain maximum function, and has filed a request for an expedited internal appeal.
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the time frame for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, and has not yet been discharged from a facility.

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether their request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

What Happens After the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial review to reverse or modify the IRO's decision.
- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.
- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

Subsequent Legal Action

If your appeal is denied in whole or in part, you have the right to file a lawsuit challenging the denial. You should be aware of the matters below before filing suit.

Importance of Exhausting Plan's Claim Procedures before Filing Suit

The claim procedures described above are required by federal law and are designed to ensure that the Claims Administrator and the Trustees decide disputes regarding the Plan. Therefore, courts usually require that claimants exhaust a plan's claims procedures before filing suit (both filing the initial claim and appealing the denied claim). If you fail to do so, the court will likely dismiss the lawsuit.

Evidence Courts Consider in Reviewing a Decision to Deny a Claim

In a lawsuit, the court generally will review the decision on the claim based on the evidence and arguments that were presented by you. Except in rare circumstances, the court will not allow you to introduce new evidence or arguments to support the claim. Thus, you should make sure that everything that you believe supports your position is submitted during the claim process.

Deference to Decision of Claims Administrator and Trustees

The Claims Administrator and the Trustees have discretion to interpret the terms of the Plan and to make any and all factual determinations necessary to administer the Plan. That includes all decisions as to whether you are entitled to benefits, and, if so, the amount of such benefits. The decisions of the Claims Administrator or the Trustees on any matter affecting the Plan are to be given the maximum deference permitted by the law.

Time Limits

Any lawsuit challenging a claim denial must be commenced within six months after the date on the letter denying the appeal.

No action at law or in equity will be brought to recover on the Plan before the exhaustion of the claims and appeals procedures outlined in this booklet. All lawsuits involving Plan benefits must be commenced no later than two years after you first receive information that constitutes a clear repudiation of the rights that you are seeking to assert. This two-year limitation period will not run during the period of time, if any, when your claim is in the claims procedure process. Once that process is completed, however, the two-year period will continue running where it left off.

Facility of Payment

If a participant or beneficiary is not legally capable of providing a valid receipt for a benefit payment, the Fund has the right (if there is no legal guardian) to pay the party it believes is entitled to such payment. Once such a payment is made, the Fund has no further obligation with respect to the amount paid.

Reimbursement/Subrogation

The Fund has the right of first recovery against any other party, including any individual or entity, which may be legally responsible for the Injury or Sickness, which created the need for the services or supplies paid by the Fund. The term "other party" does not include any individual or entity providing benefits or services under any "other plan."

The Fund's claim for reimbursement is an equitable lien by agreement and will be paid in full prior to and takes precedence over any claim against the other party for any general or special damages allegedly payable to a Family Member. The Fund will be reimbursed in full prior to the payment of any general or special damages to a Family Member even if the funds available to satisfy any judgment against the other party are not sufficient to compensate the Family Member fully for his or her injuries. The Plan will not be responsible for any share of the attorneys' fees or costs the Family Member incurs in pursuing or obtaining any recovery from the third party, unless the Plan has entered into a separate written agreement with the Family Member that specifically so provides.

The Family Member must cooperate with the Fund in assisting it to protect its legal rights under this reimbursement/subrogation provision and must do nothing to prejudice the Fund's right under this provision. The Family Member must provide written notice to the Fund that the Family Member has made a claim or demand for payment or has commenced a lawsuit against any other party within 30 days of the date the Family Member first made that claim or demand or commenced suit. The notice must state the name and address of the other party; notify the Fund that it may have a legal claim against the other party; summarize the factual and legal basis for that claim; and provide copies of all claim or demand letters and legal documents (including the summons and complaint) served on the other party by the Family Member. The Family Member also must provide written notice to the Fund of any proposed settlement of a Family Member's claim against the other party at least 30 days before entering into such a settlement and must provide written notice of the receipt of any funds from a settlement or judgment within 14 days of the date the Family Member receives or gains control over those funds.

The Fund may bring suit against any other party in the Family Member's name, and in such a case, the Fund shall be entitled to recover from the proceeds of any settlement or judgment the full amount of its reimbursement claim (including all reasonable attorneys' fees and litigation expenses in bringing such suit). The Family Member shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses.

The Fund may recover the full amount of its reimbursement claim from the proceeds of any settlement or judgment obtained by a Family Member from or against any other party, regardless of how those proceeds are designated (e.g., whether designated as damages for past or future medical expenses, wage loss, lost earning capacity, disability, pain and suffering, disfigurement, emotional distress or any other item of general or special damages). The Family Member must hold those proceeds in Trust for the benefit of the Fund under this reimbursement provision and must pay the Fund the full amount of its reimbursement claim (including all reasonable attorneys' fees and litigation expenses) within 14 days of the date the Fund requests such payment in writing. If the Family Member fails to deliver the proceeds held in Trust to the Fund within 14 days, the Fund may commence legal proceedings to obtain those funds and shall be entitled to recover all reasonable attorneys' fees and litigation expenses it incurs in collecting the proceeds held by the Family Member, as well as interest on the amount of the claim from the date the Fund made the request for payment until the date payment is actually received. In its sole discretion, the Fund may elect to recover all or part of its reimbursement claim by subtracting the amount owed to the Fund from any future benefits otherwise payable by the Fund until the Fund's claim has been fully recovered.

The Family Member is responsible for payment of all legal fees with respect to the Family Member's workers' compensation claim. The Fund's recovery for any workers' compensation intervention interest will not be reduced to pay any legal fees of the attorney representing the Family Member.

All benefits paid by the Fund are subject to the Fund's reimbursement and subrogation rights as described in this section, whether or not the Fund requires the Family Member to sign and return the Fund's reimbursement/subrogation form. Prior to the payment of any benefits, the Fund in its discretion may require the Family Member to sign and return the Fund's reimbursement/subrogation form (including any promissory note) for this benefit.

72 Privacy Policy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Plan protect the confidentiality and security of your Protected Health Information (PHI).

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

The Plan will distribute its Privacy Notice periodically and if changes are made to the policies and procedures, as required by HIPAA rules.

This Plan and the Plan Sponsor will not use or further disclose your PHI except as necessary for treatment, payment, health plan operations, and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose your PHI for employment-related actions and decisions or in connection with any other Plan benefit or employee benefit plan.

The Plan hires professionals and other companies to assist it in providing health care benefits. The Plan has required these entities, called "Business Associates," to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates. It will describe your rights with respect to benefits provided by that company.

Your rights under HIPAA with respect to your PHI include the right to:

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

If you need a copy of the Privacy Notice, please contact the Fund Office.

The benefits payable to a Family Member under this Plan will be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the benefits payable by any other plan will not exceed the total of such Allowable Expenses.

Other Plan

"Other plan" means any plan providing medical, dental or vision benefits under:

- Group, blanket or franchise insurance coverage;
- Group Blue Cross or Blue Shield, group Hospital service prepayment plan, group medical service prepayment plan, group practice, individual practice offered on a group basis, or other group prepayment coverage;
- Labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans, or any other arrangement of benefits for individuals of a group;
- Governmental programs or coverage required or provided by any statute;
- Any group coverage of a child sponsored by, or provided through, any educational institution;
- Group arrangements for members of associations of individuals; and
- Group or individual automobile no-fault coverage. No-fault coverage does not include any uninsured or underinsured motorist coverage.

The term "plan" will be construed separately as to each policy, contract or other arrangement for benefits or services, and separately as to any part of a plan that may consider benefits or services of other plans in determining its benefits and any part that does not.

Allowable Expense

Any necessary Allowable Charge incurred by a Family Member, part or all of which would be covered under any of the "plans," including Medicare. If a plan provides benefits in the form of services and supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an Allowable Expense) will be deemed both an Allowable Expense and a benefit paid.

Order of Benefit Payment

If a Family Member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefit first, and then the other plan(s) pay(s).

- The primary plan (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
- The secondary plan (the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed the greater of:
  a. 100% of the total Allowable Expense; or
  b. The amount of benefits it would have paid had it been the primary plan.

The following rules determine the order in which benefits are paid:

- When another plan does not have a Coordination of Benefits (COB) provision, that plan must pay benefits first.
- When another plan does have a COB provision, the first of the following rules that applies governs:
  a. If a plan covers a person as an Employee, then that plan will pay its benefits first.
  b. If the Dependent is a child whose parents are not unmarried, divorced or separated, then the plan of the parent whose birthday is earlier in the Calendar Year will pay first, except:
     i. If both parents' birthdays are on the same day, whichever parent has been covered for a longer period of time will pay first.
     ii. If another plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that plan's COB rule will determine the order of benefits.
- For claims on behalf of Dependent children of unmarried, divorced or separated parents, the following rules apply:
  a. If there is a court decree that establishes financial responsibility for medical expenses, the plan covering the Dependent children of the parent who has that legal responsibility will be primary.
  b. If there is no court decree, the plan that covers the parent with custody will be primary.
- If there is no court decree and the parent with custody of the child has remarried, that parent's plan will pay first, the stepparent's plan second, and the plan of the parent without custody third.
- If none of the above rules apply, the plan that has covered you for the longer period of time will pay its benefits first, except when:
  a. One plan covers you as a laid-off Employee or Retiree (or a Dependent of such an Employee); or
  b. The other plan includes this COB rule for laid-off Employees or Retirees (or is issued in a state that requires this rule by law).
- Then, the plan that covers you as other than a laid-off Employee or Retiree (or a Dependent of such an Employee) will pay first.

Where part of the plan coordinates benefits and a part does not, each part will be treated like a separate plan.

Owner-Operators will be treated as Employees for the purposes of this section, including persons who meet the Fund's definition of an Owner-Operator except that they are not contributing to or having contributions made on their behalf to this Fund.

Effect of Medicare

The benefits payable to a Family Member under this Plan will be reduced to the extent necessary so that the sum of the benefits payable under this Plan and the amounts paid under Medicare Part A and Part B will not exceed the total of Allowable Expenses.

Effect on Benefits

If you are Eligible for benefits as a retired or disabled Employee or Owner-Operator, and are also Eligible for Hospital insurance under Medicare Part A, but are not enrolled in Part A or the voluntary portion of Medicare B, the benefits provided to you under this Plan will be paid as if you had enrolled in both Medicare Part A and Medicare Part B.

If you are a Medicare-Eligible Retiree and you enroll for Medicare prescription drug coverage (Medicare Part D), you and your Dependents will lose prescription drug coverage under this Plan. If you drop your Medicare prescription drug coverage, you must call the Fund Office to reinstate your prescription drug coverage under the Plan. If you fail to reinstate your coverage within one year of terminating your Medicare prescription drug coverage, you will not be able to reenroll for the Plan's drug coverage ever again.

Order of Benefit Determination

This Plan has primary responsibility for expenses incurred by an Employee or Owner-Operator who has current employment status (or his or her Dependent Spouse) and who meets the following qualifications:

- Is at least Age 65;
- Is Eligible for Medicare Part A, however, not on the basis of end-stage renal disease; and
- With respect to the Employee only, is actively employed by a participating ADEA Employer that pays all or part of the required contributions for Eligibility.

This Plan has primary responsibility (during the first 30 consecutive months that the person is Eligible for Medicare Benefits) for the claim of any Family Member who is Eligible for Medicare Benefits solely because of end-stage renal disease where Medicare has secondary responsibility.

This Plan has primary responsibility for expenses incurred by an Employee and for an Owner-Operator who has current employment status, and for the Employee's or Owner-Operator's Dependents, who are Eligible for Medicare Benefits because of any other disability and have received Social Security disability benefits for 24 consecutive months.

Effect of Medicaid

Benefit payments on behalf of the Employee who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Employee, as created by an assignment of rights made by or on behalf of the Employee or the Employee's Dependent as may be required by the state medical assistance plan.

In determining that individual's Eligibility or payment of benefits, this Plan may not take into consideration an individual's qualification for medical assistance under a state Medicaid plan.

This Plan will honor any subrogation rights that a state may have gained from a Medicaid-Eligible Dependent covered by the Plan by virtue of the state's having paid Medicare Benefits for which this Plan has a legal liability to cover.

Definitions

Medicare Benefits
Benefits for services and supplies that the person receives or is entitled to receive under Medicare Part A, Part B, or both.

Age 65
The age attained at 12:01 a.m. on the first day of the month in which the person's 65th birthday occurs.

ADEA Employer
An Employer that:

- Is subject to the U.S. Age Discrimination in Employment Act (ADEA), as amended from time to time; and
- Has 20 or more Employees each working day in 20 or more calendar weeks during the current or preceding Calendar Year.

Important Plan Information

Plan Name: Twin City Ironworkers Health and Welfare Fund

Fund Office:
Twin City Ironworkers Health and Welfare Fund
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: (952) 854-0795
Toll-free: (800) 535-6373
Fax: (952) 854-1632

Board of Trustees: The Board of Trustees is responsible for the operation and administration of this Plan, and consists of Employer and Union representatives who have entered into a collective bargaining agreement that relates to this Plan. As of January 1, 2023, the Trustees of this Health and Welfare Plan are:

Union Trustees

Barry Davies, Secretary
Twin City Iron Workers #512
851 Pierce Butler Route
St. Paul, MN 55104

Keith Musolf
Iron Workers Local #512
3752 Midway Road
Hermantown, MN 55810

Michael Walters
Twin City Iron Workers #512
851 Pierce Butler Route
St. Paul, MN 55104

Marc Jurek
Iron Workers Local Union #512
410 South 22nd Street
Bismarck, ND 58504

Nate O'Reilly
Twin City Iron Workers #512
851 Pierce Butler Route
St. Paul, MN 55104

Employer Trustees

Sture Berg, Chairman
Retired

Butch Perrin
Industrial Contractors, Inc.
701 Channel Drive
Bismark, ND 58501

Mark Ziegler
Amerect, Inc.
1110 7th Avenue
Newport, MN 55055–1207

Heidi Gunderson
Woody's Rebar Co., Inc.
3561 Centerville Road
St. Paul, MN 55127–7125

Todd Rothe
J.R. Jensen Construction Co.
814 21st Avenue East
Superior, WI 54880

John Dahl, Alternate
Sowles Co. Steel Erectors/Northwest Tower Cranes
700 Canterbury Road
Shakopee, MN 55379–1840

Fallon Ratzlow, Alternate
Amerect, Inc.
1110 7th Avenue
Newport, MN 55055–1207

Plan Sponsor and Administrator: The Board of Trustees is both the Plan Sponsor and Plan Administrator.

Plan Number: The number assigned to this Plan by the Board of Trustees according to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 41-6023463.

Agent for Service of Legal Process: Scott Crossman is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon Mr. Crossman at:

McGrann Shea Carnival Straughn & Lamb, Chartered
800 Nicollet Mall, Suite 2600
Minneapolis, MN 55402-7035
(612) 338-2525
sbc@mcgrannshea.com

You can also serve any individual Trustee at the address of the Fund Office.

Source of Contributions: All contributions to the Fund are made by Employers in accordance with their collective bargaining agreements with the Union. The Fund Office will provide you, upon written request, information as to whether a particular Employer is contributing to the Fund on behalf of participants working under the collective bargaining agreements. A copy of the collective bargaining agreement is available for viewing at the Fund Office.

Under certain circumstances, the Fund allows an Employee or Owner-Operator whose Eligibility is about to terminate to continue coverage by making Self-Contributions to the Fund.

With the approval of the Trustees, a Contributing Employer may continue to contribute on behalf of its Employees even though they may be doing work outside the territorial jurisdiction of the Fund.

Trust Fund: All assets are held in Trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

Plan Year: The records of the Fund are kept separately for each Plan Year. The Plan Year begins on January 1 and ends December 31.

Plan Type: The Plan is maintained for the purpose of providing death, disability, medical, vision, and dental benefits. Plan benefits are self-funded with the exception of the life and accidental death and dismemberment benefits, which are provided under policies of group insurance underwritten by an insurance company (Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166), and benefits provided under the Medicare Advantage Prescription Drug Plan;

- The medical network is provided through Blue Cross and Blue Shield of Minnesota.
- The prescription drug retail network and mail order services are provided through Sav-Rx.
- The dental network is provided through Delta Dental.
- The Employee Assistance Program (EAP) is provided through T.E.A.M., Inc.

The fully insured Medicare Advantage Prescription Drug Plan is underwritten by the UnitedHealthcare Insurance Company, P.O. Box 30769, Salt Lake City, UT 84130-0769.

For contact information, refer to page 6.

Plan Amendment or Termination: The benefits described in this booklet are not vested benefits. The Trustees expressly reserve the right, in their sole discretion and without notice to Employees, Owner-Operators, Retirees, Dependents, Employers, the Union, and others affected hereby, but upon a nondiscriminatory basis, to interpret, amend, modify, suspend or terminate all or part of this Plan at any time and for any reason, in accordance with the terms of the Plan, the Trust Agreement governing the Plan, and the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Plan participants will be notified in writing of any changes.

In the event of a termination, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with a dissolution plan adopted by the Trustees, to continue the benefits provided by the existing Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any contributing Employer, Association, or labor organization.

Mistaken Benefit Payments: The Trustees may correct any errors that occur in administering the Plan. Erroneous benefits under this Plan must be returned. Erroneous payments can also be offset by the Trustees against future benefits.

Discretionary Authority: The Trustees and any other persons who have authority with respect to the management or administration of the Plan or the investment and control of Plan assets may exercise that authority in their full discretion, subject only to the duties imposed under law. It is intended that the exercise of authority be given deference in all courts of law to the greatest extent allowed under law.

Severability of Provisions: If any provision of the Plan is held illegal or invalid for any reason, such illegality or invalidity will not affect the remaining provisions of the Plan, but the Plan will be construed and enforced as if such illegal or invalid provision had never been added to the Plan.

Choice of Law: The Plan will be governed by the laws of the state of Minnesota to the extent such laws are not preempted by the laws of the United States. All controversies, disputes and claims arising under the Plan must be submitted to the United States District Court of Minnesota.

Forfeitures: Forfeitures from any Plan benefits will be used to reduce the cost of administering the Plan or to provide increased benefits to participants in subsequent years in any weighted or uniform fashion that the Trustees deem appropriate.

80 Statement of ERISA Rights

Statement of ERISA Rights

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

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include 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.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description and Plan Document. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to 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/Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. For instance, if you request a copy of the Summary Plan Description and Plan Document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at:

Nearest Regional Office:

Employee Benefits Security Administration
Kansas City Regional Office
2300 Main Street, Suite 1100
Kansas City, MO 64108
(816) 285-1800

National Office:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
(866) 444-3272

For more information on your rights and responsibilities under ERISA, including COBRA, the Affordable Care Act, and other laws affecting group health plans, or for a list of EBSA offices, contact the EBSA by visiting their website at **dol.gov/ebsa**.

Active Employee
An individual who meets the Eligibility requirements to participate in the Plan, based on contributions made by the Employer or by Self-Contributions.

Active Plan
The Active Plan offers Employees, Owner-Operators, and Dependents of Employees and Owner-Operators benefits under the Plan. Specific benefits of this Plan are listed in this booklet.

Air Ambulance
Medical transport services and supplies, as may be Medically Necessary, by a certified rotary wing Air Ambulance, as defined in 42 CFR 414.605, or certified fixed wing Air Ambulance, as defined in 42 CFR 414.605, for patients.

Allowable Charge
A specific dollar amount corresponding to a specific item or service that the Plan will use, in combination with other information, to determine the amount of benefits that are payable with respect to the specific item or service.

No benefits are payable with respect to any amount billed for any item or service that exceeds the Allowable Charge amount except as otherwise required by the No Surprises Act. No benefits will be paid for any item or service in an amount that exceeds the Allowable Charge except as otherwise required by the No Surprises Act. The Allowable Charge amount is not determined by reference to or intended to reflect any usual, customary or reasonable charge. The Plan will determine benefits by reference to the Allowable Charge amount that is determined by the applicable procedure set forth below. The determination of the Allowable Charge amount is subject to the policies and procedures of the applicable claims administrator. The claims administrator may bundle services, take multiple procedure discounts or other reductions as a result of the procedures performed and billed on the claim.

For in-network provider expenses, the Allowable Charge amount is the negotiated amount that the provider has agreed to accept as full payment for the applicable item or service at the time your claim is processed. The claims administrator periodically may adjust the negotiated amount at the time your claim is processed as a result of expected settlements or other factors. The negotiated amount with in-network providers for certain items and services may not be based on a specified charge. Through annual or other global settlements, rebates, prospective payments or other methods, the claims administrator may adjust the negotiated amount due to in-network providers without reprocessing individual claims. These annual or other global adjustments will not cause any change in your out-of-pocket amount. If the negotiated amount is decreased, the amount of the decrease is credited to the Plan. If the negotiated amount is increased, the Plan pays that cost on your behalf and you are not required to pay anything further out-of-pocket.

For out-of-network provider expenses within Minnesota, the Allowable Charge amount will be 180% of the Medicare allowed charge for the same or similar service or, if Medicare does not have an applicable allowed charge, 40% of the billed charge, except in the case of No Surprises Act Services. For out-of-network provider expenses outside of Minnesota, the Allowable Charge amount will be the out-of-network amount determined by the procedures of the Blue Cross or Blue Shield Plan in the state where the expenses were incurred, or, if there is no such amount, 30% of the billed charge, except in the case of No Surprises Act Services.

Under certain circumstances, the Plan may be required by law to provide benefits based on an Allowable Charge amount that exceeds the amount determined by the procedures described above. In such cases, the Allowable Charge amount is the amount determined by law**.**

Ancillary Services
Ancillary services are, with respect to a participating health care facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at such facility.

Association
Associated General Contractors of Minnesota Builders Divisions, Minneapolis, St. Paul and Duluth Contractors Association.

Calendar Year
The period from January 1 through December 31 of the same year. The Plan Year for recordkeeping and governmental reporting purposes is the Calendar Year.

Caregiver
A person not associated with a Hospice Agency, who resides in the home and provides nonmedical services and companionship. This may be a Family Member.

Consolidated Omnibus Budget Reconciliation Act of 1985 or **COBRA**
The federal law, as amended from time to time, that requires the Fund to offer Employees and their Dependents an opportunity to continue their coverage under certain circumstances.

Continuing Care Patient
An individual who, with respect to a provider or facility:

- Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Cost Sharing
The amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the plan.

Cost Sharing Amount
The Cost Sharing Amount for emergency and Non-emergency Services at in-network facilities performed by out-of-network providers will based on the recognized amount.

Covered Expenses, Covered Charges
Any necessary medical expense that is an Allowable Charge and that is specifically payable under this Plan. Covered Expenses or Covered Charges do not include any charges:

- For a service or supply that is not Medically Necessary; or
- In excess of the Allowable Charge for a service or supply.

Covered Work
Work performed by an Owner-Operator or by an Employee for an Employer under a written agreement with the Union, requiring contributions to the Fund for such work.

Dentist
A legally qualified Dentist or a Physician authorized by a license to perform, at the time and place involved, the particular dental procedure rendered.

Dependent
Dependent includes any of the following individuals:

- The participant's same- or opposite-sex lawful Spouse, that is, the person to whom the Employee or Retiree was lawfully married in a state that recognized that marriage;
- The participant's child up to the end of the month in which the child attains age 26, which is the participant's natural or adopted child, stepchild or child for whom the participant has provided proof of legal guardianship;
- Grandchildren who do not have any parent age 18 or older exercising parental control, who live with the participant, and for whom the participant provides at least 50% of financial support. Grandchildren are Eligible up to age 19 or age 23 if a full-time student (taking at least 12 credits or the equivalent). However, if the grandchild is unable to meet the full-time student criteria due to a Medical Necessity, then the grandchild may continue coverage until the first of the following dates:
  a. The date one year after the start of the Medically Necessary leave of absence or change in enrollment;
  b. The date that coverage for Eligible Dependents is terminated; or
  c. The date the grandchild no longer meets the Plan's definition of Dependent for any reason except full-time student status.

  You must provide written proof that your grandchild is on a leave of absence or had a change of enrollment that is both (i) Medically Necessary and (ii) due to a serious Illness or Injury, by having your grandchild's Physician submit this information to the Plan. If you fail to submit any required proof, the grandchild will not be considered a full-time student and coverage will be terminated.

- The child is the unmarried child of the Eligible Employee or Spouse who is named as an alternate recipient in a Qualified Medical Child Support Order (QMCSO). A QMCSO is a state court order that meets certain requirements and provides that the Plan will cover the named alternate recipients. The Plan has established written procedures for qualifying and administering QMCSOs. You may obtain a copy, free of charge, by contacting the Fund Office.
- An unmarried child or Dependent who is age 26 or older and who is incapable of self-sustaining employment due to his or her disability, provided:
  a. The child was a covered Dependent of this Plan on December 31, 1993;
  b. The child is Dependent on the Active Employee or Retiree for his or her support; and
  c. Proof of the child's disability, from his or her Physician, is furnished to the Fund Office no later than 31 days after the child reaches age 26. The Fund Office may request proof of continued disability once per year.

Eligible or Eligibility
Being entitled to the benefits payable under Plan provisions by virtue of having fulfilled the Plan's Eligibility requirements.

Eligibility Period
Any three or six-consecutive-month period that begins on the first day of any month, which is used to determine Eligibility for Plan benefits.

Emergency Medical Conditions
A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Services
Emergency Services means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Employee
Employee includes any of the following individuals:

- Any Employee represented by the Union and working for an Employer, and with respect to whose employment an Employer is required to make contributions into the Trust Fund.
- An officer or Employee of the Union who has been proposed for benefits under the Trust Fund by the Union and who has been accepted by the Trustees and for whom the Union agrees in writing to contribute to the Trust Fund at the rate fixed for contributions for other Employers.

- An individual, represented by or under the jurisdiction of the Union, who is employed by a governmental unit or agency, and on whose behalf payment of contributions is made at the time and at the rate of payment equal to that paid by an Employer, in accordance with a written agreement, ordinance or resolution, or an individual who had been so employed and who had temporarily been making Self Contributions under rules established by the Trustees.
- Any other Employee, as the Trustees may agree to include, on whose behalf contributions are made and whose inclusion will not impair the tax-exempt status of the Fund or the contribution to but not including any partner, independent contractor, or self-employed individual unless such individual has entered into an agreement with the Trustees requiring contributions and allowing him or her to be Eligible upon receipt of the required contributions.

Employer
An Employer signatory to a collective bargaining agreement with the Union requiring contributions to this Fund, and any member of the Association that bargains with the Union, or any Employer not personally a party to such collective bargaining agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the collective bargaining agreement and Trust and who, with the consent of the Trustees, will make like payments or contributions to the Fund. Employer also includes the Union.

Employer Contribution or Contributions
Payments due from or made by Employers to the Trust according to any collective bargaining agreement or participation agreement requiring payments to the Fund.

ERISA
Employee Retirement Income Security Act of 1974, as amended from time to time.

Experimental and/or **Investigational**
A service or supply is Experimental and/or Investigational if, based on the information and resources available at the time the service was performed or the supply was provided, any of the following conditions are present:

- The service or supply is described as an alternative to more conventional therapies:
  a. In the consent document signed, or required to be signed, to receive the prescribed service or supply; or
  b. In the protocols of the health care provider that prescribes or renders the service or prescribes or dispenses the supply.
- The prescribed service or supply may be given only with the approval of an "institutional review board" as defined by federal law.
- The preponderance of expert medical or scientific opinion, as shown by reliable evidence, classifies the service or supply as Experimental and/or Investigational or indicates that more research is required before the service or supply could be classified as equally or more effective than conventional therapies. For this purpose, reliable evidence means only reports and articles in the authoritative medical and scientific literature published in the United States and written by experts in the field, including:
  a. Centers for Medicare & Medicaid Services (CMS)
  b. United States Pharmacopoeia;
  c. American Hospital Formulary Service; or
  d. Peer-reviewed opinions of the:
    i. American Medical Association (AMA), such as AMA Drug Evaluation reports and Diagnostic and Therapeutic Technology Assessment (DATTA) reports;
    ii. Specialty organizations recognized by the AMA;

iii. National Institutes of Health (NIH);
iv. Centers for Disease Control (CDC); or
v. Office of Health Technology Assessment.

- Food and Drug Administration (FDA) approval is required for the service or supply to be lawfully marketed and has not been granted at the time the service was performed or the supply was provided.
- The prescribed service or supply is available to the individual only through participation in FDA Phase I or Phase II clinical trials or FDA Phase III Experimental or research clinical trials or corresponding trials sponsored by the National Cancer Institute or National Institutes of Health.
- A current Investigational new drug or new device application has been submitted and filed with the FDA.
- As a whole, the service or supply would not be classified as Experimental and/or Investigational under the above criteria, but one or more essential provisions of the service or supply are Experimental and/or Investigational based on the above criteria.

Family Member
An Employee, Owner-Operator and any Dependent of an Employee or Owner-Operator covered under the Plan.

Health and Welfare Fund, **Fund**, or **Trust Fund**
The entire Trust estate of the Twin City Ironworkers Health and Welfare Fund as it may, from time to time, be constituted, including, but not limited to, policies of insurance, investments and the income from any and all investments, Employer Contributions, and any and all other assets, property or money received by or held by the Trustees for the uses and purposes of this Trust.

Health and Welfare Plan or **Plan**
The Plan Document, as adopted by the Trustees and as amended by the Trustees.

Health Care Facility
For non-emergency services, Health Care Facility is each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- Critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

Home Health Care Agency
A Home Health Care Agency is an agency or organization that fully meets each of the following requirements:

- It is primarily engaged in and licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;
- It has policies established by a professional group associated with the agency or organization that include at least one Physician and at least one registered graduate nurse to govern the services provided and such services must be under the full-time supervision of a Physician or registered graduate nurse;
- It maintains a complete medical record on each patient; and
- It has a full-time administrator.

Home Health Care Plan
A Home Health Care Plan is a program for continued care and treatment of a Family Member established and approved in writing by the attending Physician within seven days following termination of a Hospital confinement as a resident inpatient and is for the same or related condition for which the Family Member was hospitalized. The Physician must certify that the proper treatment of the disease or Injury would require continued confinement as a resident inpatient of a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice Agency: A public or private organization that:

- Administers and provides hospice care; and
- Meets one of the following conditions:
  a. Licensed or certified as such by the state in which it is located;
  b. Certified (or is qualified and could be certified) to participate as such under Medicare;
  c. Accredited as such by the Joint Commission on the Accreditation of Hospitals; or
  d. Meets the standard established by the National Hospice Organization.

Hospice Plan: A coordinated, interdisciplinary program to meet the physical, psychological and social needs of terminally ill persons and their families:

- By providing palliative (pain controlling) and supporting medical, nursing and other health services; and
- That is provided through home or inpatient care during the Sickness or bereavement.

Hospice Services: Any services provided:

- Under a Hospice Plan; or
- By a Hospital or related institution, Home Health Care Agency, hospice or other facility licensed by the state to operate a hospice.

Hospital
A Hospital is an institution that fully meets each of the following:

- It is primarily engaged in providing, for compensation and on an inpatient basis, facilities for the diagnosis, treatment and care of injured and sick persons under the supervision of a staff of Physicians;
- It continuously provides 24-hour registered graduate nursing service; and
- It is not, other than incidentally, a place for rest, for the aged, or a nursing home.

Illness (Sickness)
Any bodily Illness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician. Illness also includes pregnancy.

Independent Freestanding Emergency Department
A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Individual Record System
An Employee's or an Owner-Operator's individual account in which excess hours of contributions are credited for use in maintaining Plan Eligibility.

Injury
Any unforeseen or unintended trauma to the body, excluding over-utilization of a body part, which is sustained directly and independently of all other causes. This Plan only covers injuries that are not employment-related.

Lag Period
The one-month period between the Eligibility Period and the date coverage under the Plan starts.

Medically Necessary or Medical Necessity
A service or supply that:

- Is appropriate and consistent with the diagnosis and in accordance with accepted standards of community practice; and
- Could not have been omitted without adversely affecting the individual's condition or the quality of medical care.

Medicare Advantage Prescription Drug Plan
Offers supplemental benefits to Medicare and prescription drug benefits available to the following individuals who are all Eligible for Medicare:

- Retirees and their Dependents;
- Disabled Employees and their Dependents; and
- Surviving Spouses and their Dependents.

No Surprises Act and No Surprises Act Services
The No Surprises Act (Public Law 116-260, Division BB) was signed into law on December 27, 2020, as part of the Consolidated Appropriations Act of 2021. The term "No Surprises Act Services" means the following, to the extent covered under the Plan:

- Non-network Emergency Services;
- Non-network Air Ambulance Services;
- Non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by a non-network Provider at a network facility; and
- Other non-network non-Emergency Services performed by a non-network Provider at a network facility with respect to which the Provider does not comply with written federal notice and consent requirements.

Non-Occupational Disease
A disease is Non-Occupational only if it does not arise out of (or in the course of) any work for pay or profit, nor, in any way, results from a disease or Injury that arises out of (or in the course of) such work.

A Non-Occupational Disease does not include any disease for which an individual has received or is Eligible to receive benefits under workers' compensation or other similar law. If an individual is not covered under workers' compensation or similar law, but would have been had an appropriate election been made, a Non-Occupational Disease includes any disease for which an individual could have been Eligible to receive benefits under workers' compensation or similar law had the appropriate election been made. If an individual otherwise is or could have been covered under workers' compensation or other similar law and such law does not provide benefits for a particular disease, that disease is considered a Non-Occupational Disease regardless of its cause.

For comprehensive medical benefits, an individual who is covered under workers' compensation or other similar law and has requested but been denied benefits under workers' compensation or similar law is still considered Eligible to receive benefits until:

- The individual, for a legitimate reason, irrevocably withdraws the request for benefits;
- A court finally determines that the individual is not entitled to benefits; or
- The Health and Welfare Fund executes a stipulation resolving the individual's request for benefits or acknowledging that the disease is a Non-Occupational Disease.

For comprehensive medical benefits and weekly disability benefits, the term Non-Occupational Disease includes any pregnancy. However, this paragraph will not apply to Employees, Owner-Operators or their Dependents if the Employees or Owner-Operators are retired.

The Board of Trustees has the discretion to determine whether a disease is Non-Occupational, and in making its determination, the Board of Trustees is not bound by any determination under a workers' compensation or other similar law.

Non-Occupational Injury
An Injury is Non-Occupational only if it does not arise out of (or in the course of) any work for pay or profit nor, in any way, results from a disease or Injury that arises out of (or in the course of) such work.

Non-Occupational Injury does not include any Injury for which an individual has received or is Eligible to receive benefits under workers' compensation or other similar law. If an individual is not covered under workers' compensation or similar law, but would have been had an appropriate election been made, a Non-Occupational Injury includes any Injury for which an individual could have been Eligible to receive benefits under workers' compensation or similar law had the appropriate election been made.

For comprehensive medical benefits, an individual who is covered under workers' compensation or other similar law and has requested but been denied benefits under workers' compensation or similar law is still considered Eligible to receive benefits until:

- The individual, for a legitimate reason, irrevocably withdraws the request for benefits;
- A court finally determines that the individual is not entitled to benefits; or
- The Health and Welfare Fund executes a stipulation resolving the individual's request for benefits or acknowledging that the Injury is a Non-Occupational Injury.

The Board of Trustees has the discretion to determine whether an Injury is a Non-Occupational Injury, and in making its determination, the Board of Trustees is not bound by any determination under workers' compensation or other similar law.

Out-of-Network Emergency Facility
An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to emergency services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively

Out-of-Network Provider
For emergency services and non-emergency services at Participating Facilities by an out-of-network provider, out-of-network provider means health care provider who does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

Out-of-Network Rate
Out-of-Network Rate means one of the following:

- the amount the parties negotiate;
- the amount approved under the independent dispute resolution (IDR) process; or
- if the state has an All-Payer Model Agreement, the amount that the state approves under that system

Owner-Operator
Any Employee who:

- Owns directly or indirectly 5% or more of the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporate Employer; and
- Performs any work for that corporate Employer of a type that would be covered under a written agreement with the Union.

For the purpose of this definition, an Employee is deemed to own all stock owned by his or her Spouse and children.

Any individual who meets this definition of Owner-Operator during a calendar quarter will be treated as an Owner-Operator for the six calendar quarters following the calendar quarter, whether or not that individual meets this definition of Owner-Operator during any of those six calendar quarters. However, the six calendar-quarter period will lapse during any calendar quarter in which the individual engages in at least 300 hours of work for one or more unrelated Employers for which contributions are made to the Fund, or is retired and receiving a monthly pension benefit from the Twin City Iron Workers Pension Fund. If the six calendar-quarter period lapses with respect to any individual, that individual will not be treated as an Owner-Operator until that individual again satisfies the definition of Owner-Operator. Owner-Operators who retire will be defined as Retirees, just like Employees are when they retire.

Physician
Any individual licensed under applicable state law to prescribe and administer all nonnarcotic drugs, to provide medical services, and to perform all surgery payable under the Plan.

Private Duty Nursing (PDN)
Extended hours of skilled nursing care provided in a participant's home, which is more complex and skilled care than can be provided by a Home Health Care Agency.

The extended hours of skilled nursing must help to assist the participant with complex, direct skilled nursing care, to develop Caregiver competencies through training and education, and to optimize the participant's health status and outcomes. The nursing tasks must be required so frequently that the need is continuous. The duration of extended hours of skilled nursing services is temporary in nature and is not intended to be provided on a permanent basis.

Psychiatrist
A legally qualified Physician who either specializes in psychiatric medicine or has, by reason of training or experience, a specialized competency in the field of psychiatric medicine sufficient to render the necessary evaluation and treatment of Mental Disorders. Charges for the services of a licensed psychologist, a licensed consulting psychologist, or a Psychiatrist are Covered Expenses.

Qualifying Payment Amount (QPA)
Generally, the median contracted rates of the plan or issuer for the item or service in the geographic region.

Recognized Amount
For items or services furnished by a nonparticipating provider or nonparticipating emergency facility, Recognized Amount means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or

- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)
- For ambulance services, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

Regular Retiree Plan
Offers a continuation of most benefits available to Employees and Owner-Operators under the Active Plan to the following individuals:

- Retirees and their Dependents;
- The following individuals who have either reached Age 65 or become Eligible for Medicare:
  a. Disabled Employees and their Dependents; and
  b. Surviving Spouses and their Dependents.

The specific benefits of the Regular Retiree Plan are listed in this booklet. If the optional vision and dental benefits are chosen, they must be elected together.

Retiree
An individual who meets the Plan's Eligibility requirements and is Eligible for Retiree benefits. This includes retired Owner-Operators meeting those requirements.

Room and Board Charges
Room and Board Charges include, in addition to charges for room and board, any charges that are made by an institution as a condition of occupancy or on a regular daily or weekly basis for other services, such as general nursing services.

Self-Contributions
Payments made to the Fund by an Employee, Owner-Operator or Dependent to continue Eligibility for Plan benefits, subject to the provisions of the Plan, which include quarterly self-payments or monthly COBRA payments.

Serious and Complex Condition
With respect to a participant, beneficiary, or enrollee under the Plan one of the following:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent;
- In the case of a chronic illness or condition, a condition that:
  a. is life-threatening, degenerative, potentially disabling, or congenital; and
  b. requires specialized medical care over a prolonged period of time.

Serious Health Condition
An Illness or Injury that involves inpatient care or continuing treatment by a health care provider and includes any period of incapacity due to pregnancy or prenatal care.

Skilled Nursing Care Confinement
Confinement in a Skilled Nursing Care Facility:

- Upon the specific recommendation and under the general supervision of a Physician;
- Beginning within seven days after discharge from a required Hospital confinement for a period of at least three days for which Room and Board Charges are paid; and
- For the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the preceding Hospital confinement.

Skilled Nursing Care Facility
An institution or that part of any institution that:

- Operates to provide convalescent or nursing care; and
- Is primarily engaged in providing:

a. Skilled nursing care and related services for inpatients who require medical or nursing home services; or
b. Rehabilitation services to inpatients who are injured, disabled or sick;

- Has policies that are developed with the advice of (and with provisions for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more registered graduate nurses, to govern the skilled nursing care and related medical or other services it provides;
- Has a Physician, a registered graduate nurse, or a medical staff responsible for the execution of such policies;
- Has a requirement that the health care of every patient be under the supervision of a Physician and provides for having a Physician available to furnish necessary medical care in case of emergency;
- Maintains clinical records on all patients;
- Provides 24-hour nursing service that is sufficient to meet nursing needs in accordance with the policies developed as provided above, and has at least one registered graduate nurse employed full-time;
- Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
- In the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature, is:
  a. Licensed according to such law; or
  b. Approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and
  c. Meets any other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof.

Spouse
The legal Spouse of the participant. See the definition of Dependent for more information.

Terminated
In the context of Continuity of Care, Termination includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Totally Disabled or Total Disability
An Employee or Owner-Operator is Totally Disabled if he or she is unable:

- During the first two years he or she is Totally Disabled, to perform iron work; and
- After the first two years he or she became Totally Disabled, to engage in any occupation for which he or she is, or may reasonably become, qualified by reason of education, training (including rehabilitative training), or experience.

Comprehensive medical benefits are extended to the following:

- An Employee or Owner-Operator who is prevented, solely because of Injury or disease, from engaging in his or her customary occupation and is performing no work of any kind for pay or profit; or
- A Dependent (or a Retiree or Owner-Operator) who is prevented, solely because of Injury or disease, from engaging in substantially all of the normal activities of an individual of like age in good health.

Trust
The document, and all amendments, executed by the Union and Employer Trustees, creating the Fund.

Trustees or Board of Trustees
The Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement. A Union Trustee is a Trustee selected by the Union. An Employer Trustee is a Trustee selected by the Association. The Trustees, collectively, are the administrator of this Fund as that term is used in ERISA.

Union
Iron Workers Local No. 512 International Association of Bridge, Structural and Ornamental Iron Workers.

Work-Related
An Injury or disease arising out of (or in the course of) any work for pay or profit, or the type of Injury or disease that would be covered under workers' compensation law or other similar law.

Twin City Iron Workers Health and Welfare Plan

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