

# **IRON WORKERS DISTRICT COUNCIL (Philadelphia and Vicinity)**



## **HEALTH BENEFIT PLAN**

6401 Castor Avenue

Philadelphia, Pennsylvania 19149

Telephone (215) 537-0900

### **BOARD OF TRUSTEES**

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E. W. Nick Craggs

#### **FIELD REPRESENTATIVE**

Lawrence O'Donnell

#### **LEGAL COUNSEL**

Steven G. Wolschina, Esq.

#### **CONSULTANTS**

The Segal Company

# GENERAL INFORMATION

## Fund Administration

The Iron Workers District Council (Philadelphia and Vicinity) Benefit Plan is administered by a joint Board of Trustees, composed of an equal number of Union and Employer Trustees. The address of the Board is 6401 Castor Avenue, Philadelphia, Pennsylvania 19149.

Members of the Board Include:

NAME	BUSINESS ADDRESS
Joseph Dougherty Local Union #401	11600 Norcom Road Philadelphia, PA 19154
Albert Frattali Local Union #405	2433 Reed Street Philadelphia, PA 19146
Edward McHugh Local Union # 161	3460 N. Delaware Avenue Philadelphia, PA 19134
James Murphy Local Union #489	641 Main Street Avoca, PA 18641
Robert C. Kilpatrick Local Union #36	521 5th Street Whitehall, PA 18052
Gary Martin Local Union #420	17th and Fairview Streets Reading, PA 19606
Morris Rubino Local Union #68	2595 Yardville - Hamilton Square Road Trenton, New Jersey 08690
William Pauls Local Union #350	3924 West End Avenue Atlantic City, N.J. 08401
Jeffrey Hendrickson Local Union #451	203 Old DuPont Road Wilmington, Delaware 19804
Kerry Zettlemyer Local Union #404	981 Peifers Lane Harrisburg, PA 17109
Robert C. Sweeney Local Union #399	409 Crown Point Road Westville, New Jersey 08093
Joseph B. Korycki Delaware Contractors Association	Post Office Box 2662 Wilmington, Delaware 19805

NAME	BUSINESS ADDRESS
Alvin Cragle Northern Pennsylvania Contractors Association	1095 Mt. View Drive Dallas, PA 18612
Richard L. Forman Associated General Contractors of N.J.	Raritan Center Plaza II Fieldcrest Avenue Edison, NJ 08837-3627
William Gardner Steel Erectors Association of Phila.	Post Office Box 505 Warner Lane & Route 29 Devault, PA 19432
Frank Hake Contracting Riggers Association of Phila.	1500 Chester Pike Eddystone, PA 19013
Stephen R. Karba Lehigh Valley Contractors Assoc., Inc.	6813 Chrisphalt Drive Bath, PA 18014
Michael K. Kowalchick Building Contractors Association of South Jersey	1525 Locust Street Suite 64 Philadelphia, PA 19102
James E. Magaro Union Iron Worker Employers of Central PA	187 Meadow Grove Rd. Newport, PA 17074
Richard A. Pulaski Pulaski Construction	436 Princeton Avenue Mercerville, NJ 08619
William Anderson General Building Contractors Association	220 Park Road North Wyomissing, PA 19610
James F. Sassaman General Building	36 S. 18th Street P.O. Box 15959 Philadelphia, PA 19103

The Board of Trustees is the agent for service of legal process in accordance with the proposed regulations under the Employee Retirement Income Security Act of 1974.

The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is EIN 23-1599740.

Contractors Assoc., Inc.

## **Investments**

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Fund's Assets and Reserves are invested and held in custody by Harbor Capital Management Co., Inc.

## **Employer Contributions**

The Iron Workers District Council (Philadelphia and Vicinity) Welfare Plan receives contributions in accordance with collective bargaining agreements with various Employers in the industry and the Iron Workers Locals — 36, 68, 161, 350, 399, 401, 404, 405, 420, 451, and 489. These collective bargaining agreements provide that Employers contribute to the Fund on behalf of each covered employee on the basis of a fixed rate per hour, in accordance with the applicable collective bargaining agreement.

## **Income and Reserves**

Income received by the Fund from Contributing Employers is held in a Trust Fund for the purpose of providing benefits to covered Employees and defraying reasonable administrative expenses.

For purposes of maintaining the Fund's fiscal records, the date ending the fiscal year is September 30.

## **Insurance Provisions — Effective October 1, 2002**

Life Insurance, Accidental Death and Dismemberment and Weekly Disability benefits are provided through group insurance purchased by the Trustees from Amalgamated Life Insurance Company.

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## SCHEDULE OF BENEFITS

### Members Only

Life Insurance ..... \$30,000.00

Accidental Death and Dismemberment Ins. .... 30,000.00

Accidental Death and Dismemberment

Work Related ..... 70,000.00

Weekly Disability Benefits ..... maximum 26 weeks  
@ \$150.00 per week

### Members and Dependents

Optical Benefits ..... Per Plan Rules

Prescription Drug ..... Per Plan Rules

Dental..... Per Schedule

# Personal Choice

## Iron Workers Summary of Benefits

Personal Choice<sup>®</sup>, our popular Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing care through Personal Choice’s expansive network of hospitals, doctors and specialists, or by accessing care through preferred providers that participate in the BlueCard PPO program. Of course, with Personal Choice, you have the freedom to select providers who do not participate in the Personal Choice network or BlueCard PPO program. However, if you receive services from out-of-network providers, you will have higher, out-of-pocket costs and may have to submit your claim for reimbursement.

### With Personal Choice...

- You do not need to enroll with a primary care physician
- You never need a referral

Benefit	In-Network	Out-of-Network*
<b>DEDUCTIBLE</b>		
Individual	\$0	\$250
Family	\$0	\$500
<b>AFTER DEDUCTIBLE, PLAN PAYS</b>		
<b>OUT-OF-POCKET MAXIMUM</b>		
Individual	None	\$1,000
Family	None	\$2,000
<b>LIFETIME MAXIMUM</b> (includes psychiatric services)	Unlimited	\$1 Million
<b>DOCTOR'S OFFICE VISITS</b>		
Primary Care Services	\$5 Copayment	80%, after deductible
Specialist Services	\$5 Copayment	80%, after deductible
	In-	Out-of-

Benefit	Network	Network*
PREVENTIVE CARE FOR ADULTS AND CHILDREN	\$5 Copayment	80%, after deductible
PEDIATRIC IMMUNIZATIONS	100%	80%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP		
1 per calendar year for women of any age	100%	80%, NO deductible
MAMMOGRAM	100%	80%, NO deductible
MATERNITY (Excludes Dependent Daughters)		
First OB visit	\$5 Copayment	80%, after deductible
Hospital	100%	80%, after deductible
INPATIENT HOSPITAL SERVICES	100%	80%, after deductible
INPATIENT HOSPITAL DAYS	365	70
OUTPATIENT SURGERY	100%	80%, after deductible
EMERGENCY ROOM	\$25 Copayment (waived if admitted)	\$25 Copayment (waived if admitted)
OUTPATIENT LABORATORY	100%	80%, after deductible
OUTPATIENT RADIOLOGY	100%	80%, after deductible
OTHER THERAPY SERVICES		
Physical, Speech and Occupational	\$10 Copayment	80%, after deductible
Cardiac Rehabilitation (18 visits per calendar year)	\$10 Copayment	80%, after deductible
Pulmonary Rehabilitation (12 visits per calendar year)	\$10 Copayment	80%, after deductible
Respiratory Therapy	\$10 Copayment	80%, after deductible

Benefit	In-Network	Out-of-Network*
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE	\$10 Copayment	80%, after deductible
CHEMO/RADIATION AND RENAL DIALYSIS THERAPY	100%	80%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%	80%, after deductible
SKILLED NURSING CARE	100%	80%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	80%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	100%	80%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%	Not covered
OUTPATIENT PSYCHIATRIC	Self-Administered by the Fund	Self-Administered by the Fund
INPATIENT PSYCHIATRIC	Self-Administered by the Fund	Self-Administered by the Fund
SERIOUS MENTAL ILLNESS CARE		
Outpatient	Self-Administered by the Fund	Self-Administered by the Fund
Inpatient	Self-Administered by the Fund	Self-Administered by the Fund
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	Self-Administered by the Fund	Self-Administered by the Fund
Rehabilitation	Self-Administered by the Fund	Self-Administered by the Fund
Detoxification	Self-Administered by the Fund	Self-Administered by the Fund

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross— independent licensees of the Blue Cross and Blue Shield Association.

### What Is Not Covered?\*\*\*

- Services determined not to be medically necessary or medically appropriate
- Cosmetic services, supplies or treatment
- Supportive devices for the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes
- Military or occupational injuries or illness
- Assisted fertilization techniques such as, but not limited to, in-vitro fertilization, artificial insemination, GIFT, ZIFT (except as specified in a group contract)
- Experimental or investigative services
- Acupuncture
- Maintenance of chronic conditions when treatment has reached maximum therapeutic value
- Services not billed and performed by a provider properly licensed and qualified to render the medically necessary treatment, service or supply
- Routine foot care
- Benefits payable by the government, Medicare
- Charges in excess of benefit maximums or allowable charges as set forth in the group contract
- Inpatient private duty nursing
- Immunizations required for employment or travel
- Wellness programs
- Automobile accidents (see page 37)
- Sterilization reversals
- Transplants (see page 36)
- Blood

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\*\*\*This summary represents only a partial listing of the benefits and exclusions of the Personal Choice program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully for a complete listing of the terms, limitations and exclusions of the program. If you need more information, please call 1-800-626-8144 (outside Philadelphia) or 215-557-7577 (if calling within the Philadelphia area).

## Services That Require Pre-Authorization

Service	In-Network (Personal Choice network provider or BlueCard® PPO provider)	Out-of-Network
ALL NON-EMERGENCY INPATIENT ADMISSIONS (EXCEPT MATERNITY ADMISSIONS)	Required	Required
<hr/>		
OUTPATIENT SURGICAL PROCEDURES		
Bunionectomy	Required	Required
Cataract Surgery	NOT Required	Required
Laparoscopic Cholecystectomy	Required	Required
Hemorrhoidectomy	Required	Required
Hernia Repair	NOT Required	Required
Arthroscopic Knee Surgery/ Diagnostic Arthroscopy	Required	Required
Ligation and Stripping of Varicose Veins	Required	Required
Prostate Surgery	NOT Required	Required
Spinal/Vertebral Surgery	NOT Required	Required
Submucous Resection (nasal surgery)	Required	Required
Tonsillectomy and/or Adenoidectomy	Required	Required
<hr/>		
OPERATIVE AND DIAGNOSTIC ENDOSCOPIES	NOT Required	Required
MRI	NOT Required	Required
CAT SCAN	NOT Required	Required
OUTPATIENT THERAPIES Physical, Speech, Occupational, Cardiac, Pulmonary, Respiratory, Infusion	Required	Required

RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE AND RELATED SERVICES	Required	Required
OUTPATIENT PRIVATE DUTY NURSING	Required	Required
OTHER FACILITY SERVICES: Skilled Nursing, Hospice, Home Health, Birth Center	Required	Required
NON-EMERGENCY AMBULANCE	Required	Required
RENTAL OF DURABLE MEDICAL EQUIPMENT	Required	Required
PURCHASE OF DURABLE MEDICAL EQUIPMENT OVER \$100	Required	Required
PROSTHETICS	Required	Required

Personal Choice network providers will obtain pre-authorization for you, if it is required for the service provided. You are not required to obtain pre-authorization when you are treated in a Personal Choice network hospital or facility, or by a Personal Choice network doctor. Members are not responsible for financial penalties because a Personal Choice network provider does not obtain prior approval.

If you use a provider who is a BlueCard PPO network provider, or an out-of-network provider, you must obtain pre-authorization required for the service or supply being provided. You may be subject to financial penalties if you do not obtain pre-authorization.

Call Independence Blue Cross at the pre-authorization telephone number listed on the back of your identification card to initiate pre-authorization.

You may be responsible for financial penalties if you do not pre-authorize services when you use a BlueCard PPO provider, or out-of-network provider. There is a \$1,000 penalty for failure to pre-authorize inpatient services or treatment, and a 20% reduction in benefits for failure to pre-authorize outpatient services or treatment.

Pre-authorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the pre-authorization is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

## **ELIGIBILITY FOR BENEFITS**

Effective January 1, 2003 all new members who are active participants in a bona fide Apprentice Training Fund for Iron Workers will become eligible for all Benefits on the first day of the month following the completion of three consecutive calendar months of employment with contributing employers during which you are credited with at least 200 hours of employment with contributing employers.

New members, other than apprentices, will become eligible for Benefits on the first day of the month immediately following the completion of at least 1,000 hours of employment with contributing employers, provided that the 1,000 hours was earned over 12 consecutive calendar months or less. In addition, all other applicable rules of eligibility must also be met.

## **EFFECTIVE DATE OF COVERAGE**

You become covered on the date you become eligible.

## **DEFINITION OF DEPENDENTS**

### **ELIGIBLE DEPENDENTS**

For the purposes of this Plan the following are the persons who will be eligible for dependent coverage:

1. Your lawful spouse;
2. Each of your unmarried dependent children from birth to the first day of the month following 90 days after the child's 19th birthday. Dependent full-time college students may be insured to the first day of the month following 90 days after the child's 23rd birthday or after ceasing to attend on a full-time basis, whichever comes first and provided that the necessary supporting documents are forwarded to the Fund Office.

"Unmarried dependent children" shall mean legitimate children who are a part of the eligible Employee's household and who are fully dependent upon the employee for support. Unmarried dependent children shall also include legally adopted children.

"Unmarried dependent children" shall also mean mentally or physically disabled children who otherwise fulfill the requirement of this definition but who are over age 19, unmarried and incapable of self-sustaining employment.

An Employee must notify the Fund Office within 31 days after the child's 19th birthday to qualify for continued dependent coverage. Evidence of disability from the attending physician must be submitted at this time.

"Unmarried dependent children" shall not mean step-children.

### **NO MEDICAL EXAMINATION**

No medical examination is required in order to become covered under this Plan. However, in order to obtain this insurance, it is necessary to fill in a Health Benefit Enrollment Card which has been prepared for this purpose.

### **INDIVIDUAL CERTIFICATES OF INSURANCE**

As an insured member you will receive a certificate from the Amalgamated Life Insurance Company which sets forth the benefits which are insured by that Company and outlines the particular terms and conditions of the policies issued to the Trustees. In the event of any question regarding the interpretation of this certificate or the proper payment of benefits, you may obtain further information from the Trustees or, if you prefer, you may direct your inquiry to the Home Office of the Amalgamated Life Insurance Company.

### **TERMINATION OF BENEFITS**

Effective January 1, 2003

If you once become insured for Benefits and later work less than 200 hours with contributing employers during any three consecutive calendar months, your Life Insurance, Accidental Death and Dismemberment Coverage, Surgical, Diagnostic Laboratory and X-Ray, Physician's Expense, Hospitalization, Drug, Dental and Optical Benefits will remain in effect until the end of the calendar quarter following the calendar quarter during which you failed to work 200 hours with contributing employers.

Your Weekly Disability Benefits will terminate at the end of the month which follows any three-month period in which you did not work a minimum of 200 hours with contributing employers.

For anyone who retires on or after October 1, 1993 all of your Health Benefits will be continued until normal run-out of termination in accordance with the Health Fund rules. (See page 38 for benefits provided to certain type pensioners.) Benefits will also terminate on the date you enter active Military Service.

See page 21 for information regarding the privilege of converting to an individual Life Insurance Policy at your own expense.

Your dependents' Benefits terminate when the dependent ceases to be dependent as defined on page 14 or upon termination of your Benefits, whichever first occurs.

However, if your Benefits are terminated solely because of your death, coverage of your dependents will be continued to the first day of the month coinciding with or next following the end of thirty months after your death or entitlement for Medicare, whichever occurs sooner. If a dependent is eligible for Medicare at the time of the spouse's death, their coverage will only be continued for an additional six months.

(Continuation of medical benefits under the Comprehensive Omnibus Budget Reconciliation Act (COBRA) see pages 47 and 48.)

### **CONTINUATION OF MEDICAL EXPENSE BENEFITS FOR CERTAIN DISABLED CHILDREN**

The Medical Expense Benefits of this plan can be continued for an unmarried child who is incapable of earning his own living because of a mental or physical handicap and is chiefly dependent on you for support on the date the child ceases to be eligible for Medical Expense Benefits due to attainment of the limiting age. Coverage for such a child can be continued for the duration of the incapacity provided coverage does not terminate for any other reason. Proof of incapacity must be furnished to the Fund Office within 31 days after the child attains the limiting age and must be furnished thereafter as required.

### **ELIGIBILITY DURING PERIODS OF DISABILITY**

If after you meet the eligibility requirements, you are then unable to work because of a disability for which you receive Workmen's Compensation benefits or Weekly Disability benefits from the Health Benefits Plan, you will receive credit toward eligibility on the basis of 17 hours of employment for any week during which you receive such benefits up to a maximum of 26 weeks in the 12 month period commencing from the date the disability was incurred. Such credit may be granted only once during a 12 month period.

Periods of disability, for the same illness or injury, separated by less than 10 days of active work are considered as the same (one) period of disability.

Periods of disability for different illnesses or injuries separated

by one day of active work shall be considered as separate periods of disability.

You will receive credit toward continued eligibility based upon those hours in accordance with the regular eligibility rules which are stated on page 14.

If you receive Workmen's Compensation Benefits be sure to notify the Benefit Plan office, so that you can receive credit towards eligibility for the period you collect the Workmen's Compensation Benefits.

## **REINSTATEMENT OF BENEFITS**

If you are covered for Benefits and lose eligibility, except for entrance into the military service, and this loss of eligibility is for less than twenty four (24) consecutive months, you will be reinstated for all Benefits on the first day of the month following the achievement of 200 hours or more of work with a contributing employer in any three consecutive month period.

If you were covered for Benefits and your eligibility was terminated solely because of entrance into active military service, you will be reinstated for all of your previous benefits on the day you commence work with a contributing employer, provided you commence work within 90 days from the date of your discharge from the Armed Forces. Otherwise, you will be treated as a new employee for purpose of determining your benefit coverage. If you were covered only for Benefits prior to entering the active military service and return to covered employment within 90 days as described above, your time in the Armed Forces will be applied toward eligibility. If you were covered for Benefits and lose eligibility, except for entrance into the military service, for 24 consecutive months or more you will be reinstated for Benefits on the first of the month immediately following the completion of at least 1000 hours of employment with contributing employers, provided that the 1,000 hours was earned over 12 consecutive months or less.

## **EFFECT OF MEDICARE**

### **MEDICARE COVERAGE**

Any person Medicare eligible is entitled to Medicare, a broad program of health benefits which includes Hospital insurance

(Part A) and Medical insurance (Part B).

Enrollment in Part A is automatic and effective January 1, 1989 all persons eligible are covered by the Medicare Catastrophic Coverage Act. Under these provisions the maximum per benefit period deductible payable by a Medicare beneficiary for hospitalization will be paid by the Benefit Plan regardless of the length of hospital stay.

Enrollment in Part B is required for all pensioners and their dependents at time of eligibility for Medicare to qualify for continuation of Health Benefits from this Plan.

Effective January 1, 1991 there is no reimbursement for this premium by the Fund.

### **ACTIVE MEMBERS**

If you are an active employee (not retired) and Medicare eligible, you will be covered for regular Fund benefits with the Fund acting as primary carrier — that is, paying on claims first. Medicare will act as the secondary carrier and pay differences in covered benefits, if any, that were not paid by the Fund and if less than Medicare would have normally paid.

If your spouse is Medicare eligible, the spouse will be covered for the regular Fund benefits as noted above, as long as you retain eligibility.

Benefits not provided by Medicare which are provided by the Fund (such as Drugs and optical) will be continued for you and your eligible dependents so long as you retain eligibility under the Plan and regardless of your age.

We strongly suggest that prior to retirement, you contact your local Social Security office to determine your (and your spouse's) rights to Medicare coverage.

### **PAYMENT OF CLAIMS**

Claims incurred on and after the effective date of your coverage will be processed for payment. For example, a Life Insurance claim is incurred on the date of death, a Disability claim is incurred on the date the member becomes disabled and is unable to work, a Physician's Expense claim is incurred on the date the Member receives the first treatment, a surgical claim is incurred on the date the surgical procedure is performed, a Laboratory and X-Ray claim is incurred on the date an examination is performed.

Please keep in mind that if a Dental or Vision claim is incurred,

a Dental or Vision claim form should promptly be secured from the Plan office. Do not wait until you return to work to make a report.

Please use your Blue Cross PPO and/or Advance PCS cards when applicable. This will eliminate the need for claim forms.

Written notice of claim must be furnished within 31 days of commencement of a period of disability. Written proof of loss (a form to be completed by your doctor) must be furnished within 90 days of commencement of a period of disability.

Benefits will be paid promptly if the forms are properly completed.

Benefits will be paid for the period covered by the statement of claim form. If disability continues beyond that period additional claim forms will be requested.

No claim will be considered for payment if the claim incurred date is more than one year prior to the date the claim form is received in this office.

## **CONTINUATION OF PLAN**

The Board of Trustees intend to continue the Plan described in this Summary Plan Description indefinitely. Nevertheless, they reserve the right, subject to the provisions of any pertinent collective bargaining agreements to terminate or amend the Plan. The Plan may be terminated in writing by the Board of Trustees when there is no longer in effect an agreement between the Employer and the Unions requiring payment to the Fund. Upon termination of the Plan, the Board of Trustees shall apply the monies of the Fund to provide benefits or otherwise carry out the purposes of the Plan in an equitable manner until the entire remainder of the Fund has been disbursed.

Plan benefits for active, retired or disabled participants are not guaranteed.

The Board of Trustees reserves the right to amend, modify or terminate the Benefit Plan in order to maintain the financial integrity of the Benefits being provided to eligible participants as defined by the Plan. Such action will be taken at a Trustee meeting properly constituted in accordance with the provisions of the Agreement and Declaration of Trust. The decisions made and implemented by the Trustees shall be final and binding on all affected participants.

## **PRE-AUTHORIZATION FOR CERTAIN TYPES OF SURGERY**

Any type of Surgical Claim that could possibly be considered cosmetic in nature, or any Surgery performed by a Podiatrist will first have to have pre-authorization by the Plan's Medical Insurance Carrier.

### **Hospital Benefits**

When you or an insured member of your family needs hospital care, simply present your Identification Card at the time of admission to the Hospital.

### **Drug Benefits**

See page 24 regarding payment of prescribed drug claims.

## **LIFE INSURANCE FOR EMPLOYEES**

Effective October 1, 2002 Amalgamated Life Insurance Company

The Life Insurance is payable in event of your death from any cause at any time or place while you are insured. Payment will be made in a lump sum or in installments to the beneficiary designated by you. The beneficiary may be changed whenever you wish by contacting the Plan Office.

A person who, while covered under the Plan's eligibility rules becomes totally and permanently disabled will continue to have his life insurance remain in force for the period of disability until attainment of age 62 provided satisfactory proof is furnished to the Trustees.

Total and permanent disability shall mean

a) The employee is totally disabled as a result of bodily injury or disease and is unable to perform any work;

b) The disability is permanent and continuous for the remainder of the employee's life;

c) The employee is unable to engage in or secure any other employment or gainful pursuit; and

d) The disability is not a result of a self-inflicted injury, addiction to narcotics or alcohol, or was incurred in the course of perpetrating a crime.

The disability must be incurred during a period of time the person is eligible for life insurance benefits under the Plan's rules. Application for benefits may be made at any time but should not be made at a date later than nine months after the disability was incurred.

Effective May 1, 2003 the life insurance benefit for a person who is approved for this continuation due to total and permanent disability will be adjusted to the level of \$3,000.00 if the Disability Pensioner has at least 15 but less than 20 Pension Credits, \$4,000 if the Disability Pensioner has at least 20 but less than 25 Pension Credits and \$5,000 if the Disability Pensioner has at least 25 Pension Credits. This adjusted level will also be applicable to individuals with at least 15 Pension Credits upon attainment of age 62. Those individuals with less than 15 years of Pension Credit will receive a benefit of \$3,000.

If your death should occur within thirty-one days after your Life Insurance has terminated in accordance with the termination rules, the death benefit will be payable. By making application and paying the first premium to the Amalgamated Life Insurance Company, within this thirty-one day period, you may convert your Group Life Insurance to an individual Life Insurance policy on any regular Whole Life or Endowment Plan. This individual policy will be issued without medical examination at the Insurance Company's regular rates, according to occupation and attained age.

### **ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE FOR EMPLOYEES**

Accidental Death and Dismemberment Coverage provides benefits for your loss of life, limbs, or the entire and irrecoverable loss of sight including losses resulting from occupational bodily injuries. Benefits are payable if the loss is a direct result of a bodily injury caused by an accident and the loss is sustained within ninety days after the date of the accident.

The full Principal Sum to which you are entitled in accordance with the Schedule of Insurance, will be paid for the loss of:

- Life
- Both Hands
- Both Feet
- One Hand and One Foot
- One Foot and Sight of One Eye
- One Hand and Sight of One Eye
- Sight of Both Eyes

One-half the Principal Sum will be paid for the loss of one hand, one foot or the sight of one eye. In no case will more than

the full Principal Sum be paid for all losses sustained through any one accident.

Payment will be made directly to you, if living, otherwise to your Beneficiary.

Since the purpose of this coverage is to provide benefits for losses due to accidents, no benefits are paid on account of a loss caused or contributed to by:

bodily or mental infirmity; or  
disease, ptomaines or bacterial infections; or  
medical or surgical treatment (unless made necessary by an injury covered under the Plan; or  
suicide or intentionally self-inflicted injury; or war  
or any act of war.

The loss must occur while insurance is in force.

### **WEEKLY DISABILITY BENEFITS FOR EMPLOYEES**

The Plan pays you a weekly benefit while you are disabled and prevented from working as a result of a non-occupational accidental bodily injury or disease.

The weekly benefit to which you are entitled will commence on the first day of disability resulting from injury or on the eighth day of disability resulting from disease. After benefits have been payable for disease for three consecutive weeks or more, benefits are payable for the first seven days of disability. Benefits are payable for a maximum period of twenty-six weeks for any one disability.

Payment will be made for as many separate and distinct periods of disability as may occur.

If you recover from a disability and again become disabled after less than two weeks of active work on a full-time basis, both disabilities will be considered as one period of disability unless the subsequent disability is due to an injury or disease entirely unrelated to the causes of the previous disability and commences after you have returned to work and have completed at least one day of continuous active employment.

When benefits have been paid for the maximum period of twenty-six weeks, Weekly Disability Benefits will terminate. However, you will again be eligible for this coverage as soon as you have returned to active work and have completed one day of continuous active employment.

It is not necessary to be confined to your home to collect benefits, but no benefits are payable for any period during which you are not under the care of a legally qualified physician. The period of disability must commence while insurance is in force.

## **OBSTETRICAL EXPENSE BENEFITS FOR FEMALE EMPLOYEES AND WIVES OF EMPLOYEES**

Benefits for female member or wife of member are payable only if member is covered under the Fund's eligibility rules at time of this birth or at time of a termination of pregnancy. No Obstetrical Benefits provided for Dependent Children.

## **COVERAGE FOR ALCOHOLISM OR SUBSTANCE ABUSE**

The Fund will provide detoxification and rehabilitation coverage to covered Participants and Dependents.

The program provides up to 5 days of coverage in a 12 month period in a hospital for detoxification (drying out) up to twice in a lifetime.

The program also covers up to 28 days of rehabilitation following hospitalization for alcoholism or substance abuse. The rehabilitation program is limited to two (2) periods of rehabilitation in a lifetime.

The program is provided only in a non-governmental facility whose plan of treatment is approved by a joint Commission on Accreditation.

Out-patient rehabilitation service is covered only if the program is started within 60 days of hospitalization for detoxification or rehabilitation.

If a covered person enters a detoxification or substance abuse program and voluntarily does not complete the 5 days of detoxification and the 28 days of rehabilitation program, no benefits are payable by the Fund.

You may obtain information concerning the program and the facilities in which this coverage is offered by calling the Fund Office.

## **DENTAL OR ORAL SURGERY**

Benefits are provided for hospitalization for dental or oral surgery consisting of cutting procedures for treatment of diseases and injuries of the jaw or treatment of fractures and dislocations of the jaw; and for extraction of impacted teeth. Other extractions, and care of teeth, are included as a dental benefit (refer to "Schedule of Dental Services").

Emergency facility charge, lab, or x-ray studies, etc., will not be funded if it is determined by the nature of the illness or injury did not constitute a true emergency situation.

## **HOSPITAL PLAN EXCLUSIONS**

Benefits are not provided under the Hospital Plan in cases covered by workmen's compensation laws; for diagnostic service; for convalescent or rest cures; for ambulance service; for charges of physicians, surgeons or special nurses; for blood or blood plasma; for radium; for out-patient treatment other than in emergency accident cases and minor surgery; for hospitalization for dental or oral surgery except as described previously; for services received (or which patient is entitled to receive) under laws or regulations of any government or its agencies except for treatment in a Veteran's Hospital for non-military service related illness or injury.

## **HOSPITAL BENEFITS**

When you need hospital care, simply present your Identification Card when you are admitted to the hospital. You will be entitled to all the benefits described and the bill for these benefits will be sent to the Insurance Company.

## **PRESCRIPTION DRUG PROGRAM FOR EMPLOYEES AND DEPENDENTS**

Covered Drugs are those which, under Federal Law, are required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription," or which require a prescription by state law. Insulin is also a covered drug.

## **MANDATORY GENERIC ACUTE PRESCRIPTION DRUG PROGRAM**

Benefits will be provided for Covered Drugs for out-of-hospital use (but not while a patient in a nursing home or other institution) dispensed on and after the effective date by a legally licensed pharmacy.

## **HOW THE PRESCRIPTION DRUG PROGRAM WORKS**

Effective January 1, 2003, the Iron Workers Health Benefit Fund Prescription Drug Benefit will be administered by Advance PCS. Your identification card can be used at any participating drug store that displays the Advance PCS decal in the store window or near the pharmacy area.

There is a \$5.00 co-pay for brand named drugs when no generic equivalent is available.

The mandatory generic provision of this Plan means if a generic is available the Plan will only pay for generic even if you receive

a brand named drug.

## **MANDATORY GENERIC MAINTENANCE PRESCRIPTION DRUG PROGRAM**

Advance Rx.com through Advance PCS

If you or your eligible dependents are being treated for a chronic (long duration or frequently reoccurring) illness that requires a prescription drug you are now required to obtain those drugs from Advance PCS. Your physician must complete the prescription on the form supplied by the Fund Office (one prescription per form). The member must complete the section of the form as indicated. Use the prepaid postage addressed envelopes (also furnished by the Plan Office) to mail the prescription form to Advance PCS. Do not send money or checks. The prescribed drugs will be mailed to you and will be paid for by the Health Benefit Fund (Welfare Fund). If your physician requires that a prescription be taken for more than 12 months, you must have a new prescription form completed every 12 months. The Provider of the maintenance drugs for the Fund will only supply the generic equivalent of the drug unless you and/or your doctor elect to have the brand drug dispensed. In this case the Provider will bill you directly for the difference in cost. The Fund will pay the Provider only for the cost of generic equivalent. If there is no generic substitute available, you will receive the brand drug with a \$5.00 co-pay for each 30 day supply.

## **BENEFIT EXCLUSIONS AND LIMITATIONS**

Certain items are not covered by the Plan.

Any charge for any type of vitamin, even if such medication is a prescription legend drug; any charge for Rogaine or any other hair growth product and any charge for devices or appliances, regardless of their intended use.

The diagnosis, name of medication and approximate length of treatment is needed for Prior Authorization from the Fund for the following:

- Retin A
- Viagra
- All injectables other than Insulin

Any charge for administration of Covered Drugs.

The charge for any prescription order refill in excess of the number specified by a doctor, or any refill dispensed after one year from the date of the original prescription order.

The charge for any drug which has not been prescribed by a doctor of medicine, osteopathy, dental surgeon, dental medicine, or surgical chiropody.

The charge for any medication for which the employee or dependent is entitled to receive reimbursement under any Workmen's Compensation Law or is entitled to from any municipal, State or Federal program of any sort whether contributory or not.

The charge for medication covered under any other prescription drug, drug coverage plan or policy of insurance.

### **OPTICAL BENEFIT EFFECTIVE OCTOBER 1, 1998**

Optical Benefits under your Plan are provided on a self-insured basis. Benefits may be provided for each eligible employee and dependent once in every two-year period.

Covered dependent children 18 years of age or younger may have an eye examination and new lenses once a year, if there is a prescription change.

Benefits are payable up to the following amounts:

\$20.00 for an eye examination

\$40.00 towards the purchase of single vision lenses

\$60.00 towards the purchase of bifocal lenses

\$100.00 towards the purchase of eyeglass frames.

A maximum benefit of \$84.00 will be paid toward the purchase of prescribed contact lenses when using an out of network provider.

Contact the Fund Office for the required forms and submit the completed form along with an itemized bill to the Fund Office for payment.

The Fund Office also has a contract with National Vision Associates which will enable you to have eye examination, lenses and eyeglass frames provided at discount prices. Please contact the Fund Office for proper forms and a list of participating doctors.

### **DENTAL BENEFIT**

Employees and their eligible dependents are covered for den-

tal plan benefits. The Plan pays you a benefit for a dental service as shown in the schedule of Dental Services.

### How the Dental Plan Works

You or your dependents select any dentist of your choice.

You make your dental appointment for a time that is convenient for both you and your dentist.

You are not limited to certain dentists. You may change dentists at your convenience without endangering your benefits. However, in the event an eligible employee or dependent transfer from the care of one dentist to that of another dentist during the course of treatment or have more than one dentist perform services for one dental procedure, the Plan shall be liable for not more than the amount it would have been liable for had one dentist performed the service.

Treatment will be performed in your dentist's own office.

### What Benefits are Paid

The Dental Plan will pay a benefit up to the maximum allowance as shown in the Schedule of Maximum Allowance (refer to Dental Benefits) or the dentist's actual charges, whichever is less.

If two or more dental services are rendered, payment will be made for each dental service unless the Schedule of Maximum Allowances specifies a maximum amount for a particular combination of dental services.

## **DENTAL BENEFIT PROGRAM SCHEDULE OF MAXIMUM ALLOWANCES**

EFFECTIVE OCTOBER 1, 1998

	Maximum Allowance
1. GENERAL	
110 Initial Exam.....	\$ 22.00
120 Oral Exam & Diagnosis .....	\$ 17.00
111 Prophylaxis .....	\$ 32.00
1203 Stannous Fluoride Treatment .....	\$ 16.00
130 Emergency Treatment of Dental Pain .....	\$ 16.00

## 2. DENTAL X-RAY

270	Bitewing X-Rays, each film.....	\$ 8.00
220	Periapical X-Ray, each film .....	\$ 8.00
230	Periapical additional film .....	\$ 7.00
210	Maximum Periapical & Bitewing X-Ray .....	\$ 50.00
330	Panoramic Film .....	\$ 45.00

## 3. EXTRACTION OF TEETH

7110	Extraction with local anesthesia .....	\$ 40.00
7120	Extraction each additional tooth .....	\$ 36.00

## 4. INLAYS AND FILLINGS

2140	Amalgam involving one tooth surface .....	\$ 34.00
1351	Occlusal Pitt & Groove Sealer .....	\$ 21.00
2150	Amalgam involving two tooth surfaces .....	\$ 45.00
2160	Amalgam three or more tooth surfaces .....	\$ 56.00
2334	Amalgam Pin .....	\$ 10.00
2950	Silicate build up .....	\$ 50.00
2380	Silicate filling each tooth .....	\$ 50.00
2410	Gold Foil, one tooth.....	\$140.00
2420	Gold Foil, two tooth surfaces .....	\$185.00
2430	Gold Foil, three or more tooth surfaces .....	\$220.00
2510	Gold Inlay, one tooth surface .....	\$160.00
2520	Gold Inlay, two tooth surfaces .....	\$175.00
2530	Gold Inlay, three or more tooth surfaces .....	\$195.00
2610	Porcelain Inlay, each .....	\$200.00

## 5. CROWNS, PERMANENT, EACH

2740	Porcelain crown .....	\$340.00
2750	High noble porcelain crown .....	\$410.00
2810	Three quarter gold crown .....	\$265.00
2830	Stainless steel crown.....	\$140.00
2790	Cast gold crown .....	\$340.00

## 6. PONTICS

6240	Porcelain or acrylic pontic .....	\$335.00
6242	Gold acrylic pontic .....	\$320.00

## 7. ENDODONTICS

3410	Apicoectomy .....	\$185.00
3310	One root canal .....	\$230.00
2891	Gold core and post .....	\$115.00
3320	Two root canals .....	\$330.00
3330	Three root canals .....	\$400.00
3230	Therapeutic pulpotomy .....	\$ 90.00
3220	Vital pulpotomy .....	\$ 45.00
3110	Pulp capping .....	\$ 18.00

8. SPACE MAINTAINERS

1510	Space maintainers, acrylic .....	\$140.00
1515	Space maintainers, metal .....	\$185.00

9. REMOVABLE DENTURES

5110	Full dentures, either jaw each .....	\$450.00
5130	Full denture immediate and permanent .....	\$450.00
5213	Partial maxillary .....	\$460.00
5214	Partial mandibular .....	\$460.00
5711	Rebasing with slow cure acrylic .....	\$125.00

10. REPAIRS AND ADDITIONS TO DENTURES

5620	Repair of broken denture .....	\$ 50.00
5520	Broken teeth on denture replace .....	\$ 35.00
5630	Reattaching undamaged clasp .....	\$ 40.00
5660	Replacing broken clasp on denture .....	\$ 42.00

11. PERIODONTICS

4330	Occlusal adjustments-complete .....	\$110.00
4345	Root scaling initial treatment .....	\$ 75.00
4910	Root scaling subsequent treatments .....	\$ 75.00

12. REPAIRS TO INLAYS, CROWNS AND BRIDGES

2910	Recementing inlay. ....	\$ 20.00
2920	Recementing crown .....	\$ 25.00
6930	Recementing bridge .....	\$ 40.00

13. ORTHODONTICS

8050	Removable Ortho appliance each arch .....	\$ 295.00
8070	Diag and initial Ortho, appliance .....	\$ 400.00
8641	Active Orthodontic treatment 24 mos. x \$75.00 .....	\$1,800.00
8060	Active Orthodontic treatment 12 mos. x \$40.00 .....	\$ 480.00
	Phase I Treatment	
	Orthodontic Maximum \$2,200.00 — Once in a lifetime	
	Initial Consultation Fee and banding .....	\$ 400.00

Please call the Fund Office for the fee schedule for any procedures not listed.

Pre-authorization for dental treatment must be submitted when dentist charges are \$250.00 or more.

### **EXCLUSIONS & LIMITATIONS**

1. Any service unless rendered by a duly licensed dentist.
2. Any procedure or the supplying or fitting of any appliance unless required in accordance with accepted standards of dental practice.
3. Replacing any lost appliance.
4. Any service for which the patient incurs no dentist's charge.
5. Plastic surgery or dental work solely for cosmetic purposes.
6. Injuries, diseases or conditions, the treatment of which is available without cost to the person treated under laws enacted by the legislature of any State or the Congress of the United States (such as Workmen's Compensation, Veterans Compensation, etc.).
7. Any service received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or other similar person or group.
8. Any prosthetic appliance, fixed or removable, made as an adjunct to periodontal care, unless it replaces a missing tooth.
9. The replacement of any full or partial permanent denture by another permanent denture unless a period of two years has elapsed from the installation of the original appliance.
10. In connection with dentures, crowns or fixed bridgework:
  - a. Expenses for replacement of crowns, as restoration and/or abutment or pontics more often than once every five years.
  - b. Expenses for replacement of fixed bridge replacing same teeth originally provided under dental plan more often than once every five years.
  - c. Expenses for crowns or pontics originally placed if

included in second placement more often than once every five years.

- d. Replacement of fixed bridgework or splint by a denture or dentures unless a period of five years has elapsed from installation of original appliance.
  - e. If work in making a crown, denture or bridge started prior to effective date of coverage of the individual.
11. Maximum allowance for prosthetic or crowns for restoration or splints which includes crown and bridge, crown for abutment teeth and any associated charges will be \$3,500.00 per year, with a maximum amount of \$7,000.00 extended in two consecutive years if two separate arches are treated. A maximum of \$3,500.00 per arch will be paid in any consecutive 60 month period.
  12. A \$3,500.00 yearly maximum Fund Allowance will be applied to all crowns, crown and bridge, pontics post and core, and precision attachments.

There will be no allowances for second arch crowns, crown and bridge pontics, post and core precision attachments until 12 months after the date of insertion of the last procedure in a series of treatment which caused the maximum to be applied.

13. All claims must be filed within one year of the Dental Procedure.

### **COVERED MEDICAL EXPENSES**

Covered Medical Expenses included under the plan are the charges which you are required to pay for the following services and supplies received, while insurance is in force, for the treatment of non-occupational accidental bodily injuries and diseases (Also see Exclusions & Limitations):

#### **Hospital Expenses**

These are the charges made by a hospital for:

1. Board and room including any charges which are made by the hospital as a condition of occupancy or on a regular daily or weekly basis such as for general nursing services. However, if private accommodations are

used, any excess of daily board and room charges over the hospital's average semi-private charge will not be counted as a Covered Medical Expense. The Definitions section contains a definition of a hospital.

2. Necessary hospital services and supplies, other than board and room, furnished by the hospital.

### **Other Medical Expenses**

These are the charges made for the following medical services and supplies.

1. The services of a legally qualified physician.
2. The services of a registered nurse (R.N.) — other than a nurse who ordinarily resides in your home, or who is a member of your or your spouse's family.
3. Drugs and medicines obtainable only upon a prescription of a physician (as defined in Item 1 above).
4. Diagnostic X-ray and laboratory examinations.
5. X-ray, radium and radioactive isotopes therapy.
6. Anesthetics and oxygen.
7. Rental of iron lung and other durable medical or surgical equipment.
8. Artificial limbs and artificial eyes, but not eye examinations, eye glasses, or hearing aids.
9. Professional ambulance service when used to transport the individual from the place where he is injured by an accident or stricken by a disease to the first hospital where treatment is given. However, no other charges in connection with travel are included.
10. The Hearing Aid Benefit will be provided through an arrangement that has been made with the Delaware Valley Health Care Coalition. Under this Plan, you will be covered for up to 2 hearing aids every 2 years as long as you remain in Health Plan coverage. Each hearing aid will be covered up to a maximum cost of \$850.00 per hearing aid but you will be responsible for the first \$100.00 of cost for each hearing aid. Hearing examinations and evaluations will be included as part of the Program.

### **Special Conditions**

Dental Work and Oral Surgery

Hospital and Other Medical Expenses incurred in connection with dental work or oral surgery for the prompt repair of natural teeth or other body tissues and required as a result of a nonoccupational accidental bodily injury occurring while the individual is insured are included as Covered Medical Expenses. Also, Hospital and Other Medical Expenses required for the performance of the following oral surgical procedures are included as Covered Medical Expenses.

- (a) the excision of partially or completely unerupted impacted teeth;
- (b) the excision of a tooth root without the extraction of the entire tooth; or
- (c) Other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

### Cosmetic Surgery

Hospital and Other Medical Expenses incurred in connection with cosmetic surgery which are necessary for the prompt repair of a non-occupational accidental bodily injury occurring while the individual is insured are included as Covered Medical Expenses. However, no other expense for cosmetic surgery are included as Covered Medical Expenses.

### Complications of Pregnancy

Hospital and Other Medical Expenses incurred for surgical operations for extra-uterine pregnancy or for other complications requiring intra-abdominal surgery after termination of pregnancy are included as Covered Medical Expenses. Also included as Covered Medical Expenses are expenses incurred in connection with pernicious vomiting of pregnancy (hyperemesis gravidarum), or toxemia with convulsions (eclampsia of pregnancy). However, no other expenses in connection with pregnancy or resulting childbirth or miscarriage are included as Covered Medical Expenses.

## **CO-ORDINATION OF BENEFITS PROVISION**

Quite frequently, because husband and wife are working, members of a family are covered under more than one plan of employee benefits. Realizing there have been many instances of duplication of benefits — two plans paying benefits for the same dollar of medical expense — a “co-ordination of benefits” provision has been included in our plan for all covered benefits excluding life insurance, accidental death and dismemberment

insurance, weekly accident and sickness benefits and long term disability benefits.

This provision will co-ordinate the benefits payable as described in this booklet with similar benefits payable under other plans. The other plans are those which provide benefits or services in connection with hospitalization, medical or dental care, etc. or treatment toward the cost of which an Employer makes contributions or for which an Employer makes payroll deductions, and any government or tax-supported program.

One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then make up the difference up to the Allowable Expenses. No plan will pay more than it would have paid without this special provision. If one plan has no co-ordination of benefits provision, it automatically is Primary.

Information necessary to the administration of this provision will be required of the employee at the time a claim is submitted. Co-ordination of Benefit Forms not returned in a timely manner may delay processing of your claims.

In determining whether this Plan or another plan is primary, the following shall apply:

1. The Plan covering the patient other than as a dependent will be the primary plan.
2. Where both plans cover the patient as a dependent child, the plan covering the patient as a dependent child will be that of the parent with a birth date earlier in the year except as follows: Dependent Children of Separated or Divorced Parents:

When parents are separated or divorced, neither the male/female nor the birthday rules apply. Instead:

- a) The plan of the parent with custody pays primary;
- b) The plan of the parent without custody pays secondary

However, if the specific terms of a Court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obliged to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first. If any benefits are actually paid or provided before that entity has actual

knowledge, this "court decree" rule is not applicable during the remainder of the plan year or policy year.

3. Where the determination cannot be made in accordance with (1) or (2) above, the plan which has covered the patient for the longer period of time will be the primary plan.

This Plan will provide its regular benefits in full when it is the primary plan. As a secondary plan, this Plan will provide a reduced amount which when added to the benefits under other group plans will equal up to 100% of the charges for the patient's eligible expenses under this plan but in no event will this Plan's liability as a secondary plan exceed its liability as a primary plan.

Should a spouse be employed and the spouse's employer has a group health plan that has a provision that a doctor will accept that Plan's reasonable and customary fee as payment in full, the Iron Workers District Council of Philadelphia and Vicinity Health Plan will not pay as a secondary carrier any additional fee.

## **EXCLUSIONS**

No benefits are payable under this plan for the charges listed below, and the amount of any such charges will be deducted from the individual's expenses before the benefits of this plan are determined.

- (1) Charges that would not have been made if no Benefit Plan existed or charges that neither you nor any of your dependents are required to pay; or or
- (2) Charges for services or supplies which are furnished, paid for or otherwise provided for by reason of the past or present service of any person in the armed forces of a government; or
- (3) Charges for services or supplies which are paid for or otherwise provided for under any law of a government except where the payments or the benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents; or
- (4) Charges for services and supplies which are not necessary for treatment of the injury or disease or are not recommended and approved by the attending physician or charges to the extent that they are unreasonable.
- (5) Hypnosis (including diet, obesity and smoking sessions).
- (6) All diet control programs and related drugs.
- (7) Infertility testing except as noted under "Limitations".

- (8) Bio-Feedback therapy.
- (9) Orthotics and related appliances.
- (10) Charges for services that are payable by any insurance policy for which the premiums were paid by the member participant or his spouse or his dependents.

## **LIMITATIONS**

### Chiropractic Services —

\$7.00 per visit, \$500 per covered person per calendar year (no Major Medical coverage).

All hospital, medical, surgical and major medical claims and length of hospital stays will be paid on a usual, customary, and reasonable fee basis.

Reasonableness of charge and length of stay in hospital will be based on diagnosis of illness and the reasonable charges for that illness with the doctors and hospitals within the Plan's geographical location.

Surgical fees are ordinarily considered to cover the operative procedure and include post operative evaluation and care. The first two post operative office visits are also ordinarily covered by the surgical fee.

In the administration of benefits for AIDS related services, the Trustees shall consistently use the definition of AIDS as it is promulgated by the Center for Disease Control (Atlanta, Georgia), an agency of Public Health Services of the United States Department of Health and Human Services.

### Coverage for Infertility

Coverage for infertility treatment through drug therapy for participants and covered dependent spouses based on a requirement that such drugs be purchased through the Fund Office and subject to a lifetime maximum of \$10,000.00 per covered individual. This maximum is inclusive of prescription drugs and physician fees.

A prescription made out by a legally qualified physician must be sent to the Health Benefit office. The office in turn will have the medication sent to your home directly. The Fund office will need a phone number where you can be reached in case there are any questions about your medications.

## DEFINITIONS

To be recognized as a hospital for benefit purposes, an institution must keep patients regularly overnight, have full diagnostic, surgical and therapeutic facilities under the supervision of a staff of physicians who are doctors of medicine and regularly provide 24 hour nursing service by registered graduate nurses. Unless they fully meet this definition, institutions such as clinics, nursing homes, and places for rest, the aged, drug addicts or alcoholics do not qualify as hospitals.

To be covered by this plan, the services or supplies must be for the treatment of a nonoccupational accidental bodily injury or disease. Thus, elective services such as routine physical are not covered, nor are expenses in connection with occupational accidental bodily injuries or disease.

### Automobile Accidents

Effective as of October 1, 1984, no benefits are payable under the Benefit Plan for claims arising out of a member or dependents' involvement in any type of motor vehicle accident including accidents involving motorcycles.

Effective May 1, 2002, should you or your spouse or any of your covered dependent children be injured in an automobile accident and the medical bills exceed the maximum insurance coverage offered by your automobile insurance company or, if applicable, the maximum insurance protection permitted under the law of your state of residence, this Plan will cover any additional medical bills up to the limit of this Plan's coverage.

In order to take advantage of this new benefit, you must submit proof that you have paid all the required deductibles and that your medical bills exceed the maximum coverage offered by your automobile insurance company or, if applicable, the maximum permitted in state of residence.

## PENSIONER BENEFITS

### **Pensioners with effective Date of Pension on and after January 1, 1993**

The benefits and rules and regulations of the Iron Workers District Council (Philadelphia and Vicinity) Pension Plan are outlined in a separate section of this binder.

In addition to monthly cash pensions payable by the Pension Plan upon retirement, the Iron Workers District Council (Philadelphia and Vicinity) Benefit Plan will continue to provide

certain benefits to eligible pensioners and their eligible dependents.

Regular Retirement Pensioners who retire on or after January 1, 1993 and who have 25 years or more of Pension Credit in the Pension Plan of which at least 2 full years of pension credit were earned under the Pension Plan in the prior 4 calendar years at the time of retirement are covered for the following benefits: surgical, anesthesia, physician's expense, diagnostic X-ray and lab, major medical, hospitalization, prescription drug and optical as described in this booklet if you are age 62 or more at time of retirement and pay the required co-payment.

Effective January 1, 2002, those Pensioners who retire on or after January 1, 1993 on an Early Retirement Pension are covered for the benefits described above between the ages of 62 and 65 if they retire prior to age 62, return to work in covered employment for at least 3 years and again leave covered employment on or after age 62 with 25 years or more Pension Credit in the Pension Plan and pay the required co-payment.

Pensioners with an effective date of Jan. 1, 1993 or after who are eligible for Health Benefits at the time of pension shall have a \$5,000.00 death benefit.

Of course, any benefit for which a retired employee is eligible shall be subject to the nonduplication with Medicare provision (see page 18).

### **Effective July 1, 1993**

Pensioners (and eligible dependents) — who are currently eligible for and are covered for Health Benefit coverage will be required to pay a monthly assessment of \$100.00. This assessment is the same for single coverage as for family coverage, and is subject to change.

Active Members — The above self-pay provision will apply to any participant who retires on and after July 1, 1993 who is eligible for coverage under the Plan.

If a pensioner who is eligible for Health Fund Benefits is covered under any other group Plan by his current employer this Plan will provide secondary coverage. This means the other Employer Group Plan must pay benefits first, then this Plan will pay on the balance of covered expenses in accordance with Plan provisions.

Plan benefits for active, retired or disabled participants are not guaranteed.

The Trustees reserve the right to change or discontinue (1) the types and amount of benefits under this Plan and (2) the eligibil-

ity rules, including those rules providing extended or accumulated eligibility even if the extended eligibility has already been accumulated.

## **DENIAL OF CLAIMS AND APPEALS PROCEDURES**

If an Eligible Person or a Covered Employee (or the beneficiary of a Covered Employee in the case of a death benefit) files a claim for benefits under the Plan and payment of the benefit is wholly or partially denied, the Fund shall, within sixty days of the date the claim for benefits was filed, provide notice in writing to such Eligible Person, covered Employee, or beneficiary, as the case may be, setting forth the specific reason or reasons for denying payment of the benefits stated in as clear a manner calculated to be understood by that individual. The notice shall also make specific reference to the pertinent Plan provision upon which the denial is based and shall describe any additional material or information necessary for the claim to be honored along with an explanation of why such material or information is necessary. A person whose claim has been denied has a right within sixty (60) days of written notification of claim denial to request a hearing before the Board of Trustees for the purpose of carrying out a full and fair review by the Board or a committee designated by the Board of the claim denial. If a hearing is requested by the person whose claim was denied, it will take place, if possible, at the next regularly scheduled meeting of the Board of Trustees, but in any event within ninety days of the date the Board is advised that the person whose claim was denied requests such a hearing. After the hearing, the Board of Trustees will decide the issue on the basis of the merits and the decision of the Board shall be final and binding on all parties. The decision of the Board shall be in writing and shall be rendered no later than 120 days after the request for a hearing. This decision shall also include specific reasons for the denial and specific references to the Plan.

## **YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

This Plan was established as the result of collective bargaining agreements and its purpose is to improve the security and well-being of the employees and their beneficiaries. The Trustees, the employers, and the Union want you as a participant in the Plan to enjoy its benefits. This booklet describes the Plan and tells you and your beneficiary how to get more information. The description of the claims and the appeals procedure tells you how to apply for benefits and how to follow up, if necessary.

However, in addition to what the Trustees, the employers and the Union have done to see that the Plan's obligations are fulfilled, federal regulations require the following summary of rights and protections to which every participant in the Plan is entitled under the law (ERISA).

ERISA provides that you, as a Plan participant, shall be entitled to:

Examine, without charge, at the Plan administrator's office and other specified locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan administrator. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a benefit and, if so, what your benefits would be. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge. The Plan will provide this information to the extent it is able to be based on available records. 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 pension benefit or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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 frivolous.

Board of Trustees employer identification number:  
23-1599740.

Plan number: 501

Fiscal year end date: September 30th

This has been no more than a brief and very general explanation of the most important provision of the Benefit Plan. No general explanation such as this can adequately explain all the details of the Plan. Nothing in this statement is meant to interpret, extend or change in any way the rules or regulations expressed in the Plan itself.

Accordingly, your rights, if you are covered by this Plan, can only be determined by consulting the Plan itself. Further information, if necessary, may be secured by inquiring at the Fund Office or a Union Office. For your convenience, a complete copy of the Plan is printed in the next section of this booklet.

## **RECIPROCAL AGREEMENTS FOR HEALTH AND WELFARE FUNDS**

### **BRIEF EXPLANATION OF POINT OF CLAIM RECIPROCIITY**

Point of Claim Reciprocity is an arrangement under the Iron Workers International Reciprocal Health and Welfare Agreement whereby an employee can maintain his eligibility for benefits under this Plan even though he is working in the jurisdiction of another health fund. The other health fund (a Cooperating Fund, in whose jurisdiction the employee is working, agrees under certain circumstances to transfer employer contributions it has received on the employee's behalf to this Fund (the Home Fund). Therefore, hours of service with a Cooperating Fund(s) will be considered service with the Home Fund for the purpose of maintaining the employee's eligibility for benefits with the Home Fund, regardless of the dollar amount of the contributions transferred.

For this Fund to be an employee's Home Fund, he must either be (1) a member of the local union(s) which participates in this Plan and have established his eligibility to be a Plan participant, or (2) have had the largest amount of employer contributions made on his behalf in the preceding 12-month period paid to this Fund. If an employee changes his membership to another local union which does not participate in this Plan, this Fund will no longer be the employee's Home Fund. The health fund in which his new local union participates would then become the employee's Home Fund.

Employees should follow the procedures listed below when filing claims for benefits:

- (1) File claims for benefits with your Home Fund as long as your service with the Home Fund is enough to meet its eligibility requirements, (refer to the eligibility requirements of this Plan), even though you may be working in the jurisdiction of a Cooperating Fund when you file your claim.
- (2) File claims for benefits with a Cooperating Fund if you have lost your eligibility status with your Home Fund but have been working in the jurisdiction of the Cooperating Fund for a period long enough to meet its eligibility requirements.
- (3) Where you do not meet the eligibility requirements of either your Home Fund or a Cooperating Fund, you should file claims for benefits with your Home Fund. In this instance, Point of Claim Reciprocity becomes effective. Your service with a Cooperating Fund will be used towards meeting the eligibility requirements of your Home Fund. You will not be entitled to benefits from any of the Funds if your service, including service with Cooperating Funds, is not enough to reestablish eligibility with your Home Fund.

In filing claims for benefits with your Home Fund, indicate all Cooperating Funds in whose jurisdiction you have worked. Contact the Fund Office to determine if a welfare fund is a Cooperating Fund with your Home Fund.

This Plan is signatory to Exhibit "A" of the Iron Workers International Reciprocal Health and Welfare Agreement. A copy of the text of the Agreement follows.

Some Plans have also executed Exhibit "B" of the International Agreement which requires the transfer of contributions to the employee's Home Fund.

If you have worked outside the Jurisdiction of this Fund and have or expect to have a medical claim, you should contact the

Fund Offices of the other Fund to determine as to what type of reciprocity you are entitled.

## **EXHIBIT “A”**

### **Article Point-Of-Claim Reciprocity**

Section 1. Purpose — Eligibility is continued for health, welfare and insurance benefits under this Agreement for Employees who would otherwise lose eligibility for health, welfare and insurance benefits because their employment is divided between Local Union jurisdictions and in some cases such Employees may not have sufficient hours of contributions in one Fund to be eligible for benefits because of the division of hours and contributions among such Funds.

Section 2. Definitions —

- (a) “Employee” shall mean any employee on whose behalf payments are required to be made to a Cooperating Fund by an Employer pursuant to a collective bargaining agreement or other written agreement with a Local Union or District Council of the International Association of Bridge, Structural and Ornamental Iron Workers.
- (b) “Employer” shall mean any employer signatory to a collective bargaining agreement or other written agreement providing for contributions to a Cooperating Fund.
- (c) “Cooperating Fund” shall mean any Health, Welfare or Insurance Fund which by resolution of the Board of Trustees, has approved participation in and executed the Iron Workers International Health and Welfare Reciprocal Agreement.
- (d) “Home Fund”, each Employee who has Employer contributions made on his behalf to one or more of the Cooperating Funds shall have a determined Home Fund. In the absence of evidence substantiating a claim to the contrary, the following rules shall be used in determining an Employee’s Home Fund:
  - (1) If the Employee is a member of a local union and he has established eligibility in a Health and Welfare Fund in which his local union participates, that Fund shall be his Home Fund.
  - (2) If an Employee is not a member of a local union

or if he has not established eligibility in a Health and Welfare Fund, his Home Fund shall be that Cooperating Fund which has received the largest amount of contributions on his behalf in the preceding twelve month period.

Section 3. Transfer of Contributions —

(a). Employment in Other Than Home Fund Jurisdiction — If an Employee is working in the jurisdiction of a Cooperating Fund other than his Home Fund, and he is not eligible for benefits from that Cooperating Fund, he shall continue to file all claims incurred with his Home Fund for so long as he remains eligible in his Home Fund. If he is not eligible in his Home Fund, but is eligible in another Cooperating Fund, such claim shall be filed with that Cooperating Fund. If the Employee is not eligible in any Cooperating Fund, then the claim shall be filed with his Home Fund which shall contact the other Cooperating Funds in whose jurisdiction the Employee worked to determine if a transfer of contributions will reinstate the Employee's eligibility in his Home Fund at the time the claim was incurred. If such a transfer will make the Employee so eligible in his Home Fund the contributions shall be transferred in accordance with the following paragraph (b).

(b) Transfer of Contributions to Home Fund—

(1) upon a request by a Home Fund to another Cooperating Fund in whose jurisdiction an Employee has worked, the Cooperating Fund shall, subject to the conditions of Section 3(a) of this Article transfer all Employer contributions made on Employee's behalf back to his Home Fund. The amount of contributions transferred shall be based on all of the Employee's hours of work up to and including the month in which the claim was incurred during the eligibility period set forth in the Home Fund's Plan. Such hours shall be multiplied by the contribution rate of the transferring Cooperating Fund. Upon transfer of hours and contributions, such hours transferred shall not be used for determining future eligibility for the Employee under the Cooperating Fund's rules.

(2) Hours and contributions shall first be transferred from the Cooperating Fund in whose jurisdiction the Employee was working when the claim was incurred. If those hours and contributions do not result in establishing the Employee's eligibility on the basis of hours, then contributions shall be transferred from all other

Cooperating Funds in reverse order of employment until such eligibility is established within the Home Fund's eligibility period.

- (3) Upon the transfer of contributions by a Cooperating Fund in connection with an Employee's claim, the hours represented by such contributions transferred shall not be included in a determination of eligibility for benefits for that Employee under that Cooperating Fund's rules. However, subsequent hours worked, but not transferred, in the jurisdiction of the Cooperating Fund shall be used in the determination of such an Employee's eligibility for benefits.

Section 4. Designation of New Home Fund — If an Employee changes his membership from one Local Union to another Local Union his Home Fund shall be the Health, Welfare or Insurance Fund in the jurisdiction of his new Local Union. Claims incurred by such an Employee shall be filed with his new Home Fund if he is eligible under the new Home Fund. If he is not eligible in his new Home Fund, but is eligible in his prior Home Fund, such claims shall be filed with his prior Home Fund. If he is not eligible in either his new Home Fund or the prior Home Fund, but would be eligible in the new Home Fund if contributions were transferred from his prior Home Funds, the contributions shall be transferred in accordance with Section 5 to the new Home Fund as designated.

Section 5. Transfer of Contributions to New Home Fund — Upon a request from a new Home Fund to a prior Home Fund, the prior Home Fund shall transfer employer contributions made on the Employee's behalf to the new Home Fund. The amount of contributions transferred shall be based on the Employee's actual hours of work during the period that will establish his eligibility in the new Home Fund for the claim he incurred. However, such hours shall be limited to those worked after the date on which such Employee lost eligibility in his prior Home Fund. In any event, such hours shall not include hours which an Employee may have to his credit in any "hours bank" arrangement. Such hours shall be multiplied by the contribution rate to be transferred.

Section 6. Information To Be Transferred — The transfer of hours and contributions specified in Sections 3 or 5 shall be made within thirty (30) days of the date requested by the Home Fund or the new Home Fund.

Section 7. Effective Date — This Article and the point-of-claim reciprocity between Cooperating Funds, shall be effective no earlier than 1-1-1983 for purposes of contribution transfer.

## **FUND'S RIGHT TO REPAYMENT FROM RECOVERY IN THIRD-PARTY ACTIONS**

- (1) If any claim is made against any entity for medical benefits payable under any applicable Workers' Compensation statute or other similar statute providing for payment of medical expenses, or if any legal action is brought against any third party to recover damages for injuries or illness, or if the right to make such a claim or bring such an action exists and arises out of an event which gave rise to charges, costs, expenses or fees which make up all or part of a benefit under the Plan, the Covered Person (which term for purposes of this Section shall mean "Covered Person and/or his Dependents") shall notify the Fund of such action and the Fund shall be entitled to reimbursement from any payment made as a result of such action or claim to the full extent of the benefits paid out by the Fund without any deduction for attorney fees.
- (2) At the time of application for benefits under the Plan, the Covered Person and/or any Dependent on whose behalf benefits are payable shall execute a Repayment Agreement which fully implements the intent of (1) above.
- (3) In the event that a Covered Person and/or any Dependent on whose behalf benefits are payable fails or refuses to execute the required Repayment Agreement, such failure or refusal shall constitute a basis for denial of any benefit payments to such Covered Person and/or Dependent unless and until the Repayment Agreement is duly executed and delivered in a timely manner so as not to prejudice the Fund's rights. In the event that the Covered Person fails to notify the Funds Office of the existence of an action as to which he or one of his Dependents recovered or could recover damages from which the Fund would have been repaid had the Fund known of such action or fails to remit or otherwise deliver to the Fund Office any monies to which the Fund is entitled, irrespective of the existence of a Repayment Agreement, then upon becoming aware of such recovery, the Fund shall inform the Covered Person that he is obligated to return to the Fund the portion of such recovery which should have been paid over to the Fund, and the Fund shall make no benefit payments on any account to such Covered Person until the amount due the Fund from such recovery is returned or offset against amounts which should otherwise have been paid to such Covered Person.

## **CONTINUATION OF COVERAGE**

The Federal Law — Comprehensive Omnibus Budget Reconciliation Act (called COBRA) requires that Plans, such as this Plan, offer Participants and their eligible dependents an opportunity to continue coverage upon termination of eligibility for specific reasons, specific periods of time and on a “self-payment” of premium basis.

The continuation of coverage is available in the event eligibility (coverage) terminates due to a “Qualifying Event” such as:

- (a) Termination of the employee’s employment for any reason, except gross misconduct.
- (b) Loss of the employee’s eligibility due to reduced work hours.
- (c) Death of the employee.
- (d) Divorce of the employee.
- (e) Ceasing coverage as to a spouse from whom you are legally separated.
- (f) A dependent child ceasing to be a dependent, as defined on page 14. A child eligible to be continued under the health plan’s handicapped child provision will still be considered to have dependent status.
- (g) A dependent’s loss of eligibility because the employee becomes entitled to Medicare benefits.

If one of the employee’s dependents would lose coverage due to the reasons above, the employee or the dependent must notify the Fund office within sixty days of the event so that the Fund Administrator can give appropriate notice of COBRA continuation coverage rights and the terms which apply to the continuation. Try to give notification within 30 days of the event to assure there will not be a break in coverage.

Please note that when the Fund Office is notified of one of the “qualifying events”, they will notify you that you have the right to choose continuation of coverage. You will then have 60 days from the date coverage was lost or will be lost to notify the Fund Office that you want continuation coverage. Failure to do so within this time period will nullify your right for continuation of coverage.

### **Termination of COBRA Continuation Coverage**

COBRA continuation coverage will terminate on the earliest of:

- (a) Failure to pay the required premium on time.
- (b) The date the individual becomes covered under another employer-funded group health plan or entitled to Medicare benefits.
- (c) The date the group health plan terminates as to the eligibility of which you were a member. If the coverage is replaced, you will be continued under the new coverage.
- (d)
  - (i) 18 months from the date coverage would have otherwise terminated if coverage is being continued for an employee, spouse or dependent because the employee ceased covered employment or lost eligibility due to reduced hours; or
  - (ii) 29 months from the date coverage would have otherwise terminated if coverage is being continued for disability; or
  - (iii) 36 months from the date coverage would have otherwise terminated, if coverage is being continued for a spouse or dependent.

### **Extended COBRA Coverage for Eligible Retirees**

Effective July 1, 1998, your Health Benefit Plan will institute Extended COBRA Coverage for those retirees not otherwise eligible for this Plan's benefits. Any retiree who is receiving Health Benefits from this Plan by way of self paying the COBRA rate as of July 1, 1998 or thereafter, will be eligible for this extended coverage. The extended coverage will mean that you no longer will be governed by the Federal Government mandates on COBRA but you will be eligible to continue paying for your extended coverage until you and/or your spouse becomes eligible for Medicare. This program will be especially advantageous to that member who wishes to retire before he reaches the normal retirement age, or one who reaches the normal retirement age and does not have the 25 years of continuous coverage required by the Health

## Plan Rules.

The Trustees of this Plan are offering this Benefit on a trial basis and will only keep it in effect as long as it proves it is not resulting in a negative manner on the financial integrity of the Health Benefit Plan.

The Trustees of this Plan intend to continue this provision as long as it is financially feasible but reserve the right to change or discontinue this benefit at any time at their discretion.

## Self Pay Premium

The Fund will determine premium payments according to Federal Law, which allows the premiums to cover the full cost of the Plan plus administrative expenses. If the cost changes, the Fund will revise the charge you are required to pay. In addition, if the benefits change for active employees your coverage will change as well.

Full details of COBRA continuation coverage will be furnished to you or your dependents when the Fund Office receives notice that one of the qualifying events, as shown above, has occurred. Therefore, we urge employees and dependents to contact the Fund Office as soon as possible after one of those events. Rates are subject to change on June 1st of every year.

**Iron Workers District Council  
Philadelphia and Vicinity  
Health Benefits Fund**

**Plan Document Amendment**

Use and Disclosure of Protected Health Information

A. Use and disclosure of Protected Health Information (PHI): The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

“Payment” includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determining individual eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim),
2. Coordination of benefits,
3. Adjudication of health benefit claims (including appeals and other payment disputes),
4. Subrogation of health benefit claims,
5. Establishing employee contribution rates,
6. Establishing contribution rates for contributing employers, including risk adjusting amounts due based on enrollee health status and demographic characteristics,
7. Billing, collection activities and related health care data processing,
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes,
9. Responding to participant, beneficiaries (and their authorized representatives') inquiries about payments,
10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges,
11. Utilization review, including precertification, preauthori-

zation, concurrent review and retrospective review,

12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, SSN, payment history, account number, and name and address of the provider and/or health Plan),
13. Reimbursement of individual overpayments to the Plan, and
14. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance),

Health Care Operations include, but are not limited to, the following activities:

1. Quality Assessment,
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,
3. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
4. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies,
7. Business management and general administrative activities of the entity, including, but not limited to:

- a. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
  - b. Customer service, including the provision of dataanalysis for policyholders, Plan sponsors, or other customers,
  - c. Resolution of internal grievances, and
  - d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.
8. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, SAR's, and other documents.
- B. The Plan will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Plan will disclose PHI to the[list other plans to which information may be disclosed, including pension plan, disability plan, reciprocal benefit plans, workers' compensation insurers, etc.] for purposes related to administration of these plans.
- C. For purposes of this section the Board of Trustees of the Iron Workers District Council Philadelphia and Vicinity Health Benefits Fund, is the "Plan Sponsor." The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information,
3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual,
4. Not use or disclose the information in connection with

any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual,

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
  6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
  7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
  8. Make available the information required to provide an accounting of disclosures,
  9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA, and
  10. If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
- D. Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
1. The Plan Administrator,
  2. Assistant Plan Manager/Controller, Assistant Controller, Administrative Assistant, Receptionist, Claims Clerk, Claims Clerk/Secretary,
  3. Staff designated by the Fund Administrator based on their job title and function. The Fund staff has access to individually identifiable health information, including claims information, in the Fund's computer system.
- E. The persons described in section D may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.
- F. If the persons described in section D do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary

sanctions.

- G. For purposes of complying with the HIPAA privacy rules, this Plan is a “Hybrid Entity” because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.