2019 BENEFITS ENROLLMENT GUIDE

Iron Workers Welfare Plan of Western Pennsylvania

October 2018

Your enrollment opportunity is from November 1, 2018 through November 30, 2018.

2019 Benefits Enrollment

A Message from the Board of Trustees

Welcome to Open Enrollment for the Iron Workers Welfare Plan of Western Pennsylvania. This is your opportunity to review the health and welfare benefits program available through the Welfare Plan during the 2019 Plan year, and to make your benefit elections.

The Welfare Plan's design offers members more choice and flexibility, and the ability to use the funds in their Value Bank to pay for certain non-covered expenses.

However, in order to take advantage of the benefits program that best meets your needs, you must make an election. This Benefits Enrollment Guide provides direction on what you need to do. It also provides information about the comprehensive health care package available to you, which includes:

- Medical and Prescription Drug Coverage;
- Voluntary Dental Programs;
- A Voluntary Vision Program;
- A Member Assistance Program and Blues On Call℠;
- Life Insurance;
- Accidental Dismemberment and Loss of Sight Insurance; and
- Weekly Accident & Sickness Benefit

We understand that the benefits you receive are important. We recommend that you review this Guide thoroughly with your family and then elect the benefits that best suit your needs.

Sincerely,

The Board of Trustees

What's Inside

ENROLLMENT INFORMATION

Open Enrollment—What's It All About?

Each year, Open Enrollment will provide you with the opportunity to review the benefits that will be available during the upcoming year. This year's Open Enrollment period runs from *November 1, 2018 through November 30, 2018.* The benefits you elect during this year's Open Enrollment will be in effect for the Plan year January 1, 2019 through December 31, 2019

If you do not make an election by the end of the Open Enrollment period, you will be automatically defaulted into the Community Blue plan and coverage category, as shown below:

Situation	Automatic Default Plan
Member with health coverage in 2018	Community Blue Plan with prior coverage level and tier
Newly Eligible Member (who does not have beneficiary/dependent information on file at the Plan Office)	• Premier Plan • Family Coverage
Newly Eligible Member (who does have beneficiary/dependent information on file at the Plan Office)	• Premier Plan • Status as indicated for beneficiary/dependent information on file at the Plan Office

We recommend you review this Guide to become familiar with the Welfare Plan's offerings for 2019.

Who's Eligible For Coverage?

Members:

Initial Eligibility—You become eligible for coverage on the first day of the month after your Value Bank has sufficient contributions (within a 12-month period) to cover the cost of 3 months of coverage at the Deluxe Plan family rate.

Note: If you are currently working under the Metal Building Agreement, you become eligible for coverage on the first day of the month after your Value Bank has sufficient contributions (within a 12-month period) to cover the cost of 3 months of coverage.

Dependents:

Dependents are eligible for coverage on the date you become eligible. Eligible dependents are your spouse and your biological child(ren), stepchild(ren), and adopted child(ren) who have not reached his or her 26th birthday. Disabled children are covered regardless of age.

Important:

After November 30, 2018, you will not be able to elect your coverage level and tier until the next Open Enrollment, unless you have a special enrollment event or a mid-year change in status. Refer to the Important Plan Information section on page 13 to learn more about mid-year election changes.

Enrollment Checklist

- ✓ Review the Guide carefully to understand what's available in 2019.
- ✓ Consult with your family to determine the benefits coverage that will best meet your needs.

Your Enrollment Responsibility

Understanding the benefit options and coverage levels available will help you determine which one to choose.

▪Review Your Choices for Health Care

The out-of-pocket expenses you incur when you seek medical care depend on the medical plan in which you are enrolled. Therefore, you should study the plan options carefully.

▪Choose Who To Enroll

The amount deducted from your Value Bank each month is based on the number of dependents you elect coverage for in the plan. You can choose to cover yourself only, yourself and your spouse, yourself and your children or yourself and your family.

▪What Happens If You Don't Enroll

If you do not make an election by November 30, 2018, you will automatically be enrolled in the plan and a coverage category, as shown on page 3. Therefore, to be enrolled in the plan of your choice, you must make an election before the Open Enrollment period ends.

How To Enroll

Here's what you need to do:

Step 1: Thoroughly review this brochure with your family.

Step 2: Make your election via on-line or paper enrollment.

Step 3: Make a copy of the form for your records (if applicable).

Step 4: Submit your on-line request or return your form no later than **November 30, 2018 to the Plan Office:**
Iron Workers Welfare Plan of Western Pennsylvania
2201 Liberty Avenue, Room 203
Pittsburgh, PA 15222

Step 5: A letter of confirmation will be mailed to you.

Where To Go For Answers

If you still have questions after you have read this Guide, contact the Plan Office at **412-227-6740** or toll-free at **800-927-3199.**

The Open Enrollment period runs from November 1, 2018 through November 30, 2018

HEALTH PLAN BENEFITS

The Iron Workers Welfare Plan of Western Pennsylvania has enhanced its benefits coverage by offering members access to a "Flexible Benefit Plan" that gives you more control over your health care spending. With the Flexible Benefit Plan, you have…

- ***For Active Plan Members, COBRA Recipients, the Contractor Group and the Early Retiree Group***

You have a choice between five medical plan options:

- The Deluxe Plan
- The Premier Plan
- The Standard Plan
- The Core Plan
- The Value Plan

You also have the option to elect a particular coverage level (yourself only, yourself and your spouse, yourself and your children, or yourself and your family). The plan option in which you are enrolled and the coverage level you choose will determine how much your monthly premium will be.

- ***For Members of the Metal Building Group***

  If you are currently eligible under the Metal Building Group, you have coverage under the Metal Building Plan. Your monthly premium will be the same amount regardless of whether you have coverage for yourself only, for yourself and your spouse or for yourself and your family (unless you elect one of the other plan options).

  Unlimited funds in your Value Bank. There is no limit to the amount that can accumulate in your Value Bank.

  Reimbursement privileges. If you are a member with funds in your Value Bank which exceed three months of premium banked at the coverage level and tier in which you are enrolled, you can request to be reimbursed (a minimum of $50) for any copays, deductibles and coinsurance within 24 months of the incurred date. Members may also be reimbursed from their Value Bank for certain medical expenses as designated in the Summary Plan Description and approved by the Board of Trustees. F**or instructions, important information and requests for forms regarding Value Bank Reimbursement Requests, please contact the Plan Office.**

  The Plan Office will diligently review the documentation you submit to substantiate your claim. If the Plan Office determines that your claim is fraudulent (e.g., you submit a claim for healthcare services you did not receive or for which you have already been reimbursed, through the Welfare Plan or otherwise), you will not receive reimbursement for the claim and the full amount you requested will be deducted from your Value Bank balance and transferred to the general assets of the Welfare Plan. This action will be considered a denial of healthcare benefits for which you may submit an appeal according to the Claims and Appeals Procedures.

  The ability to pay for voluntary dental premiums. Two voluntary dental programs are available and premiums may be paid through a Value Bank deduction at Open Enrollment. You also have the option to make a self-payment for this program.

  The ability to pay for voluntary vision premiums. A voluntary vision plan is available and premiums may be paid through a Value Bank deduction at Open Enrollment. You also have the option to make a self-payment for this program.

HIGHLIGHTS FOR 2019

Five Plans Are Offered

With the rising cost of healthcare, the Board of Trustees is offering five plans to help participants best meet their medical and prescription needs.

- Deluxe Plan
- Premier Plan
- Standard Plan
- Core Plan
- Value Plan

Please review the summaries of each plan on page 7 to determine the right one for you. A complete description of the plans is enclosed (Summary of Benefits and Coverage).

Don't Forget About Telemedicine Services

Telemedicine Services are available with a $10 co-pay. Download the app, or log on via your PC.

Easy Enrollment

- **On-Line Enrollment.** You can complete the Open Enrollment process on-line at www.ironben.com.

  You can also enroll for one of the voluntary dental plans and/or the voluntary vision plan on-line, **as long as you elect to have payment made from your Value Bank.**

Members With Chronic Conditions Can Save Money

- **Value Based Benefits.** Highmark Blue Cross Blue Shield and the Iron Workers Welfare Plan of Western PA want to make it as easy as possible for you to stay healthy and control your medical costs. When you receive office visits and certain prescription drugs for:

  - Diabetes,
  - Asthma,
  - COPD,
  - High Cholesterol,
  - High Blood Pressure,
  - Coronary Artery Disease,
  - Congestive Heart Failure and
  - Depression,

your Community Blue with Value Based program includes waived co-payments for these services.

Additional information regarding this benefit can be obtained from the Plan Office..

How the Plan Works

Generally, when you or a family member needs medical treatment, the majority of the eligible expenses will be covered. Certain provisions will define exactly what will be covered and the amount, if any, that you will have to pay. Here's how it works:

Deductible

You may have to pay 100% of your eligible medical expenses up to a dollar limit. This limit is called the "deductible." The plans have both single and family deductibles.

Coinsurance

You may have to pay a percentage of the eligible charges for the services you receive, usually after the deductible has been met. This is called "coinsurance." A higher percentage of the eligible charges will be covered for services you receive from an in-network provider.

Copay

You may have to pay a flat dollar amount toward certain services. This is called a "copay."

Out-of-Pocket Maximum

There's a cap on the amount you pay each year, which is called the "out-of-pocket maximum." Once you've paid an amount equal to the maximum, 100% of the remaining eligible expenses will be covered.

THE HEALTH PLAN OPTIONS

Highlights of the Health Plan Options

The chart on page 7 highlights some of the covered services and provisions applicable under each plan option. The Plan Office can provide you with a more complete list of benefits.

The Prescription Drug Program

Highmark also provides the prescription drug program.

You must purchase your medications from a network pharmacy or through the contracted network's mail order program in order to be eligible for benefits under the Plan. *No benefits are available if drugs are purchased from a non-network facility.*

The amount of your copay will depend on whether your prescription medication is a generic, formulary brand, or non-formulary brand, as shown in the chart on page 7.

Call the Plan Office at 412-227-6740 or toll-free at 800-927-3199, or Highmark toll-free at 800-811-0391 for a list of network pharmacies, or for instructions on how to obtain prescriptions through the mail order program.

Medicare Notice of Creditable Coverage

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under this plan is or is not creditable (as valuable as Medicare's prescription drug coverage). Your prescription drug coverage under the plan options offered by the Iron Workers Welfare Plan of Western Pennsylvania is creditable. You should review the Plan's Medicare Part D Notice of Creditable Coverage available from the Plan Office.

2019 SCHEDULE OF BENEFITS FOR COMMUNITY BLUE

Active Plan Members (except those currently eligible under the Metal Building Group), COBRA Recipients, the Contractor Group and the Early Retiree Group

	Deluxe Plan		Premier Plan		Standard Plan	
Medical	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Deductible Single Family	 $0 $0	 $250 $500	 $200 $400	 $400 $800	 $1,000 $2,000	 $2,000 $4,000
Coinsurance *(Plan covers)*	100%	70%	90%	70%	90%	70%
Out of pocket max Single Family	N/A	 $2,000 $4,000	 $1,500 $3,000	 $3,000 $6,000	 $2,500 $5,000	 $3,000 $6,000
Copays [1]	$20	70%	$20, then 10% of remaining balance [2]	70%	$20 then 10% of remaining balance [2]	70%
ER Services	$50		$100, then 10% of remaining balance [2]		$100, then 10% of remaining balance [2]	
Prescription Drugs	**Retail**	**Mail order**	**Retail**	**Mail order**	**Retail**	**Mail order**
Deductible	$0		$0		$0	
Generic copay	$10	$10	$10	$20	$15	$30
Formulary Brand copay	$20	$20	$20	$40	$25	$50
Non-Formulary Brand copay	$35	$35	$35	$70	$40	$80

[1] In-network benefits for certain physician office visits and spinal manipulation care are copay arrangements.
[2] Copay is not subject to your in-network deductible.

	Core Plan		Value Plan	
Medical	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Deductible Single Family	 $2,500 $5,000	 $5,000 $10,000	 $4,000 $8,000	 $10,000 $20,000
Coinsurance (Plan covers)	90%	70%	80%	60%
Out of pocket max Single Family	 $5,000 $10,000	 $10,000 $20,000	 $5,000 $10,000	 $10,000 $20,000
Copays [1]	$25, then 10% of remaining balance [2]	70%	$30, then 20% of remaining balance [2]	60%
ER Services	$100, then 10% of remaining balance [2]		$100, then 20% of remaining balance [2]	
Prescription Drugs	**Retail**	**Mail order**	**Retail**	**Mail order**
Deductible	$0		$0	
Generic copay	$15	$30	$15	$30
Formulary Brand copay	$25	$50	$30	$60
Non-Formulary Brand copay	$40	$80	$45	$90

[1] In-network benefits for certain physician office visits and spinal manipulation care are copay arrangements.
[2] Copay is not subject to your in-network deductible.

There are certain requirements that must be met in order to be eligible for the Retiree Health Insurance Reimbursement Benefit. Contact the Plan Office at 412-227-6740 or toll-free at 800-927-3199 for more information.

2019 MONTHLY PREMIUM CONTRIBUTIONS

The cost of coverage depends on the health plan option you elect and the coverage level that you choose.

If you are eligible under the Metal Building Group, your coverage is the Premier Plan, and your monthly premium will be the same dollar amount regardless of whether you have coverage for yourself only, for yourself and your spouse or for yourself and your family, *unless you elect one of the other plan options.*

Retiree Health Insurance Reimbursement Benefit:

Retired members who meet the requirements are eligible for a monthly medical reimbursement of $400 per person, with a maximum benefit of $800.

If you retire during 2019, you will receive this benefit until the earlier of when you reach age 65 or 5 years. Spouses who are younger than the member will receive this benefit to the later of the member's reimbursement period or a maximum of five years. Spouses who are older than the member will receive this benefit to the earlier of the member's reimbursement period or age 65.

VOLUNTARY VISION PROGRAM

A voluntary vision program is offered through Vision Service Plan (VSP).

VSP Advantage – Keep your eyes healthy with VSP Vision care. You will get great savings on your eye exam and eyewear, and discounts on laser vision correction. VSP Advantage offers a broad network of providers and also provides coverage with an out-of-network benefit.

Value and Savings. You will get great benefits on your exam and eyewear at an affordable price.

Personalized Care. You willl get quality care that focuses on your eyes and overall wellness with a WellVision Exam® from a VSP doctor. They will look for vision problems and signs of other health conditions.

Eyewear. Choose the eyewear that is right for you and your budget. From classic styles to the latest designer fashions, you will find hundreds of options for you and your family.

Choice of Providers. With open access to see any eyecare provider, you can see the one who is right for you. Choose a VSP doctor or any other provider. To find a VSP doctor visit **ironben.vspforme.com**

Enroll today. You will be glad you did.

To use your vision coverage, simply tell your eyecare provider that you have VSP.

No ID card is necessary.

Your Coverage with a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness
- $10 copay ..... **every plan year**

Prescription Glasses
- **$25 copay**

Lenses ..... every plan year
- *Single vision, lined bifocal, and lined trifocal lenses.*

Frame ..... **every other plan year**
- **$150** *allowance for a wide selection of frames*
- *20% off the amount over your allowance*

-OR-

Contact Lens Care
- **No copay ..... every plan year**

$130 allowance for contacts and the contact lens exam (fitting and evaluation).

Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of replacement lenses.

Extra Discounts and Savings

Glasses and Sunglasses
- *20% off non-covered lens options*
- *20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam*

Contacts
- *15% off cost of contact lens exam (fitting and evaluation)*

Laser Vision Correction
- *Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.*

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam ..... *Up to $40*
Single vision lenses ..... *Up to $25*
Lined bifocal lenses ..... *Up to $40*
Lined trifocal lenses ..... *Up to $50*
Lenticular lenses ..... *Up to $75*
Frame ..... *Up to $45*
Contacts ..... *Up to $100*

VOLUNTARY DENTAL PROGRAM

A voluntary dental program is offered through United Concordia, a subsidiary of Highmark. **The program offers two plans to choose from:**

Concordia Plus – A Dental Maintenance Organization (DMO) program, which is similar to an HMO and provides in-network benefits only.

Concordia Flex – A Preferred Provider Organization (PPO) program, which has a broader network of providers and provides a deductible and coinsurance arrangement, along with an out-of-network benefit.

Plan Highlights

Concordia Plus	Concordia Flex
In addition to no annual deductibles or maximums, no claim forms to file and no waiting periods, you also receive: ■ Free annual cleanings, exams and x-rays ■ Affordable copayments for more extensive services like fillings and crowns ■ Orthodontic benefits for dependents to age 19 ■ Emergency care coverage no matter where you are	Members have the flexibility of using any licensed dentist. The Concordia Flex Plan participates in the Concordia **Advantage *Plus*** network, which offers excellent access, significant discounts and quality dental care. ■ Preventive & Diagnostic 100% ■ Basic Services 80% ■ Major Services 50% ■ Orthodontic 50% $1,000 Lifetime Orthodontia Maxiumum per child $1,000 Annual Maximum for all other services
Find a DHMO Concordia Plus Provider With DHMO Concordia Plus, each enrolled family member can choose their own primary dental office (PDO) from our large network of credentialed dentists. **To find a dentist**, log on to www.unitedconcordia.com and click Find a Dentist. Step 1 – Select the Type of Dentist. Step 2 – Enter your location. Step 3 – Select DHMO Concordia Plus General Dentist or DHMO Concordia Plus Specialist. Don't have Internet access? Call Customer Service at 1-866-357-3304.	**Find a Concordia Advantage Plus Provider** Participating dentists accept the Maximum Allowable Charge as payment in full. **To verify if your provider participates** with this program, please visit our website at www.unitedconcordia.com and click Find a Dentist. Step 1 – Select the Type of Dentist. Step 2 – Enter your location. Step 3 – Select Advantage Plus. You may also contact Customer Service at 1-800-332-0366.

MEMBER ASSISTANCE PROGRAM

Balancing work responsibilities and your personal well-being can be a difficult challenge at times. Not sure where to turn? The Member Assistance Program (MAP) and Personal Health Partners offered by Lytle Behavioral Health (Lytle) are free benefits that provide help to you and your household members. Personal Health Partners also covers your parents and parents-in-law.

With Lytle, a MAP counselor is available 24/7, 365 days a year to help with a wide range of problems, such as:

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

Personal Health Partners is also available 24/7, 365 days a year to help with a medical or insurance problem such as:

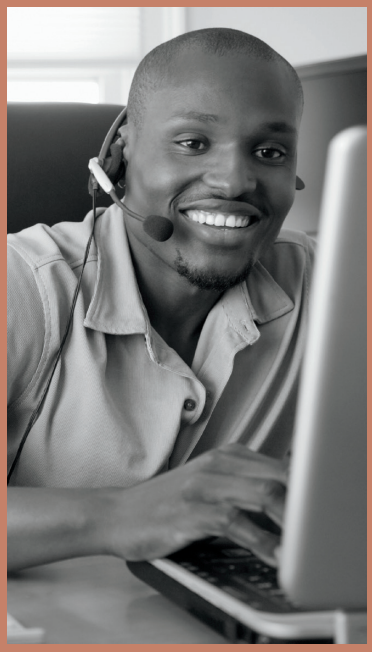
- Guidance through preauthorization and predeterminations
- Help with understanding benefits costs
- Explanations of confusing conditions and chronic illnesses
- Assistance to resolve issues involving prescription medications
- Securing appointments with specialists
- Assistance with transition of care
- Helping to get answers from insurance companies

Lytle's services are completely confidential and their MAP professionals are available to you and your household members as part of your benefit package. You can reach a counselor 24 hours a day, 7 days a week by phone at 888-877-8997, or you can go to www.lytleeap.com and enter the password, "ironworkers." Through Lytle's web site, you can also connect to several resources that can help you cope with everyday obstacles.

BLUES ON CALL SM

Blues on CallSM is a toll-free health care information and support services program that allows you to connect to specially trained registered nurses called Health Coaches 24 hours a day, 7 days a week. The program is offered through Highmark and is available to you as part of your benefit package.

You can call the toll-free line, 888-258-3428, and speak to a Health Coach about your medical condition(s) and treatment options, as well as ways to manage your illness more effectively. You can also call for general health inquiries and health care assistance on any health care topic.



Services received through the Member Assistance Program and Blues On Call℠ are provided free of charge to members.

LIFE INSURANCE AND ACCIDENTAL DISMEMBERMENT & LOSS OF SIGHT INSURANCE

The Welfare Plan has contracted with MetLife for the provision of life and accidental dismemberment and loss of sight insurance.

Life Insurance (For Certain Active Members)

Your designated beneficiary will receive the following amount in a single lump sum payment upon your death:

- $50,000 – if you were insured under this benefit for 12 consecutive months or more; or
- $25,000 – if you were insured under this benefit for less than 12 consecutive months.

You may name anyone as your beneficiary, and you may also change your beneficiary at any time by obtaining and completing the proper form and returning it to the Plan Office.

Total and Permanent Disability

If you become permanently and totally disabled while you are an active member before you reach age 62, the Welfare Plan will pay the premiums necessary to provide you with life insurance coverage. You will be required to provide proof that you obtained a Social Security disability award showing that you were totally disabled from any gainful employment. The Life Insurance benefit will be continued until you:

- Attain age 62; or, if sooner,
- Are no longer considered to be permanently and totally disabled.

For more information on the Welfare Plan's Life Insurance benefit, contact the Plan Office.

Accidental Dismemberment and Loss of Sight Insurance (For Certain Active Members)

Your Welfare Plan provides insurance to cover the loss of limbs, paralysis, loss of sight, speech or hearing, and other losses caused by an accidental injury – on or off the job. The benefit is up to $20,000, depending on the loss.

For more information on the Welfare Plan's Accidental Dismemberment and Loss of Sight Insurance, contact the Plan Office at **412-227-6740** or toll-free at **800-927-3199.**

If you are injured either on or off of the job, contact the Plan Office at 412 -227-6740 or toll-free at 800-927-3199 to see what benefits may be available.

IMPORTANT Plan Information

Mid-Year Changes To Your Medical Plan Elections

IMPORTANT: After this Open Enrollment period is completed, generally you will not be allowed to change your benefit elections, which means that you will not be able to add or delete dependents and thereby change your coverage level/tier until next year's Open Enrollment period, unless you have a Special Enrollment event or a Mid-year Change in Status.

Special Enrollment Event: You may be able to change your coverage level/tier by adding an eligible dependent if, sometime during 2019, you experience one of the following Special Enrollment events:

- If you decline enrollment for your eligible dependents (including your spouse) during this current enrollment period (or during some other prior enrollment period) because your dependents have other health insurance or group health plan coverage, you may be able to enroll your dependents for Plan coverage in 2019 if they lose eligibility for that other coverage. However, you must request their enrollment within 30 days after the other coverage ends. Coverage will then become effective on the first day of the month after the Fund receives your request for enrollment

- Note: This special enrollment event applies in the event your spouse loses his or her job and consequently his or her health insurance or group health coverage; provided your spouse previously declined coverage under this Plan due to having coverage under his or her provided plan.

- If your eligible dependents (including your spouse) are not enrolled for 2019 Plan coverage during this open enrollment period, you may be able to enroll your spouse and your eligible dependents in this Plan if, sometime during 2019 they (1) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and they later lose eligibility for that coverage, or (2) they become eligible to participate in a financial assistance program through Medicaid or SCHIP during 2019. You must request their enrollment in this Plan within 60 days after they lose eligibility for or become eligible for financial assistance under the Medicaid or SCHIP program. Coverage will then become effective on the first day of the month after the Fund receives the request for enrollment.

- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption sometime during 2019, you may enroll your new dependent during 2019. You must request their enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If the Fund receives your enrollment request within 30 days of the date the new dependent was acquired, coverage will be effective retroactive to the date of birth, adoption, or placement for adoption. For marriage, coverage will become effective on the first day of the month after the Fund receives your enrollment request.

  If your request is not timely received, the change will not be effective and you will have to wait until the next Open Enrollment period to make the change. As an exception, in the case of birth, adoption, or placement for adoption, if the request is not received within 30 days, but is received in the same Plan Year as the birth, adoption, or placement for adoption, the change will be effective the first day of the month following the date the Plan Office receives your request.

To request Special Enrollment or to obtain more information, contact the Plan Office. The Welfare Plan will determine if your change request is permitted.

Change in Status Event: You may be able to change your coverage level/tier by dropping an eligible dependent if during 2019, you experience one of the following Change in Status events:

- ***Death of a Dependent:*** You must request this change in coverage level by notifying the Fund Office within 30 days of the death.
- ***Divorce or Legal Separation:*** Your request must be received by the Fund Office within 30 days of the date the divorce or legal separation becomes effective.
- ***Loss of Dependent Status:*** Your request must be received by the Fund Office within 30 days of the date the dependent loses coverage eligibility.
- ***Dependent Becomes Eligible for Other Health Plan Coverage:*** Your request must be received by the Fund Office within 30 days of the date the dependent becomes covered under his or her employer's health insurance or group health plan coverage.
- ***Exception — Spousal Change in Election Under Employer's Plan:*** Your request to add or drop your spouse must be made within 30 days of the date the spouse's coverage changed under the employer's plan due to his or her election change under that plan.

NOTE: You must immediately notify the Fund Office of the death of a dependent, your divorce or legal separation, and the loss of dependent status. Failure to notify the Fund Office may result in your having to reimburse the Plan for coverage for an ineligible person.

Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own health care information.

This Welfare Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you gain eligibility in the Welfare Plan. To get another copy of this Notice, write or call the Plan Office.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

You or your dependents may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

Plan limits, deductibles, copayments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact the Plan Office.

When Your Coverage Ends - COBRA and the Healthcare Marketplace

In compliance with a federal law called COBRA, this Welfare Plan offers its eligible members and their eligible covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events). See your Summary Plan Description for details.

Alternatively, you may choose to purchase coverage through the government's Healthcare Marketplace. Depending on your circumstances, you may be eligible for a premium tax credit to help you pay for the insurance you purchase through the Marketplace. However, one of the requirements for obtaining the premium tax credit is that you do not have a Value Bank balance. Therefore, you may elect to forfeit your Value Bank balance so that you will not be prevented from obtaining the premium tax credit. Contact the Fund Office for more information regarding the forfeiture of your Value Bank balance. For more information on the Healthcare Marketplace and the requirements for the premium tax credit, visit HYPERLINK "http://www.healthcare.gov" www.healthcare.gov.

IMPORTANT *Contact Information*

FOR ANSWERS ABOUT...	CONTACT
Eligibility, benefits provided directly by the Fund (not through Highmark), mid-year change of status, enrollment	Iron Workers Welfare Plan of Western Pennsylvania 2201 Liberty Avenue, Room 203 Pittsburgh, PA 15222 Phone: (412) 227-6740 Toll Free: (800) 927-3199
Medical plan network providers, Retail and Mail Order Prescription Drug Program	Highmark Blue Cross Blue Shield Toll-free: (800) 811-0391
Voluntary Dental Plan Voluntary Vision Plan	Iron Workers Welfare Plan of Western Pennsylvania 2201 Liberty Avenue, Room 203 Pittsburgh, PA 15222 Phone: (412) 227-6740 Toll Free: (800) 927-3199
Member Assistance Program	Lytle Behavioral Health Phone: (888) 877-8997
Blues on Call℠	Phone: (888) 258-3428
Life Insurance and Dismemberment benefits, Accident and Sickness benefits	Iron Workers Welfare Plan of Western Pennsylvania 2201 Liberty Avenue, Room 203 Pittsburgh, PA 15222 Phone: (412) 227-6740 Toll Free: (800) 927-3199

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 2201 Liberty Avenue, Pittsburgh, PA 15222. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This Guide is only a summary and is not a substitute for the official plan documents. If there is a discrepancy between the official plan documents and this summary, the official documents will govern. The Iron Workers Welfare Plan of Western Pennsylvania retains the right to amend this plan described at any time. Receipt of this Guide does not guarantee benefits.

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