Teamsters Local 170
Health and Welfare Fund
Summary Plan Description
Amended and Restated
Effective as of
January 1, 2023

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TO: **ALL PLAN PARTICIPANTS**

RE**: TEAMSTERS LOCAL 170 HEALTH & WELFARE FUND'S RESTATED SUMMARY PLAN DESCRIPTION.**

Dear Participant,

The Board of Trustees of the Teamsters Health & Welfare Fund is pleased to provide you with the enclosed Restated Summary Plan Description ("SPD") binder. This binder replaces the previously distributed SPD's and Summary of Material Modifications. This binder is important. Please review this binder carefully. It contains a description of the Plan's current provisions for your Health & Welfare benefits and changes made to the Plan as well as clarifications of existing provisions and your rights. Please note some sections of the binder may not apply to you. To be eligible to participate in the Plan, you must meet the eligibility requirements outlined in the binder. Please keep this binder in a place where you can refer to it again.

If you have any difficulty in understanding any part of this binder, please contact the Health & Welfare Fund Office at 508-791-3416 or check our web page at https://teamsters170hwf.com.

Respectfully submitted,

The Board of Trustees

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Worcester, MA 01604

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The Local 170 Health & Welfare Fund Board of Trustees consists of an equal number of employer and union representatives who serve without fees or compensation. A complete list of the employers' sponsoring the plan may be obtained by participants, dependents and beneficiaries upon written request to the Fund Administrator, and is available for examination by participants; as is required by law.

GENERAL DEFINITIONS

Active Employee

The term "Active Employee" is defined as a person who is employed by an Employer and for whom the Employer is required by a Collective Bargaining Agreement or Participation Agreement to make contributions to the Local 170 Health and Welfare Fund. Active Employees shall also mean employees of the Local 170 Health and Welfare Fund and Employees of the Teamsters Local Union 170, for whom contributions are made to the Fund.

Adverse Benefit Determination

The term "Adverse Benefit Determination" is defined as any of the following: a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit, that is based on a determination of a Participant's, Dependent's or Beneficiary's eligibility to participate in a Plan, or for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental, Investigational, or not Medically Necessary or appropriate.

Allowable Charge

The term "Allowable Charge" is defined as the amount resulting after subtracting the applicable network discount from a charge submitted by an In-Network provider or the appropriate Fee Allowance for charges submitted by an Out-Of-Network provider.

Beneficiary

The term "Beneficiary" is defined as any person designated in writing by the Participant or by the terms of the Plan, who is now or may hereafter, become entitled to a benefit from the Plan.

Coinsurance

The term "Coinsurance" or "cost sharing percentage" is defined as that portion of an Allowable Charge that is not covered by the Plan and thus payable by the Participant, Dependent or Beneficiary. This means the cost for covered services will be calculated as a percentage. The Schedule of Benefits shows the covered services for which payment of co-insurance is required.

Co-Payment

The term "Co-Payment" is defined as a fixed dollar amount payable by the Participant, Dependent, or Beneficiary to a provider upon incurring certain claim types as identified in the applicable Schedule of Benefits.

Contributions

The term "Contributions" is defined as the amount paid by an Employer to the Fund on behalf of his Employees, on a monthly basis, pursuant to the terms of an applicable Collective Bargaining Agreement or Participation Agreement. The term "Contributions" shall also mean the amounts paid to the Fund on behalf of their Employees by the Local 170 Health and Welfare Fund and Teamsters Union Local 170 that constitute "Employers" within the meaning of this Plan.

Deductible

The term "Deductible" is defined as the amount which the Participant pays for medical expenses before benefits are paid by the Plan. When your health plan includes a deductible, the amount that is put toward your deductible is calculated based on the health care providers actual charge or allowed charge, whichever is less (unless otherwise required by law). A Schedule of Benefits shows the amount of a member's deductible, if there is one. Your Schedule of Benefits also shows those covered services for which you must pay the deductible before you receive benefits.

Dependent

The term "Dependent" is defined as any of the following:

- The Participant's Spouse;

- The Participant's children under age 26 (which will be no less than the end of the month when such child attains the age of 26), whether married or unmarried, regardless of his/her student or employment status and regardless of whether your home is his/her principal place of abode or whether you support him/her financially;

  The Participant's children over the age of 26 and are unmarried and (i) primarily dependent on you for support because of mental retardation or physical handicap; and (ii) first became disabled before turning the age of 26 and were covered by this Plan at that time.

A "Child" or "Children" may include the following: a son, daughter, step-son, step-daughter, adopted child, a child placed for adoption, a foster child, a child named in a Qualified Medical Child Support Order, a child for whom you are responsible under court order, a child for whom you are appointed legal guardian.

Employer

The term "Employer" is defined as any Employer who has been and remains approved for participation by the Fund's Board of Trustees and has a Collective Bargaining Agreement in effect with the Union or a Participation Agreement requiring periodic Contributions to the Fund. The term Employer shall also mean the Local 170 Health and Welfare Fund and Teamsters Local Union 170, provided such Employers make contributions to the Local 170 Health and Welfare Fund on behalf of their Employees.

Essential Health Benefit

The term "Essential Health Benefit" includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care.

Fund

The term "Fund" is defined as the Local 170 Health and Welfare Fund also known as the Teamsters Local 170 Health & Welfare Fund.

Gender

"He, his and him" means she, her or hers, respectively when referring to a female.

In-Network

The term "In-Network" is defined as the use of a covered primary care provider or other covered provider who participate in the network such that all claims incurred by such a provider will be processed under the "In-Network" benefit level as described in the applicable Schedule of Benefits.

Medical Benefits

The term "Medical Benefits" is defined as all benefits provided under this Plan, other than the Life Insurance Benefit, Accidental Death and Dismemberment Benefit, Spousal Burial Benefit, Dependent Burial Benefit, Short Term Disability Income Benefit and certain Wellness Benefits or Programs.

Medically Necessary

The term "Medically Necessary" is defined as services or supplies which the Trustees or their delegate determine, in the exercise of their discretion, are generally acceptable by the national medical professional community as being safe and effective in treating a covered illness or injury, consistent with the symptoms or diagnoses, furnished at the most appropriate medical level and not primarily for the convenience of the patient, a health care provider, or anyone else. Because a health care provider has prescribed, ordered, or recommended a service or supply does not, by itself, mean that it is Medically Necessary.

Out-of-Network

The term "Out-of-network" is defined as the use of a provider that does not participate in the network such that all claims incurred by such a provider will be processed under the "Out-of-network" benefit levels as described in the applicable Schedule of Benefits.

Participant

The term "Participant" is defined as an active Employee, or retired Employee, who has met the necessary requirements to receive benefits from the Fund.

Plan

The term "Plan" is defined as this Plan or program of benefits established by the Trustees pursuant to the Agreement and Declaration of Trust.

Qualified Beneficiary

The term "Qualified Beneficiary" is defined as:

- The Spouse and Qualifying Children of a Participant who, on the day before a Qualifying Event, were eligible for benefits under the Plan;
- Any Qualifying Child who is born to or placed for adoption with a covered Participant during a period of COBRA Continuation Coverage; and
- Any covered Participant who had retired before the date of termination of benefits caused by the bankruptcy of his last regular Employer, his Spouse or Surviving Spouse, and Dependent Children

Schedule of Benefits

The term "Schedule of Benefits" is defined as the benefits listed and described within documents entitled "Schedule of Benefits" available to all Participants and their dependents. It describes the cost share amount a Participant and or dependent must pay for each covered service. It provides deductibles, co-payments, co-insurance, out of pocket maximums, prior authorization limitations, and benefit limits. The term schedule of "Schedule of Benefits" is further defined to include the benefits set forth in the Benefit Description and Riders for Participants and their dependents who are enrolled in a Blue Cross Blue Shield Plan.

Spouse

"Spouse" means the individual to whom you are legally married or in the event of a divorce, the participant's former spouse may remain covered unless:

- The divorce decree does not require (or no longer requires) the participant to maintain coverage for his former Spouse;
- or either the participant or his former Spouse remarries

Total Disability

A participant will be considered totally disabled during any period when as a result of a non-occupational injury or illness, he is unable to perform duties of his occupation, as documented by a treating physician's orders.

Trust Agreement

The term "Agreement and Declaration of Trust" or "Trust Agreement" is defined as the Agreement and Declaration of Trust made and entered into on April 14, 1954, and as amended from time to time known as the Local 170 Health and Welfare Fund and/or the Teamsters Local 170 Health & Welfare Fund.

Trustees

The term "Trustees" as used herein is defined as "Trustees," "Board of Trustees," "Board" or "Trustee" or "one of the Trustees," as the context may require, designated by the Agreement and Declaration of Trust, together with their successors designated and appointed to administer the Fund. The Trustees, collectively, shall be the "Plan Administrator" of this Plan as that term is used in the Employee Retirement Income Security Act, 29 U.S.C. Sections 1001, et seq.

Union

The term "Union" is defined as Teamsters Local Union 170 affiliated with the International Brotherhood of Teamsters, which has Collective Bargaining Agreements with Employers requiring periodic Contributions to the Fund created by the Trust Agreement.

I. INTRODUCTION

We are pleased to provide you with this Summary Plan Description ("SPD") summarizing the Teamsters Local 170 Health and Welfare Fund Plan (the "Plan") sponsored by Teamsters Local 170 Health and Welfare Fund for eligible members and their eligible dependents.

The Plan is composed of the following benefits:

- Medical Benefits (including medical and prescription drug)
  - Attachment #1- Blue Choice New England Plan 2 (Tier 1)
  - Attachment #2- Blue Care Elect PPO
  - Attachment #3- Network Blue New England Options (Tier 2)
- Dental Benefits
  - Attachment #4- Active Employees
  - Attachment #5- Retired Employees
- Vision Benefits
  - Attachment #6- Davis Vision Plan Benefit Description
- Life Insurance, AD&D Benefits
  - Attachment #7 and #8- Life Insurance AD&D Benefit
- Short Term Disability Income Benefit – Active Employees only
- Spousal Burial Benefit - Active Employees only
- Dependent Child Life Benefit - Active Employees only
- Certain Wellness Benefits and Programs

A summary of each benefit provided under the Plan is set forth in this SPD and attached benefit booklets, certificate of insurance or other documents.

This document, together with Attachments #1-8, and their respective policies, descriptions, riders and other materials (either written or electronic), constitute the summary plan description to the extent required by Section 102 of the Employee Retirement Income Security Act of 1974 (ERISA) and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Plan.

This document is intended to complement the booklets provided by Blue Cross Blue Shield of MA, Plan, Davis Vision and Symetra Life Insurance Company to create a Summary Plan Description for purposes of ERISA. The policies, contracts or booklets for each underlying Benefit feature govern the benefits to be provided and include more details on how the Benefit features operate. If there is any conflict between this document and such policies, contracts or booklets, then such other documents will control unless otherwise required by law. Participants and dependents should not rely on any oral description of the Plan because the written terms of the Plan will always govern.

II. GENERAL INFORMATION ABOUT THE PLAN

This section contains general information that you may need to know about the Plan.

Plan Name

Teamsters Local 170 Health and Welfare Fund

Plan Number

The Plan Sponsor has assigned Plan Number 501 to the Plan.

Plan Employer Identification Number

The Plan's E.I.N. is 04-2219623

Effective Date

The provisions of the SPD are effective as of January 1, 2023.

Plan Year

The Plan Year is January 1 – December 31.

Plan Sponsor

Board of Trustees
Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff, Suite 202
Worcester, MA 01604
Telephone Number: (508) 791-3416 (800) 447-7730 Fax (508) 792-0936
E.I.N.: 04-2219623

Plan Administrator

Board of Trustees
Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff, Suite 202
Worcester, MA 01604
Telephone Number: (508) 791-3416, (800) 447-7730 and Fax (508) 792-0936
E.I.N.: 04-2219623

Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Fund Administrator
Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff, Suite 202
Worcester, MA 01604

Service of legal process may also be made upon the Plan Administrator (Board of Trustees).

Medical Claims Administrator

The Fund does not process or administer medical claims. The Board of Trustees has contracted with two (2) separate organizations to provide administrative services, such as claims processing, individual case management, utilization review, quality assurance programs, claim review and other related services and to arrange for a network of health care providers and/or prescription drug providers whose services are covered by this Plan. The names and addresses of the two (2) organizations can be found on pages 53 of this SPD.

None of these organizations serve as an insurer, but rather, serve as claims processors. Claims for benefits or services are sent to these organizations. They process the claims, then request and receive funds from the Plan to pay these claims, and they in turn, make payment to doctors, hospitals and other providers. Each of the medical administrators has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the plan in which you are enrolled.

Type of Plan

The Plan is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1). The benefits provided thereunder with the exception of Short Term Disability Income Benefit and certain Wellness Benefits are intended to be eligible for exclusion from income under the Internal Revenue Code to the extent permitted by law. The Short-Term Disability Income Benefit is intended to provide partial income replacement in the event of an employee's disability as defined by the Plan.

Type of Administration and Funding

Teamsters Local 170 Health and Welfare Fund receives contributions from employers who have entered into collective bargaining agreements with Teamsters Local 170. Contributions are also received from eligible employees, retired employees and dependents who continue their coverage under self-payment and/or the COBRA rules of the Plan. Additionally, the Fund receives income from rent and investments.

The Fund's assets and reserves are invested on behalf of the Fund by qualified investment managers who are authorized and approved by the Board of Trustees.

The Plan is (partially) maintained as a result of Collective Bargaining Agreements (CBAs) between Teamsters Local 170 and participating employers. You may obtain a copy of the applicable CBA upon written request to the Plan Administrator. A reasonable charge will be made for copies of the agreement. You may also examine the applicable Collective Bargaining Agreement, without charge, during regular business hours at the Fund Office.

Upon written request, the Fund will provide you with information as to whether a particular employer is contributing to the Plan on behalf of participants working under a Collective Bargaining Agreement.

Assets are held in a Trust Fund for the exclusive purpose of providing benefits to covered participants and defraying reasonable administration expenses. Some of the benefits are provided through insurance policies.

Benefits, other than life and accidental death and dismemberment benefits are paid directly from the assets of the Trust. Life and accidental death and dismemberment insurance and excess medical risk (stop-loss) coverage are purchased with premiums paid from assets of the Trust. The insurance carriers pay life and accidental death and dismemberment benefits directly to beneficiaries and reimburse the Plan when medical and pharmacy claims exceed a stated amount. Benefits are provided from Fund assets, which are accumulated under the provisions of the Trust Agreement.

Amendment and Termination

The Plan Sponsor reserves the right to amend any one or more of the underlying Plan features or Benefits at any time without the consent of or prior notice, to the extent permitted by law, to any participant. Although the Plan Sponsor expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan, any benefit, or any feature thereof at any time without liability. Upon the termination of the Plan, benefit, or feature, as the case may be, all elections and reductions in compensation relating to the Plan, benefit, or feature will terminate, and the rights of a participant covered under the Plan are limited to the payment of eligible expenses incurred prior to termination.

III. ELIGIBILITY

All regular full-time and part-time employees covered by a Collective Bargaining Agreement between the participating employer and Teamsters Union Local 170 or those employed by an organization established or maintained by the Union or by the Union jointly with a contributing employer are eligible to participate in the Plan after meeting the eligibility requirements listed below. In addition, retired employees who have participated in the Active Employee plan and who meet the age, requisite number of years of participation and other requirements set forth in this SPD are eligible to participate in the Plan.

The Fund does not allow Company owners to participate in the Fund. Owners are defined as follows: (this includes the interest of spouses.)

- A sole proprietor who is a contributing employer, and the spouse of a sole proprietor; or
- A partner in a partnership which is a contributing employer, regardless of the size of the partnership interest; a spouse of any partner is also considered an owner; or
- Anyone who, alone or with a spouse, owns fifty-one (51%) percent or more of the stock of a corporation which is a contributing employer; or
- Anyone else whose ownership interest in a contributing employer would, in the opinion of the Trustees jeopardize the status of the Employee Health & Welfare Fund or violate the Employee Retirement Income Security Act of 1974 (ERISA).

ACTIVE EMPLOYEES

FULL TIME PARTICIPATION

You are eligible for coverage in the Plan if you are covered by a Collective Bargaining Agreement between the participating employer and Teamsters Union Local 170, or you are employed by an organization established or maintained by the Union or by the Union jointly with a contributing employer. A participant or beneficiary may obtain a copy of the applicable collective bargaining agreement upon written request to the Fund Administrator, and a copy of the applicable bargaining agreement is available for examination by participants and beneficiaries as required by law.

New or Reinstated Employee

A new or reinstated employee will be eligible for insurance for the remainder of an insurance period on the first day of the month following the month during which you accumulate 500 hours of credited employment by contributing employers during 6 consecutive months.

Continued Eligibility

You will remain eligible for insurance as of the first day of each insurance period, provided contributions of 400 hours have been made to the Fund during the current eligibility period. Surplus hours in excess of 400 in the three (3) eligibility periods preceding the current eligibility period, will be credited to the period immediately following, provided you have not been credited with 400 hours in that eligibility period. * Surplus hours may only be used once.

Eligibility Period	**Insurance Period**
400 Credited Hours in:	**Gives Full Coverage in:**
Mar., Apr., May	July, Aug., Sept.
June, July, Aug.	Oct., Nov., Dec.
Sept., Oct., Nov.	Jan., Feb., Mar.
Dec., Jan., Feb.	April, May, June

You will only receive credit toward eligibility if the contributions are received by the Fund.

Pay-In Provision

An employee to remain insured, may contribute on his own behalf the balance of hours required in order to qualify for any given coverage period. The employee's contribution will be calculated at a rate per hour upon which the employer contributions are based.

Should the employee not pay the balance of hours, the employee's coverage will terminate on the last day of the eligibility period. The employee will have to work 500 hours to become eligible for reinstatement.

Failure to Self-Pay on Time

If you are eligible to make a self-pay contribution but choose not to make such self-pay contribution or fail to make the payment on time, you will be terminated as an Active participant on the last day of the eligibility period. You will forfeit all hours in your hour bank and you will have to meet the Plan's eligibility requirement of 500 hours to become eligible again.

Re-establishment of Eligibility for Active Full-time Employees

The rules for re-establishing eligibility are the same as the rules for establishing "initial eligibility for full-time employees".

***Notwithstanding anything contained herein, an employee who retires shall only be allowed to utilize surplus hours for a maximum period of the balance of the eligibility period for when the employee retires and the subsequent quarter.**

PART TIME PARTICIPATION

Eligibility for Employee Insurance

You are eligible for coverage through the Plan if you are covered by a Collective Bargaining Agreement between the participating employer and Teamsters Union Local 170, or you are employed by an organization established or maintained by the Union or by the Union jointly with a contributing employer. A participant or beneficiary may obtain a copy of the applicable collective bargaining agreement upon written request to the Fund Administrator, and a copy of the applicable bargaining agreement is available for examination by participants and beneficiaries as required by law.

New or Reinstated Employee

A new or reinstated employee will be eligible for insurance for the remainder of an insurance period on the first day of the month following the month during which you accumulate 400 hours of credited employment by contributing employers during 6 consecutive months.

Continued Eligibility

You will remain eligible for insurance as of the first day of each insurance period, provided contributions of 250 hours have been made to the Fund during the current eligibility period. Surplus hours in excess of 250 in the three (3) eligibility periods preceding the current eligibility period, will be credited to the period immediately following, provided you have not been credited with 250 hours in that eligibility period. * Surplus hours may only be used once.

Eligibility Period	Insurance Period
250 Credited Hours in:	Gives Full Coverage in:
Mar., Apr., May	July, Aug., Sept.
June, July, Aug.	Oct., Nov., Dec.
Sept., Oct., Nov.	Jan., Feb., Mar.
Dec., Jan., Feb.	Apr., May, June

You will only receive credit toward eligibility if the contributions are received by the Fund.

Pay-In Provision.

An employee to remain insured, may contribute on his own behalf the balance of hours required in order to qualify for any given coverage period. The employee's contribution will be calculated at a rate per hour upon which the employer contributions are based.

Should the employee not pay the balance of hours, the employee's coverage will terminate on the last day of the eligibility period. The employee will have to work 400 hours to become eligible for reinstatement.

Failure to Self-Pay on Time

If you are eligible to make a self-pay contribution but choose not to make such self-pay contribution or fail to make the payment on time, you will be terminated as an Active participant on the last day of the eligibility period. You will forfeit all hours in your hour bank and you will have to meet the Plan's eligibility requirement of 400 hours to become eligible again.

Re-establishment of Eligibility for Active Part-time Employees

The rules for re-establishing eligibility are the same as the rules for establishing "initial eligibility for part-time employees".

***Notwithstanding anything contained herein, an employee who retires shall only be allowed to utilize surplus hours for a maximum period of the balance of the eligibility period for when the employee retires and the subsequent quarter.**

ELIGIBLE DEPENDENT COVERAGE

You may also enroll the following members of your family in the Plan ("Eligible Dependents") Eligible dependents can be defined as including the following:

Your spouse "Spouse" means the individual to whom you are legally married or in the event of a divorce, the participant's former spouse may remain covered unless:

- The divorce decree does not require (or no longer requires) the participant to maintain coverage for his former Spouse;
- or either the participant or his former Spouse remarries

The Plan Sponsor shall have the sole discretion to determine the legal status of a Participant's marriage, which determination shall be based upon the laws of the state in which the Participant maintains his or her legal residence.

Your children The Participant's children until the end of the calendar month in which the child turns age 26, whether married or unmarried, regardless of his/her student or employment status and regardless of whether your home is his/her principal place of abode or whether you support him/her financially;

The Participant's children over the age of 26 and are unmarried and (i) primarily dependent on you for support because of mental retardation or physical handicap; and (ii) first became disabled before turning the age of 26 and were covered by this Plan at that time.

- A "Child" or "Children" may include the following: a son, daughter, step-son, step-daughter, adopted child, a child placed for adoption, a foster child, a child named in a Qualified Medical Child Support Order, a child for whom you are responsible under court order, a child for whom you are appointed legal guardian.

You may be required to verify the eligibility of your Eligible Dependents for coverage (e.g., by providing a birth or marriage certificate). If you fail to timely provide the documentation upon request to prove the eligibility of any of your Eligible Dependents or the Plan Administrator (or its

delegate) is unable to verify the submitted documentation, your dependent (or dependents) will lose coverage under the Plan, whether or not he or she (they) is (are) otherwise eligible for benefits under the respective plan.

NOTE: IF YOU APPLY FOR OR CONTINUE COVERAGE FOR ANYONE WHO IS NOT AN ELIGIBLE DEPENDENT, IT MAY BE CONSIDERED FRAUD OR INTENTIONAL MISREPRESENTATION AND YOU AND YOUR FAMILY'S COVERAGE MAY BE RESCINDED TO THE EXTENT PERMITTED BY LAW. IN ADDITION, IF THE PLAN EXPENDS FUNDS FOR COVERAGE OF INELIGIBLE INDIVIDUALS, YOU MAY BE LIABLE FOR PREMIUMS AND ALL COSTS RELATED TO COVERAGE FOR SUCH INDIVIDUALS WHO ARE NOT ELIGIBLE DEPENDENTS.

NEW PARTICIPATING EMPLOYERS

If you work full time when your employer begins participating with Teamsters Local 170 Health and Welfare Fund, you will be eligible for Teamster benefits on the first day of the month your employer contributes the required hours to the Health & Welfare Fund.

CONTINUATION OF COVERAGE AFTER ACTIVE EMPLOYEE BECOMES DISABLED

Notwithstanding anything to the contrary, a disabled Active Employee's benefits will not be terminated provided he remains eligible to receive short term disability income benefits and the disabled active Employee makes the necessary self- pay contributions, if necessary, to the Fund to remain eligible.

TERMINATION OF ELIGIBILITY

Except in the event of an Active employee's death, an Active Employee and his Dependents eligibility for benefits will terminate automatically on the earliest of the following dates:

- The date the policy is cancelled;
- The Employer's voluntary participation under the plan ceases; coverage shall terminate immediately; and in such case the active Employee shall forfeit all surplus banked hours;
- The date on which the Plan's grace period ends for the Participant's Employer to make a required contribution; and in such case the active Employee shall not forfeit paid banked hours;
- The date the policy is changed to cancel insurance on the class of Active Employees the Participant is in;
- A Dependent's eligibility terminates when the Active Employee's eligibility ceases, except as in the event of an active employee's death
- The last day of the insurance period that the Participant's combined credited and banked hours do not qualify him for the next insurance period; except that he may continue his insurance, provided the Participant pays directly to the Fund prior to the insurance period, the balance of the required hours under his Collective Bargaining Agreement.

CONTINUATION OF INSURANCE AFTER ACTIVE EMPLOYEE'S DEATH

Notwithstanding anything contained to the contrary, a Dependent is eligible for Dependent Coverage when an Active Employee dies while still eligible for coverage under this plan. The Dependent will remain eligible for coverage, at no cost, until the first to occur of:

- One (1) year after the active Employee's death;
- As to the surviving spouse, the date he/she remarries;
- The date the person would have ceased to be a Dependent, if the Active Employee were alive; or
- The date the Dependent becomes eligible to be covered under any group policy or other arrangements for benefits (insured or not) as an active employee or
- as a Dependent of another active Employee.

RECIPROCITY

You may have contributions made on your behalf reciprocated (forwarded) to the Employee Health & Welfare Fund when you work in an area where Employer Contributions are made to another Health & Welfare Fund if:

- There exists a reciprocal agreement between the Teamsters Local 170 Health & Welfare Fund and the other fund; and
- You have provided both funds with a written request to have the contributions reciprocated (made on your behalf).

You will not receive credit for hours worked in another area until reciprocated contributions are received by the Teamsters Local 170 Health & Welfare Fund, see "Continuing Eligibility with Reciprocal Contributions". However, you may continue eligibility by making self-payments, if necessary. See Pay-In Provision under Full or Part-Time Participation.

IMPORTANT: You should complete the proper form immediately upon working in another Fund's area so that you do no lose credit for any time worked. Contact the Local 170 Union Business Office or the administration office of the other plan or call Teamsters Local 170 Health & Welfare Fund office for help.

Most reciprocal agreements have deadlines concerning the transferring of contributions. If you wait too long to apply, benefits may be lost.

Reciprocal agreements are established so that members can have hours and contributions transferred back to their home Health & Welfare Fund. The home Health & Welfare Fund as defined in the reciprocal agreement is the Fund to which your Home Local Union is a party. Reciprocal agreements are not intended to allow anyone to pick and choose which Health & Welfare Fund they want their contributions to be transferred to or to remain in.

Continuing Eligibility with Reciprocal Contributions

If a contributing employer has paid contributions on your behalf into another Health & Welfare Fund, and the contributions have not been reciprocated back to this Fund in a timely manner, which you need for eligibility, credit shall be given to you for the purposes of your continued eligibility based on the eligibility rules of the Plan, provided that all of the following conditions have been satisfied:

- Your employer is a signatory to a Collective Bargaining Agreement or Assent of Participation with a Union affiliated with Teamsters Local 170.
- There is a Reciprocity Agreement in effect between the Plan to which payment has been made and this Plan.
- Contribution Payment has been made to the affiliated Health & Welfare Plan associated with reciprocal agreement.
- You have requested reciprocity transfer of the contribution back to this Fund as your Home Fund in a timely manner.
- The reason why the contributions have not been transferred to this Fund is because of some delay in the reciprocity transfer of funds and not because of any issue of dispute which could jeopardize the transfer of contributions.
- The other Fund cooperates with Teamsters Local 170 Health & Welfare Fund and provides the Teamsters Local 170 Health & Welfare Fund Office with all necessary information so that proper credit can be given to you.

RETIRED EMPLOYEES

An Employee participating in the active Plan shall be eligible to participate in the Retired Employee Plan, but only if the Employee:

- Is retired; and
- Is at least age fifty-seven (57) but under age sixty-five (65); and
- Has had contributions paid on his behalf to the Fund (hereinafter referred to participation in the Fund) for the minimum requisite years of participation in the Fund. Prior to March 1, 2006, eligibility in the Retired Employee Plan required ten (10) years of participation in the Fund. The program was modified to require twenty (20) years of participation in the Fund. The Trustees "grandfathered" active Employees who were participating in the Fund at that time by granting these active Employees 10 years of credited coverage and permitted any Employee in the Retired Employee Plan to remain in the Retired Employee Plan. The Trustees, in their discretion may permit participation in any Teamster Health and Welfare Fund to be treated as participation in this Fund for purposes of establishing eligibility; and
- The retired Employee must elect enrollment after his eligibility in the active Plan terminates and within thirty (30) days of receiving notice from the Fund Office; and
- At the time of retirement, the Employee must be participating in the Fund's active plan;

*Eligibility for benefits from Medicare will not automatically disqualify a retired Employee, and/or his Spouse and/or his Dependent from participation in the Retired Employee Plan. In such a circumstance, to the extent permitted by law, Medicare will be the primary payer and this Fund will be the secondary payer only.

Contributory Payments (Premiums)

Monthly contributory payments to the Fund shall be due by the first (1st) day of the calendar month coverage is to be provided; provided however, that a monthly contributory payment for any particular month shall be deemed to have been made by the due date so long as such payment is received by the Fund Office by the last day of such month ("grace period"). Contributory payments may be automatically deducted from the monthly benefits provided by the Teamsters New England Pension Fund upon written request of the Participant. The Trustees have established a single composite rate of contribution. The

contributory payment is the same for all participants, irrespective as to whether single or family coverage is provided. The Trustees reserve the right to change the rate of contributory payments at any time.

Benefits Effective Date

Benefits for retired employees become effective on the first (1st) day after the retired Employee's coverage terminates under the Fund's active Plan.

ELIGIBLE DEPENDENT COVERAGE

You may also enroll the following members of your family in the Plan ("Eligible Dependents") Eligible dependents can be defined as including the following:

Your spouse "Spouse" means the individual to whom you are legally married or in the event of a divorce, the participant's former spouse may remain covered unless:

- The divorce decree does not require (or no longer requires) the participant to maintain coverage for his former Spouse;
- or either the participant or his former Spouse remarries

The Plan Sponsor shall have the sole discretion to determine the legal status of a Participant's marriage, which determination shall be based upon the laws of the state in which the Participant maintains his or her legal residence.

Your children The Participant's children until the end of the calendar month in which the child turns age 26, whether married or unmarried, regardless of his/her student or employment status and regardless of whether your home is his/her principal place of abode or whether you support him/her financially;

The Participant's children over the age of 26 and are unmarried and (i) primarily dependent on you for support because of mental retardation or physical handicap; and (ii) first became disabled before turning the age of 26 and were covered by this Plan at that time.

- A "Child" or "Children" may include the following: a son, daughter, step-son, step-daughter, adopted child, a child placed for adoption, a foster child, a child named in a Qualified Medical Child Support Order, a child for whom you are responsible under court order, a child for whom you are appointed legal guardian.

You may be required to verify the eligibility of your Eligible Dependents for coverage (e.g., by providing a birth or marriage certificate). If you fail to timely provide the documentation upon request to prove the eligibility of any of your Eligible Dependents or the Plan Administrator (or its delegate) is unable to verify the submitted documentation, your dependent (or dependents) will lose

coverage under the Plan, whether or not he or she (they) is (are) otherwise eligible for benefits under the respective plan.

NOTE: IF YOU APPLY FOR OR CONTINUE COVERAGE FOR ANYONE WHO IS NOT AN ELIGIBLE DEPENDENT, IT MAY BE CONSIDERED FRAUD OR INTENTIONAL MISREPRESENTATION AND YOU AND YOUR FAMILY'S COVERAGE MAY BE RESCINDED TO THE EXTENT PERMITTED BY LAW. IN ADDITION, IF THE PLAN EXPENDS FUNDS FOR COVERAGE OF INELIGIBLE INDIVIDUALS, YOU MAY BE LIABLE FOR PREMIUMS AND ALL COSTS RELATED TO COVERAGE FOR SUCH INDIVIDUALS WHO ARE NOT ELIGIBLE DEPENDENTS.

Dependent Coverage After Death of Retired Employee

In the event a retired Employee dies or reaches the age of 65 while participating in the Retired Employee Plan, their dependents shall be permitted to continue participation in the Retired Employee Plan, subject to the following limitations:

- The Spouse shall be eligible to participate until reaching 65 years of age; and
- The Spouse does not have other primary coverage; and
- The Dependent shall be eligible to participate so long as he satisfies the definition of dependent as set forth by this SPD
- Provided the contributory payment is timely made.

Termination of Retired Employee's Eligibility for Retired Employee Plan Benefits

A retired Employee's eligibility will end on the earliest of the following dates:

- On the first day of the month of the retired Employee's 65th birthday;
- On the date of the retired Employee's death;
- The date the policy is cancelled;
- The last day of the month following any period for which the contributory payment is not timely paid.

Termination of Retired Employee Spouse's Eligibility

In the event the retired employee is no longer participating in the Retired Employee Plan; the Dependent Spouse's eligibility will end on the earliest of the following dates:

- The Spouse's 65th birthday; or
- On the date of the Spouse's death; or
- The date the policy is cancelled; or
- The last day of the month following any period for which the contributory payment is not timely paid.

Termination of Retired Employee Dependent's Eligibility

In the event the retired employee is no longer participating in the Retired Employee Plan, the Dependent's eligibility will end on the earlier of the following dates:

- The date the Dependent no longer satisfies the definition of a Dependent as defined in this SPD; or
- Neither the retired employee nor the retired employee's Spouse participate in the Retired Employee Plan; or

- The date the policy is cancelled; or
- The Dependent Child's date of death; or
- The last day of the month following any period for which the contributory payment is not timely paid.

IV. ENROLLMENT

ACTIVE EMPLOYEES

When you have reached the appropriate number of hours required for coverage, the Fund office will send you an enrollment packet. You can also contact the Fund office for a packet of information and/or if you have any questions about the information. A participant will not be eligible to enroll in our plan until they are eligible for coverage. For example, a part-time employee must work 400 hours and a full-time employee must work 500 hours before they are eligible to enroll.

You must complete a census card and insurance application and return to the Fund office with the required documents, (i.e. certified marriage certificate, birth certificates). After you have worked the required hours, you will become eligible and the fund office will issue your insurance, effective the first day of the month following the completion of the required hours.

Your coverage includes medical benefits, dental benefits, prescription drug benefits, vision care benefits, weekly disability benefits, life insurance benefits, accidental death and dismemberment insurance benefits, spousal and dependent burial benefits and certain wellness benefits. You are automatically enrolled in the Life and AD&D Benefit (Attachment #7 & 8) Short Term Disability Income Benefit, Vision Benefit (unless you opt out), the Spousal/ Dependent Burial Benefits, Dental Benefits (unless you opt out) and certain wellness benefits upon becoming eligible and completing your census and application.

You may elect to join one of the various medical plans offered by completing the appropriate insurance application as provided by the Fund office. The Plan provides numerous medical plan choices from which active employees, COBRA participants, retired Employees and eligible spouses can choose. There are two tiers of coverage, Tier 1 and Tier 2. Your Collective Bargaining Agreement (CBA) determines your tier of coverage. Within those coverage tiers you may choose from various plans offered by Blue Cross Blue Shield of MA.

Special Enrollment Rights

If you do not enroll yourself and your Eligible Dependents in the Plan after you become eligible or during annual open enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual initially

declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you initially declined coverage because you had other health care coverage that you have now lost through no fault of your own, or (ii) since declining coverage initially, you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. When you have previously declined coverage, you must have given (in writing) the alternative coverage as your reason for waiving coverage when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all Eligible Dependents within 30 days after you lose your alternative coverage or the date of your marriage or the birth, adoption, or placement for adoption of your child.

You may also enroll yourself and your Eligible Dependent(s) if you or your Eligible Dependent(s) coverage under Medicaid or the state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, or if you or one of your Eligible Dependents become eligible for premium assistance under a Medicaid or CHIP plan. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/CHIP coverage or of the determination of eligibility for premium assistance under Medicaid/CHIP.

Contact the Plan Administrator for details about special enrollment.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for a parent to provide a child or children with health insurance under a group health plan. The Plan Administrator will comply with the terms of any QMCSO it receives, and will:

- Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under ERISA Section 609;
- Promptly notify you and any alternate recipient (as defined in ERISA Section 609(a)(2)(C)) of the receipt of any medical child support order, and the Plan's procedures for determining whether medical child support orders are qualified medical child support orders; and
- Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify you and each alternate recipient of such determination;
- A copy of the Plan's Qualified Medical Child Support Order procedures will be provided to you free of charge upon request by calling the Fund office

RETIRED EMPLOYEES

Please contact the Fund Office once you have made your decision to file for Retirement benefits.

The Fund Office will notify you when you are eligible to continue your coverage under the Early Retiree benefit. An insurance packet with the necessary enrollment forms will be sent to you at the appropriate time. You must complete the enrollment forms and return them to the Fund Office with your first month's payment as soon as possible after you receive the packet of information. **Failure to enroll in the Early Retiree benefit at this time will waive your right to coverage in the future.** The benefits available to you as an early retiree and to your dependents include: medical, pharmacy, vision, dental coverage, and may include certain wellness benefits. You are not eligible to continue enrollment in the Life Insurance/AD&D benefit once you retire.

V. NOTICES AND DISCLOSURES

Special Rule for Maternity and Infant Coverage

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

Special Rule for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Medical Benefit. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator.

HIPAA Compliance

The Board of Trustees recognizes that the Fund must comply with all applicable HIPAA requirements and shall take appropriate measures to do so. For example, the Plan does not contain any pre-existing exclusions; the Plan permits special enrollments and late enrollments pursuant to federal law. The Fund provides creditable coverage. The Fund must comply with HIPAA Privacy and Security laws. Lastly, the Plan must comply with HIPAA; Administrative Simplification Requirements; known as Operating Rules as applicable.

Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost-sharing restrictions and treatment-duration limitations. For further details, please contact the Plan Administrator.

Genetic Information Nondiscrimination Act

The plan shall comply with all requirements of the Genetic Information Nondiscrimination Act of 2008 (GINA).

Patient Protection and Affordable Care Act

The Trustees have elected "non-grandfathered" status for purposes of complying with the Patient Protection Affordable Care Act and have taken all measures in accordance therewith. For example, the Fund does not impose any lifetime or annual limits on essential health benefits nor does the Plan contain or impose any preexisting exclusions. The Plan provides preventive health services, including women's preventative health services, as required by the PPACA. The following is a list of some of the PPACA requirements as of the date of publishing of this SPD.

Recommended Preventive Services

The Affordable Care Act requires the Plan to provide certain Recommended Preventive Services on an in-network basis at no cost to you and your dependents. To determine which services provided on an in-network basis are Recommended Preventive Services for which no co-payments may be charged and no cost-sharing may be imposed, please refer to the list posted on the Federal government's Recommended Preventive Services website.

To access the Federal government's website regarding Recommended Preventive Services, go to http://www.healthcare.gov/law/resources/regulations/prevention/recommendations.html. Alternatively, you may contact the Plan Administrator.

Recommended Preventive Services often include certain immunizations for children and adults, such as those for:

- Hepatitis,
- Rotavirus,
- Diphtheria, Tetanus, Pertussis,
- Poliovirus,
- Measles, Mumps Rubella,
- Varicella,
- Meningoccoccal, and
- Human Papillomavirus.

Recommended Preventive Services also often include certain screening tests for health issues, such as:

- Depression,
- High blood pressure,
- Cholesterol,
- Obesity,
- Breast, cervical and colorectal cancer,
- Diabetes,
- Hepatitis B
- HIV,

- Congenital hypothyroidism,
- Iron anemia, and
- Osteoporosis.

In addition, Recommended Preventive Services often include services included in comprehensive guidelines for infants, children, and adolescents, such as those relating to:

- Measurement (ex., length, height, weight, head circumference, BMI, blood pressure), and
- Screenings (ex., vision, hearing, autism, psychosocial/behavioral, alcohol/drug use, lead screening).

Essential Health Benefits and Plan Limits

Annual dollar limits and lifetime dollar limits do not apply to Essential Health Benefits. Essential Health Benefits include benefits, items and services that fall within the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance abuse disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services,
- Chronic disease management, and
- Pediatric services, including oral and vision care.

The rules regarding whether an annual or lifetime dollar limit applies to an Essential Health Benefit are complex and detailed. The restrictions and prohibitions regarding limitations in the Plan do not apply to services (even Essential Health Benefit services) which are limited by the number of visits or other criteria. For example, if a Plan provision provides that coverage for a chiropractor is limited to 20 visits, this limitation is not prohibited by the law which restricts the Plan from imposing certain annual or lifetime dollar limits.

Benefits that do not constitute Essential Health Benefits, as determined in accordance with the Plan Administrator's good faith interpretation of the requirements of federal law and any applicable Plan provisions, may still be subject to annual and lifetime dollar limits.

Emergency Care

If you obtain emergency services, you will not be required to obtain a prior authorization, regardless of whether services are provided in network or out of network.

The Fund does not impose more restrictive requirements or benefit limitations, including cost sharing, in or out-of-network emergency services than those imposed on in-network emergency services. This parity with respect to cost sharing applies to copayment or coinsurance rates.

Lifetime Limits

The Fund does not impose any lifetime or annual limits on "essential health benefits". However, if otherwise permitted under federal or state law, the Fund may place lifetime limits on specific benefits that are not "essential health benefits." *Essential health benefits* (which are to be more precisely defined by regulatory guidance) include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Preexisting Conditions – No Exclusions or Limitations for Eligible Dependents

The Patient Protection and Affordable Care Act (PPACA) prohibits plans from imposing any preexisting condition exclusion for enrollees under the age of 19. However, our Fund prohibits any preexisting condition exclusion for all enrollees.

Limitations on Requirements Relating to Designation of Primary Care Providers

The following notice is made regarding your choice of health care professionals:

- Blue Cross Blue Shield of MA generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For a list of participating professionals, you may contact Blue Cross Blue Shield of MA (800-217-7878).
- You may designate a pediatrician as a primary care physician for a child, if that physician will accept the child as a patient.
- A female participant or beneficiary does not need a prior authorization or a referral from her primary care physician to obtain services from an in-network obstetrical or gynecological specialist. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of professionals who specialize in obstetrics or gynecology, contact Blue Cross Blue Shield of MA (1-800-217-7878).

VI. RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator

The Plan Administrator has (i) the power and authority in its sole, absolute and uncontrolled discretion to control and manage the operation and administration of the Plan and (ii) all powers necessary to accomplish these purposes.

The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA and other applicable laws. With respect to the Plan, the Plan Administrator has discretion (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, (iv) to determine the conditions under which benefits become payable under the Plan, and (v) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Subject to any applicable claims procedure, any determination made by the Plan Administrator will be final, conclusive and binding on all parties. The Plan Administrator may establish minimum contribution rates and the Plan Administrator may, at its discretion permit a deviation from a minimum contribution rate. The Plan Administrator may delegate all or any portion of its authority to any person or entity. A claims administrator may, at the discretion of the Plan Administrator, have the authority to administer, apply, and interpret Plan provisions. All claims should be directed to the applicable administrator (either the Claims Administrator or the Plan Administrator).

Under the terms of any insurance contracts issued for Life Insurance and/or the AD&D benefit, the insurance company issuing the contract has full discretionary authority to make all benefit decisions concerning eligibility for benefits under the contract, payment of claims or benefits, and interpretation of the terms and provisions of the insurance contract. Only the insurance company can resolve insurance contract ambiguities, correct errors or omissions in the contract, and interpret contract terms. The insurance company has the full discretionary authority to interpret, construe and administer the terms of such policies, and its decisions are final and binding on all parties. The Plan Administrator does not guarantee the payment of any benefit described in an insurance coverage contract and you must look solely to the insurance carrier for the payment of benefits.

Duties of the Plan Administrator

The Plan Administrator will (i) administer the Plan in accordance with its terms, (ii) decide disputes which may arise relative to a Plan participant's rights, (iii) keep and maintain the Plan documents and all other records pertaining to the Plan, (iv) pay or arrange for the payment of claims, (v) establish and communicate procedures to determine whether a medical child support order is qualified under Section 609 of ERISA, and (vi) perform all necessary reporting as required by ERISA.

Plan Administrator Compensation

While the Plan Administrator serves without compensation, all expenses for administration, including compensation for hired services, will be paid by the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to eligible employees and their eligible dependents and defraying reasonable expenses of Plan administration. These duties must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in accordance with Plan documents to the extent that they are consistent with ERISA.

The Named Fiduciary

The Plan Administrator is a "named fiduciary" with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. The Plan Administrator has delegated certain day-to-day administration of the Plan and claims fiduciary responsibility for the processing and review of claims for benefits under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures or (ii) the named fiduciary breached its fiduciary responsibility under ERISA Section 405(a).

Certificate of Coverage Under a Group Health Plan

Certificates of coverage are written documents provided by a group health plan to show the type of health care coverage a person had (e.g., employee only, employee plus spouse, etc.) and how long the coverage lasted. Most group health plans provide these certificates automatically when a person's coverage terminates. If you do not receive a certificate, however, you have the right to request one. Certificates apply to you and your eligible dependents. The primary purpose of the certificates is to show the amount of "Creditable Coverage" that you had under a group health plan or other health insurance coverage, because this can reduce or eliminate the length of time that any preexisting condition clause in a new plan otherwise might apply to you. Upon request the Fund Office will provide a Certificate of Coverage.

Coordination of Benefits

If you or your Eligible Dependent has or is entitled to benefits under another health plan, you are subject to a coordination of benefits process. Coordination of benefits is designed to prevent the payment of benefits from exceeding 100% of any allowable expenses that have been incurred. The Plan Administrator may request an Explanation of Benefits (EOB) which provides detailed claim reimbursement information from any other plans under which you are insured. If any of these plans provide coverage for services that are also covered under the Plan, the carrier will determine which plan is considered primary before any payments are made. The certificates of coverage and/or benefit booklets attached hereto provide more detailed information on how your benefits under this Plan will be coordinated with other coverage you may have.

To determine how the plans coordinate benefits, one plan is considered "primary" and the other is considered "secondary". The primary plan pays benefits first, up to that plan's limits. The secondary plan will not pay benefits until the primary plan pays or denies a claim. In no instance will the primary and secondary plans pay, in total, more than the actual cost of the healthcare services.

If the other plan does not include a coordination of benefits or non-duplication provision, that plan will be primary.

The following are the provisions for determining which plan will be "primary":

Description	Primary	Secondary
Active Employee Note: If employee is covered as an "employee" under two plans, the plan covering the employee for the longest period of time is considered the primary plan.	Teamsters Local 170 Health and Welfare Fund	Other Health Plan
Dependent spouse with other coverage as "active employee"	Other Health Plan	Teamsters Local 170 Health and Welfare Fund
Active Employee & Spouse with children: both parents' health plans cover children	Follow birthday rule*	Follow birthday rule*
Active Employee, divorced or separated, both parents' health plans cover children with court order	Follow court decree	Follow court decree

*Under the birthday rule, the plan of the parent whose birthday falls earliest in the calendar year is the child's primary plan. If both parents have the same birthday, the parent who has been covered longer has the primary plan. If the other plan does not have the birthday rule, then the rule in the other plan will determine which is primary.

- If parents are divorced or separated and both parents' plans cover a dependent child, benefits for the child are determined in this order:
- First, the plan of the parent with custody;
- Then, the plan of the stepparent (spouse of the parent with custody of the child); and
- Finally, the plan of the parent not having custody of the child.

Active/Inactive Employee

The benefits of a plan, which covers a person as an employee who is neither laid off nor retired, are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retired employee and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine which plan is primary.

Where the determination cannot be made in accordance with other provisions in this section, the plan that has covered the Plan participant for the longer period of time will be primary.

The term "plan" as used in this section means any of the following that provide benefits for services, for or by reason of, medical or dental care or treatment:

- Any health plan which provides services, supplies, or equipment for hospital, surgical, medical, or dental care or treatment, or prescription drug coverage, including, but not limited to, coverage under group or individual insurance policies, non-profit health service plans, health maintenance organizations, self-insured group plans, pre-payment plans, and Medicare as permitted by federal law. This does not include hospital daily indemnity plans, specified diseases-only policies, or limited occurrence policies that provide only for intensive care or coronary care in the hospital.

- Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under SCHIP Title XXI or Medicaid Title XIX (grants to States for Medical Assistance Programs of the United States Social Security Act as amended). It also does not include any law or plan when, by law, its benefits are in excess to those of any private insurance program or other non-governmental program.

- Any individual automobile no-fault insurance plan.

- Any labor-management trusted plan, union welfare plan, employer organization plan, or employee benefit organization plan.

Each plan or other arrangement for coverage outlined immediately above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

For the purpose of this provision, BCBSMA or Davis Vision, without consent or notice to any person, release to or obtain from any insurance company or other organization or person any information that may be necessary regarding coverage, expenses, and benefits.

Participants claiming benefits under the Plan must furnish BCBSMA and Davis Vision such information as may be necessary for the purpose of administering this provision.

Where any medical payment sums are applicable under any coverage, including but not limited to, automobile and premises liability policies, the limits of any such coverage must be applied to related claims before any benefits will be provided under this Plan.

Medicare Coordination

The Plan is the primary payer for an active employee, active employee's spouse, and active employee's dependent child that is also covered by Medicare.

Medicare is the primary payer for a retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is:

- Age 65 or older

- Under age 65 with Social Security disability; or
- Under age 65 with end-stage renal disease after the first 30 months of Medicare eligibility

If the participant does not elect Medicare Part A or B, benefits will be reduced as though Medicare is the primary payer. The Plan will calculate the benefits assuming the participant has Medicare A and B.

A surviving spouse or dependent of a retired employee or surviving spouse age 65 or older is assumed to have Medicare Part A and B regardless of that participant's Medicare eligibility. The Plan will calculate benefits assuming the participant has Medicare Part A and B.

If a retiree is retroactively approved for Medicare due to Social Security disability, the Plan will update their records to reflect Medicare as the primary coverage effective the date of Medicare eligibility. The Plan will also refund any overpayment of premiums and reprocess claims to calculate the benefit as secondary to Medicare.

Medicare Coordination – End-Stage Renal Disease

The Plan is the primary payer for:

- An active employee or employee's dependent spouse or child with end-stage renal disease during the first thirty (30) months of Medicare eligibility solely by reason of end-stage renal disease (Medicare is primary after the first 30 months).
- A retired employee, surviving spouse, or retired employee's or surviving spouse's dependent spouse or child under age 65 with end-stage renal disease during the first 30 months of Medicare eligibility.

Medicare is the primary payer for:

- An active employee or employee's dependent spouse or child with end-stage renal disease after the first 30 months of Medicare eligibility solely by reason of end-stage renal disease
- A retired employee, surviving spouse, or dependent of a retired employee or surviving spouse who is under age 65 with end-stage renal disease after the first 30 months of Medicare eligibility.
- If the participant does not elect Medicare Part A, B, or D, benefits will be reduced as though Medicare is the primary payer. The Plan will calculate benefits assuming the participant has Medicare A, B, and D.

Uniformed Services Reemployment Rights

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums in the manner specified by the Plan Sponsor.

If you do not elect to continue to participate in a group health plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage for the 18-month period that begins on the first day of your leave of absence. You must pay the premiums for continuation coverage with after-tax funds, subject to the rules that are set out in the Plan.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Set forth below is more information about your COBRA rights. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Family Medical Leave Act ("FMLA")

If you take a leave of absence (i) for your own serious health condition, (ii) to care for family members with a serious health condition, (iii) to care for a newborn or adopted child, (iv) to care for an injured or ill covered service member of the Armed Forces, or (v) due to a qualifying exigency arising out of a covered service member's active duty, you may be able to continue your health coverage under the Plan. If you drop your health coverage during the leave, you can also have your health coverage reinstated on the date you return to work assuming you pay any contributions required for the coverage.

COBRA

Introduction

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **The following generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your COBRA rights and obligations under the Plan and under Federal law, you should ask the Plan Administrator.

The Participant, his Spouse and other eligible Dependents may continue eligibility for benefits for specified periods set forth below by making self- payments at the rates determined by the Trustees where eligibility would have otherwise terminated as a result of a "Qualifying Event."

Benefits Provided

When a Participant or Qualified Beneficiary elects COBRA Continuation Coverage, he must select a Schedule of Benefits. An individual electing COBRA Continuation Coverage will be eligible for the same benefits provided under the Schedule of Benefits that he was covered by on the date coverage

otherwise would have terminated as a result of the Qualifying Event. However, individuals electing COBRA may select benefits provided under any lower Schedule of Benefits offered by the Fund. The individual may not change the Schedule of Benefits selected once COBRA Continuation Coverage has begun.

Core and Non-Core Benefits

If an individual is covered under a Schedule of Benefits which provides dental and vision care benefits, he may reject coverage for such and select only medical and prescription drug coverage. An individual must be provided medical coverage (core benefits), including prescription drug coverage, but may reject dental and/or vision benefits (non-core benefits).

Non-Medical Benefits Not Covered

COBRA Continuation Coverage does not provide coverage for non-Medical Benefits. Consequently, Life Insurance Benefit, the Spousal Burial Benefit, Dependent Burial Benefit, the Accidental Death and Dismemberment Benefit, the Short-Term Disability Benefit and certain Wellness Benefits are not provided under COBRA Continuation Coverage.

If, after the Reinstatement of Active Coverage Eligibility, there is another Qualifying Event, the individual may elect COBRA Continuation Coverage and may elect among applicable Schedules of Benefits.

COBRA Continuation Coverage

Eligibility

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the group health plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the group health plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the group health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the group health plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as an Eligible Dependent.

Notification

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or entitlement of the employee to Medicare (Part A, Part B, or both), the member must notify the Plan Administrator within 60 days of the date you would otherwise lose coverage under a group health plan due to a qualifying event, whichever is later.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The group health plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs or the date you would otherwise lose coverage under a group health plan due to a qualifying event, whichever is later. You must send this notice to the Plan Administrator in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator."

Election

Within 30 days of the Plan Administrator receiving notice (in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator") that a qualifying event has occurred, the Plan Administrator will send out an election notice, offering COBRA continuation coverage to each of the qualified beneficiaries.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that group health plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

The maximum COBRA continuation coverage period is 24 months for employees on military leave who are covered by USERRA.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended (see below).

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the group health plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the latest of the date of the determination, the date of the qualifying event or the date you would otherwise lose coverage under a group health plan due to a qualifying event, and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator."

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, and such event would result in loss of health coverage if the first qualifying event had not already occurred, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, becomes entitled to Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the group health plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event or the date you would otherwise lose coverage under a group health plan due to a qualifying event, whichever is later. This notice must be sent to the Plan Administrator in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator."

Furnishing Notice to Plan Administrator

YOU SHOULD FOLLOW THESE PROCEDURES WHEN NOTIFYING THE PLAN ADMINISTRATOR OF A QUALIFYING EVENT OR A DISABILITY DETERMINATION. FAILURE TO FOLLOW THESE PROCEDURES MAY CAUSE LOSS OF COVERAGE.

When furnishing a notice to the Plan Administrator with respect to the occurrence of a qualifying event or with respect to a disability determination by the Social Security Administration, such notices must be delivered to the Plan Administrator (i) by hand-delivery, (ii) via facsimile (iii) first class mail, or (iv) by registered or certified mail, return receipt requested. Such notices must include the name(s) of the covered employee and/or qualified beneficiaries, as applicable, a general description of, and circumstances surrounding, the qualifying event or disability determination, and the date of such qualifying event or disability determination. Once the Plan Administrator receives such notice, it reserves the right to make further inquiry to verify the circumstances surrounding such qualifying event or disability determination.

Payment of Premiums for COBRA Continuation Coverage

In order to remain eligible for COBRA Continuation Coverage, an individual must pay the premium for such coverage by the premium due date as described below:

First Premium

The first (1st) monthly premium for COBRA Continuation Coverage (which includes payment of the premiums for each month from the date coverage would otherwise have terminated through the month in which payment is made), must be paid to the Fund no later than forty-five (45) days after the date on which an individual elects such coverage;

Subsequent Premiums

The premium due date for all subsequent monthly premiums is the first (1st) day of the calendar month for which COBRA Continuation coverage is being obtained; provided, however, that a monthly premium for any particular month shall be considered to be timely made so long as it is received by the Fund by the thirtieth (30th) day of such month ("grace period").

Amount of Premium

The Fund will charge a monthly premium for COBRA Continuation Coverage

The Board of Trustees, on an annual basis, will establish the monthly premiums to be charged for such coverage for each Schedule of Benefits offered by the Fund. The amount of the premium shall be based on single, two (2) persons or family coverage and shall not exceed one hundred and two percent (102%) of the Fund's actual cost for providing benefits to similarly situated individuals, as determined by the Fund's actuary. The premium shall not exceed one hundred fifty percent (150%) of such actual cost for all months of COBRA Continuation Coverage after the eighteenth (18th) month for a Participant whose coverage was extended under the special disability rule set forth in the previous section.

The Fund will credit the Participant for the dollar amount of all Contributions actually made on his behalf in any month by any participating Employer provided that a Participant who elects COBRA continuation coverage at a lower Schedule of Benefits than that provided by his Employer's contributions shall not be entitled to any cash refund in excess of the cost of the COBRA Schedule of Benefits and shall not have any Employer contributions credited from one month to the next.

For any Participant who elects COBRA coverage at the same Benefit Schedule as provided by his Employer's contribution, the first week of Employer contribution paid on his behalf in any month shall be credited as 2 weeks of contribution.

Types of Premiums

Core coverage, or if eligible, core and non-core coverage, shall be offered.

End of Continuation Coverage

Continuation coverage will end earlier that the period elected if:

- Timely payment of premiums for the continuation coverage is not made;

- The qualified beneficiary first becomes covered under any other group health plan, after the COBRA election, as an employee or otherwise;
- The qualified beneficiary first becomes entitled to benefits under Medicare, after the COBRA election;
- The Plan Sponsor ceases to provide any group health plan to any employer ;
- You, as the covered employee, cease to be disabled, if continuation coverage is due to your disability; or
- The period of continuation coverage expires.

Health Insurance Marketplace

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

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

VII. HIPAA PRIVACY PROVISIONS

Your Rights under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that helps protect the continuity of health benefits coverage. HIPAA:

- Limits exclusions for pre-existing medical conditions
- Credits prior health coverage in the form of certificates

- Prohibits discrimination in enrollment or in premiums charged, based on health-related factors
- Guarantees renewability of health insurance coverage in the group insurance markets
- Preserves the states' role in regulating health insurance

HIPAA helps individuals who lose coverage under one health plan get coverage under another plan, in cases where that second plan may contain "pre-existing condition" exclusions. HIPAA requires the "second plan" to reduce the length of its pre-existing exclusion period by the amount of time the individual was covered under the previous plan.

Since the Teamsters Local 170 Health & Welfare Plan does not have "pre-existing condition" limitations, Participants who lose Teamsters Local 170 eligibility and are looking for new coverage may encounter this problem for the first time. HIPAA entitles individuals to get a "certificate" from their previous plan that documents the length of their prior health coverage. This certificate can then be used to reduce whatever pre-existing condition exclusions might be imposed by the new plan. This HIPAA certification requirement applies only when you or your dependents(s) lose eligibility for Teamsters Local 170 health benefits.

For members who lose eligibility, Teamsters Local 170 Health &Welfare Fund will issue a certificate under the following circumstances:

- Automatically
    - When certification is required under HIPAA
    - When an individual who is losing eligibility under the Plan is not entitled to COBRA
    - When an individual has been covered by COBRA, but then COBRA coverage ends this is true even when the individual may have previously received a certificate verifying earlier, pre-COBRA coverage under Teamsters Local 170 Health and Welfare Fund
- Upon request
    - Before losing coverage or within 24 months of losing coverage
    - If you need such a certificate, please call Teamsters Local 170 Health and Welfare Fund see Appendix 2 for contact information.

HIPAA PRIVACY PROVISIONS

Disclosure of Information

The Plan Sponsor may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. §164.501) as permitted by the "Standards for Privacy of Individually Identifiable Health Information" under the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, and applicable guidance (the "Rule").

The Plan will disclose Protected Health Information to the Plan Sponsor only upon its receipt of a

certification by the Plan Sponsor that the Plan has been amended to incorporate the following provisions and that the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

- Ensure that any agents, including subcontractors, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

- Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Rule of which it becomes aware;

- Make available Protected Health Information based on HIPAA's access requirements in accordance with 45 C.F.R. §164.524;

- Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;

- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Rule;

- If feasible, return or destroy all Protected Health Information received from the Plan that the Plan 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, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- Ensure that adequate separation of the Plan and the Plan Sponsor is established as required by 45 C.F.R. 164.504(f) (2) (iii) as described below.

There are some special rules under HIPAA related to "electronic protected health information." Electronic health information is generally protected health information that is transmitted by, or maintained in, electronic media. "Electronic media" includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

Please be advised that, as required by HIPAA, the Plan will take additional action with respect to the implementation of security measures (as defined in 45 C.R.F. 164.304) for electronic protected health information. Specifically, the Plan will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

- Ensure that the adequate separation required to exist between the Plan and the Plan Sponsor is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;

- Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect that information;

- Report to the Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information systems; and

- Comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic protected health information by the issuance of additional regulations or other guidance pursuant to HIPAA.

Certification of Plan Sponsor

The Plan (or a health insurance issuer with respect to the Plan if applicable) will disclose Protected Health Information to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR 164.504(f) (2) (ii). The Plan will not disclose and may not permit a health insurance issuer to disclose Protected Health Information to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 CFR 164.520(b)(1)(iii)(C) is included in the appropriate notice.

Separation of Plan and Plan Sponsor

The following employees (or classes of employees) or other persons under the control of the Plan Sponsor will be treated as the workforce of the Plan Sponsor and are permitted to have access to Protected Health Information disclosed by the Plan ("Permitted Employees"):

- The Fund administrator, Fund employees
- Board of Trustees
- HIPAA Privacy and Security Officers and their delegates.

Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business, will also be included in the definition above of Permitted Employees.

Permitted Employees

The Permitted Employees may only use the Protected Health Information for Plan administrative functions that the Plan Sponsor performs for the Plan.

HIPAA Notice of Privacy Practices

The Plan Sponsor or the group health issuers maintain a HIPAA Notice of Privacy Practices that provides information to individuals whose protected health information will be used or maintained by the Plan. This notice can be found in the Appendix to this document.

VIII. ADDITIONAL PLAN INFORMATION

Your Rights Under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

- Obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;

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

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan, particularly the rules governing your COBRA continuation coverage rights; and

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called

"fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants. No one, including the Plan Sponsor or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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, if for example, it finds your claim is frivolous.

Assistance with Your Questions: If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical

Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also visit their website at www.dol.gov/ebsa.

IX. BENEFITS

General

The Local 170 Health and Welfare Fund provides a bundled plan of benefits consisting of medical benefits, dental benefits, life insurance benefits, accidental death and dismemberment insurance benefits, short-term disability income benefits, prescription drug benefits, spousal burial benefits, dependent life benefits, vision benefits and certain wellness benefits. The Fund files a form 5500 each year, as required by ERISA, and identifies itself as one plan. Participating Employers are required to make contributions on behalf of their Employees as a condition of plan coverage.

The Plan Administrator establishes a minimum rate of contribution for each tier of benefits and the Union and the participating Employers engage in contract negotiations including the cost and benefit of participating in the Fund. Each company has the opportunity to negotiate the tier of benefits, as described hereafter. All benefits are bargained and paid for as one package. Once negotiated, the Employees individually select which medical care provider network they desire to utilize in the Blue Cross Blue Shield network. The medical networks are very similar in size; the standard of care is equally comprehensive and employees are provided with excellent medical and prescription drug benefits in both plans. All participants and dependents are offered dental benefits as administered by Blue Cross Blue Shield MA, and vision benefits administered by Davis Vision.

Further, each active Employee is automatically provided welfare benefits. It is, and has been the intention of the Plan Administrator, that the health and welfare benefits of the Plan encompass and constitute one benefit plan for ERISA purposes. The plan has one name, the Teamsters Local 170 Health and Welfare Plan.

WELFARE BENEFITS

Life Insurance Benefit – ACTIVE EMPLOYEES ONLY

The Fund has procured group life insurance coverage from Symetra Life Insurance Company (Symetra), which provides fifty thousand dollars ($50,000) in coverage for active full time employees and twenty-five thousand dollars ($25,000) for active part time employees. The coverage applies only to active employees. **Retired Employees and Dependents are not provided the life insurance benefit.** Active employees are automatically enrolled in this plan when they meet eligibility requirements. Payment will only be made by Symetra if all terms and conditions of the policy have been satisfied. **Consequently, the terms, conditions and exclusions of the life insurance policy shall in all respects govern the payment of benefits.** A copy of the life insurance benefit plan can be found in Attachments #7 and #8.

Filing a Life Insurance Claim

To file a life insurance claim:

- A family member must call Teamsters Local 170 Health and Welfare Fund and ask for the appropriate claim form
- Teamsters Local 170 Health and Welfare Fund will send the claim form to the designated beneficiary
- The beneficiary completes and returns the form to the Teamsters Local 170 Health and Welfare Fund
- A certified copy of the death certificate must be provided

- See attachments #7 and #8 which describe the Plans Claims and Appeals procedures for filing claims and appeals for life insurance benefits

Facility of Payment

If, at the time of death, there is no designated Beneficiary with respect to all or any part of the Life Insurance Benefit, or if the designated Beneficiary does not survive the Participant, the Life Insurance Benefit (or any portion thereof) for which there is no designated Beneficiary will be paid in the following order of priority to the Participant's:

- Executor/Administrator; or
- Spouse; or
- Child or Children (in equal shares); or
- Mother and or Father (in equal shares)

Beneficiary Form

A Participant may designate or change the name of his Beneficiary by filing a written, signed and witnessed request in a form satisfactory to the Fund Office. No change of Beneficiary will take effect until received by the Fund. When the change has been received, however, regardless of whether the Participant is then living or not, it will take effect as of the date of execution of the written request but without prejudice to the Fund on account of any payment made or any action taken or permitted by the Fund or its life insurance carrier before receipt of the request. Consent of the Beneficiary will not be required to change the Beneficiary.

Limitations

No payment shall be made for any loss which is excluded by Symetra Life Insurance Company Plan found in the Attachments #7 and #8 to this document.

Converting Teamsters Local 170 Health and Welfare Fund Life Insurance to an Individual Policy

If your Teamsters Local 170 Health and Welfare Fund Life insurance ends for any reason, you can "convert" from Teamsters Local 170 Health and Welfare Fund to an individual policy. You will need to pay the premiums for this continued coverage.

To convert, you will not need to show evidence of insurability. However, you must apply for the conversion by completing a notice of Conversion Right Form within 31 days after your active Teamsters Local 170 Health and Welfare Fund coverage ends or within 15 days after the Fund signs the form, whichever is later. No request for conversion will be accepted if these forms are not received Symetra Life Insurance Company more than 91 days after your coverage with the Fund ends.

In addition, if you should die anytime during the 31-day conversion period Symetra will pay to your designated beneficiary the full amount of insurance you would have been entitled to convert.

The conversion rights provided to you are subject to the terms and conditions set forth in attachments #7 and #8 of this Summary Plan Description.

Accelerated Death Benefit Option-Active Employees Only

Teamsters Local 170 Health and Welfare Fund offers a special life insurance option that applies if you are under age 60 and certified by a doctor as being terminally ill and your illness is caused by a condition that is reasonably expected to result in a drastically limited life span of 24 months or less.

To help with some of the emotional and financial burdens that can occur at such a time, you are eligible to receive up to 80% of your total $50,000 for full time employees or 80% of your total $25,000 for part time employees while living. This option may only be exercised once. There are no restrictions on how to use the money you receive.

The accelerated death benefit is provided to you is subject to the terms and conditions set forth in attachments #7 and #8 of this Summary Plan Description

Life Insurance Benefits if You're Disabled – Waiver of Premium

Waiver of Premium is a provision which allows you to continue your life insurance coverage without paying premium while you are disabled and qualify for waiver of premium.

Disabled, means you are prevented by injury of sickness from doing any work for which you are, or could become qualified by: 1) education, 2) training or 3) experience. In addition, you would be considered disabled if you have been diagnosed with a life expectancy of 24 months or less.

The waiver of premium benefit is provided to you is subject to the terms and conditions set forth in attachments #7 and #8 of this Summary Plan Description.

Accidental Death and Dismemberment Benefit - ACTIVE EMPLOYEES ONLY

The Teamster Local 170 Health and Welfare Fund Accidental Death and Dismemberment (AD&D) Insurance Benefit provides the active employee with additional life and accident insurance protection. AD&D coverage is provided for the active employee only. Retired Employees and Dependents are not eligible for this benefit.

The Fund has procured group Accidental Death and Dismemberment coverage from Symetra Life Insurance Company. Symetra shall pay those benefits in accordance with the terms and conditions of the Symetra policy. If an active employee suffers certain kinds of serious injury as a result of an accident,

Symetra pays the AD&D benefit to the active employee. If an active employee dies as a result of an accident, the AD&D insurance pays a benefit to the beneficiary designated by the active employee. The Plan provides this AD&D benefit in addition to the normal life insurance.

AD&D Basic Benefits

If you sustain an injury that results in any of the following losses within 365 days of the date of accident, you will be paid the amount of the principal sum, which is $50,000.00 for full time active employees or $25,000.00 for Part time employees, or a portion of the principal sum, as shown opposite the loss.

Loss	**Benefit**
Loss of Life	Principal Sum
Loss of Both Hands or Both Feet	Principal Sum
Loss of Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Sight of One Eye	One-half Principal Sum
Loss of Thumb and Index Finger of either Hand	One-quarter Principal Sum
Quadriplegia (movement of both upper and lower limbs)	Principal Sum
Triplegia (movement of three limbs)	Three-quarters Principal Sum
Paraplegia (movement of both lower limbs)	Three-quarters Principal Sum
Hemiplegia (movement of the upper and lower limbs of one side of the body)	One-half Principal Sum
Loss of Speech or Hearing (both ears)	One-half of Principal Sum
Loss of One Hand or One Foot	One-half of Principal Sum
Uniplegia (movement of one limb)	One-fourth Principal Sum

The Plan has certain technical definitions of the particular losses, limbs, or faculties identified above. If you need specific information on any of the occurrences described above contact the Fund office (see attachments #7 and #8 of this Summary Plan Description). It is important to note that the maximum AD&D benefit for any one accident is $50,000.00 for active full time employees and $25,000.00 for active part time employees.

The terms, conditions and exclusions of the accidental death and dismemberment insurance policy shall in all respects govern the payment of benefits. A copy of the Accidental Death and Dismemberment Benefit Plan can be found in Attachment #7 and #8.

Limitations

No payment shall be made or any loss which is excluded by the AD&D benefit plan found in the Attachments #7 and #8 of this document.

Additional Provisions

There is coverage for additional benefits, including a repatriation benefit, seatbelt coverage and an education benefit. These benefits are subject to the terms and conditions of the plan which can be found in the Attachments #7 and #8 to this document.

Short Term Disability Income Benefit- ACTIVE EMPLOYEES ONLY

If while eligible for benefits, an active Employee becomes totally disabled and therefore is unable to perform the duties of his occupation or employment because of a non-occupational injury or illness, the Fund shall pay Short Term Disability Income Benefits to the Employee. A participant will be considered totally disabled when as a result of a non-occupational injury or illness, he is unable to perform duties of his occupation, as documented by a treating physician's orders. Such payments will be made for the period that begins as described in Section labeled "Commencement" below, and ends as described in Section labeled "Termination". Pregnancy, child birth and related medical conditions are considered an eligible disability for weekly disability benefits for the duration that it is deemed medically necessary.

Commencement

The period for which Short-Term Disability Income Benefits are payable shall begin as follows:

In the case of an Injury or Illness, on the eighth (8^{th}) day that the Employee becomes totally disabled. Documentation of the treatment by a Physician must be submitted to the Fund Office.

Termination

The period for which Short Term Disability Income Benefits are payable shall end on the earlier of:

- The last day that the Employee is disabled as described above;
- The day the Employee has exhausted the maximum of twenty-six (26) weeks of benefits in a fifteen (15) month period;
- The date the Employee retires, regardless as to whether the member receives a pension; or
- The day the Fund does not timely (14 days from the date the same is due) receive the supplemental form required from the disabled Employee's physician.

Limitations

No payment shall be made:

- For any employment related illness or injury; or

- For any period during which the Employee is not undergoing regular treatment by a Physician for a disability; or

- For any period during which the Employee works for wages or profit; or

- To or for anyone who contributed to his or her injury by: a) operating a motor vehicle while under the influence of alcohol, marijuana, or any narcotic drug, or b) while committing a felony or seeking to avoid arrest by a police officer; or c) with the specific intent of causing injury to himself or others.

Benefits

Full time active Employees will be paid 75% of their gross weekly wage to a maximum of three hundred fifty dollars ($350) or four hundred fifty dollars ($450) per week. The maximum weekly benefit is determined by the tier of benefits of the disabled Employees Collective Bargaining Agreement. Full time tier 1 Employees are paid a short-term disability benefit equal to 75% of the gross weekly wage up to four hundred fifty dollars ($450) per week. Otherwise, the disabled Employee will be provided 75% of his gross weekly wage up to three hundred fifty dollars ($350) per week. The 75% benefit is to be calculated based upon the disabled Employees average thirteen (13) week gross pay immediately prior to the covered incident.

Part time Employees will be provided a short-term disability benefit equal to 75% of their gross weekly wage to a maximum of two hundred dollars ($200) per week. The 75% benefit is to be calculated based upon the disabled Employees average thirteen (13) week gross pay immediately prior to the covered incident.

Continuation of Benefits If You Become Disabled

For the first four (4) weeks of disability, your Employer (if set forth in the applicable Collective Bargaining Agreement) is required to contribute to the Fund at a rate of 32 hours per week, for a full-time employee and 16 hours per week for a part- time employee. After the first four (4) weeks of disability, the Fund Office will credit full-time employees 30 hours per week and part-time employees 17 hours per week.

Active Employee Benefit

Only active Employees are eligible to receive Short Term Disability Income Benefit.

Timeliness of Claims

Disability claims must be submitted to the Fund Office within sixty (60) days of the date of disability. Claims submitted after sixty (60) days will not be paid.

Disability Resulting from Motor Vehicle or Motorcycle Accident

If you have a disability claim related to a motor vehicle or motorcycle accident, you, or someone acting on your behalf, must notify the Fund as soon as possible. The Fund's coverage varies with a number of factors. If you are involved in a motor vehicle accident covered by a no-fault insurance carrier, initial the no-fault insurance will be liable for weekly disability benefits up to the first $8,000 of expenses related to the accident, as required by law. The Fund will also be liable for weekly disability benefits up to the maximum of 26 weeks, including the weeks paid by the auto insurance carrier. For example; if the no-fault carrier pays 12 weeks of disability payments the Fund may pay additional 14 weeks of disability payments for a maximum benefit of 26 weeks. In order to collect disability benefits you must provide a copy of the Police Report and/or a copy of your accident report. No disability benefits will be paid without this information. You must also provide a completed form and a completed and signed Subrogation, Assignment of Rights Reimbursement Agreement.

Spousal Burial Benefit- ACTIVE EMPLOYEES ONLY

The Fund presently self-insures and provides a Spousal Burial Benefit of Three Thousand Dollars ($3,000). The Fund shall pay this benefit if:

- The active Employee as defined in this Summary Plan Description must be actively employed by an Employer at the time of his Spouse's death;
- The active Employee must be legally married at the time of his Spouse's death;
- The active Employee or his representative must provide a death certificate of his Spouse to the Fund Office.

Upon receipt of a certified death certificate, the Fund shall pay the active Employee the sum of Three Thousand Dollars ($3,000).

Only active Employees are eligible to receive the Spousal Burial Benefit.

Dependent Child's Life Benefit-ACTIVE EMPLOYEES ONLY

The Fund presently self-insures and provides a Dependent Child's Life Benefit of Three Thousand Dollars ($3,000). The Fund shall pay this benefit if:

- The active Employee as defined in this Summary Plan Description must be actively employed by an Employer at the time of his Dependent Child's death;
- The active Employee or his representative must provide a death certificate of his Dependent Child to the Fund Office

Upon receipt of a certified death certificate, the Fund shall pay the active Employee the sum of Three Thousand Dollars ($3,000).

Only active Employees are eligible to receive the dependent Child Life Benefit.

Wellness Programs

The Fund may provide wellness benefits or programs (a Welfare Benefit) subject to the provisions of the Patient Protection and Affordable Care Act, the Genetic Information Nondiscrimination Act, ERISA, the Internal Revenue Code and HIPAA. By way of example these programs may be subject to reasonable design limitations; voluntary participation; limits on incentives; and information subject to confidentiality

requirements. Presently, the Plan provides certain wellness benefits programs in conjunction with Blue Cross Blue Shield MA, who administer the programs. The Fund shall pay for the cost and expense of any Wellness Program/Benefit provided to the Participants and their dependents. In addition, the Fund shall pay the rewards and or incentives established by such a program to the Participants and their dependents, subject to any limitations or requirements set forth in the particular Wellness Program.

HEALTH BENEFITS

Medical, Dental, Pharmacy and Vision Claims Administrators

The Fund does not process or administer medical, dental, pharmacy or vision claims. The Board has contracted with two (2) separate organizations to provide administrative services, such as claims processing, individual case management, utilization review, quality assurance programs, claim review and other related services and to arrange for a network of health care providers and/or prescription drug providers whose services are covered by this Plan. The names and addresses of the two (2) organizations are:

Blue Cross Blue Shield of Massachusetts, Inc.
401 Park Drive
Boston, Massachusetts 02199
1-800-217-7878
www.bluecrossma.com

Live Support: 1-800-999-5431

Davis Vision Inc
175 East Houston Street
San Antonio, Texas 78205
1-800-328-4728

www.davisvision.com

Customer Relationship and Information Technology Center
Capital Region Health Park, Suite 301
711 Troy-Schenectady Road
Latham, New York 12210

None of these organizations serve as an insurer, but rather, serve as claims processors. Claims for benefits or services are sent to these organizations. They process the claims, then request and receive funds from the Plan to pay these claims, and they in turn, make payment to doctors, hospitals and other providers. Each of the organizations has sole and complete discretionary authority to determine claims and appeals in accordance with the terms of the documents or instruments governing the plan in which you are enrolled.

Medical Benefits and Pharmacy Benefits

The Benefits set forth hereinafter describe summarily the medical and pharmacy benefits to be provided to Participants and their Dependents. The Fund shall pay for the medical benefits and Pharmacy benefits

described in a Participant's Schedule of Benefits and applicable Benefit Description documentation (including Riders) as provided by Blue Cross Blue Shield subject to all of the limitations contained therein, including deductibles, co-payments, co-insurance, benefit limitations, pre-authorization requirements, referral requirements, other utilization management requirements, referral requirements, advance notice requirements and the limitations imposed in Article 4 ("General Limitations"). Further the Fund shall pay for vision benefits to be provided to Participants and their Dependents as described by Davis Vision documents including the Vision Care Plan Benefit Description. See attachment #6.

Pharmacy benefits are provided as part of all Blue Cross Blue Shield plans for participants and their dependents who enroll in a Blue Cross Blue Shield Plan. Blue Cross Blue Shield partners with CVS Caremark as the Pharmacy Benefit Manager for its Pharmacy Plans. Blue Cross Blue Shield/CVS is responsible for all aspects of the prescription drug plan including formulary development, claims processing and customer service. In general, the benefits are substantially similar although there may be differences in the list of drugs covered, the drug tier levels etc.

Coverage Tiers

The Plan establishes two tiers or levels of coverage, Tier 1 and Tier 2. Your Collective Bargaining Agreement establishes your tier of coverage and all employees eligible for coverage will be allowed to elect coverage from that tier/level. Retired Employees (ages 57-65) will be eligible for Tier 1 coverage.

Plan Choices and Types

The Plan provides medical plan choices from which active employees, COBRA participants, retired Employees (ages 57–65) and eligible spouses can choose.

Through Teamsters Local 170 Health and Welfare Fund, your health plans are administered for the Fund by Blue Cross Blue Shield of MA Health Plan. These plans all have networks of providers or providers that participate in their plans. For some of these plans (HMOs), you must see a participating in-network provider or no coverage is allowed. Other plans (PPO and POS plans) allow you to have services performed by non-participating providers but the amount you pay out of your pocket (deductibles, co-pays and/or co-insurance) will be higher.

Plans may also have different levels of coverage depending on the specific participating provider you see within the network, with higher copayments for services you receive from different levels/categories of providers. In addition, plans may require you to choose a primary care provider (PCP), who is responsible for coordinating your health care and providing referrals to specialists. For some plans, if a referral is not received from your primary care provider, no coverage is allowed at all while with other plans you may be required to pay a higher copay if you don't receive a referral from your designated PCP.

Provider Networks

All of the Plans offered use a provider network or a group of physicians, hospitals and/or other health care providers who agree to accept a negotiated payment or fees (allowable charge) for services provided to Plan members. Network providers also agree to file the claims on behalf of Plan members. Blue Cross Blue Shield is responsible for recruiting, credentialing, and communicating with providers.

Participants are encouraged to check the network status of their physician and hospital prior to, and each time they obtain a covered service. Hospitals and physicians may from time to time, change their status under the Plan. Consultation should be made to the most current version of the Blue Cross Blue Shield provider directories. Participants are encouraged to call the Blue Cross Blue Shield Customer Service line at 1-800-821-1388 or use the online physician directory at www.bluecrossma.org to determine the status of their provider or to find a network provider.

Member Costs

For all plans, you will pay a copay for office visits to in-network providers. For some specific and limited preventive services, you will not have a copay. You may also have a co-payment for in-patient and out-patient hospital services and other types of services such as x-rays, MRIs and other diagnostic imaging or laboratory tests. The amount you pay for a copayment in-network may depend on the category level of in-network provider you receive services from.

If you visit an out-of network provider, some plans will not allow coverage at all while others will require co-insurance or a percentage dollar amount that you will be responsible for if you choose to visit an out-of network provider.

Plans may have deductibles. This is a dollar amount that you will be required to pay before coverage begins. In addition, a plan may limit the amount you pay out of pocket.

Prior-Authorization and Utilization Management

In order to ensure that care is medically necessary, Plans may require prior-authorization or pre-approval for some services and may implement individual case management or other utilization management procedures for certain conditions/treatment. In certain cases, no payment will be provided if the appropriate process is not followed or if the treatment is not considered to be medically necessary. In addition, plans may limit the number of days or the frequency of certain procedures if the care is not found to be medically necessary.

Plans may also implement disease management programs for members with specific risk factors and/or disease states. Plans may contact you via mail, phone or electronic means regarding your condition and/or gaps in care, appropriateness of care and/or other issues related to your care. In addition, plans may limit the use of experimental or investigational services/care. In general, plans have committees that meet periodically to review new or investigational services/drugs etc. to determine the safety, efficacy and comparative effectiveness of treatments. You should discuss all treatments with your provider who can help you to determine whether a particular service is covered by the plan. You can also call the plan directly.

For specific plan requirements for pre-service review like for a hospitalization or surgery that is not an emergency, you should check with your health care provider or call Blue Cross Blue Shield member services by phone or check-online for a listing of those services that may require authorization.

Medical Plans Offered

Blue Cross Blue Shield:

Tier 1

- **Blue Choice New England Plan 2-** This is a Point of Service Plan (POS) that uses a network of providers. In this Plan, you must have a referral from your PCP to see specialists or you will have a deductible and/or higher out of pocket costs. You are allowed to have services from out-of network providers but if you do, your out-of-pocket costs will be much higher. You will be required to pay 20% of the cost of care for out-of-network or non-participating providers.
- **Blue Care Elect Preferred PPO-** This is a Preferred Provider Organization (PPO) type plan, which uses a network of providers. With this plan, you are not required to have a PCP referral in order to seek specialty care. This Plan has higher out-of-pocket costs than other plans available. This plan is designed for use by early retirees who live out of state and choose it because there is out-of state coverage.

Tier 2

- **Network Blue New England Options**

  The Network Blue Plan is a Health Maintenance Organization (HMO). In this Plan, you must choose a PCP, you must receive a referral to see specialists and must always use participating providers or no coverage is provided.

  You are afforded the ability to choose, at any time, to utilize Enhanced level of in-network providers (lowest costs to members); Standard level of in-network providers or Basic level of in-network providers (greatest cost to participants and dependents). Cost sharing arrangements vary, depending on the utilization and provider choices made by you.

  Additional information regarding the medical benefits can be found in the Attachments to this SPD (#1, #3) which include the Participant's Schedule of Benefits for Blue Cross Blue Shield. Other materials that describe your benefits in more detail are incorporated by reference in the BCBSMA Benefit Description and its associated riders. Benefits are subject to all of the limitations contained therein, including benefit limitations, pre-authorization requirements and other utilization management requirements, referral requirements, and advance notice requirements.

  Copies of all of these materials can be found on the Fund's website, at the Fund office or can be obtained upon request by calling the Fund office at (800)-447-7730.

Prescription Drug (Rx) Expense Benefit

The Fund provides coverage for prescription drugs through Blue Cross Blue Shield / CVS Caremark. Each plan has a network of pharmacies. Blue Cross Blue Shield / CVS Caremark has an open formulary. In addition, plans may impose other utilization management techniques such as prior-authorization or step-therapy.

Copayments are generally structured in three tiers with Tier 1 being the least expensive for the Participant or Dependent such as generic drugs; Preferred Brand drugs on Tier 2 and Non-Preferred Brand drugs on Tier 3.

Drugs can be purchased at retail or by mail. In general, purchasing drugs by mail provides a savings to the member.

Blue Cross Blue Shield MA Rx Program

Blue Cross Blue Shield MA and CVS Caremark partner as the Fund's Pharmacy Benefit Manager for the Plan's prescription drug program for Participants and dependents enrolled in a Blue Cross Blue Shield Plan.

Blue Cross Blue Shield and CVS Caremark are responsible for:

- Developing and maintain a network of participating pharmacies;
- Negotiating with pharmaceutical manufacturers;
- Managing the prescription drug mail order program/specialty program
- Processing prescription claims from participating pharmacies;
- Processing prescription claims. Establishing and updating which Tier a Drug will be assigned. Blue Cross Blue Shield shall periodically update its pharmacy program;
- Developing and implementing fill requirements, step therapies and prior authorization requirements.

Participants and dependents are provided access to the Blue Cross Blue Shield website at www.bluecrossma.org/medication to get the most current coverage information about a specific medication.

Retail pharmacy access includes most chain and many independent pharmacies. The network is updated regularly. Participants can visit www.bluecrossma.org/pharmacy or call Blue Cross Blue Shield of MA member services number at 1-800-217-7878.

The mail order drug program is provided by CVS Caremark. You will need to visit MyBlue to create a new online account with CVS Mail Service Pharmacy. If you are not already registered on MyBlue you can download the free app at the App Store or you create an account at bluecrossma.org. You will access the Mail Service website via single sign on and complete registration of payment information, enroll in auto refill and select your communication preferences. In addition, you will also have the option to enroll in the mail order program by calling CVS Customer Care team at 877-817-0477.

The specialty mail order drug program is provided by a number of Pharmacies depending upon the specific specialty drug to be administered. A list of specialty medications can be found on the BCBSMA website. Visit the BCBSMA website www.bluecrossma.org select the "Find Care" option followed by "Look up a Medication", then select the "Specialty Pharmacy Medication List" or, contact BCBSMA Member Services at 1-800-217-7878 for additional information.

If you are taking a specialty medication, the BCBSMA pharmacy benefit plan requires that your specialty medication must be filled through one of the specialty pharmacies in the BCBSMA Specialty Pharmacy

Network. Contact one of the specialty pharmacies listed below to arrange for dispensing of your specialty medication and patient education/counseling services.

AcariaHealth
www.acariahealth.com
1-866-892-1202

Accredo
www.accredo.com
1-877-988-0058

CVS Caremark, Specialty Pharmacy
www.cvsspecialty.com
1-866-846-3096

*On-call, after hours' service may also be available by calling the specialty pharmacy customer services toll free number.

Please note that some manufacturers of select specialty medications will only permit certain specialty pharmacies to dispense their specialty products. This is called a "limited distribution drug" (also referred to as "LDD"). If your specialty medication is a limited distribution drug, your doctor should be able to assist you in identifying the specialty pharmacy which can dispense your limited distribution drug. Otherwise, make sure to ask our selected specialty pharmacy if they can dispense your limited distribution drug.

Fertility Pharmacy Network

A list of fertility medications can be found on the BCBSMA website. Visit the BCBSMA website, ww.bluecrossma.org select the "Find Care" option, followed by "Lookup a Medication", then select "Specialty Pharmacy Medication List" Coverage". Or, contact BCBSMA Member Services at 1-800-217-7878 for additional information.
If you are taking a fertility medication, the BCBSMA pharmacy benefit plan requires that your fertility medication be filled through one of the pharmacies in the BCBSMA Fertility Pharmacy Network. Contact one of the fertility pharmacies listed below to arrange for dispensing of your fertility medication and patient education/counseling services:

Freedom Fertility Pharmacy
www.freedomfertility.com
1-866-297-9452

Village Fertility Pharmacy
www.vfppharmacygroup.com
1-877-334-1610

Encompass Fertility by CVS Pharmacy

www.encompassfertility.com
1-855-443-5357

*On-call, after-hours service may also be available by calling the fertility pharmacy customer service toll free number.

Benefits Covered

The following is a list of many of the types of services covered by the medical, pharmacy, dental and vision plans to be provided to Participants and their Dependents and paid for by the Fund. Please note that this list is not exhaustive and for a complete list you should review the schedule of benefits, benefit descriptions, riders and other plan documents provided by each of the plans. In addition, the documents provided by the plans will also provide you a full list of limitations and exclusions. You may call the Fund office or the plans to request the most updated version of any and all documents or go to the Fund website. These include the following documents:

- BCBSMA Benefit Description, associated Riders and the BCBSMA Schedule of Benefits
- Dental Blue Freedom, Summary of Benefits, Benefit Description and Associated Riders (there are separate plans for active employees and their dependents and retired employees and their dependents).
- Davis Vision's Vision Care Plan Benefit Description (attachment #6)

Physician Office Visit Benefit

In General, The Fund shall pay Allowable Physician Office Visit Charges incurred by a Participant and or Dependent if such benefits are provided under the Participant's Schedule of Benefits, such benefits after application of appropriate discounts, co-payments, fee allowances, out-of-pocket maximums and other applicable provisions.

- **Allowable Physician Office Visit Charges** As used in this section, "Allowable Physician Office Visit Charges" shall include the office visit charge, second and third opinions, as well as all lab, x-ray, drugs (i.e. chemotherapy, allergy), administration charges (i.e. vaccines) and all other products or services provided within the confines of and charged by a Physician's office. In addition to charges from a Physician, benefits will be provided for charges submitted by a licensed psychologist, licensed optometrist or ophthalmologist, licensed counselor or social worker, and Registered or Licensed Practical Nurse (other than a member of the Participant or Dependent's family).

Limitations No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Covered Prescription Drugs

In General After application of the appropriate deductibles, discounts, fee allowances, out-of-pocket maximums, Coinsurance or Co-payment and other applicable provisions and in fill limits established in the Participant's Schedule of Benefits, the Plan shall provide Prescription Drug

Expense Benefits to Participants and or Dependents for Allowable Drugs if such benefits are provided under the Participant's Schedule of Benefits.

Allowable Drugs As used in this section, "Allowable Drugs" shall include the following non-Hospital items:

- Drugs and medicines lawfully obtainable upon the written prescription of a licensed Physician;

- Insulin and supplies, including syringes, needles and test materials considered necessary items in cases of a diabetic individual;

- Birth control drugs, hormone replacement therapy drugs (under certain conditions); drugs to treat cancer and drugs to treat HIV/AIDS.

- Drugs that do not require a prescription by law ("over the counter" drugs), if any, that are listed on the Blue Cross Blue Shield plan formulary as a covered drug. The Plan will also cover over the counter preventative medications as required by the PPACA.

- The Fund uses the Blue Cross Blue Shield standard three (3) Tier open formulary. For participants and their dependents enrolled in a Blue Cross Blue Shield Plan, drugs listed by Blue Cross Blue Shield as "non-covered" will be placed in Tier 3 cost sharing arrangement, unless otherwise excluded under the plan benefits.

For a more detailed description of allowable drugs you should review your Schedule of Benefits.

All Allowable Drugs must be purchased at either a participating retail pharmacy or the Fund's appointed mail order prescription drug companies or specialty drug companies.

Controlled Substances No "controlled substance" as defined in the Controlled Substances Act (21 U.S.C.§812) may be purchased from the mail order pharmacy.

Limitations No payment shall be made for:

- Drugs or medicines dispensed only for the purpose of cosmetic purposes;

- Drugs dispensed without first receiving prior authorization, when required, by the Fund's Prescription Benefit Manager, Blue Cross Blue Shield/CVS for Participants and their dependents enrolled in a Blue Cross Blue Shield Plan;

- Drugs or medicines in excess of fill limitations established by Blue Cross Blue Shield/ CVS for Participants and their dependents enrolled in a Blue Cross Blue Shield Plan;

- Drugs dispensed without following the step therapy requirements established by Blue Cross Blue Shield/CVS for Participants and their dependents enrolled in the Blue Cross Blue Shield plan;

- Services, supplies, care or treatment that are experimental or investigational as determined by the plan;

- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description;

- Drugs which are excluded in any formulary established on behalf of the Fund.

For a more detailed description of limitations you should review your Schedule of Benefits.

In addition, Blue Cross Plans, if a participant or dependent purchases a brand name drug when a generic equivalent is available, the participant or dependent is normally required to pay the difference between the cost of the brand name drug and the cost of the generic equivalent drug. See your Schedule of Benefits for a more detailed explanation of this requirement.

Diagnostic X-ray, Imaging and Laboratory Expense Benefit

In General, The Fund shall pay Allowable X-ray/Lab Expenses incurred by a Participant and or Dependent if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket maximums and other applicable provisions. As used in the preceding sentence, the term "Allowable X-ray/Lab Expenses" is defined as expenses for a diagnostic X-ray or laboratory examination as the result of a non-occupational injury or illness. The expenses may include CT scans, MRIs, PET scans and nuclear cardiac imaging tests and other out-patient tests and pre-operative tests.

Limitations No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Surgical Expense Benefit

In General, The Fund shall pay all expenses associated with and the Physician's fee incurred by a Participant and or Dependent for an Allowable Surgical Procedure if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate deductibles, discounts, fee allowances, coinsurance, co-payments, out-of-pocket maximums and other applicable provisions as used in the preceding sentence, "Allowable Surgical Procedure" is defined as a surgical procedure that is performed as a result of a non-occupational Injury or Illness.

Limitations No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Inpatient Hospital Expense Benefit

In General, The Fund shall pay the expenses incurred by a Participant and or Dependent for charges by a Hospital if such benefits are provided under the Participant's Schedule of Benefits and after application of appropriate deductibles, discounts, fee allowances, co-insurances, co-payments, out-of-pocket maximums and other applicable provisions for the following:

- Room and board for each day of hospital confinement;

- Necessary services and supplies for each day of hospital confinement.

Limitations No payment will be made for:

- Personal comfort items;
- Expenses which exceed any benefit limits as forth in the Participant's Schedule of Benefits. For example, a rehabilitation hospital will often limit admissions to a 60day benefit time period, per member, per year; or
- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Emergency Room Benefit

In General, The Fund shall pay the emergency room charge and any related charges incurred as a result of an emergency room visit incurred by a Participant and/or Dependent, if such benefits are provided under the Participant's Schedule of Benefits and after application of the appropriate deductibles, discounts, fee allowances, co-payments, out-of-pocket maximums and other applicable provisions for the following.

Limitations No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Rehabilitation Expense Benefit

In General, The Fund will pay Allowable Rehabilitative Expenses incurred by a Participant and or Dependent, if such benefits are provided under the Participant's Schedule of Benefits, after application of appropriate deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket, out-of-pocket and maximums and other applicable provisions for the Rehabilitation Program connected to the recovery from a non-occupational injury or illness which are medically necessary.

Limitations Allowable Rehabilitative Expenses will not include, and no payment will be made for expenses incurred for:

- Expenses which exceed any benefit limit under the Participant's Schedule of Benefits;
- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Organ Transplant Expense Benefit

In General, The Fund will pay Allowable Organ Transplant Expenses incurred by a Participant and or Dependent if such benefits are provided under the Participant's Schedule of Benefits after deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket maximums and other applicable provisions. As used in the preceding sentence, the term "Allowable Organ Transplant Expenses" is defined as expenses for the transplantation of an organ, patient and donor screening, organ procurement, and transportation of the organ.

Follow Up Care The Fund will pay Follow Up Care Expenses incurred by a Participant and or Dependent if such benefits are provided under the Participant's Schedule of Benefits after application of appropriate deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket maximums, and other applicable provisions.

No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Live Donor Charges

The Fund will pay live donor charges incurred by a Participant and or Dependent, if such benefits are provided under the Participant's Schedule of Benefits; after application of appropriate deductibles, discounts, co-insurance, co-payments, fee allowances, out-of-pocket and other applicable provisions.

Limitations No payment shall be made for:

- Any transplant considered experimental or investigational;
- Expenses for transportation for surgeons or family members;
- Expenses which exceed any benefit limitation as set forth in a Participant's Schedule of Benefits; or
- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Musculoskeletal (Chiropractic) Expense Benefit

In General The Fund shall pay Allowable Musculoskeletal Expenses incurred by a Participant and or Dependent if such benefits are provided under the Participant's Schedule of Benefits after application of appropriate deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket maximums visit maximums, and other applicable provisions. As used in the preceding sentence, the term "Allowable Musculoskeletal Expenses" is defined as expenses for treatment of conditions relating to musculoskeletal problems of the spine, provided that the service or procedure is:

- Medically necessary to treat the musculoskeletal problems

Allowable Musculoskeletal Expenses include, but are not limited to diagnostic lab tests such as blood tests, diagnostic x-ray and other imagine tests, and include manipulation and physical therapy.

Limitations No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Temporomandibular Joint Disorders

The Fund shall pay expenses incurred by a Participant and or Dependent regarding the diagnosis and/or treatment of Temporomandibular Joint (TMJ) disorders if such benefits are provided under

the Participant's Schedule of Benefits and after application of appropriate deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket maximums, and other applicable provisions.

Limitations No payments shall be made for:

- Expenses which exceed any benefit limitation as set forth in a Participant's Schedule of Benefits; or
- Expenses which are excluded as set forth in a Participant's Schedule of Benefits; or
- Treatment expenses will not include and no payment will be made for expenses incurred for: expenses limited in a Participant's Schedule of Benefits. For example TMJ disorders are generally only covered that are caused by or specific medical condition (such as degenerative arthritis and jaw fractures or dislocations); or
- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Preventive Health Services

The Fund shall pay expenses incurred by a Participant and or Dependent regarding preventative health services, if such benefits are provided under the Participant's Schedule of Benefits, after application of appropriate deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket maximums, and other applicable provisions. These benefits may include but are not limited to: routine pediatric care, routine adult exams and tests, routine gyn exams, family planning, routine hearing exams and tests, (including new born hearing screening). There are limitations imposed upon fitness and weight loss benefits as set forth in the Participant's Schedule of Benefits.

Limitations No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Maternity Health Services

The Fund shall pay expenses incurred by a Participant and or Dependent regarding Maternity Health Services, if such benefits are provided under the Participant's Schedule of Benefits, after application of appropriate Deductibles, discounts, Coinsurance, Co-payments, Fee Allowances, out-of-pocket maximums, and other applicable provisions. These maternity services shall include well newborn inpatient care, delivery, pre-natal and post-natal care.

Limitations No payment shall be made for:

- Expenses which exceed any benefit limitation as set forth in a Participant's Schedule of Benefits; and

- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Infertility Services

The Fund shall pay expenses incurred by a Participant and or Dependent regarding infertility services, if such benefits are provided under the Participant's Schedule of Benefits, after application of appropriate deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket maximums, and other applicable provisions.

Limitations No payment shall be made for:

- Expenses which exceed any benefit limitation as set forth in a Participant's Schedule of Benefits; and
- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Medical Formulas

The Fund shall pay expenses incurred by a Participant and or Dependent regarding medical formulas, if such benefits are provided under the Participant's Schedule of Benefits.

Limitations No payment shall be made for:

- Expenses which exceed any benefit limitation as set forth in a Participant's Schedule of Benefits; and
- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

COVID-19

The Board of Trustees and BCBS closely monitor the outbreak of the novel Coronavirus 2019. As the situation changes rapidly the benefits provided may also change to keep you safe and healthy. As recommendations relating to benefits from the federal, state, local governments healthcare providers and public health agencies are evolving, there may be additional coverage changes.

BCBS plans provide access to care and testing relating to Covid-19 for the duration of the Massachusetts declared public health emergency as follows:

- Waived member cost share (co-pays, co-insurance and deductibles) for medically necessary COVID-19 testing, counseling, vaccines and treatment and supportive care at doctor's offices, acute care facilities, hospitals, urgent care centers and emergency departments (including inpatient and outpatient care), in accordance with the Centers for Disease Control and Massachusetts Department of Public Health guidelines. Any medically necessary treatment for COVID-19 is covered under a member's health plan within the United States or internationally.
- Relax administrative procedures, such as prior authorizations and referrals, for medically appropriate treatment for COVID-19.

- Increased access to prescription medications. Members have access to early refills of their prescription maintenance medications. BCBS will ensure formulary flexibility if there are shortages or access issues.
- Add telehealth and telephonic benefits at no cost to the member through all Blue Cross Blue Shield MA. For the duration of the Massachusetts declared public health emergency there will be no copays, co-insurance or deductibles for the screening, evaluation, and/or suggested treatment of COVID-19 or for other telehealth or telephonic medically necessary covered services.
- Blue Cross Blue Shield MA will waive cost share for COVID-19 related inpatient care at both in and out-of-network acute care facilities. If a member receives out of network services for COVID-19 related care, cost share will be waived for all covered services provided in that episode of care. Regular plan rules and applicable cost share will apply if a member receives out of network services for non-COVID-19 related care.

As a reminder, disability benefits may include COVID-19 related illnesses.

Plan benefits include at home COVID-19 testing or other testing that is *deemed medically necessary and ordered by a healthcare provider*. This testing does not include tests for employment purposes. If an individual receives multiple *diagnostic* tests for COVID-19, the plans will cover each test as well as other applicable items and services.

You are encouraged to monitor the Center for Consumer Information and Insurance Oversight (CCIIO) website for any additional guidance related to COVID-1. All CCIIO guidance related to COVID-19 is available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs#COVID-19 .

EXTENSION OF DEADLINES DUE TO COVID

In April of 2020, the Department of Labor announced that certain deadlines under federal law were suspended starting March 1, 2020 until 60 days after the announced end of the COVID 19 National Emergency or such other date determined by the agencies (the Outbreak Period). The guidance suspending certain deadlines related to electing and paying for COBRA continuation coverage, enrollment of new spouse or child, submission of claims, and the appeal of the denial of a claim. The deadline suspensions apply until the earlier of the following:

1. 1 year from the date the individual was first eligible for relief
2. The end of the Outbreak period

The following deadline applicable to participants, dependents and beneficiaries are tolled (paused) during the outbreak period:

- The 30-day period (or 60-day period, if applicable) to request a HIPAA special enrollment;
- The 60-day period for electing COBRA continuation coverage;
- The date/deadline for making COBRA premium payments;

- The deadline for individuals to notify the plan of a COBRA qualifying event or determination of disability:
- The deadline within which employees can file a benefit claim, or a claimant can appeal an adverse benefit determination, under the group health plan or disability plan claims procedure described in the plan;
- The deadline for claimants to file a request for an external review after receipt of an adverse benefit Determination; and
- The deadline for a claimant to file information to perfect a request for external review upon finding that the request was not complete.

THREE WAYS TO GET IN-HOME COVID TESTS

1. **Visit an in-network pharmacy**

You can get the tests listed below at no cost when you show your member ID card when checking out at the pharmacy counter.

FIND AN IN-NETWORK PHARMACY:

www.bluecrossma.org/pharmacy

OR visit www.bluecrossma.org/myblue/at-home-covid-test-coverage

2. **Order through the mail order pharmacy**

Sign into your MyBlue account, register now if you don't have one, then go to **My Medications**. Click **Order At-Home COVID Tests** from the home page to have tests mailed to you at no cost.

SIGN IN TO MYBLUE: www.bluecrossma.org

3. **Submit a Reimbursement**

Get reimbursed for up to eight FDA-authorized tests each month, up to $12 each, when you submit a reimbursement. Sign into your MyBlue account, or create a new one, **My Medications**. Click **Benefits**, then **Forms**, then complete and submit the reimbursement form. **GO TO MYBLUE: www.bluecrossma.org**

Tests That Are Covered at No Cost When Purchased at In-Network Pharmacies:

- InteliSwab™ COVID-19 Rapid Test
- BinaxNow™ COVID-19 Antigen Self Test
- QuickVue®´ At-Home OTC COVID-19 Test
- Ellume COVID-19 Home Test
- Flowflex™ COVID-19 Antigen Home Test
- iHealth®´ COVID-19 Antigen Rapid Test
- On/Go™ COVID-19 AG At Home Test
- COVID-19 At Home Test

Learn to Live

Learn to Live is a free mental health program that provides online self-paced programs and self-assessments for members and family members (age 13 or older) struggling with depression, stress, substance use, insomnia, or social anxiety. The Learn to Live program is built on evidence-based principles of Cognitive Behavioral Therapy. Learn to Live offers 24-7 coaching and confidential self-directed programs offering tools and educational resources.

Get started by downloading the free MyBlue app, or create an account at bluecrossma.org, then click "Online Mental Health Tool" under Plans and Claims.

Dental Benefits

The Fund provides and pays for dental benefits to all of its participants and their dependents through the Blue Cross Blue Shield plans known as Dental Blue Freedom with benefit maximums for retired employees and each of their dependents and benefit maximums for active employees and each of their dependents. Incorporated by reference are the Schedule of Benefits, Benefit Descriptions and Riders of these dental plans.

In General The Fund shall pay expenses incurred by a Participant and or Dependent for eligible dental services if such benefits are provided under the Participant's Schedule of Benefits, Benefit Description/Riders, after the application of deductibles, discounts, co-insurance, fee allowance, and/or out-of-pocket maximums and the applicable provisions and not to exceed the maximum provided in the Participant's Schedule of Benefits, Benefit Description and Riders. Benefits may be categorized summarily as preventive, basic, major or orthodontic. The preventive group would include services such as oral exams, x-rays or routine cleaning. Basic services would include services such as restorative services, periodontics, or other services. Major services include crowns and dentures. These expenses are subject to maximums and exclusions as set forth under the Participant's Schedule of Benefits, Benefit Description and Riders. The Dental Plan for Retired employees and their dependents provides coverage for diagnostic and preventative services (i.e. cleanings and x-rays). The Retiree plan does not provide coverage for basic or major services. There are no annual benefit maximums, under either the active or retiree plan for enrolled dependents under the age of 19.

Limitations

No payment shall be made for:

- Expenses incurred for dental services rendered solely for cosmetic purposes;
- Charges for appointments that are not kept;
- Orthodontic services unless such benefits are provided under the Participant's Schedule of Benefits, Benefit Description and Riders, and if so, subject to any benefit maximums as set forth in the Schedule of Benefits, Benefit Descriptions and Riders;
- Services deemed to be unnecessary or inappropriate;
- Services or products which exceed any benefit maximums or are otherwise excluded pursuant to the Participants Schedule of Benefits, Benefit Description and Riders.

- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Orthodontic Care Expense Benefit

In General, The Fund shall pay allowable Orthodontic care incurred by a Participant under the age of nineteen (19) or a dependent under the age nineteen (19), if such benefits are provided under the Participant's Schedule of Benefits.

Limitations No payments shall be made for:

- Orthodontic services which are excluded and/or which exceed maximums as set forth in the Participant's Schedule of Benefits;
- Surgical service for the correction of congenital anomalies
- Replacement of orthodontic appliances for reasons such as theft, abuse, misuse, misplacement, loss, improper fit, allergies, breakage or ingestion.
- Speech therapy
- Instructions for muscle exercises to prevent or correct misalignments of the teeth (myofunctional therapy).
- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

Vision Benefits

Davis Vision is a national provider of vision care programs that provides eyeglass services and other vision service (eye exams, etc.) to the Fund. The cost sharing arrangements at Davis Vision are the same for all participants, irrespective as to whether the member is enrolled in Tier 1 or Tier 2. The Vision Care Plan Benefit Description provides additional detail on the vision benefit and can be found in Attachment #6 of this document.

Vision Care Plan Benefit Description

In General The Fund shall pay Allowable Vision Care Expenses incurred by a Participant or Dependent, subject to the benefit limitations set forth in the Davis Vision Plan. This benefit is more fully described in attachment #6. These benefits include, for eye exams, frames and eye glasses, lenses or contact lenses, and retinal imaging. Additional benefits include discounted laser vision correction, often referred to as LASIK. Additional allowance of $2,000.00 ($1,000 per eye) is available at participating locations only. For more information see www.davisvision.com.

Limitations No payment shall be made for expenses incurred:

- For more than one (1) complete eye examination during any calendar year;

- For more than two (2) sets of eye glasses (frames and lenses) or contact lenses during any one (1) year cycle, and subject to exclusions for special lens designs or coatings as described in the Davis Vision benefit description. Coverage does include digital

progressive lenses with no co-pay; coverage includes standard, premium and ultra anti reflective coating for lenses, coverage does include transition lenses;

- For medical treatment for eye disease or Injury;
- For vision therapy;
- Services not performed by licensed personnel;
- No payment will be made for expenses which are not payable under the limitations set forth in the "General Limitations" section of this Summary Plan Description.

General Limitations

Limitations

- **Employment Related Injury or Illness** No payment will be made for expenses for or in connection with an injury or illness for which a Participant or Dependent is entitled to benefits under any Workers' Compensation or similar law.
- **Payment of Benefits Pending Appeal** If a Participant or Dependent is denied Worker's Compensation benefits after providing his Employer's Worker's Compensation carrier a timely and valid application for benefits, the Fund may pay benefits after receipt of a denial. Payments will be made for benefits provided in the Participant's Schedule of Benefits which are not provided or paid for under the applicable Worker's Compensation award or benefits.
- **Prohibited Payments** No payment will be made for expenses to the extent that payment under the Plan is prohibited by law of the jurisdiction in which the Participant or his Dependent resides at the time the expenses are incurred.
- **Non-legally Required Payments** No payment will be made for expenses for charges which the Participant or his Dependent are not legally required to pay except to the extent as required by the Federal Government for services furnished by a department or agency of the United States.
- **Claim Form Charges** No payment will be made for expenses for completion of any claim forms, administrative services or service charges.
- **Cosmetic** No payment will be made for expenses for or in connection with any procedures, products or services that affect appearance only, or which are performed for a purely aesthetic superficial benefit, except as required to repair damage received in an Injury incurred while eligible for benefits, or as provided for by Federal law including but not limited to the provisions of the Women's Health Act of 1998.
- **Work-Related Examination** No payment will be made for expenses for or in connection with any work-related examination such as a Department of Transportation physical.

- **Experimental Procedures/Drugs** No payment will be made for expenses for or in connection with any experimental or investigational procedures or drugs unless deemed medically necessary. The Plan has the authority to make the final determination as to whether the procedure or drug is experimental or investigational.

- **Medically Unnecessary** No payment will be made for expenses for services and supplies provided by a Hospital, Physician, Chiropractor or other provider of health care services not consistent with the patient's condition, diagnosis, Illness or Injury or for services not consistent with standards of good medical practice. The Plan has the authority to make the final determination as to whether the service or supplies are medically necessary.

- **Custodial Care** No payment will be made for expenses for charges for Custodial Care.

- **Employer Ceasing to be a Participating Employer** If a Participating Employer ceases to make Contributions on behalf of its Employees in Active Service, the Fund will cease providing benefits to every active Employee employed by that Employer and to his Dependents on the date the eligibility of those Active Service Employees ceases, except as prohibited by federal laws and regulations (including COBRA) and notwithstanding any other provisions of this Plan Document.

- **Unnecessary Care or Treatment** No payment will be made for any unnecessary care, treatment or supplies.

- **Failure to Keep Visit** No payment will be made for expenses for failure to keep a scheduled visit.

- **Benefit Limitations** Notwithstanding anything contained in this plan, no payment will be made for expenses in excess of a benefit limitation as set forth in the Participant's Schedule of Benefits.

- **Failure to Provided Advance Notice** Payment, in the discretion of the Trustees may or may not be made for expenses where a Participant or his Dependent fails to provide advance notice or fails to obtain prior authorization as required by Blue Cross Blue Shield. Generally, in the absence of an emergency, a Participant is required to provide advance notification to obtain a covered service. The Trustees reserve the right, in their discretion, to determine whether any expenses should be paid if a Participant or his Dependent fails to provide advance notice or to obtain the required authorization as required by this Plan.

- **Admission Notification** No payment will be made for expenses of any charges that are a result of reduction in benefit payment due to non-compliance of admission notification requirements, if any.

- **Failure to Obtain Prior Approval or Proper Referral** Payment, in the discretion of the Trustees may or may not be made for expenses if a Participant or his Dependent is required to obtain prior approval or a proper referral and fails to do so. For HMO plans, in the absence of an emergency, or in the absence of pre-approval, generally, there will be no coverage or reduced coverage provided for out-of-network services.

- **Excess Charges** No part of an expense for care and treatment of an illness or injury that is in excess of the allowable charge.

X. CLAIMS PROCEDURE FOR THE PLAN

Group Health Plan Claim Processing - Medical, Pharmacy, Dental and Vision

Your claims under the Plan's group health plan will be processed under the following procedures, except to the extent inconsistent with the insurers' or claim administrator's claims procedures as set forth in an attachment hereto, in which case the insurers' or claims administrator's claims procedures will apply as long as such other claims procedures comply with the Affordable Care Act and DOL Regulations. For more detailed information, you should review the insurance carriers' certificate of coverage or benefit booklets, or you may contact the insurance carriers or claims administrators directly to obtain specific claim/appeal processes.

Initial Claim Processing

- **Post-Service Claims**

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the insurer within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The insurer will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the insurer will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide information about applicable appeal procedures.

- **Pre-Service Claims**

Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the claims administrator within 15 days of receipt of the claim. The claims administrator will notify you within this 15-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the claims administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide information about the applicable appeal procedures.

- **Urgent Claims That Require Immediate Action**

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

- you will receive notice of the benefit determination in writing or electronically within 72 hours after the claims administrator receives all necessary information, taking into account the seriousness of your condition.
- notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an Urgent Care Claim improperly, the claims administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the claims administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- the claims administrator's receipt of the requested information; or
- the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide information about applicable appeal procedures.

- **Concurrent Care Claims**

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

If the insurance company denies any part or all of a benefit claim, it will provide you with a written notice. The written notice will include the specific reason or reasons for the denial and a reference to the Plan provisions on which the denial is based. The notice will also give the name and address of the entity to which you can appeal, and a description of the Plan's appeal procedures.

Appealing the Denial of a Claim

If your claim is denied, you may appeal that decision. To appeal, you must submit a written request to the insurance company within 180 days of receiving the initial claim denial. Along with the written

request for appeal, you may submit any additional facts, documents or proof you believe will show why the claim should not be denied. If the written request for appeal is not submitted within 180 days of receiving the initial claim denial, you lose the right to appeal under the Plan.

- **Pre-Service and Post-Service Claim Appeals**

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), you will be notified by the claims administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision of the claims administrator, you have the right to request a second level appeal from the claims administrator. Your second level appeal request must be submitted to the claims administrator within 60 days from receipt of first level appeal decision. You will be notified by the claims administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), the first level appeal will be conducted by the claims administrator and you will be notified by the claims administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision of the claims administrator, you have the right to request a second level appeal from the claims administrator. Your second level appeal request must be submitted to the claims administrator within 60 days from receipt of the first level appeal decision. You will be notified by the claims administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Claims, see "Urgent Claim Appeals That Require Immediate Action" below.

For appeals of denials of a claim based on a determination of medical necessity or experimental or investigational services, as those terms are defined in each certificate of coverage, the claims administrator will notify you of the decision within 60 days from receipt of a request for appeal of a denied claim. The decision of the claims administrator regarding this type of denial of a claim is final, conclusive and binding. There is no second level of appeal for this type of denial.

Please note that the claims administrator's decision is based only on whether or not benefits are available under the medical, dental or vision plans for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

- **Urgent Claim Appeals That Require Immediate Action**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your doctor should call the claims administrator as soon as possible, and provide the claims administrator with the information identified above under "How to Appeal a Claim Decision." The claims administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition. There is no second level of appeal for this type of denial.

If the insurance company denies all or part of your appeal, it will provide you with a written notice. The written notice will include the specific reason or reasons for the denial, a reference to the Plan provision on which the denial is based, and a statement providing you with reasonable access to documents and other information related to your claim. The written notice will also advise you of your rights to bring a lawsuit under ERISA. Note that you may not bring a lawsuit unless you have exhausted your rights to appeal.

Voluntary External Review

If you are enrolled in a non-grandfathered group health plan, your internal appeal of a claim for health benefits under such plan is denied, you will have the right to request an external (i.e. independent) review if you do so within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination. Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the Plan, (ii) the denial was based on your ineligibility under the terms of the Plan, (iii) you exhausted the Plan's internal process, if required, and (iv) you provided all information necessary to process the external review. Within one business day after completing the preliminary review, you will be notified in writing if your appeal is not eligible for an external review or if it is incomplete. If your appeal is complete but not eligible, the notice will include the reason(s) for ineligibility. If your appeal is not complete, the notice will describe any information needed to complete the appeal. You will have the remainder of the four month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your appeal will be assigned to an independent review organization (IRO). If the IRO reverses the Plan's denial, the IRO will provide you written notice of its determination.

In addition, you will have the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; and

- Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

Group Welfare Plan Claims Processing: Spousal Burial, Dependent Life Benefits and certain Wellness Benefits/Programs

Under Department of Labor (DOL) regulations, claimants are entitled to a full and fair review of any claim made under the Plan. The procedures described in this document are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

Notice of Claim

The following claims procedures shall apply to welfare benefits provided by the Fund for spousal death benefits, dependent death benefits and certain Wellness Benefits/Programs. The initial benefit determination of spousal burial benefits and dependent death benefits will be made by the Fund. The initial benefit determination in certain wellness programs is made by Blue Cross Blue Shield, who administers these wellness programs. If a participant or dependent receives an adverse benefit determination for a wellness program provided by Blue Cross Blue Shield, then the following claims procedure shall apply to the participant or their dependent.

Written Notice of Claim Must be Given to the Fund Office Written Notice of Claim given by or on behalf of the Participant or Dependent to the Fund with sufficient information to identify the Participant or Dependent will be considered notice to the Fund. "Notice of Claim" is defined as the first (1st) time that the Fund is made aware that a claim was incurred on a specific date.

- **Authorized Representative** An Authorized Representative of a Participant or Dependent may act on behalf of such Participant or Dependent in pursuing a benefit claim or appeal of an Adverse Benefit Determination. A Participant's spouse or a parent of a minor Participant or Dependent

- Office. A Participant or Dependent must submit a written designation of any other representative to the Fund.

- **Failure to Follow Plan Procedures** In the case of a failure by a Participant or Dependent or an Authorized Representative of a Participant or Dependent to follow the Plan's procedures for filing a "claim", the Participant or Dependent or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Participant or Dependent or Authorized Representative, as appropriate. Notification may be oral, unless written notification is requested by the Participant or Dependent or Authorized Representative.

Claim Review Procedure

- **Manner and Content of Notification of Benefit Determination** The Fund shall provide a Participant or Dependent with written notification of any Adverse Benefit Determination. The notification shall set forth, in a manner calculated to be understood by the Participant or Dependent:

    - The specific reason or reasons for the Adverse Benefit Determination;
    - Reference to the specific Plan provisions on which the determination is based;
    - A description of any additional material or information necessary for the Participant or Dependent to perfect the claim and an explanation of why such material or information is necessary;
    - A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Participant or Dependent's right to bring a civil action under ERISA Section 502(a) if your claim is denied (you receive Adverse Benefit Determination on appeal);
    - The identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant or Dependent's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant or Dependent upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant or Dependent's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- A statement "you and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency."

Timing of Notification of Benefit Determination

The Fund shall notify a Participant or Dependent of a benefit determination in accordance with the following schedule:

The Fund shall notify the Participant or Dependent of an Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the claim by the Plan. This period may be extended by the Plan for up to thirty (30) days, provided that the Fund determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant or Dependent, prior to the expiration of the initial forty-five (45) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first (1st) thirty (30) day extension period, the Fund determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided that the Fund notifies the Participant or Dependent, prior to the expiration of the first (1st) thirty (30) day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Participant or Dependent shall be afforded at least forty-five (45) days within which to provide the specified information.

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is received by the Fund, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a Participant or

Dependent's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Participant or Dependent until the date on which the Participant or Dependent responds to the request for additional information.

Appeal Procedure for Denied Claim or Adverse Benefit Determination

If you wish to appeal an adverse benefit determination or a denial of a claim for welfare benefits, you or your authorized representative must file a written appeal with the Board of Trustees (also known as the Plan Administrator) within 180 days after receipt of written notice of denial or otherwise known as adverse benefit decision. You or your authorized representative may submit a written statement, documents, records, and other information relating to the claim for benefits. You may also, free of charge upon request, have reasonable access to and copies of Relevant Documents relating to the claim for benefits. Relevant Document means any document, record or other information that:

- Was relied upon in making a benefit determination including a decision to deny benefits;
- Was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits;
- Demonstrates compliance with any administrative processes and safeguard designed to confirm that the benefit determination was in accord with the Fund and that the Fund provisions, where appropriate, have been applied consistently regarding similarly situated individuals; or
- Constitutes a statement of policy or guidance to the Plan concerning a denied treatment option or benefit for your diagnosis, whether or not it was relied upon in making the decision to deny benefits.

Standard of Review

The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan Documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

In addition, the following procedures apply:

- The appeal decision will not defer to the initial decision denying your disability claim (the adverse benefit determination) and will be made by the Board of Trustees who are not persons who made the initial decision, nor subordinates of such person;
- If the initial denial decision was based in whole or in part on a medical judgment, the Board of Trustees will consult with health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person; and
- Any medical or vocational expert whose advise was obtained in connection with the decision to deny your disability claim will be identified upon request, whether or not the advice was relied upon.

The Board of Trustees will review all appeals of denied claims and makes final determinations. The Board of Trustees has full discretionary authority, including power to administer, construe and interpret the terms and provisions of the Plan, Summary Plan Description and Trust Agreement and to determine eligibility for benefits under the Plan. The Board of Trustees has the exclusive right to interpret the provisions of the Plan. Decisions of the Board of Trustees are final, conclusive and binding. The Board of Trustees has final claims adjudication authority under the Plan.

Timing and Appeal of Decision

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Board of Trustees after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later that five days after the decision is made.

Contents of Appeal Decision

If your appeal a denied claim, the decision on review will be in writing and will include the following information:

- The specific reason or reasons for the decision; and
- Reference to the specific Plan provisions on which the decision is based; and
- A statement of your right to receive, upon request free of charge, reasonable access to and copies of Relevant Documents; and
- A statement of your right to bring a civil action under Section 502(a) of ERISA, if your claim is denied or you receive an adverse benefit decision; and
- Any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits or review, or a statement that such was relied upon and a copy will be provided free of charge upon request; and
- If the decision or review was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or the States Insurance Regulatory Agency.”

<u>Group Welfare Plan Claims Processing; Short Term Disability Income Benefits</u>

Under Department of Labor (DOL) regulations, claimants are entitled to a full and fair review of any claim made under the Plan. The procedures described in this document are intended to comply with DOL regulation 29 C.F.R section 2560-503-1 by providing reasonable procedures governing the filing of short term disability income benefits filed under the plan on or after January 1, 2018.

Notice of Claim
The following claims procedures shall apply to short term disability income benefits filed under the plan on or after January 1, 2018. The initial benefit determination of short term disability income benefit claims will be made by the Fund. The following claims procedure will apply specifically to claims made for short term disability income benefits under one or more Plan features, including any rescission of disability coverage under such Plan features with respect to an active employee or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, rescission means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Written Notice of Claim Must be Given to the Fund Office Written Notice of Claim given by or on behalf of the Participant or Dependent to the Fund with sufficient information to identify the Participant or Dependent will be considered notice to the Fund. "Notice of Claim" is defined as the first (1st) time that the Fund is made aware that a claim was incurred on a specific date.

- **Authorized Representative** An Authorized Representative of a Participant or Dependent may act on behalf of such Participant or Dependent in pursuing a benefit claim or appeal of an Adverse Benefit Determination. A Participant's spouse or a parent of a minor Participant or Dependent may serve as the Participant or Dependent's representative without prior notice to the Fund Office. A Participant or Dependent must submit a written designation of any other representative to the Fund.

Failure to Follow Plan Procedures In the case of a failure by a Participant or Dependent or an Authorized Representative of a Participant or Dependent to follow the Plan's procedures for filing a "claim", the Participant or Dependent or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Participant or Dependent or Authorized Representative, as appropriate. Notification may be oral, unless written notification is requested by the Participant or Dependent or Authorized Representative.

Timing of Notice of Adverse Benefits Determination

The Fund shall notify an active employee or his representative of a benefit determination in accordance with the following schedule:

If a claim under the Plan is denied in a whole or in part, you or your representative will receive written notification of the adverse benefit determination within a reasonable period of time, but no later than 45 days after the Fund's receipt of the claim. The Fund may extend this period for up to 30 additional days provided the Fund determines that the extension is necessary due to matters beyond the Fund's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date the by which the Fund expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Fund determines that, due to matters beyond its control, it cannot make the

decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Fund expects to render a decision. The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

Adverse Benefits Determination Notice

A denial notice will include:

- The specific reason(s) for your adverse benefit determination;
- Reference to the specific Plan provision on which the determination is based;
- A description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- A description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- A discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
    I. The views presented by the health care professional treating you and vocational professionals who evaluated you;
    II. The views of medical or vocational experts who advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    III. A disability determination regarding you presented by you to the Plan made by the Social Security Administration;
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in make the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of the entire claim file and all documents, records, and other information relevant to your claim for benefits. A document, record, or other information will be considered "relevant" to your claim if such document, record, or other information:

    1. Was relied upon in making the benefit determination:
    2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the determination:
    3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and verify that benefit determinations are made in accordance with governing plan documents

and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly satiated claims; or

4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Appeal process

If you disagree with a claim determination, you can contact the Board of Trustees (also known as the Plan Administrator) in writing to formerly request an appeal. If the appeal relates to claim for payment, your request should include:

- The subject individual's name and the identification number from the ID card, if any.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to the Board of Trustees within 180 days after you receive the claim denial.

The Board of Trustees, who were not involved in the decision being appealed will decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Board of Trustees may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of your entire claim file and all documents, records, and other information relevant to your claim for benefits.

In addition, prior to the appeal determination noted below, the Board of Trustees will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to the date. Before an adverse benefit determination on appeal based on a new or additional rationale, the Board of Trustees will provide you, free of charge, with the rationale; the rationale will provide as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

Timing of Appeal Determination

You will be notified of the Board of Trustees decision upon review within a reasonable period of time, but no later than 45 days after the Board of Trustees receives your appeal request. The 45-day period may be extended for an additional 45-day period if the Board of Trustees determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Board of Trustees expects to render a decision.

Avoiding Conflicts of Interest

The Fund will ensure that short term disability income benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. For example, a claims adjudicator or medical or vocational expert will not be hired, promoted, terminated or compensated based on the likelihood of the persons denying short term disability income benefit claims.

Appeal Determination Notice

If denied, your review decision on appeal will include the following:

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provision on which the benefit determination is based;
- A statement that you are entitled to receive, without charge, reasonable access to any documentation (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative process and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the claim without regard to whether the statement was relied on;
- Either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- If the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgement applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- A statement describing the Plan's optional appeals procedures, if any, and your right to receive information about such procedures, as well as your right to bring a lawsuit and any applicable contractual limitation period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;" and

- A discussion of the decision, including, an explanation of the basis for disagreeing with or not following:
    I. The views presented by the health care professionals treating you and vocational professionals who evaluated you;

    II. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

    III. A disability determination regarding you presented by you to the Plan made by the Social Security Administration;

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

The Board of Trustees has the exclusive right to interpret the provisions of the Plan. Decisions of the Board of Trustees are final, conclusive, and binding. The Board of Trustees has final claims adjudication authority under the Plan.

Group Welfare Plan Claims: Processing Life Insurance, Accidental Death and Dismemberment

Life Insurance and AD&D

The life insurance claims and accidental death and dismemberment claims are to be administered by Symetra Life Insurance Company. Claims filed regarding life insurance and the accidental death and dismemberment benefit shall be forwarded to Symetra Life Insurance Company for benefit determination in accordance with Symetra's procedures found in Attachments #7 & #8 to this Summary Plan Description. Symetra Life Insurance Company has sole and complete discretion and authority to administer and interpret the provisions of the plans it insures. The Symetra Life Insurance Company shall follow the claims procedures contained in the policies, contracts, summary plan descriptions or other written materials as long as these claims procedures comply with all ERISA requirements and DOL regulations including but not limited to 29 C.F.R. section 2560-503-1.

ERISA RIGHTS FOLLOWING REVIEW

A claimant has the right to sue in Federal Court but only if the claimant has exhausted all claims procedures. You shall be deemed to have exhausted the Fund's administrative procedures if the Fund fails to strictly fulfill all applicable claims and appeals procedural requirements, regardless of whether the compliance defect materially impacted the outcome of the claims appeal decision. In such a circumstance

a claimant may pursue remedies under Section 502 of ERISA, as applicable, which include judicial review of the Plan determination to recover benefits due to him under the terms of the Plan, to enforce his rights under the terms of the Plan, or to clarify his rights to future benefits under the Plan. Additional information may be available from the local U.S. Department of Labor office.

MISCELLANEOUS

Right of Recovery; Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation

There are times that you will be required to furnish information or proof necessary to determine your or a dependent's right to a Plan benefit. When inaccurate information and/or proof is provided, this ultimately can result in the improper use of Plan assets, which adversely affects the ability of the Plan to provide the highest possible level of benefits.

Accordingly, the Plan Administrator reserves the right to terminate your coverage under the Plan and/or your Eligible Dependent(s) coverage prospectively without notice for cause, as determined by the Plan Administrator, and/or if you and/or your Eligible Dependents are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or an Eligible Dependent commits fraud or intentional misrepresentation in an application for coverage under the Plan, in a claim or appeal for benefits, or in response to any request for information by the Plan Administrator (or its delegate), or a Claims or Appeals Administrator, the Administrator may terminate your coverage retroactively upon 30 days notice. Failure to inform the Plan Administrator, or a claims or appeals administrator, as applicable, that you or your Eligible Dependent is covered under another group health plan or knowingly providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan. Of course, if the Plan pays benefits of expenses actually incurred or in excess of allowable amounts, due to error (including for example, a clerical error) or for any other reason (including, for example, your failure to notify the Plan Administrator or its delegates regarding a change in family status), the Plan Administer reserves the right to recover such overpayment through whatever means are necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action.

Subrogation and Reimbursement

Were you or your dependent injured in an accident for which someone else is liable? If so, that person or his/her insurance may be responsible for paying your or your dependent's related medical and accident & sickness expenses and these expenses would not be covered under the Plan. However, waiting for a third party to pay for those injuries may be difficult; recovery from a third party may take a long time (you may have to go to court) and your creditors may not wait patiently. Because of this, as a service to you, the Fund will advance you or your dependent benefit payments related to such an accident based on the Fund's rights of reimbursement and subrogation. You must reimburse the Fund if you obtain any recovery from any person or entity.

The Fund must be repaid out of any proceeds you or your dependents receive from the other party if:

- Benefits are paid under this Fund; and
- You or your dependent has a claim against another party who may be responsible

The Fund Office will require the participant *assign or transfer* his or her rights to any recoveries, settlements or judgments, and that the Plan be paid for such recoveries, settlements or judgments as a *first right of recovery* (i.e., ahead of participant, his or her attorneys, and any other person, and without reduction for attorneys' fees or other costs or expenses). Such recoveries, settlements or judgments shall constitute Plan assets to the extent of the benefits paid or to be paid by the Plan, and any person who handles such assets shall hold them in trust for the Plan. The participant shall be required to sign a Subrogation, Assignment of Rights and Reimbursement Agreement to be eligible for benefits arising out of this injury. However, the failure of any participant to sign this form shall in no way affect the Fund's right to enforce these provisions and to obtain proceeds of any recoveries, settlements or judgments, no matter how characterized, as described above. Any participant who has the Plan pay his or her claims does so with the understanding that these Assignment and Subrogation rules are binding upon the participant, his or her attorneys, or the agents, assigns or heirs and executors of the participant**.** The participant is required to pay his or her own legal expenses and the participant is required to notify his or her attorney of these provisions and assignment. Any amounts recovered by the participant in excess of the full amount expended by the Fund may be retained by the participant or used to pay legal expenses.

You and/or the dependent are required to notify the Fund within ten days of any accident or injury for which someone else may be liable. Further, the Fund must be notified within ten days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgment of payment relating to the accident in any lawsuit initiated to protect the Fund's claims.

If you or your dependent receive any benefit payments from the Fund for an injury or sickness and you or your dependent recover *any* amount from *any* third party or parties in connection with such injury or sickness, you or your dependent must reimburse the Fund from that recovery the total amount of all benefit payments the Fund made or will make on your or your dependent's behalf in connection with such injury or sickness.

In addition, if you or your dependent receive any benefit payments from the Fund for any injury or sickness, the Fund is subrogated to all rights of recovery available to you or your dependent arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such injury or sickness, to the extent of any and all related benefit payments made or to be made by the Fund on your or your dependent's behalf. This means that the Fund has an independent right to bring an action in connection with such injury or sickness in your or your dependent's name and also has a right to intervene in any such action brought by you or your dependent, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award settlement, and compromise, insurance or order, regardless of whether the third party is found responsible or liable for the illness or sickness, and regardless of whether you or your dependent actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the injury and sickness whether such recovery is full or partial and no matter how such recovery is characterized why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your or your dependent's own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefits payable. The 'make-whole' doctrine does not apply to the Fund's right of reimbursement, and subrogation. The Fund's rights of reimbursement and subrogation are for the *full*

amount of *all* related benefits payments; this amount is not offset by legal costs, attorneys' fees or other expenses incurred by you or your dependent in obtaining recovery. The Fund shall have a lien on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to Fund under this section, and any such amount shall be deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund.

Consistent with the Fund's rights set forth in this section, if you or your dependent submit claims for or receive any benefit payments from the Fund for an injury or sickness that may give rise to any claim against any third-party, you and/or your dependent will be required to execute a "Subrogation, Assignment of Rights and Reimbursement Agreement" affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Agreement must also be executed by your or your dependents attorney, if applicable**.** In the event of any failure or refusal by you or your dependent to execute this agreement or to take any action requested by the Fund, the Fund may withhold payment of benefits or deduct the amount of any payments from future claims of the participant or his or her dependents.

Because benefit payments are not payable unless you sign a Subrogation, Assignment of Rights and Reimbursement Agreement, your or your dependent's claims will not be considered filed and will not be paid until the fully signed Agreement is received by the Fund. This means that, if you file a claim and your Subrogation, Assignment of Rights and Reimbursement Agreement is not received promptly, the claim will be untimely and will not be paid if the period for filing claims passes before your Subrogation, Assignment of Rights and Reimbursement Agreement is received.

Further, the Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization maybe recoverable by, or on behalf of, you or your dependent in any action at law, any judgment, compromise or settlement of any claims

against any party, or any other payment you, your dependent, or your attorney may receive as a result of the accident or injury, no matter how these amounts are characterized or who pays these amounts, as provided in this section.

Under this provision, you and/or your dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your dependent's receipt of any recovery. You or your dependent also must do nothing to impair or prejudice the Fund's rights. For example, if you or your dependent choose not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund office immediately. Where you or your eligible dependent choose not to pursue the liability of a third party, the acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident.

You or your dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid.

The Fund may withhold benefits if you or your dependent waive any of the Fund's rights to recovery or fail to cooperate with the Fund in any respect regarding the Fund's subrogation rights.

If you or your dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement right, the Fund has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, offsetting the amounts paid against your future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation, Assignment of Rights, and Reimbursement Agreement and/or the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation. This reimbursement and subrogation program is a service to you and your dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays for your injuries.

Enforcement and Remedies

In addition to any legal or equitable remedy that may be available under the law, the Trustees may exercise the following remedies if a participant fails to comply with them.

- Refuse to pay any benefits related to the participant's injuries or illness;
- Recover from the participant benefits already paid through deducting any overpayments from claims otherwise payable. If the covered person is the participant, the Trustees may also offset claims payable to any eligible dependent of the participant. If the covered person is an eligible dependent, the Trustees may also offset claims payable to any other eligible dependent or the participant;
- Access interest on the outstanding benefits or the amount of claims paid at a rate of 12% per annum, compounded annually, until paid, or
- In the event the Trustees institute litigation to enforce these provisions, the participant, and any other responsible person**,** shall be required to pay the Plan's costs and attorneys' fees, as well as any investigation fees.

The Trustees may promulgate rules and regulations to govern procedures hereunder.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan will not be construed as a contract for or of employment.

NONASSIGNABILITY OF RIGHTS

Your right to receive any benefit or reimbursement under the Plan shall not be alienable by you by assignment or any other method and is not be subject to being taken by your creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

NO GUARANTEE OF TAX CONSEQUENCES

The Plan Sponsor does not make any commitment or guarantee that any amounts paid to a Plan participant or for the benefit of a participant will be excludable from the Participant's gross income for federal or state income employment tax purposes, or that any other federal or state tax treatment will

apply to, or be available to, any participant. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income and employment tax purposes, and to notify the Plan Sponsor if you have reason to believe that any such payment is not so excludable.

SEVERABILITY

If any provision of this Plan is held invalid, unenforceable or inconsistent with any law, regulation or requirement, its invalidity, unenforceability or inconsistency will not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision were not a part of the Plan.

CONSTRUCTION OF TERMS

Words of gender shall include persons and entities of any gender; the plural shall include the singular and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the Plan.

APPLICABLE LAW

The Plan shall be construed and enforced according to the laws of the Commonwealth of Massachusetts to the extent not preempted by any federal law.

NO VESTED INTEREST

Except for the right to receive any benefit payable under the Plan in regard to a previously incurred claim, no person shall have any right, title, or interest in or to the assets of the Plan.

LEGAL ACTION

No action at law or in equity may be brought to recover benefits allegedly due under the Plan before the claimant has exhausted the applicable claims procedures.

CHANGES IN LAW

Unless the context clearly indicates to the contrary, a reference to a Plan provision, statute, regulation or document shall be construed as referring to any subsequently enacted, adopted or executed counterpart; provided, however, that any other provision of this Plan to the contrary notwithstanding, this Plan may be operated in accordance with legal requirements before it is amended to reflect them.

PLAN AUTHORITY

The Board of Trustees has the right to administer the plan at its sole discretion. This includes the right to make binding and conclusive determinations regarding:

- Who is eligible for benefits
- The amount of benefits payable

- The meaning and applicability of Plan provisions

Similarly, the Board of Trustees reserves the right to amend, modify, reduce, or discontinue all or part of the Plan, according to the terms of the Plan and Trust Agreement, by appropriate action, including:

- Changing any amounts contributed to the cost of providing benefits
- Changing the level of benefits provided
- Changing the class or classes of individual eligible for benefits
- Terminating the Plan in its entirety or with respect to any covered class or classes

Only the Board of Trustees may interpret Plan provisions, including: determining eligibility for benefits and the right to participate in the Plan; how hours are credited; eligibility for any benefit; discontinuing benefits and benefit levels.

PLAN AMENDMENT, MODIFICATION, OR TERMINATION PROCEDURE

The Board of Trustees reserves the right to amend this Plan at any time or from time-to-time without the consent of or, to the extent permitted by law, prior notice to any participant. Although the Board of Trustees expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan benefit option or feature at any time without liability. A plan amendment or termination requires the affirmative vote of two (2) Union Trustees and two (2) Employer Trustees.

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Attachments and Appendix

Teamsters Local 170 Health and Welfare Fund Group Health Plan

Benefits as of January 1, 2023