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**Introduction**

On April 14, 1954, Teamsters Local Union 170 and the various employers who had entered into labor contracts with the Union, executed an Agreement and Declaration of Trust ("Trust Agreement") and adopted a Health and Welfare Fund to provide health and welfare benefits to contributing employers, employees who were represented by the Union for collective bargaining purposes, together with employees of such other employers that agreed to provide coverage for them under the Fund, and such other persons whom the Trustees desired to permit to be covered under the Fund. Plan documents and the Trust Agreement have been subsequently revised from time to time.

The Plan and Trust Agreement are intended to meet the requirements of the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act (ERISA) of 1974, as amended. The Plan has been established for the exclusive benefit of active and retired employees, their dependents and/or beneficiaries.

Pursuant to the authority derived from Article IV, Section 2(a)(k)(m) and Article VI, Section 3 an Agreement and Declaration of Trust, the Board of Trustees of the Local 170 Health and Welfare Fund hereby established effective January 1, 2025, the following rules and regulations and plan of benefits. These rules and regulations and this plan of benefits shall remain in effect until changed by future action of the Board.

# Section 1 Definitions

## Section 1.1 Accidental Bodily Injury or Injury

The term "Accidental Bodily Injury" or "Injury" is defined as accidental bodily injury sustained by an employee which does not arise from his employment.

## 1.2 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.

## Section 1.3 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.

**Section 1.4 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.

**Section 1.5 Ambulatory Surgical Facility**

The term "Ambulatory Surgical Facility" is defined as a certified facility or Hospital where surgery is performed in which the intended duration between admission and discharge is less than twenty-four (24) hours.

**Section 1.6 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.

**Section 1.7 Chiropractor**

The term "Chiropractor" is defined as an individual who is licensed to treat conditions relating to musculoskeletal problems of the spine and who is operating within the scope of a current license.

**Section 1.8 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.

**Section 1.9 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.

**Section 1.10 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.

**Section 1.11 Custodial Care**

The term "Custodial Care" is defined as that type of care, wherever furnished, which is designed essentially to assist the individual in meeting the activities of daily living, which is not given primarily to assist such person in recovering from an injury or illness, and which does not entail or require the continuing attention of trained professional medical personnel.

## Section 1.12 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.

## Section 1.13 Dentist

The term "Dentist" is defined as an individual who is licensed to practice dentistry, including orthodontics, in the state where the dental service is performed and who is operating within the scope of a current license.

## Section 1.14 Dependent

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

**A.** The participant's lawful spouse; or in the event of divorce, the participant's former spouse may remain covered unless:

**1.** The divorce decree does not require (or no longer requires) the participant to maintain health insurance coverage for his former spouse; or

**2.** Either the participant or his former spouse remarries.

**B.** Each of the participant's children, who is;

**1.** Under age 26 (which will be no less than in the end of the month in which such child attains the age of 26), whether married or unmarried, regardless of his or her student or employment status and regardless of whether your home is his or her principal place of abode or whether you support him or her financially;

**2.** 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 was covered by this Plan at that time.

For purposes of this definition, "child" or "children" includes the following: a son, daughter, stepson, 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.

## Section 1.15 Durable Medical Equipment (DME)

The term "Durable Medical Equipment" is defined as equipment that is medically necessary and used solely by the patient for the treatment of an illness or injury. Durable Medical Equipment does not include items that are environmental in nature or solely for convenience, or equipment to be used in the home, such as humidifiers, vacuum cleaners, waterbeds, etc.

## Section 1.16 Emergency Admission

The term "Emergency Admission" is defined as a severe condition, the symptoms of which occur suddenly and unexpectedly, requiring immediate medical care to prevent death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible Hospital or licensed emergency medical care facility equipped to furnish such care. Such conditions include, but are not limited to: suspected strokes, suspected heart attacks, suspected poisoning, convulsions, and other acute conditions determined to be medical emergencies by the Plan.

## Section 1.17 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.

## Section 1.18 Essential Health Benefit (EHB)

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 and chronic disease management; and pediatric services, including oral and vision care.

## Section 1.19 Expense Incurred

An expense is considered to be incurred on the date the service or the supply is rendered or delivered.

## Section 1.20 Experimental or Investigational

The term "Experimental or Investigational" is defined as treatments, procedures, devices, or drugs which the Trustees or their delegate determine, in the exercise of their discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs are excluded under this Plan unless:

**A.** Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law;

**B.** Reliable evidence shows that the treatment, procedure, device, or drug is not the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and

**C.** Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses;

**D.** Reliable evidence includes anything determined to be such by the Trustees, within the exercise of their discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

**Section 1.21 Fund**

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

**Section 1.22 Hospital**

The term "Hospital" is defined as a certified institution constituted and operated in accordance with the laws pertaining to Hospitals that provides for medical and surgical treatment for injury and illness under the care of physicians on an inpatient basis with continuous twenty-four (24) hour nursing services by registered nurses. The term Hospital does not include an institution which is, other than incidentally, a place for rest, a place for the aged, a nursing home, or a place where the participant is not legally required to make payment for the service and supplies provided unless such services and supplies are provided by a department or agency of the United States.

**Section 1.23 Hospital Confinement or Confined in a Hospital**

An individual shall be considered "Confined in a Hospital" if he is a registered patient in a Hospital upon the recommendation of a physician or is a patient in a Hospital because of a surgical operation.

**Section 1.24 Illness**

The term "illness" includes physical illness, child birth and related medical conditions and pregnancy.

**Section 1.25 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. Blue Choice New England Plan 2 uses the term "pcp/plan approved benefits" in a manner similar to in- network.

**Section 1.26 Intensive Care Unit**

The term "Intensive Care Unit" is defined as an accommodation or part of a Hospital which is established by the Hospital for a formal intensive care program and which, in addition to providing room and board, is exclusively reserved for critically ill patients who require constant audio-visual observation by a physician, or, at the direction of a physician, by a registered nurse specially trained for service in an Intensive Care Unit.

**Section 1.27 Medical Benefits**

The term "Medical Benefits" is defined as all benefits provided under Article 3 of this Plan, other than the Life Insurance Benefit, Accidental Death and Dismemberment Benefit, Spousal Burial Benefit, Dependent Burial Benefit and Short Term Disability Income Benefit.

**Section 1.28 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.

**Section 1.29 Necessary Services and Supplies**

The term "Necessary Services and Supplies" is defined as any charges, other than charges for room and board, made by a hospital on its own behalf for Necessary Medical Services and Supplies actually administered during Hospital confinement. Necessary Services and Supplies shall also include any charges for the administration of anesthesia, radiology and pathology during Hospital confinement, and charges for professional ambulance service. Necessary Services and Supplies shall also mean charges made by a hospital, ambulatory surgical facility or physician surgery site on its own behalf for necessary medical services and supplies actually administered for outpatient surgery.

**Section 1.30 Out-of-Network**

The term "Out-of-network" is defined as the use of a provider 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. Blue Cross Blue Shield uses the term "self-referred benefits" in a manner similar to out-of-network.

**Section 1.31 Participant**

The term "Participant" is defined as an active employee or retired employee.

**Section 1.32 Physician**

The term "Physician" is defined as an individual who is licensed to prescribe and administer drugs or to perform surgery and is operating within the scope of a current license. Licensed psychologists and midwives are also included in the definition of Physician.

**Section 1.33 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.

**Section 1.34 Premium**

The term "premium" is defined as the amount paid by an Employer to the Fund on behalf of their Employees, on a monthly basis, pursuant to the term of an applicable Collective Bargaining Agreement or Participant Agreement. The term "premium" 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 and constitute "Employers" within the meaning of this Plan.

**Section 1.35 Qualified Beneficiary**

The term "Qualified Beneficiary" is defined as:

**A.** The spouse and qualifying children of a participant who, on the day before a qualifying event, were eligible for benefits under the Plan;

**B.** Any qualifying child who is born to or placed for adoption with a covered participant during a period of COBRA Continuation Coverage; and

**C.** 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.

**Section 1.36 Registered Nurse/Licensed Practical Nurse**

The term "Registered Nurse" is defined as a professional nurse who has the right to use the title "Registered Nurse" and the abbreviation "R.N." The term "Licensed Practical Nurse" is defined as a professional nurse who has the right to use the title "Licensed Practical Nurse" and the abbreviation "L.P.N."

**Section 1.37 Regular Treatment by a Physician for a Disability**

The term "Regular Treatment by a Physician for a Disability" is defined as examination, and administration or prescription of medication and/or therapy by a physician that is customarily accepted and/or considered proper.

**Section 1.38 Room and Board**

The term "Room and Board" is defined as all charges commonly made for room, meals, and nursing services.

### Section 1.39 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 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 Benefits" is further defined to include the benefits set forth in the Benefit Description or Riders for participants and their dependents who are enrolled in a Blue Cross Blue Shield Plan.

### Section 1.40 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.

### Section 1.41 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.

### Section 1.42 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.

### Section 1.43 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.

### Section 1.44 Gender

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

## Section 2 Eligibility

### Section 2.1 General Provisions – Tier 1, Tier 2 and Tier 3 Plans

Plan coverage is provided only to those participants who meet the eligibility requirements of this Article 2. The benefits available to participants who meet such eligibility requirements shall only be those health and welfare benefits authorized by the Trustees that cover these persons. Such benefits are payable only if the expense in question is incurred:

**A.** While the participant is eligible for benefits under this Plan, subject to the limitations contained herein; or

**B**. In cases where a particular benefit is extended under the Plan, during the period of such extension.

**C.** 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.

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 a separate early retiree Summary Plan Description are eligible to participate in the early retiree 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).

## Section 2.2 - Initial Eligibility of Active Participants – Tier 1 and Tier 2 Plans

### 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 out-of-network or non-participating providers.

**Blue Care Elect 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 v.5 –** The Network Blue Plan is a Health Management Organization (HMO). In this Plan, you must choose a PCP, you must receive a referral to see specialist 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 cost 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.

**Full Time Participation**

**A.** **New Active Full Time Employees of Participating Employers** A new or reinstated full time employee and his dependents will become eligible for insurance on the first (1st) day of the month following the month during which the employee accumulates five hundred (500) hours of credited employment by contributing employers during six (6) consecutive months.

**Part Time Participation**

**B.** **New Active Part Time Employees of Participating Employers** A new or reinstated part time employee and his dependents will become eligible for insurance on the first (1st) day of the month following the month during which the employee accumulates four hundred (400) hours of credited employment by contributing employers during six (6) consecutive months.

**C.** **Active Employees of New Participating Employers**

If you work full time when your employer begins participating with the Fund, you and your dependents will be eligible for benefits on the first (1st) day of the month your employer contributes the required hours to the Fund. A new participating employer is required to pre-pay the first month of hourly contributions, based upon an estimate of the number of employees and the applicable rate of contribution as set forth in the applicable Collective Bargaining Agreement.

**Section 2.3 Continued Eligibility**

**Full Time Participation**

You and your dependents will remain eligible for insurance, as of the first day of each insurance period, provided contributions of four hundred (400) hours have to be made to the Fund during the current eligibility period. Surplus hours in excess of four hundred (400) in the three (3) eligibility periods preceding the current eligibility period will be credited to the period immediately following, provided the full time employee has not been credited with four hundred (400) hours in that eligibility period. Surplus hours may only be used once. Notwithstanding

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

Full Time Active Employees

| 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. | 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 active employee's coverage will terminate on the last day of the eligibility period. The employee will be required to work five hundred (500) hours to become eligible for reinstatement under the same rules for establishing initial eligibility for full-time employees. In addition, the employee will have forfeited all surplus banked hours.

## Part Time Participation

You will and your dependents will remain eligible for insurance, as of the first day of each insurance period, provided contributions of two hundred fifty (250) hours have to be made to the Fund during the current eligibility period. Surplus hours in excess of two hundred fifty (250) in the three (3) eligibility periods preceding the current eligibility period will be credited to the period immediately following, provided the part time employee has not been credited with two hundred fifty (250) hours in that eligibility period. Surplus hours may only be used once. Notwithstanding anything contained herein, an employee who retires shall 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 Active Employees

| 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 be required to work four hundred (400) hours to become eligible for reinstatement under the same rules for establishing initial eligibility for part-time employees. In addition, the employee will have forfeited all surplus banked hours.

**Continuation of Benefits 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.

**Section 2.4 Termination of Eligibility**

Except as provided in Section 2.5, an active employee and his dependents eligibility for benefits will terminate automatically on the earliest of the following dates:

- **A.** The date the policy is cancelled;
- **B.** 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;
- **C.** 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;
- **D.** The date the policy is changed to cancel insurance on the class of active employees the participant is in;

**E.** A dependent's eligibility terminates when the active employee's eligibility ceases, except as provided in Section 2.5; or

**F.** 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.

## Section 2.5 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:

**A.** One (1) year after the active employee's death;
**B.** As to the surviving spouse, the date he/she remarries;
**C.** The date the person would have ceased to be a dependent, if the active employee were alive; or
**D.** 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.

## Section 2.6 Eligibility – Tier 3 Plan (Network Blue New England Value with Hospital Cost Sharing

This is a Managed Care Tier Plan. As a member in this plan, you will pay different levels of cost share (such as copayments and/or coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from any of the network general hospitals listed in the Summary of Benefits, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital (not listed in this Summary of Benefits) for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.org/hospitalchoice. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

## Active Employees

### A. Full Time & Part Time Participation

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.

## Monthly Eligibility Requirements

### B. How Your First Become Eligible

Your eligibility for benefits under the Plan depends on the contributions made that Teamsters Local 170 Health & Welfare Fund receives on your behalf. You will be eligible for benefits when your employer makes the required contribution and submits a contribution report on your behalf on a monthly basis.

> ***Example:*** *If your employer contributes the required premium during the month of January, the coverage month will begin February 1.*

### C. Continued Eligibility

Your coverage will continue for each month for which your employer makes the required contribution and provides a contribution report on your behalf. If your employer requires you to pay for a portion of your coverage, your employer's Payroll Department will handle any such deduction. Teamsters Local 170 Health & Welfare Fund does not calculate or administer payroll deductions for any employer.

Continued eligibility is determined month-to-month based on the following schedule:

| Contribution Month | Coverage Month |
|---|---|
| January | February |
| February | March |
| March | April |
| April | May |
| May | June |
| June | July |
| July | August |
| August | September |
| September | October |
| October | November |
| November | December |
| December | January |

***The monthly minimum contribution requirement is established by the Board of Trustees and is set forth in the applicable Collective Bargaining Agreement.***

## D. New Member Enrollment

***Important Note:*** **Teamsters Local 170 Health & Welfare Fund manages all eligibility and enrollment issues.** Please submit all requested documentation directly to us. Providing updated information or documents to your employer does not guarantee your eligibility.

If, at any time, you change your address/contact information, experience a change in marital status or wish to add/terminate dependents, you must Teamsters Local 170 Health & Welfare Fund.

**Important Note:** Members who enroll dependents must select the same coverage for all persons e.g. a member may not elect "single" or "employee only" for medical benefits and "family" for dental or vision benefits. **Dependent eligibility will not be granted without proper documentation.**

## E. Dependent Enrollment at The Time of Eligibility

Upon attaining eligibility, a new member must complete the required documentation for enrollment of dependents. If the documentation is received withing 60 days of the member's initial eligibility, dependents will be enrolled retroactive to the initial eligibility date. If the documentation is received after the 60-day timeframe, dependents only will be eligible prospectively (going forward).

Due to the Affordable Care Act and IRS regulations, it is now a **requirement** to provide social security numbers for all dependents. If we do not receive a dependent's social security number, we are not able to grant eligibility.

## F. Enrolling A Spouse

You may enroll an "eligible spouse" for coverage under the Plan. An eligible spouse is the lawful spouse of a member, including a legally separated spouse. A spouse may be enrolled upon receipt of the following documentation:

- Copy of state-issued marriage certificate.
- Information for any other insurance your spouse may have through an employer, Medicare, Medicaid or any other source.
- If your spouse is terminating another source of coverage, provide the HIPAA certificate to show the date the coverage ended.
- A former spouse may only be enrolled if your divorce decree specifies that you must provide coverage of a former spouse. A copy of the divorce decree will be required prior to enrolling a former spouse.

## G. Enrolling A Child

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, may be enrolled as your dependent upon receipt of the following documentation:

- For your own biological child: copy of the state-issued birth certificate listing the names of both parents. (Hospital records for children older than 60-days, birth announcements or records from a religious institution are not sufficient.)
- For a child who has been placed for adoption or foster care with you: copy of state-issued birth certificate and copy of court order indicating the date the child was placed for adoption or foster care.
- For a child whom you have been appointed as legal guardian with custody: a copy of the state-issued birth certificate and court order indicating the date guardianship began.
- For a stepchild: copy of state-issued birth certificate and copy of divorce decree indicating **parental responsibility for health insurance.**

**Important Note:** A grandchild may only be enrolled as a dependent if you have legal guardianship and custody of the child.

## H. Adult Dependents

For the purposes of the Plan, an adult dependent is a child who is between the ages of 19 and 26. An adult dependent's coverage will terminate on the last day of the month in which the dependent attaints age 26. **An adult dependent child may be married; however, the spouse and any children of the adult dependent are not eligible dependents under this Plan.**

## I. Annual Enrollment Period

Open enrollment occurs once each year. This is the member's opportunity to make changes to the dependents covered under the Plan. Under IRS rules, the open enrollment is the only time a member may add or remove dependents, unless a "Qualifying Event" occurs.

## J. Qualifying Event

The IRS has identified certain events that will allow a member to add or delete dependents outside the open enrollment period. The member must notify the Teamsters Local 170 Health & Welfare Fund withing 30 days of the event and provide all applicable documentation within 60 days of the event. If the member wishes to add a dependent but does not complete and submit the required enrollment information within 60 days of the event, the dependent will be eligible for coverage beginning the first day of the following month after the documentation has been submitted.

| **Qualifying Events – 30 days to change your coverage:** |
|---|
| 1. Change is legal **marital status**, including marriage, death of a spouse, divorce, legal separation and annulment. |
| 2. A change in the **number of dependents**, including birth, death, adoption and placement for adoption |
| 3. A change in **employment status of the member's dependent spouse** and/or adult dependent, including termination or commencement of employment, a strike or |

| | |
|---|---|
| | lockout, a commencement of or return from an unpaid leave of absence, a change in work site, or a change in employment status which results in a change in benefits s/he receives or is eligible to receive. |
| 4. | A change in the **employment status of the member's adult dependent child** that results in loss of access to employment-based group insurance. |
| 5. | A dependent's **loss of eligible status.** |
| 6. | A change in the **place of a dependent's residence** making the current Plan unavailable. |
| 7. | **Open enrollment** under the Plan available through the dependent **spouse's employer.** |
| 8. | **Judgements**, decrees or orders. |
| 9. | Significant **cost or coverage changes** under the member's Plan. |
| 10. | Entitlement to or Loss of coverage through **Medicare or Medicaid.** |

Coverage changes made as a result of a qualifying event must relate directly to the event, *e.g., a newborn may be added at the time of birth, but another dependent's coverage may not be changed at that time.*

## K. Employer/Member Contributions

Changes in coverage may affect the amount the member's employer must pay to Teamsters Local 170 Health & Welfare Fund. Changes in coverage provided to your dependents also may affect the amount you must contribute toward the monthly premium cost. **It is your responsibility to notify your employer of the change in coverage.**

## L. Adding a Spouse

- Notify Teamsters Local 170 Health & Welfare Fund within 30 days of marriage.
- Provide state-issued marriage license and social security number within 60 days of the date of marriage for your spouse to be covered retroactive to the date of marriage. If the marriage certificate and other enrollment information are not submitted within 60 days of the marriage, the spouse will only be eligible for coverage prospectively (going forward).
- Provide information for any other insurance your spouse may have through an employer, Medicare, Medicaid or any other source. If your spouse is terminating another policy, provide HIPAA certificate to show the date coverage has ended.
- If you and/or your spouse have been divorced, provide copies of all applicable divorce decrees.

## M. Adding a Stepchild At The Time of Marriage

- Submit state-issued birth certificate and social security number within 60 days of the date of marriage for your stepchild to be covered retroactively to the date of marriage.
- Submit a copy of the divorce decree from your spouse's previous marriage that pertains to medical insurance. If a divorce decree does not exist, a Stepchild Affidavit will be required.

- Provide information for any other insurance your stepchild may have through another parent, employer, Medicare, Medicaid or other source.

**N. Adding a Newborn**

- Notify Teamsters Local 170 Health & Welfare Fund within 30 days of birth.
- Submit state-issued birth certificate and social security number within 60 days from the date of birth for the child to be covered retroactively to the date of birth.
- A hospital's Record of Birth that lists the parent's names will be accepted on a ***temporary*** basis. However, if the state-issued birth certificate is not received by the end of the 60-day period, coverage will terminate.
- If the documentation is received more than 60 days after the date of birth, coverage will be prospective only (going forward).

**O. Adding a Foster Child/Adopted Child/Legal Dependent**

- Notify within 30 days of the child being placed in your home.
- Provide state-issued birth certificate and social security number within 60 days from the date of the placement,
- Provide Certificate of Adoption or court order indicating the date of placement and indicating temporary or permanent status.

**P. Continuation of Coverage For a Disabled Dependent**

An eligible dependent child who is permanently disabled due to illness, injury or developmental conditions may be able to continue eligibility after attaining age 26 if all following qualifications are met:

- Must already be an eligible dependent.
- Must be unmarried.
- Must be incapable of independent financial self-support and/or dependent on you for support and maintenance.
- May not be using the medical benefits provided by Medicare or Medicaid.
- Must live with the member and be dependent upon the member for daily care.

Application, proof of handicapped status and supporting medical report must be submitted prior to the end of the calendar month in which the dependent attains the age of 26. An annual update from your dependent's medical provider(s) may be required to continue eligibility once it is granted.

## DIVORCE

**Q. When You Decide to Divorce**

- Provide notification if either party has moved and provide address/contact information.

- Respond to requests for completion of a Marital Status Update form. Failure to do so may result in suspension of payment of claims.
- If you intend to continue coverage for your spouse after the divorce, that requirement must be specified in your divorce decree.

## R. Divorced Spouse Eligibility Requirements

Under certain circumstances, your former spouse may be eligible. Coverage for the former spouse will commence or continue if the divorce occurs when you are covered by the Plan only if coverage is required by the Divorce Decree and if your employer allows for coverage of former spouse. A former spouse may be considered an eligible dependent subject to the following conditions:

- The Divorce Decree must require that you maintain coverage for our former spouse;
- Neither you nor your former spouse has remarried; and

In the event of your divorce, you must notify Teamsters Local 170 Health & Welfare Fund of the divorce within 30 days of the divorce and , at the same time, provide Teamsters Local 170 Health & Welfare Fund with a copy of the Divorce Decree that requires you to provide medical insurance coverage for your former spouse and provide Teamsters Local 170 Health & Welfare Fund with current contact information for your former spouse. Coverage will not be provided prior to Teamsters Local 170 Health & Welfare Fund receiving a copy of the Divorce Decree.

If your employer makes contributions under a tiered family status, *e.g.* single, double or family, you must notify your employer of the divorce and you must arrange for the continuation of contributions to cover the former spouse.

If you do not notify Teamsters Local 170 Health & Welfare Fund of your divorce in the required time frame and claims are paid for an ineligible former spouse or ineligible stepchildren, you will be required to reimburse Teamsters Local 170 Health & Welfare Fund for the cost of those claims. Refusal to provide such reimbursement may result in suspension of benefits for the member and all dependents.

If possible, the members must provide current contact information for the former spouse.

If you have provided verbal notification of a divorce but have not provided the actual divorce decree or responded to requests for completion of Marital Status Update Requests, the former spouse's coverage will be suspended until the divorce decree or the response to the marital update request is submitted.

[Important note: State laws concerning coverage for former spouses vary among states but do not apply to Teamsters Local 170 Health & Welfare Fund. However, when a state law is cited in the decree, Teamsters Local 170 Health & Welfare Fund will look at the state law to determine the intent of the decree. Therefore, if the court or the parties intend that the former spouse must remain covered until either you or your former spouse remarries, the decree

should not refer to a state statute that only requires continued coverage for a specific number of years.]

## S. Termination of Dependent Coverage After Divorce

**Re-marriage:** If you or your former spouse remarry, coverage for your former spouse will cease, regardless of the terms of the divorce decree.

**Stepchildren:** Step children are not considered to be dependents of the plan after a divorce, regardless of the terms of the divorce decree.

## T. Suspension of Benefits

There are certain instances where, although you may be otherwise eligible for Plan benefits, your benefits and/or those of your dependents could be suspended until the situation causing your suspension is remedied. A suspension of benefits could result from (including but not limited to):

- not responding to a request to repay an overpayment of a disability claim
- not repaying a lien after you receive a monetary award
- not repaying the Plan after you have received proceeds from a third party
- not repaying the Plan for claims incurred by an ineligible dependent
- not responding to a request for information
- not submitted enrollment forms and dependent documents when required to do so
- enrolling an ineligible dependent
- committing fraud or misrepresenting information for the Plan

## U. Termination of Coverage

Your coverage under the Plan will end if any of the following occur:

- **Contribution not made:** If your employer does not remit the monthly contribution, your coverage will end on the last day of the Coverage Month for which sufficient contributions were received
    - ***Example:*** *If your employer does not remit on your behalf in January for the month of February, coverage will cease on January 31.*
- **Employer Relationship:** If your employer ceases to be a contributor to Teamsters Local 170 Health & Welfare Fund, coverage will end on the last day of the month for which employer contributions granted eligibility.
- **Plan Modifications:** If Teamsters Local 170 Health & Welfare Fund ends or modifies the Plan in a manner that makes you no longer qualified for coverage, coverage will end on the corresponding date.
- **Retirement:** If you retire, your coverage ends on the last day of the coverage month for which sufficient contributions were received.
- If the member otherwise becomes ineligible, coverage will end.

**V. Termination of Dependent Coverage**

A spouse's coverage under the Plan will end:

- When the member's coverage ends.
- If the individual no longer meets the Plan's definition of "Spouse."

A dependent child's coverage under the Plan will end:

- When the member's coverage ends.
- If the individual no longer meets the Plan's definition of "Dependent."

**W. Survivor Coverage:**

If you die will covered by Teamsters Local 170 Health & Welfare Fund as an active employee, your otherwise eligible covered dependents can remain covered for a maximum period of one year at no cost and upon receipt of required documentation for said dependents.

Surviving dependents must contact Teamsters Local 170 Health & Welfare Fund within 30 calendar days of the member's death and complete the appropriate forms to be eligible for survivor coverage.

**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.

**X. 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 premiums to the Health & Welfare Fund.

**Y. 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.

**Section 2.7**

**1. Eligibility – Retired Employees**

**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 out-of-network or non-participating providers.

**Blue Care Elect 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.

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

- **a.** Is retired; and
- **b.** Is at least age fifty-seven (57) but under age sixty-five (65); and
- **c.** 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
- **d.** 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
- **e.** 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.

## 2. 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.

### 3. Benefits Effective Date

Benefits under the retiree plan become effective on the first (1st) day after the retired employee's coverage terminates under the Fund's active Plan.

### 4. Dependent Eligibility Requirements

**1.** A retired employee's dependent spouse, as defined in Section 1.14 is eligible to participate in the Retired Employee Plan provided the monthly contributory payment is timely made.

**2.** A retired employee's dependent child, as defined in Section 1.14 is eligible to participate in the Retired Employee Plan provided the monthly contributory payment is timely made.

**3.** 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.

### 5. Dependent Coverage After Death of Retired Employee

In the event a retired employee dies while participating in the Retired Employee Plan, his dependents shall be permitted to continue participation in the Retired Employee Plan, subject to the following limitations:

**a.** The spouse shall be eligible to participate until reaching 65 years of age; and
**b.** The spouse does not have other primary coverage; and
**c.** The dependent shall be eligible to participate so long as he satisfies the definition in Section 1.14; and
**d.** Provided the contributory payment is timely made.

### 6. 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:

**a.** On the first day of the month of the retired employee's 65h birthday;
**b.** On the date of the retired employee's death;
**c.** The date the policy is cancelled;
**d.** The last day of the month following any period for which the contributory payment is not timely paid.

### 7. Termination of Retiree 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:

**a.** The spouse's 65th birthday; or
**b.** On the date of the spouse's death; or
**c.** The date the policy is cancelled; or
**d.** The last day of the month following any period for which the contributory payment is not timely paid.

**8. Termination of Retiree 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:

**a.** The date the dependent no longer satisfies the definition of a dependent in Section 1.14; (ie. the Dependent is 26 years of age and not disabled); or
**b.** Neither the retired employee nor the retired employee's spouse participate in the Retired Employee Plan; or
**c.** The date the policy is cancelled; or
**d.** The dependent child's date of death; or
**e.** The last day of the month following any period for which the contributory payment is not timely paid.

**9. Owner's Ineligibility**

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

**a.** A sole proprietor who is a contributing employer, and the spouse of a sole proprietor;
**b.** A partner is a partnership is which is a contributing employer, regardless of the size of the partnership interest; a spouse of any partner is also considered an owner; or
**c.** 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
**d.** 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).

## Section 2.7 COBRA/USERRA Continuation Coverage

This section describes the procedures for continuing health coverage, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Unless stated otherwise, "COBRA Continuation Coverage" includes the coverage required by USERRA.

**A. In General** The participant, his spouse and other eligible dependents may continue eligibility for benefits for specified periods set forth in Section 2.7D, by making self- payments

at the rates determined by the Trustees where eligibility would have otherwise terminated as a result of a "qualifying event."

**B.** **Benefits Provided** When a participant or qualified beneficiary elects COBRA Continuation Coverage, pursuant to Section 2.7F3, 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.

**1**. **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 elect coverage only for medical 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).

**2.** **Non-Medical Benefits Not Covered —** COBRA Continuation Coverage does not provide coverage for Non-Medical Benefits. Consequently, Life Insurance, the Spousal Burial Benefit, Dependent Burial Benefit, the Accidental Death and Dismemberment Benefit, and the Short Term Disability Benefit 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.

**C.** **Qualifying Events and Duration of Coverage** In order to be eligible for COBRA Continuation Coverage, an individual must incur a "qualifying event" which would otherwise result in the termination of eligibility for benefits under the Plan.

**1.** **Participant Qualifying Event. Qualifying Events for Eligible Participants, Their Spouses, and Other Eligible Dependents are as follows:**

- **a**. Termination of covered employment for reasons other than gross misconduct;
- **b.** Reduction of hours of employment;
- **c.** Absence from employment because of service in the uniformed services of the United States; and
- **d.** Termination of direct pay benefits.

**2.** **Spouse and Qualifying Child Qualifying Events** Qualifying events for a Participant's eligible spouse and other eligible Dependents are as follows:

- **a.** The participant's death;
- **b.** Divorce from the participant;
- **c.** The participant's entitlement to Medicare coverage; and
- **d.** Loss of dependent status under the terms of the Plan, i.e., the dependent no longer meets the definition of dependent under the Plan.

**D.** **Duration and Termination of Coverage** An individual's eligibility to continue self-paying for COBRA Continuation Coverage shall terminate upon the end of the applicable continuation period or a termination event, whichever occurs first.

**1.** **Applicable Continuation Period**

**a.** COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the participant, entitlement to Medicare benefits (under Part A, Part B, or both), your divorce or, in some cases, a qualifying child's loss of eligibility as a dependent, COBRA continuation coverage can be extended for thirty-six (36) months. When the qualifying event is the end of employment or reduction of the Participant's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until thirty-six (36) months after the date of Medicare entitlement.

**b.** Where a participant's eligibility for benefits would have terminated as the result of a reduction of hours, the Applicable Continuation Period is thirty-six (36) months from the date coverage would have otherwise terminated.

**c.** Where a participant's eligibility for benefits would have terminated as the result of the termination of employment, the Applicable Continuation Period is eighteen (18) months from the date coverage would have otherwise terminated.

**d.** In the event that a qualified beneficiary becomes disabled under Title II or XVI of the Social Security Act within sixty (60) days after a qualifying event, then the Applicable Continuation Period is twenty-nine (29) months, provided that the fund office is notified of the social security determination before the close of the initial eighteen (18) month period of COBRA coverage. In the event the participant or qualified beneficiary ceases to be disabled, he and his dependents shall cease to be eligible to self-pay beyond the later of:

**(i)** The end of the initial eighteen (18) month period; or

**(ii)** The end of the month in which the date falls that is thirty (30) days after a final determination that the participant or qualified beneficiary is no longer disabled.

**e.** In the event that a participant becomes disabled under Title II or XVI of the Social Security Act within sixty (60) days after a qualifying event, then the Applicable Continuation Period is forty- seven (47) months, provided that the fund office is notified of the Social Security determination before the close of the initial eighteen (18) month period of COBRA coverage. In the event the participant ceases to be disabled, he and his dependents shall cease to be eligible to self-pay beyond the later of:

**(i)** The end of the initial eighteen (18) month period; or

**(ii)** The end of the month in which the date falls that is thirty (30) days after a final determination that the participant or qualified beneficiary is no longer disabled.

**f.** In the event of the participant's death, the Applicable Continuation Period is thirty-six (36) months from the date of death.

**g.** Where a participant loses eligibility because of his service in the uniformed services of the United States, the maximum period for coverage of the participant and his dependents is the lesser of:

**(i)** The thirty-six (36) month period beginning on the date on which the person's absence begins; or

**(ii)** The date on which the person fails to apply for, or return to, his position of covered employment within the meaning of USERRA Section 4312(e).

**h.** For all other qualifying events, the applicable continuation period is either 36 months from the date on which benefit eligibility otherwise would have terminated.

**i.** If two (2) or more qualifying events occur, the Applicable Continuation Period for the participant's spouse and other dependents is thirty-six (36) months from the first (1st) date on which benefit eligibility otherwise would have terminated. In any event, a spouse who was not eligible to elect COBRA Continuation Coverage at the time of the first (1st) qualifying event is not entitled to do so upon subsequent qualifying events.

**E**. **Termination Events** No other self-pay coverage (other than retiree coverage, if eligible) is available from the Plan once an individual's COBRA coverage ceases as a result of a Terminating Event. A Terminating Event occurs on the earliest of the following dates:

**1**. The conclusion of the Applicable Continuation Period;

**2.** The date on which all health care coverage offered by the Fund terminates;

**3.** The date on which the individual becomes covered by another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition of the individual;

**4.** The date on which the individual becomes entitled to Medicare coverage;

**5.** The last day of the period preceding any period for which a premium is not timely paid; or

**6.** Reinstatement of active coverage eligibility.

**F.** **Notice Requirements** In order to obtain COBRA Continuation Coverage from the Fund, an individual must comply with the following notice requirements:

**1.** **Timeliness** A covered participant or qualified beneficiary must notify the Fund Office in writing of each qualifying event within sixty (60) days after the later of:

**a.** The date of the qualifying event; or

**b**. The date the qualified beneficiary would lose coverage on account of the qualifying event. An individual will be considered to have satisfied the notice requirements set forth in this paragraph if the participant's employer reports a qualifying event in a timely-filed contribution report covering the period during which the event occurred.

**2.** **Fund Notification** Within thirty (30) days of receipt of notice that a qualifying event has occurred, the Fund Office will notify the participant, his spouse, and any other qualifying child not living with him (whose address is known to the Fund) whose coverage is affected by the qualifying event of the right to elect COBRA Continuation Coverage. The Fund Office also will provide notice of the applicable premiums, and instructions for electing COBRA Continuation Coverage.

**3.** **Election of COBRA Continuation Coverage** To elect COBRA Continuation Coverage, the Participant, his spouse, or his qualifying child must complete the COBRA election form provided by the Fund Office and must pay the premium for such coverage. This completed election form must be submitted to the Fund Office within sixty (60) days after the later of the following dates:

- **a.** The date that eligibility for benefits would otherwise terminate as a result of the qualifying event; or
- **b.** The date of the notice of his right to elect COBRA Continuation Coverage sent out by the Fund Office;

Failure to timely elect COBRA Continuation Coverage will result in the loss of eligibility for such coverage.

**4.** **Notice of Subsequent Qualifying Events** A participant or qualified beneficiary who is eligible to self-pay under Section 2.7.D.1.e must notify the Fund of the determination of disability by Social Security within sixty (60) days of such determination, but in no event later than the close of the initial eighteen (18) month period. In the event the participant or qualified beneficiary is subsequently determined by Social Security to be no longer disabled, the participant or qualified beneficiary must notify the Fund within thirty (30) days of such determination.

**G.** **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:

**1.** **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;

**2.** **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").

**H.** **Amount of Premium**

**1.** **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 Section 2.7.D. 1.e.

**2.** 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.

**3.** 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.

**I.** **Types of Premiums** Core coverage, or if eligible, core and non-core coverage, shall be offered.

**Section 2.7.5 Participant's Extension Eligibility** A participant for whom the required contributions to provide eligibility for benefits are not remitted by a contributing employer, shall be considered to have earned a sufficient number of contribution weeks in a month provided that his employer has contributed on his behalf at least 20 weeks in the 6 month period ending that month.

**Section 2.8 Coverage Pursuant to Qualified Medical Child Support Orders**

**A.** **In General.** The Fund shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order. A Qualified Medical Child Support Order with respect to any participant or beneficiary shall apply to the Fund when it has received such an order with respect to a participant or beneficiary who is eligible to receive such benefits, and with the respect to which the requirements of Section 2.8.D are met.

**B.** **Definitions** For purposes of this subsection:

**1.** **Qualified Medical Child Support Order** The term "Qualified Medical Child Support Order" is defined as a Medical Child Support Order:

- **a.** Which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under the Fund's Plan of Benefits; and
- **b.** With respect to which the requirements of Section 2.8.C and Section 2.8.D are met.

**2.** **Medical Child Support Order** The term "Medical Child Support Order" is defined as any judgment, decree, or order (including approval of a settlement agreement) which:

- **a.** Provides for child support with respect to a qualifying child of a participant or provides for health benefit coverage to such a qualifying child, is made pursuant to a state domestic relations law (including community property law), and relates to benefits under the Plan; or

**b.** Is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan, if such judgment, decree, or order:

**(i)** Is issued by a court of competent jurisdiction; or

**(ii)** Is issued through an administrative process established under State Law and has the force and effect of law under applicable State law. For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in sub clause (ii) of the preceding sentence and which has the effect of an order described in clause (a) or (b) of the preceding sentence shall be treated as such an order.

**3.** **Alternate Recipient** The term "Alternate Recipient" is defined as any qualifying child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Plan with respect to such participant;

**4.** **Qualifying Child** The term "Qualifying Child" includes any qualifying child adopted by, or placed for adoption with, a participant of the Plan.

**C.** **Information to be Included in Qualified Order** A Medical Child Support Order meets the requirements of Section 2.8, only if such order clearly specifies:

**1.** The name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a state or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient;

**2.** A reasonable description of the type of coverage to be provided to each alternate recipient, or the manner in which such type of coverage is to be determined; and

**3.** The period to which such order applies.

**D.** **Restriction on New Types or Forms of Benefits** A Medical Child Support Order meets the requirements of Section 2.8 only if such order does not require the Fund to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

**E.** **Procedural Requirements**

**1.** **Timely Notifications and Determinations** In the case of any medical child support order received by the Fund,

**a.** Within five (5) business days after the receipt of such order, the Fund shall promptly notify the participant and each alternate recipient of the receipt of such order and the Fund's procedures for determining whether Medical Child Support Orders are Qualified Medical Child Support Orders; and

**b.** Within fifteen (15) business days after receipt of such order, the Fund shall determine whether such order is a Qualified Medical Child Support Order or if additional information is necessary to make a determination. The Fund shall

notify the participant and each alternate recipient of either the determination or the need for additional information.

**2.** **Requirement for Additional Information** In the event that it cannot be determined from the face of the judgment, decree or order, based on the ready knowledge of the Fund, that such judgment, decree, or order meets the requirements of set forth in Section 2.8.F.1. The Fund shall promptly request in writing from the participant, the participant's representative, and/or the alternate recipient's designated representative such additional information as is deemed necessary to make a determination.

**a.** If the information requested is not received within thirty (30) days of its request, the judgment, decree, or order shall be considered as not constituting a QMCSO (Qualified Medical Child Support Order), and the Fund shall within five (5) business days so notify in writing all persons who received initial notification of receipt of the judgment, decree or order by the Fund.

**(i)** Any appropriate party aggrieved by such decision may exercise the right of appeal to the Trustees of the Fund.

## F. National Medical Support Notice Deemed to be a Qualified Medical Child Support Order

**1.** **In General** If the participant or beneficiary of the Plan is a non-custodial parent of a Qualifying Child and the Fund receives an appropriately completed National Medical Support Notice promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998 in the case of such qualifying child, and the notice meets the requirements set forth above shall be deemed to be a Qualified Medical Child Support Order in the case of such qualifying child.

**2.** **Enrollment of Qualifying Child in Plan** In any case in which an appropriately completed National Medical Support Notice is issued in the case of a qualifying child of a participant under the Plan who is a non-custodial parent of the qualifying child, and the notice is deemed to be a Qualified Medical Child Support Order, the Fund, within (forty) 40 business days after the date of the notice, shall:

**a.** Notify the state agency issuing the notice with respect to such child whether coverage of the qualifying child is available under the terms of the Plan and, if so, whether such qualifying child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision thereof substituted for the name of such qualifying child to effectuate the coverage; and

**b.** Provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage;

**2.** **Rule of Construction** Nothing shall be construed as requiring the Fund, upon receipt of a National Medical Support Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such notice.

**G.** **Actions taken by Fiduciaries** If a fund fiduciary acts in accordance with his fiduciary responsibilities as established in the Employee Retirement Income Security Act in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Fund's obligation to a participant and each alternate recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

**H. Treatment of Alternate Recipients**

**1.** **Treatment as Beneficiary Generally** A person who is an alternate recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the Plan for all purposes.

**2. Treatment as Participant for Purposes of Reporting and Disclosure Requirements**

A person who is an alternate recipient under any Medical Child Support Order shall be considered a Participant under the Plan for purposes of reporting and disclosure requirements of the Employee Retirement Income Security Act.

**I.** **Direct provision of Benefits Provided to Alternate Recipients** Any payment for benefits made by the Fund pursuant to a Medical Child Support Order in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

**J.** **Payment to State Official Treated as Satisfaction of Obligation to Make Payment to Alternate Recipient** Payment of benefits by the Fund to an official of a state or a political subdivision thereof whose name and address have been substituted for the address of an alternate recipient in a Qualified Medical Child Support Order, pursuant to Section 2.8.C.1, shall be treated, for purposes of Section 2.8.J, as payment of benefits to the alternate recipient.

**K. Rights of Payment Where Participants or Beneficiaries are Eligible for Medicaid Benefits**

**1.** **Assignment of Rights** Payment for benefits with respect to a participant under the Plan will be made in accordance with any assignment of rights made by on or behalf of such participant or a beneficiary of the participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912 (a)(1)(A) of such Act.

**2.** **Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility** In enrolling an individual as a participant or beneficiary or in determining or making any payments for benefits of an individual as a participant or beneficiary, the fact that the individual is eligible for, or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act, will not be taken into account.

**3.** **Acquisition by States of Rights of Third Parties** To the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Fund has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance

with any state law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

**L. Coverage of Dependent Children in Cases of Adoption**

**1. Coverage Effective Upon Placement for Adoption** In any case in which the applicable Schedule of Benefits provides coverage for qualifying children of participants or beneficiaries, the Fund shall provide benefits to qualifying children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of qualifying children who are natural children of participants or beneficiaries under the Plan, irrespective of whether the adoption has become final.

**2. Definitions** For purposes of this Section:

**a. Qualifying Child** The term "Qualifying Child" is defined as, in connection with any adoption, or placement for adoption, of the Qualifying Child, an individual who has not attained the age 18 as of the date of such adoption or placement for adoption.

**b. Placement for Adoption** The term "placement", or being "placed", for adoption, in connection with any Placement for Adoption of a qualifying child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such person of a legal obligation for a total or partial support of such qualifying child in anticipation of adoption of such qualifying child. The qualifying child's placement with such person terminates upon the termination of such legal obligation.

**M. Continued Coverage of Costs of Pediatric Vaccines** The Fund will not reduce its coverage of the costs of pediatric vaccines (as defined under section 1928(h)(6) of the Social Security Act as amended by section 13830 of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993.

**Section 2.9 Participants –Reinstatement of Active Coverage Eligibility**

If a Participant's eligibility for benefits terminates under the Plan, he will again become eligible as follows:

**A.** Except as set forth in Sections 2.7B and 2.7C.

**1.** For a participant who initially became eligible for benefits under Sections 2.2A and/or 2.2B, on the first day of the month which represents the second ($2^{nd}$) month following the month to which his employer contributes to the Fund on his behalf the appropriate weekly contribution for all, or all but one (1) of the weeks of the month.

**B**. On the first (1st) day of the week for which contributions are first paid upon return from active duty as provided for by the Uniform Services Employment and Reemployment Rights Act ("USERRA") 38 U.S.C. §4312(e)(1)(a)(i). As a general rule, if an employee left covered employment for induction into the uniformed services of the United States, his coverage shall be reinstated when he returns to covered employment under the following general schedule:

**1**. If the period of service in the uniformed services was less than thirty-one (31) days, the participant or dependent must report no later than the beginning of the first (1st) full regularly scheduled work period on the first (1st) full calendar day after the participant or dependent completes service. Allowance will be made, however, for the participant or dependent's safe transportation from the place of service to his residence plus an eight (8) hour period. If this is impossible or unreasonable through no fault of the returning veteran, then the returning veteran must give notice as soon as possible after the eight (8) hour period;

**2.** If the period of uniformed service is more than thirty (30) days but less than one hundred eighty (180) days, the participant or dependent must submit an application no later than fourteen (14) days after completion of service. If meeting the deadline is impossible or unreasonable, the next first (1st) full calendar day when making application is possible is sufficient;

**3.** If the period of uniformed service is more than one hundred eighty (180) days, the participant or dependent has ninety (90) days after completion of service to reapply for employment;

**4.** A veteran who is hospitalized or convalescing from a service-related injury or illness is allowed up to two (2) years for recovery before deadlines apply. This schedule is for information purposes only and is not intended to address the various exceptions to the general rules. The provisions of 38U.S.C. §4312(e) (1) (A) (i) will control the administration of the Fund.

## Section 2.10 Dependents – Initial Eligibility

**General Rule** Except as otherwise provided, a person who is a Dependent of a Participant shall become eligible for benefits on the later of the following dates:

**1.** The date that the participant becomes eligible for benefits; or
**2.** The date that the person becomes a dependent of the participant.

## Section 2.11 Dependents – Continued Eligibility

All Dependents who are eligible for benefits will continue to be eligible for the benefits specified in the Plan until their eligibility for benefits terminates in accordance with the applicable provision of the Plan.

## Section 2.12 Dependent's Termination of Eligibility

Except as provided elsewhere in this Plan, the eligibility for benefits of any dependent of a Participant shall terminate on the earliest of the following dates:

**A.** The last date on which such person is a dependent;

**B.** The date immediately preceding the dependent's induction into the Armed Forces of the United States on full-time active duty;

**C.** The date the participant's eligibility for benefits terminates unless;

**1.** Sufficient contributions are provided by the participant's employer as required under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") to maintain eligibility as though the participant were employed or

**2.** In cases of death of the participant, the last day the participant would have been eligible for contribution based benefits;

**A.** The date the participant's employer ceases to be a participating employer.

**B.** The day of the dependent's death.

### Section 2.13 Dependents – Reinstatement of Eligibility

**A.** **General Rule** If a dependent's eligibility for benefits terminates as a result of the termination of a participant's eligibility, the dependent will again become eligible at the same time that the participant's eligibility is reinstated.

**B.** **Exceptions** The following exceptions apply to the reinstatement of eligibility rule contained in Section 2.13:

A dependent's eligibility will not be reinstated if he is not a dependent on the participant's reinstatement date.

### Section 2.14 Termination of Group Coverage for Active Participants

If a participating employer ceases to make contributions on behalf of its employees in Active Service, the Fund will cease providing benefits to every participant 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.

## Section 3 Benefits

### Section 3.1 Life Insurance Benefit

The Fund has procured group life insurance coverage from the 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. 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 plan is attached hereto as 'Exhibit A". Retired employees and Dependents are not provided life insurance coverage. Active employees are automatically enrolled in this plan when they meet eligibility requirements.

**1.** **Proof of Death** Upon receipt by the Fund of due proof of the death of an active Employee and any other required documents while eligible for benefits, the Fund or the Fund's life insurance carrier will pay to his designated beneficiary the amount of Life Insurance Benefits determined in accordance with the Schedule of Benefits covering him on the date of his death.

**2.** **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:

**a.** Executor/Administrator;
**b.** Spouse,
**c.** Child or Children (in equal shares),
**d.** Mother and/or Father (in equal shares).

**3.** **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.

**4.** **Limitations**

No payment shall be made under this Section 3.1 for any loss which is excluded by Symetra plan attached hereto as Exhibit "A".

**5.** **Converting Life Insurance, Waiver of Premium, Accelerated Benefit**

The insurance policy purchased by the Fund allows a member to convert coverage, to an individual policy, subject to the terms and conditions of Symetra policy. Further, the policy allows a member to obtain a waiver of premium under certain terms and conditions (such as a disability) as set forth in Symetra policy. Additionally, the policy allows a member to obtain an accelerated benefit subject to the terms and conditions (such as a terminal illness) as set forth in Symetra policy.

**Section 3.2 Accidental Death and Dismemberment Benefit**

The Fund has procured group Accidental Death and Dismemberment coverage from Symetra. The Fund shall pay those benefits in accordance with the terms and conditions of Symetra plan attached hereto as Exhibit "A' and subject to the limitations contained therein.

**A. In General** Upon receipt by the Fund of sufficient proof that a participant, while eligible for benefits, has received an Accidental Bodily Injury and, as a result, has suffered any of the losses, the Fund's life insurance carrier shall pay a benefit based on the loss suffered. The amount of benefit payable shall be the percentage shown as shown on the policy for the loss of life or bodily injury, multiplied by the principal sum shown in the Schedule of Benefits covering the participant at the time the loss occurred; in no event, however, shall the total amount payable for all losses suffered by a participant as a result of any one (1) accident exceed one hundred percent (100%) of that principal sum. **The terms, conditions and exclusions of the accidental death and dismemberment insurance policy shall in all respects govern the payment of benefits.**

**B.** **Payment of Benefits** Payment of benefits under Section 3.2 shall be made in accordance with the rules of Section 3.1, "Life Insurance Benefit," in the case of loss of life, and otherwise in accordance with Section 3.1.

**C.** **Limitations** No payment shall be made under this Section 3.2 for any loss which is excluded by Symetra policy.

**D.** **Additional Provisions** There is coverage for additional benefits, including a repatriation benefit or education benefit, subject to the terms and conditions of Symetra policy.

**Section 3.3 Short Term Disability Income Benefit**

**A.** **In General** If while eligible for benefits, an active employee becomes totally disabled and 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 3.3.B., and ends as described in Section 3.3.C. 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.

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

**1.** 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.

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

**1.** The last day that the employee is disabled as described in Section 3.3A;

**2.** The day the employee has exhausted the maximum of twenty six (26) weeks of benefits in a fifteen (15) month period;

**3.** The date the employee retires, regardless as to whether the member receives a pension; or

**4.** 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.

**D.** **Limitations** No payment shall be made under Section 3.3:

**1.** For any employment related illness or injury; or

**2.** For any period during which the employee is not undergoing regular treatment by a physician for a disability; or

**3.** For any period during which the employee works for wages or profit; or

**4.** 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.

**E**. **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.

**F.** **Continuation of Benefits if you Become Disabled** For the first four (4) weeks of disability, your employer is required (if set forth in the collective bargaining agreement) to contribute to the Fund as 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.

**G.** **Active Employee Benefit** Only active employees are eligible to receive short term disability income.

**H**. **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.

**I.** **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.

## Section 3.4 Wellness Programs

The Fund may provide wellness benefits or programs (a welfare benefit) subject to the provisions of the Patient Protection 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 administers 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 Wellness Program.

**Medical and Pharmacy Benefits** The benefits set forth in Sections 3.5 – 3.22B describe summarily the medical and pharmacy benefits to be provided to a participant and his 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 and for the medical and pharmacy benefits described in a participant's Schedule of Benefits, subject to all of the limitations contained therein, including deductibles, co-payments , co-insurance, benefit limitations, pre-authorization requirements, referral requirements, advance notice requirements and the limitations imposed in Article 4 ("General Limitations").

## Section 3.5 Inpatient Hospital Expense Benefit

**A. In General** The Fund shall pay the expenses incurred by a participant 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:

**1.** Room and board for each day of Hospital confinement.

**2.** Necessary services and supplies for each day of Hospital confinement.

**B. Limitations** no payment will be made under section 3.5 for:

**1.** Personal comfort items;

**2.** 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 60 day benefit time period, per member, per year; or

**3.** No payment will be made under Section 3.5 for expenses which are not payable under the limitations set forth in Article 4 of this Plan Document ("General Limitations").

## Section 3.6 Emergency Room Benefit

**A. 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.

**B.** **Limitations** No payment will be made under Section 3.6 for expenses which are not payable under the limitations set forth in Article4 of this Plan Document ("General Limitations").

**Section 3.7 Surgical Expense Benefit**

**A.** **In General** The Fund shall pay all expenses associated with and the physician's fee incurred by a participant 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.

**B.** **Certified Surgical Assistant** If deemed medically necessary by the plan or its designee, the Fund shall pay the charges for a Certified Surgical Assistant 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. The Plan has final authority to determine what is medically necessary.

**C.** **Ambulatory Surgery** The Surgical Expense Benefits provided under Section 3.7 will be equally available for surgery performed at a Hospital or at a certified ambulatory surgical facility if such benefits are provided under the participant's Schedule of Benefits.

**D.** **Limitations** No payment will be made under 3.7 for expenses which are not payable under the limitations set forth in Article 4 of this Plan Document ("General Limitations").

**Section 3.8 Diagnostic X-ray and Laboratory Expense Benefit**

**A.** **In General** The Fund shall pay Allowable X-ray/Lab Expenses incurred by a participant 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 that is performed by or under the supervision of a legally qualified physician 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.

**B.** **Limitations** No payment shall be made under this section for:

**1.** Expenses which are not payable under the Plan according to Article 4, "General Limitations."

**Section 3.9 Prescription Drug Expense Benefit**

**A.** **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 dependents for allowable drugs if such benefits are provided under the participant's Schedule of Benefits.

**B.** **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.

**C.** **Purchase Location** 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.

**D.** **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.

**E.** **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 Caremark 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 Caremark 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 Caremark 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 Plan;

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

- Expenses which are not payable under the Plan according to Article 4, "General Limitations".

For a more detailed description of limitations you should review your Schedule of Benefits. In addition, for 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.

**Section 3.10 Dental Expense Benefit**

**A. In General** The Fund shall pay expenses incurred by a participant or dependent for eligible dental services if such benefits are provided under the participant's Schedule of Benefits, 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. Benefits may be categorized summarily as preventative, basic, major or orthodontic. The preventative 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. There are no annual out of pocket maximums, under the active plan for enrolled dependents under the age of 19.

**B. Limitations**

**1.** No payment shall be made under Section 3.10 for:

**a.** Expenses incurred for dental services rendered solely for cosmetic purposes;
**b.** Charges for appointments that are not kept;
**c.** Orthodontic services unless such benefits are provided under the Participant's Schedule of Benefits, and if so, subject to any benefit maximums as set forth in the Schedule of Benefits;
**d.** Services deemed to be unnecessary or inappropriate;
**e.** Services or products which exceed any benefit maximums or are otherwise excluded pursuant to the participant's Schedule of Benefits, benefit descriptions and riders; or

**f.** Expenses which are not payable under the Plan according to Article 4, "General Limitations."

## Section 3.11 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 Article 4, "General Limitations".

## Section 3.12 Vision Care Plan Benefit Description

**A.** **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 contract. This benefit is more fully described in a separate Plan Document attached as EXHIBIT 6 to the Summary Plan Description first effective January 1, 2023. As used in the preceding sentence, the term "Allowable Vision Care Expenses" means expenses for charges made by licensed personnel for eye exams, eye glass, lenses or contact lenses and retinal imaging.

**B.** **Limitations** No payment shall be made under section 3.12 for expenses incurred:

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

**2.** For more than two (2) sets of eyeglasses (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 plan benefit description. Coverage does include digital progressive lenses with no co-pay; coverage includes standard, premium and ultra-anti reflective coating for lenses and coverage does include transition lenses;

**3.** For medical treatment for eye disease or injury;

**4.** For vision therapy;

**5.** Services not performed by licensed personnel; or

**6.** For benefits which are not payable according to Article 4 of this Plan Document ("General Limitations").

## Section 3.13 Physician Office Visit Benefit

**A.** **In General,** The Fund shall pay allowable physician office visit charges incurred by a Participant 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.

**B.** **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).

**C.** **Limitations**

**1.** The payment of physician office visit benefits is subject to the limitations set forth in Article 4 of this Plan Document ("General Limitations").

## Section 3.14 Out-of-Pocket Expense Benefit

**A.** **General Rule** The Fund will pay 100% of allowable Out-of-Pocket Expense charges after a participant, a dependent, or the participant's family satisfies the out-of-pocket limit.

**B.** **Allowable Out-of-pocket Expense Charges** "Allowable Out-of- pocket Expense Charges" is defined as all expenses incurred that require payment of coinsurance.

**C.** **Limitations** Benefits under this section are not payable with respect to:

**1.** Any expenses incurred prior to the date the participant or dependent became eligible for benefits;

**2.** Charges that exceed the allowable charge;

**3.** Charges that are for services and supplies that are not covered by the Plan;

**4.** Charges that are in excess of Schedule of Benefit maximums;

**5.** Charges you pay when your coverage is reduced or denied because you did not follow the requirements of a utilization review program;

**6.** The amount you pay for your health plan;

**7.** Your Schedule of Benefits may provide other costs that you have to pay that do not count towards your out-of-pocket maximum including but not limited to: deductibles, co-pays, co-insurance for durable medical equipment, pharmacy co-pays and out-of-network co-pays;

**8.** Benefits that is not payable according to Article 4 of this Plan ("General Limitations").

## Section 3.15 Rehabilitation Expense Benefit

**A.** **In General** The Fund will pay allowable rehabilitative expenses incurred by a participant 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.

**B.** **Limitations** Allowable rehabilitative expenses will not include, and no payment will be made for expenses incurred for:

**1.** Expenses which exceed any benefit limit under the participant's Schedule of Benefits;

**2.** Benefits which are not payable under the Plan according to Article 4 ("General Limitations").

## Section 3.16 Organ Transplant Expense Benefit

**A.** **In General** The Fund will pay Allowable Organ Transplant Expenses incurred by a Participant 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.

**B.** **Follow Up Care** The Fund will pay Follow Up Care Expenses incurred by a participant 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. As used in the preceding sentence, the term "Follow-up Care" is defined as expenses for immunosuppressant drugs as administered and medical care provided in the home or Hospital.

**C.** **Live Donor Charges** The Fund will pay live donor charges incurred by a participant 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.

**D.** **Limitations** No payment shall be made under section 3.16 for:

**1**. Any transplant considered experimental or investigational;

**2.** Expenses for transportation for surgeons or family members;

**3.** Expenses which exceed any benefit limitation as set forth in a participant's Schedule of Benefits; or

**4.** Expenses which are not payable under the plan according to the limitations set forth in Article4 ("General Limitations").

## Section 3.17 Musculoskeletal (Chiropractic) Expense Benefit

**A. In General**. The Fund shall pay Allowable Musculoskeletal Expenses incurred by a participant 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 of the spine. Allowable Musculoskeletal Expenses include, but are not limited to comprehensive and progress examinations, office visits including manipulation, physical therapy modalities, braces, cervical collar, spinal x-rays, and lab work.

**B. Limitations** The payment of Musculoskeletal Expense Benefits is subject to the limitations set forth in Article4 of this Plan Document ("General Limitations").

## Section 3.18 TMJ Disorder Treatment

The Fund shall pay expenses incurred by a participant 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.

**A. Limitations** No payments shall be made under section 3.18 for:

1. Expenses which exceed any benefit limitation as set forth in a participant's Schedule of Benefits;
2. Expenses which are excluded as set forth in a participant's Schedule of Benefits;
3. 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),
4. Expenses which exceed any benefit limitation as set forth in a participant's Schedule of Benefits; or
5. Expenses which area not payable under the Plan according to Article 4 ("General Limitations").

**3.19 Preventative Health Services** The Fund shall pay expenses incurred by a participant 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 (1 per member per year), 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 paid for expenses which are not payable under the Plan according to Article 4 of this Plan Document ("General Limitations").

**3.20 Medical Formulas** The Fund shall pay expenses incurred by a participant or dependent regarding medical formulary, if such benefits are provided under the participant's Schedule of Benefits.

**A. Limitations** No payment shall be made under section 3.20 for:

**1.** Expenses which exceed any benefit limitation as set forth in a participant's Schedule of Benefits; and

**2.** Expenses which area not payable under the Plan according to Article 4 of this Plan Document ("General Limitations").

**3.21 Maternity Health Services** The Fund shall pay expenses incurred by a participant 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.

**A. Limitations** No payment shall be made under Section 3.21 for:

**1.** Expenses which exceed any benefit limitation as set forth in a participant's Schedule of Benefits; and

**2.** Expenses which area not payable under the Plan according to Article 4 ("General Limitations").

**3.22 Infertility Services** The Fund shall pay expenses incurred by a participant 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.

**A. Limitations** No payment shall be made under Section 3.22 for:

**1.** Expenses which exceed any benefit limitation as set forth in a participant's Schedule of Benefits; and

**2.** Expenses which area not payable under the Plan according to Article 4 ("General Limitations").

**3.22 A COVID-19.**

**Diagnosis, Prevention, Testing, and Treatment of COVID-19**

In 2020, the federal government declared a national emergency (NE) and a public health emergency (PHE) due to COVID-19. During this time, the federal and state governments outlined several requirements and recommendations regarding coverage for certain services related to COVID-19. At that time, the Fund adopted the required services as well as additional services to assist members in getting the care that they needed without worry of any financial or other barriers.

The NE ended on April 10, 2023, and the PHE ended on May 11, 2023. On May 11, 2023, coverage for most services was no longer required. However, the Trustees of Teamsters Local 170 HWF decided that since the virus continued, the Fund would continue to provide coverage for services even without the government requirements until December 31, 2023. Unfortunately, Covid 19 continues to persist and is escalating. The Trustees have decided to extend the Covid protections and services as set for below until December 31, 2025. The Trustees will continue to monitor the virus and adjust coverage if and/or when it is appropriate to do so.

***Continue to Cover Over the Counter COVID 19 Test Kits and Tests Ordered by a Clinician at No Charge to the Member***

As stated above and in line with guidance issued as part of the federal government's declaration of a public health emergency, BCBSMA expanded coverage for COVID-19 tests, vaccines, and treatment. The national emergency formally expired on April 10, 2023, one month earlier than expected. As of May 11, 2023, BCBSMA no longer covered over the counter (OTC) COVID-19 tests.

However, the Trustees of Teamsters Local 170 Health and Welfare Fund have decided to continue to cover over the counter Covid test kits through December 31, 2025. Coverage will continue to be capped at $12 per test with a limit of 8 per member per month.

COVID-19 tests ordered by a clinician will continue to be covered at no cost to members and without prior authorization or other medical management requirements.

***Continue to Waive Cost Share for COVID-19 Related Services (Vaccines, Paxlovid, Inpatient, Outpatient, and Cognitive Rehabilitation Services***

The Trustees of the Teamsters Local 170 Health and Welfare Fund have decided to continue to waive eligible in-network copays and other cost-sharing through December 31, 2025, for members obtaining services related COVID-19 testing, diagnosis and treatment. Cost share will continue to be waived for services including Inpatient, Outpatient, Emergency and Cognitive Rehabilitation, Paxlovid and Covid-19 vaccines when administered by an in-network or clinician/pharmacy. This will save money for members who need services related to COVD-19 and its effects. Regular plan rules and applicable cost share will apply if a member receives out-of-network services related to COVID-19 and for in or out-of-network services for non-related(non-COVID-19) care.

***-Continue to Waive Cost Share for all Telehealth Services***

The Trustees of the Teamsters Local 170 Health and Welfare Fund have decided to continue to waive eligible in-network copays and other cost-sharing for members obtaining in-network telehealth services until December 31, 2025. This waiver does not apply to out-of-network services. This will save money for members who need and utilize in-network telehealth services.

**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

**3.22B 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.

### 3.23 Spousal Burial Benefit

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

**a.** The active employee as defined in Section 1.2 must be actively employed by an employer as defined in Section 1.17 at the time of his spouse's death;
**b.** The active employee must be legally married at the time of his spouse's death;
**c.** The active employee or his representative must provide a death certificate of his/her 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.

### 3.24 Dependent Child's Life Benefit

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:

**a**. The active employee as defined in Section 1.2 must be actively employed by an employer as defined in Section 1.17 at the time of his dependent child's death;
**b.** 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's life benefit.

## Section 4 General Limitations

### Section 4.1 Limitations

**A.** **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.

**1.** **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.

**B.** **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.

**C.** **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.

**D.** **Claim Form Charges** No payment will be made for expenses for completion of any claim forms, administrative services or service charges.

**E.** **Cosmetic** No payments will be made for expenses for or in connection with any procedures, products or services that affect the appearance only, or which are performed for a purely aesthetic superficial benefit, except as required to repair damage received in an injury, or as provided for by federal law, including but not limited to the provisions of The Women's Health Act of 1998.

**F.** **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.

**G.** **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.

**H.** **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.

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

**J.** **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.

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

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

**M.** **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.

**N.** **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.

**O. 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.

**P. 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.

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

**Section 4.2 Non-Duplication**

To the extent that the participant or his dependent receives or is entitled to receive benefits under more than one provision of the Plan, the participant or his dependent shall only be entitled to receive benefits from the provision of the Plan that provides the greatest benefit.

**Section 4.3 Termination of Group Coverage for Active Participants**

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.

**Section 4.4 Limitations on Uses and Disclosures of Health Information**

**USES AND DISCLOSURES OF HEALTH INFORMATION**

As part of its operations, the Fund creates or receives certain information about individuals relating to past, present, or future physical or mental health or condition, the administration of health care to individuals, and the past, present, or future payments for the administration of health care to individuals.

"Individual" refers to all participants in the Fund, including deceased Individuals or their personal representative, personal representatives of individuals, and parents or guardians of minor children, so long as disclosure to the personal representative or parent or guardian is not otherwise prohibited by state law.

Protected Health Information is information that is identifiable to a particular individual. An individual's Protected Health Information may be disclosed by the Fund to the Board of Trustees, the Plan Sponsor for the Health and Welfare Fund. Disclosure to the Board of Trustees is dependent upon the Board of Trustees' certification that it will not use or disclose information

other than as set out in these plan documents, or as otherwise permitted by law. The Board of Trustees' certification may be found in Section 4.5. Additionally, Section 4.4.B.16.d. describes the classes of employees of the Fund who have access to Protected Health Information. These employees use Protected Health Information to perform plan administration functions. Employees of the Fund may not use or disclose Protected Health Information except as described in the plan documents, or as otherwise permitted by law. Employees who violate their duties with respect to Protected Health Information shall be sanctioned up to and including discharge from their employment.

The following sets forth required and permitted uses and disclosures of an Individual's Protected Health Information that the Board of Trustees may make.

**A. Required Disclosures**

**1.** All Protected Health Information must be disclosed when required by the Secretary of Health and Human Services or any other officer or employee of Department of Health and Human Services to whom the authority involved has been delegated;

**2.** All records contained in a designated record set must be disclosed to the individual, when requested in writing, except for

- **a.** Psychotherapy notes; or
- **b.** Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

**B. Permitted Disclosures** The Board of Trustees may make the following uses or disclosures without obtaining the Individual's prior consent, either oral or written:

**1.** The Board of Trustees may make disclosures to the individual;

**2.** The Board of Trustees may disclose Protected Health Information for the treatment activities of a health care provider;

**3.** The Board of Trustees may use or disclose Protected Health Information to any person or entity for the purposes of carrying out the Fund's payment, or health operations;

**4.** The Board of Trustees may disclose Protected Health Information to another covered entity or health care provider for the payment activities of the entity that receives the information;

**5.** The Board of Trustees may disclose Protected Health Information to another covered entity for the health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the Protected Health Information being requested, the Protected Health Information pertains to such relationship, and the disclosure is:

- **a.** For a purpose of conducting quality assessment and improvement activities, including outcomes, evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to

improving health or reducing health care costs, protocol development, case management and care coordination, contacting of heath care providers and patients with information about treatment alternatives; and related functions that do not include treatment; reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; or

**b.** For the purpose of health care fraud and abuse detection or compliance;

**6.** The Board of Trustees may use or disclose Protected Health Information as incident to a use or disclosure otherwise permitted or required by the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 provided that the Board of Trustees only uses or discloses the minimum necessary information and has in place other safeguards to protect an Individual's health information;

**7.** The Board of Trustees may use Protected Health Information to create information that is not individually identifiable health information or disclose Protected Health Information only to a business associate for such purpose, whether or not the de-identified information is to be used by the Board of Trustees. Information that has been de-identified is not covered by the requirements of the Standards for Privacy of Individually Identifiable Health Information provided that:

**a.** Disclosure of a code or other means of record identification designed to enable coded or otherwise de-identified information to be re-identified constitutes disclosure of Protected Health Information; and

**b.** If de-identified information is re-identified, the Board of Trustees may use or disclose such re-identified information only as permitted or required by the Standards for Privacy of Individually Identifiable Health Information;

**8.** The Board of Trustees may use Protected Health Information to create a limited data set, or it may disclose Protected Health Information to a business associate for such purpose, whether or not the limited data set will be used by the Board of Trustees. The Board of Trustees may also use or disclose a limited data set, only for the purpose of research, public health, or health care operations, if the Board of Trustees has entered into a data use agreement with the limited data set recipient;

**9.** The Board of Trustees may disclose Protected Health Information to a business associate and may allow a business associate to create or receive Protected Health Information on its behalf, if the Board of Trustees obtains satisfactory assurance that the business associate will appropriately safeguard the information. This standard does not apply:

**a.** With respect to disclosures by the Board of Trustees to a health care provider concerning the treatment of the individual; or

**b.** With respect to disclosures by the Fund to the Board of Trustees, so long as the requirements for certification are met;

**10.** A member of the Board of Trustees or a business associate may make a disclosure if:

**a.** The member or business associate believes in good faith that another Trustee or the Fund has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public; and

**b.** The disclosure is to:

**(i)** A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the Trustee or the Fund; or

**(ii)** An attorney retained by or on behalf of the Trustee or business associate for the purpose of determining the legal options of the member or business associate with regard to the conduct described in Section 4.4.A;

**11.** The Board of Trustees may disclose Protected Health Information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

**a.** The health care system;

**b.** Government benefit programs for which health information is relevant to Beneficiary eligibility;

**c.** Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

**d.** Entities subject to civil rights laws for which health information is necessary for determining compliance.

For purposes of disclosures permitted by this paragraph, a health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

**a.** The receipt of health care;

**b.** A claim for public benefits related to health; or

**c.** Qualifications for, or receipt of public benefits or services when a patient's health is integral to the claim for public benefits or services.

However, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of this paragraph;

**12.** The Board of Trustees may disclose Protected Health Information for a law enforcement purpose to a law enforcement official:

**a.** As required by law including laws that require the reporting of certain types of wounds or their physical injuries, except for laws subject to Section 4.4.B.12.b and about victims of domestic abuse; or

**b.** In compliance with and as limited by the relevant requirements of:

**(i)** A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;

**(ii)** A grand jury subpoena; or

**(iii)** An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

**(1)** The information sought is relevant and material to a legitimate law enforcement inquiry;

**(2)** The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and

**(3)** De-identified information could not reasonably be used;

**13.** The Board of Trustees may disclose Protected Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault;

**14.** The Board of Trustees may make uses or disclosures of Protected Health Information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Uses or disclosures under this paragraph must also comply with Section 4.4.B.12 and Section 4.4.B.16.

**15.** Oral agreement required prior to use or disclosure. The Board of Trustees may disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the Protected Health Information directly relevant to such person's involvement with the Individual's care or payment related to the individual's health care.

**a.** If the individual is present for, or otherwise available prior to, a use or disclosure described above and has the capacity to make health care decisions, the Board of Trustees may use or disclose the Protected Health Information if it:

**(i)** Obtains the individual's agreement;

**(ii)** Provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or,

**(iii)** Reasonably infers from the circumstances, based on the exercise of professional judgment that the individual does not object to the disclosure.

**b.** If the individual is not present for, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the Board of Trustees may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the Protected Health Information that is directly relevant to the person's involvement with the Individual's health care.

**16.** **Notice of Disclosure Must Be Given to the Individual** The Board of Trustees may disclose Protected Health Information in the course of any judicial or administrative proceeding:

**a.** In response to an order of a court or administrative tribunal, provided that the Board discloses only the Protected Health Information expressly authorized by such order; or

**b.** In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if

**(i)** The Board receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the Protected Health Information that has been requested has been given notice of the request.

**(ii)** The Board may disclose Protected Health Information in response to lawful process without receiving satisfactory assurance if the Board makes reasonable efforts to provide notice to the individual.

**c.** **Written Authorization From Individual Required** Except for the uses and disclosures above, or as otherwise required or permitted by law, the Board of Trustees will make no uses or disclosures of Protected Health Information unless the individual has given their written authorization to the Board permitting it to use or disclose the information. Furthermore, the individual may revoke the written authorization given to the Board at any time, provided that the revocation is also in writing. There are certain circumstances under which the individual may not revoke the written authorization. Those circumstances are:

**(i)** If the Board has taken action in reliance on the authorization; or

**(ii)** If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the Board with the right to contest a claim under the policy or the policy itself.

**d.** **Classes of Health and Welfare Fund Employees and their access to Protected Health Information**

**(i)** **Administrator** The Fund Administrator proofreads and presents all appeals submitted by Fund's participants to the Board of Trustees. The Fund Administrator has access to all files necessary to proofread and present such appeals. The Fund Administrator may from time to time review participant records to determine if the provisions of the Plan Document have been properly applied to individual claims, eligibility, etc. The Fund Administrator may access identifiable health information to address participant complaints. The Fund Administrator may accumulate and review identifiable health information as prepared for use by business associates of the Fund.

**(ii)** **Fund Employees** The Fund Employees receive faxes, mail and UPS packages sent to the Fund Office. The faxes, mail and packages may contain individually identifiable health information. Fund employees exposed to individually identifiable health information necessary to respond to the above types of submissions or documents created in-house for use in day-to-day operations.

**Section 4.5 Board of Trustees Limitations on Uses and Disclosure of Health Information**

The Board of Trustees certifies that the Plan Document has been amended to incorporate the following provisions and the Board of Trustees agrees to the following provisions:

**A.** The Board of Trustees will not use or further disclose an individual's Protected Health Information other than as permitted or required by the plan documents or as required by law;

**B.** The Board of Trustees ensures that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Health and Welfare Fund agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information;

**C.** The Board of Trustees will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

**D**. The Board of Trustees will report to the Health and Welfare Fund any use or disclosure of the information that is inconsistent with the uses or disclosures provided, for which it becomes aware;

**E.** The Board of Trustees will make available any Protected Health Information it maintains to the Individual who is the subject of the Protected Health Information in accordance with the procedures set out in 45 C.F.R. § 164.524;

**F.** The Board of Trustees will make available any Protected Health Information it maintains for amendment and incorporate any amendments to Protected Health Information in accordance with the procedures set out in 45 C.F.R. § 164.526;

**G.** The Board of Trustees will make available the information required to provide an accounting of disclosures in accordance with the procedures set out in 45 C.F.R. § 164.528;

**H.** The Board of Trustees will make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Health and Welfare Fund available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Health and Welfare Fund with the requirements to provide notice in the plan documents;

**I.** The Board of Trustees will, if feasible, return or destroy all Protected Health Information received from the Health and Welfare Fund that the Board 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

**J.** The Board of Trustees will ensure that adequate separation exists between it and the Health and Welfare Fund. Furthermore, all employees' access to individually identifiable health information is restricted to that necessary to perform their functions for plan administration. Any employee who violates the Health and Welfare Fund's privacy practices and procedures will be subject to sanction, up to and including discharge.

## Section 5 Coordination of Benefits

If a participant is covered by another employer's benefit plan or another group type health benefit plan, there may be some duplication of benefit coverage between this Plan and the other plan. The Plan coordinates benefits with other plans to prevent duplication of payments for the same services. This section describes how Coordination of Benefits (COB) works under the Plan.

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<br>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 Local170 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 retiree 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 CHIP 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, Blue Cross Blue Shield of Massachusetts and or CVS Caremark or Davis Vision may, 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, Blue Cross Blue Shield of Massachusetts and or CVS Caremark 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:

**a.** Age 65 or older;
**b.** Under age 65 with social security disability; or
**c.** 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 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 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 benefits 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 retiree, surviving spouse, or retiree'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.

# Section 6 Payment of Benefits and Miscellaneous

## Section 6.1 Claims Procedures – Medical Benefit Claims; Dental Claims; Prescription Drug Benefit Claims

The Fund does not administer medical benefit claims, dental claims or prescription drug benefit claims.

The Trustees have delegated the responsibility of administration and processing of medical benefits claims, dental claims and prescription drug claims to Blue Cross Blue Shield of Massachusetts and or CVS Caremark and Davis Vision. Each of these 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. The claims procedures utilized by these organizations must comply with all federal laws applicable to group health plans including but not limited to ERISA, the Patient Protection and Affordable Care Act of 2010, as amended and the applicable regulations promulgated there under. Each of these organizations has agreed to conduct internal appeals in accordance with all federal laws applicable to group health plans. However, only Blue Cross Blue Shield of Massachusetts and or CVS Caremark have agreed to conduct external appeals in accordance to federal laws applicable to group health plans. For those organizations who do not conduct external appeals, the plan has retained three (3) Independent Review Organizations to administer external appeals for these claims. Attached hereto as Exhibit "B" is the procedures to be followed by the medical claims reviewers/administrators who are acting on behalf of the Fund.

## Section 6.2 Claims Procedures: 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.

### A. Notice of Claim

The following claims procedures shall apply to welfare benefits provided by the Fund including spousal death benefits, dependent death benefits and certain wellness benefits. The life insurance claims and accidental death and dismemberment claims are to be administered by Symetra Life and Accident Insurance Company. Claims filed regarding life insurance and the accidental death and dismemberment benefit shall be forwarded to Symetra for benefit determination in accordance with Exhibit "A". The initial benefit determination of spousal burial benefits and dependent death benefits will be made by the Fund. Blue Cross Blue Shield MA administers the wellness program in conjunction with the Plan. If the participant or dependent receives an Adverse Benefit Determination (i.e. denied a reward/incentive for any reason), then the

determination of the wellness benefit claim will be made by the Plan in accordance with and subject to the claims procedures set forth in this section 6.2 of the Plan.

**1. 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. As used in section 6.2, "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.

**2. 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.

**3. 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.

**B. Claim Review Procedure**

**1. 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:

- **a.** The specific reason or reasons for the Adverse Benefit Determination;
- **b.** Reference to the specific Plan provisions on which the determination is based;
- **c.** 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;
- **d.** 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);
- **e.** 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;
- **f.** 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;

**g.** 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;

**h.** 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."

**2.** **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 under this Section 6.2.B.2.a, 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;

**3. 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.

**4. 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 safeguards 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:

**a.** 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;
**b.** 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;
**c.** 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
**d.** 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, SPD and Trust Agreement and to determine eligibility for benefits 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 you appeal a denied claim, the decision on review will be in writing and will include the following information:

- **a.** The specific reason or reasons for the decision; and
- **b.** Reference to the specific Plan provisions on which the decision is based; and
- **c.** A statement of your right to receive, upon request free of charge, reasonable access to and copies of Relevant Documents; (as set forth in section 6.2B4); and
- **d.** 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
- **e.** 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
- **f.** 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
- **g.** 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."

## Group Welfare Plan Claims Processing; Short Term Disability Income Benefits

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, 2023.

### Notice of Claim

The following claims procedures shall apply to short term disability income benefits filed under the plan on or after January 1, 2023. 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 for benefit determination in accordance with Symetra Life Insurance Company's procedures found in Attachments #7, #8 for Tier 1 and Tier 2 Plans to the SPD and Attachments #4 and #5 for the Tier 3 Plan to the SPD. Symetra Life and Accident Insurance Company has sole and complete discretion and authority to administer and interpret the provisions of the plans it insures. Symetra Life and Accident 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.

### Section 6.3 Physician-Patient or Dentist-Patient Relationship

Although the Fund provides financial incentives to encourage the use of network Hospitals and physicians, participants and dependents will have free choice of any physician or dentist practicing legally. The Fund will in no way disturb the physician-patient or dentist-patient relationship.

### Section 6.4 Assignment

The rights or benefits provided to any participant or dependent by the Fund, as well as any proceeds, rights, claims, interests or causes of action arising there from, are non-assignable, except as provided in Section 6.5.

### Section 6.5 Subrogation

In the event the Fund pays medical benefits, including prescription drug benefits, to any participant, dependent or assignee for injuries, expenses, or loss, caused by the negligence or any wrongful act of a third party, the Fund shall be subrogated, for the amount of such payments to all rights of the participant or dependent against any person, firm, corporation or other entity which is, or may become, liable or otherwise obligated to said participant or dependent as respects, arises or results from such injuries, expenses or loss, of such participant or dependent.

The Fund shall be subrogated, and entitled to first right of reimbursement, for the amount of such payments to all rights of the participant or dependent against any person, firm, corporation, or other entity which is, or may become, liable or otherwise obligated to said participant or dependent, as respects, arises, or results from such injuries, expenses, or loss, of such participant or dependent. The Fund shall be entitled to all such reimbursements irrespective of whether the participant, dependent, assignee or heir recovers any or all of his claims.

The Fund, by counsel of its choice, may sue, compromise, or settle in the name of the participant or dependent, or otherwise, all such rights, claims, interest, or causes of action to the extent of the benefits paid. The participant or dependent, or his attorney, shall not discharge or release any such right, claim, interest, or cause of action against any third party without first obtaining the express consent of the Fund.

If the participant or dependent chooses to proceed by legal action against the third party with the assistance of his own attorney, the Fund shall be fully reimbursed without any deductions for

legal fees or costs. The Fund does not recognize the "common fund" doctrine. If the participant or dependent resolves his claim, by settlement or judgment, with or without the assistance of an attorney, they shall fully reimburse the Fund from the proceeds of such judgment or settlement proceeds without any deductions. In the event that the participant or dependent realizes a recovery from such third party, without the participation or consent of the Fund, the Fund shall be entitled to proceed by civil action against said participant or dependent, in a court of competent jurisdiction, to seek an equitable lien, constructive trust or other equitable or legal relief that may be allowed by law.

The Fund's right of subrogation shall apply regardless of whether the participant or dependent who suffers the injury, expense, or loss is made whole from the recovery realized from said third party. The Fund is entitled to reimbursement first and completely from any recovery. The Fund does not recognize the so called "make whole" doctrine.

The participant or dependent who suffers any such injuries, expenses, or loss shall so notify the Fund as soon as practicable after the date of the first occurrence of such injury, expense, or loss, shall provide the Fund with all information requested by the Fund, and shall assist the Fund in prosecuting any such rights, interests, claims, or causes of action (civil and/or criminal) against any person, firm, corporation, or other entity which is or may become liable or otherwise obligated therefore.

The participant or dependent who fails to notify the Fund of the Injury, expense or loss, to provide to the Fund with requested information, to cooperate with, or assist the Fund in any such prosecution of a recovery, or advise the Fund of any recovery for such injury, expense of loss will result in the denial of benefits hereunder, and denial of any other benefits to which the participant or dependent may have otherwise been entitled under the applicable Plan of Benefits until the Fund has realized full reimbursement.

The Trustees have delegated subrogation of medical benefits, including prescription drugs, and dental benefits to the Blue Cross Blue Shield of MA and CVS Caremark and Davis Vision. Further, the sums recovered by these entities do not constitute plan assets until actual receipt of the same has been made by the Fund.

In the event the Fund pays Short Term Disability Income Benefits, Spousal Burial Benefits and/or Dependent Life Benefits to any Participant or Dependent, or assignee for injuries, expenses, or loss caused by the negligence or wrongful act of a third party, the Fund shall be subrogated, and entitled to first right of reimbursement, for the amount of such payments to all rights of the participant or dependent against any person, firm, corporation, or other entity which is, or may become, liable or otherwise obligated to said participant or dependent, as respects, arises, or results from such injuries, expenses, or loss, of such participant or dependent. The Fund shall be entitled to all such reimbursements irrespective of whether the participant, dependent, assignee or heir recovers any or all of his claims.

The Fund, by counsel of its choice, may sue, compromise, or settle in the name of the participant or dependent, or otherwise, all such rights, claims, interest, or causes of action to the extent of the benefits paid. The participant or dependent, or his attorney, shall not discharge or release any such right, claim, interest, or cause of action against any third party without first obtaining the express consent of the Fund.

If the participant or dependent chooses to proceed by legal action against the third party with the assistance of his own attorney, the Fund shall be fully reimbursed without any deductions for legal fees or costs. The Fund does not recognize the "common fund" doctrine. If the participant or dependent resolves his claim, by settlement or judgment, with or without the assistance of an attorney, they shall fully reimburse the Fund from the proceeds of such judgment or settlement proceeds without any deductions. In the event that the participant or dependent realizes a recovery from such third party, without the participation or consent of the Fund, the Fund shall be entitled to proceed by civil action against said participant or dependent, in a court of competent jurisdiction, to seek an equitable lien, constructive trust or other equitable or legal relief that may be allowed by law.

The Fund's right of subrogation shall apply regardless of whether the participant or dependent who suffers the injury, expense, or loss is made whole from the recovery realized from said third party. The Fund is entitled to reimbursement first and completely from any recovery. The Fund does not recognize the so called "make whole" doctrine.

The participant or dependent who suffers any such injuries, expenses, or loss shall so notify the Fund as soon as practicable after the date of the first occurrence of such injury, expense, or loss, shall provide the Fund with all information requested by the Fund, and shall assist the Fund in prosecuting any such rights, interests, claims, or causes of action (civil and/or criminal) against any person, firm, corporation, or other entity which is or may become liable or otherwise obligated therefore.

The participant or dependent who fails to notify the Fund of the injury, expense or loss, to provide to the Fund with requested information, to cooperate with, or assist the Fund in any such prosecution of a recovery, or advise the Fund of any recovery for such injury, expense of loss will result in the denial of benefits hereunder, and denial of any other benefits to which the participant or dependent may have otherwise been entitled under the applicable Plan of Benefits until the Fund has realized full reimbursement.

**Section 6.6 Miscellaneous**

**A.** **Law Applicable** All questions pertaining to the validity or construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the Employee Retirement Income Security Act of 1974 ("ERISA") and, as to matters not preempted by ERISA, the laws of the Commonwealth of Massachusetts.

**B.** **Savings Clause** Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of this Fund.

**C.** **Captions** Shall be read as integral elements of this Plan to assist in the interpretation of the Plan provisions to which they relate.

**D.** **Schedule of Benefits** References in this plan to the "Schedule of Benefits" shall be deemed references to the benefits that cover the participant and eligible dependents.

**E.** **Construction** The Trustees are empowered to determine all questions pertaining to the interpretation, administration, construction, and application of the Plan, including, but not limited to, the determination of all questions of eligibility and the status and rights of all individuals claiming an interest in benefits provided by the Plan; their decisions are final and binding on all parties.

**F.** **Trustees** All questions arising under or with respect to the Plan shall be determined by the Board of Trustees, whose decisions shall be final and binding on all parties.

**G.** **Abandoned Property** Plan benefits that are payable directly to a participant, spouse, or a participant's family member or estate, shall be considered abandoned if, after reasonable efforts to contact said participant, spouse, family member or estate, such benefits remained unclaimed for more than three (3) years after the date the claim is incurred.

"Reasonable efforts" shall include, but not be limited to, mailing or delivering the benefits payments to the last known address of the participant, spouse, family member or estate.

**H.** **No Vesting in Fund** No participant shall have any right to, or interest in, any assets of the Fund upon termination of his employment or otherwise, except as provided under this Plan, and then only to the extent of the benefits payable under the Plan to such participant out of the assets of the Fund. No participant, dependent, or qualified beneficiary shall at any time have any vested right to any benefits currently provided or hereafter provided by the Plan, including retiree health benefits. Except as otherwise may be provided under Title IV of ERISA, all payments of benefits as provided for in this Plan shall be made solely out of the assets of the Fund and none of the fiduciaries shall be liable therefore in any manner.

**I.** **Amendment and Termination of Benefits** Notwithstanding any other provision of the Plan, the Trustees shall have the absolute right, in their sole discretion, to amend or terminate Health and Welfare Benefits for participants, dependents, and qualified beneficiaries at any time.

## Section 7 Refund of Excess Contributions to Participating Employers

The Trustees may, in their discretion, refund excess employer contributions, if there has been a mistake of fact or law. This determination is a matter of Trustee discretion. The Trustees have adopted written policy. The Trustees should consider equitable factors as well as the impact such refund would have on a member's eligibility, and/or the impact to the financial soundness or integrity of the Fund. A Trustee must at all times act as a fiduciary in making such a determination.

## Section 8 Plan Administration

The Plan is a self-insured plan (with the exception of life insurance and accidental death and dismemberment insurance procured with Symetra. When an organization manages a self-insured plan, it means the organization (the Trust) bears the responsibility for its own participants/beneficiaries benefit plan. This means the Trust is responsible for paying claims and other expenses associated with providing Plan participants with health and welfare coverage.

The Teamsters Local 170 Health and Welfare Fund Board of Trustees (Board) are fiduciaries and the Plan Administrator pursuant to ERISA. The Board consists of six (6) members: three (3)

Employer Trustees Monica Chester, Ronald J. Bevens and Robert Robinson and three (3) Union Trustees Shannon R. George, Sean M. Foley and Elias Gillen. The Board has the sole legal authority to promulgate rules and regulations governing the operation of the Plan. The Fund Administrator provides the day to day management of the Plan.

The Board selects and monitors all vendors who provide services under the Plan. These services include claims administration, pharmacy benefits management, provider network administration, utilization management, wellness and health promotion, data management and actuarial and consulting services.

The Board has full discretionary authority to interpret and administer the plan, to make factual determinations, to determine eligibility status, interpret plan benefits and rules and determine whether a claim should be paid or denied according to the provisions of the Plan. The Board has complete authority to control, operate and manage the Plan. The Board reviews participant and beneficiary appeals of adverse benefit determinations of short term disability income claims, spousal burial benefit claims, dependent life benefit claims and certain wellness program/benefits. The Board has delegated these responsibilities to the medical claims administrators for medical claims, pharmacy, vision and dental claims as well as Symetra for life insurance and accidental death and dismemberment claims. Each of these 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.

The Board or its delegates shall perform its duties as the plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Board or its delegates shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Board or its delegates shall be final and legally binding on all parties. Any interpretations, determination or other action of the Board or its delegates shall be subject to reversal only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Board or its delegates shall be based only on evidence presented to, or considered by, the Board or its delegates at the time it made the decision that it is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with, and consent to, any decisions that the Board or its delegates makes in its sole discretion and further, constitutes agreement to the limited standard and scope of review described by this section.

## Section 9 Powers and Duties of the Board of Trustees

The Board of Trustees will have the powers and duties of the general administration of this Plan, including the following:

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status, and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

- To make factual findings;
- To decide disputes which may arise relative to a participant's rights and/or availability of benefits;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the plan documents and all other records pertaining to the Plan;
- To appoint and supervise claims administrators to pay claims;
- To perform all necessary reporting as required by ERISA;
- To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
- To delegate to any person or entity such powers, duties, and responsibilities it deems appropriate;
- To establish one or more committees to assist in administration of the Plan; and
- To perform each and every function necessary for or related to the Plan's administration.

## Section 10 Bundled Plan

The Local 170 Health and Welfare Fund provides a bundled plan of benefits consisting of medical, dental, life insurance, accidental, death and dismemberment insurance, short-term disability income benefit, prescription drug benefits, spousal burial benefit, Dependent life benefit, vision benefits and certain wellness benefit/programs. 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 Board 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. Employees are provided with excellent medical and prescription drug benefits. Further, each active employee is automatically provided welfare benefits. It is, and has been the intention of the Board, 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.

## Section 11 Medical Claims Administrators

The Fund does not process or administer medical 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:

**1.** Blue Cross Blue Shield of Massachusetts, Inc.
Landmark Center
401 Park Drive

Boston, Massachusetts 02215-3326
1-800-217-7878
www.bluecrossma.com

**2.** Davis Vision, Inc.
Davis Vision Live Support: 1-800-999-5431
881 Elkridge Landing Road, Suite 300
Lithicum, MD 21090
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 these 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.

## Section 12 Medical Plan Choices

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

The Plan establishes two tiers of coverage. Tier 1 is the most expensive and therefore, the most generous in benefits provided. The Fund offers two Tier 1 plan choices: Blue Choice New England Plan 2, (a Blue Cross Blue Shield plan) and Blue Care Elect Preferred (a Blue Cross Blue Shield plan). Generally, these two plans contain the most favorable and expansive networks and the most favorable cost sharing arrangements for participants. Deductible, co-pays and co-insurance are generally, if not always, the same or less than under a Tier 2 plan. Incorporated by reference is the Schedule of Benefits and benefit descriptions for these two Plans. These Schedules identify the services provided and the applicable cost sharing arrangements, i.e. co-pays, deductible, co-insurance, etc. Further, the schedules identify limitations regarding services, including prior authorization requirements and/or proper referral requirements.

Tier 2 includes one (1) plan; namely Network Blue New England Option (Network Blue) through Blue Cross/Blue Shield. The Network Blue New England Plan is, in and of itself, a tiered plan. Participants are afforded the ability to choose, at any time, to utilize enhanced benefits (lowest costs to members); standard benefits or basic benefits (greatest cost to Participants). Cost sharing arrangements vary, depending on the utilization and choices made by Participants. Participants are encouraged to check the status of their physician and hospital prior

to, and each time they obtain a covered service. Incorporated by reference is the Schedule of Benefits and Benefit Descriptions. The cost sharing arrangements are set forth therein. However, the 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 directory. Participants are encouraged to call the Blue Cross Blue Shield Physician Selection Services or use the online physician directory at www.bluecrossma.com. Incorporated by reference is the Blue Cross Blue Shield provider directory.

Tier 3 includes one (1) plan; namely Network Blue New England Value with Hospital Cost Sharing through Blue Cross Blue Shield. This is a Managed Care Tier Plan. As a member in this plan, you will pay different levels of cost share (such as copayments and/or coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from any of the network general hospitals listed in the Summary of Benefits, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital (not listed in this Summary of Benefits) for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.org/hospitalchoice. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.

The Plan also offers to retired employees, a plan of the Blue Cross Blue Shield for out of state residents known as Blue Care Elect, Preferred. This Plan utilizes a PPO health care network. Incorporated herein is also the Benefit Description and Riders regarding this Plan.

The Fund offers dental benefits to all of its participants and dependents through the Blue Cross Blue Shield networks. Incorporated by reference is the Benefit Descriptions and Schedule of Benefits of these dental plans.

Davis Vision, Inc. is a leading 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.

## Section 13 Provider Networks

### Blue Cross Blue Shield of Massachusetts

The Blue Cross Blue Shield Network (Network) is a network of physicians, hospitals and other health care providers. The Network is responsible for recruiting, credentialing, and communicating with providers. Providers in the Network agree to accept the allowable charge fees set by the network and agree to file claims for participants.

Under the Blue Choice New England Plan 2, participants may choose any covered participating or non-participating provider, primary care or specialist; however, utilizing providers that participate in the Network provides participants the maximum benefits available through the Plan. Participants choosing to use providers that do not participate in the Network are responsible for paying any fees charged over the allowable charge, in addition to paying a higher annual deductible and higher co-insurance amounts for covered services.

Under the Network Blue New England Value with Hospital Cost Sharing participants may choose any covered participating provider, primary care or specialist; however, utilizing providers that participate in the Network provides participants the maximum benefits available through the Plan. Participants choosing to use providers that do not participate in the Network are responsible for paying all fees charged except in an emergency for emergency room or urgent care services.

Under Network Plans, participants, in the absence of an emergency, or in the absence of pre-approval from Blue Cross Blue Shield, must chose in-network providers or they may be responsible for the full cost or an additional cost of any service.

**Davis Vision, Inc**

Davis Vision Network is identified by a document entitled "Teamsters Union Local 170 Health and Welfare Fund Vision Care Participating Network Providers". This document is incorporated herein.

Davis Vision provides various services and products to participants including eye exams, (including dilation, if appropriate) eye glasses, frames, contact lenses and retinal imaging.

Davis Vision is the Claims Administrator with respect to all claims submitted for services provided in and out of the network. Davis Vision has the 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.

**Blue Cross Blue Shield MA and or CVS Caremark Rx Program**

Blue Cross Blue Shield of Massachusetts 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 of MA and CVS Caremark are responsible for:

- **a.** Developing and maintain a network of participating pharmacies;
- **b.** Negotiating with pharmaceutical manufacturers;
- **c.** Managing the prescription drug mail order program/specialty program
- **d.** Processing prescription claims from participating pharmacies;
- **e.** Processing prescription claims;

**f.** 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.

# Trustees of Teamsters Local 170 Health and Welfare Fund

## Group Life Insurance Benefits
### Summary Plan Description

LG-12128 04/18

**PLEASE READ THIS IMPORTANT NOTICE**

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Sponsor provide a Summary Plan Description to Plan Participants.

This document, together with the attached Certificate of Insurance ("Certificate") issued by Symetra Life Insurance Company ("Symetra") to the Plan Sponsor, is your Summary Plan Description. It provides you an overview of the Plan and addresses certain information that may not be included in the attached Certificate.

This document is not intended to give a Plan Participant any substantive rights to benefits that are not already provided by the attached Certificate. If the terms of this summary document conflict with the terms of the insurance contract, then the terms of the insurance contract will control, unless superseded by applicable law.

**Plan Name**
Group Basic Term Life and AD&D Plan for Trustees of Teamsters Local 170 Health and Welfare Fund

**Plan Effective Date**
June 1, 2022

**Policyholder**
Trustees of Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff, Suite 202
Worcester, Massachusetts 01604

**Plan Sponsor, EIN and Number**
Trustees of Teamsters Local 170 Health and Welfare Fund
Plan EIN: 04-2219623
Plan Number: 501

**Type of Plan Administration**
Symetra and Plan Administrator

**Plan Administrator and Named Fiduciary**
Trustees of Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff, Suite 202
Worcester, Massachusetts 01604
Telephone Number: (508) 791-3416

**Plan Year**
June 1 to May 31

**Type of Plan**
Fully Insured Group Term Life Plan

**Policy Number**
01 020443 00

**Insurance Company and Contact Information**
Symetra Life Insurance Company
P. O. Box 2993
Hartford, CT 06104-2993
Toll Free Number: 1-800-943-2107
Fax Number: 1-860-392-3672

**Claims Administrator**
Claims administration for life insurance benefits under your Plan is provided by Symetra Life Insurance Company (Symetra) according to the terms of a Group Life Insurance policy. The Plan Administrator has designated Symetra as a Named Fiduciary for benefit claims.

**If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.**

## Funding Medium and Type of Plan Administration

The Plan is fully insured. Benefits are provided under the terms of a Group Life Insurance policy entered into between Trustees of Teamsters Local 170 Health and Welfare Fund and Symetra. Claims for benefits are sent to the Insurance Company. Symetra (not Trustees of Teamsters Local 170 Health and Welfare Fund) is responsible for paying benefits. Trustees of Teamsters Local 170 Health and Welfare Fund is the Plan Administrator. As the Plan Administrator, Trustees of Teamsters Local 170 Health and Welfare Fund is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs and filing an annual report about the Plan with the U.S. Department of Labor).

Insurance premiums for covered individuals are paid by the Plan Sponsor out of its general assets.

Trustees of Teamsters Local 170 Health and Welfare Fund provides a schedule of the applicable premiums; contact the Human Resources Manager of Trustees of Teamsters Local 170 Health and Welfare Fund if you need another copy.

## Plan Interpretation

The Plan Administrator has delegated to Symetra the exclusive right, power, and authority, in its sole and absolute discretion, to interpret the Plan (including the terms of the Plan set forth in the attached Certificate) including (but not limited to) the sole and absolute discretionary authority to take all actions and make all decisions regarding questions of coverage, eligibility, and entitlement to benefits, and benefit amounts, and to process and approve or deny all claims for benefits.

## Amendment or Termination

Trustees of Teamsters Local 170 Health and Welfare Fund, as the sponsor of the Plan, has the general right to amend or terminate the Plan or any component benefit program under the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Trustees of Teamsters Local 170 Health and Welfare Fund or any of its delegates who are authorized to amend or terminate the Plan.

## No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Trustees of Teamsters Local 170 Health and Welfare Fund to the effect that you will be employed for any specific period of time.

## Information in Attached Certificate of Insurance

Benefits under the Plan are described in the attached Certificate issued by Symetra to the Plan Sponsor. The Certificate contains important information about your coverage, including:

- Eligibility and Participation Requirements
- Enrollment Requirements
- Description of Benefits
- Definitions
- Termination Provisions
- Continuation of Coverage
- Effective Date of Coverage
- Benefit Reductions, Exclusions and Limitations

In order to understand your benefits under the Plan, you must read the attached Certificate.

## Claims Procedures

The Plan's claims procedures are set forth in the attached certificate of insurance, as supplemented by the Symetra Disability Plan Claim Procedures and Symetra Non-Disability Plan Claim Procedures (including Group Life Claims). The Symetra Disability Plan Claim Procedures and Symetra Non-Disability Plan Claim Procedures (including Group Life Claims) are being furnished to you automatically, without charge, as a separate document accompanying this Summary Plan Description.

## Statement of ERISA Rights

**Your Rights**

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

**If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.**

**Receive Information About Your Plan and Benefits**
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

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

**Enforce Your Rights**
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance With Your Questions**
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory), or contact 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.

**Your Certificate of Insurance, issued by Symetra Life Insurance Company, is attached.**

**This Certificate is furnished to you automatically without charge.**

**If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.**

# Symetra Disability Plan Claim Procedures

Symetra's Disability Plan Claim Procedures are set forth in the attached certificate of insurance, as supplemented by the procedures set forth below. The Disability Plan Claim Procedures are followed by Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York when processing group short term disability claims, group long term disability claims, and waiver of premium claims under a group life insurance plan.

These Disability Plan Claim Procedures are being furnished to you automatically, without charge, as a separate document accompanying the Summary Plan Description.

**What you should do and what you should expect if you have a disability claim?**

To claim benefits under the Plan, you* must first apply for the benefit according to Symetra's requirements. Claims can be submitted telephonically, electronically, or via paper application. You may request the claim form from Symetra by calling (877) 377-6773 or from the Plan Administrator by contacting your benefits coordinator. If Symetra's claim form or instructions for completing it are not available, you must submit to Symetra a written statement of the reasons you are entitled to benefits, and you must include your name, address and contact information, and your employer's name, address and contact information. After you have completed the claim form or written statement, you must submit it to Symetra at the following address:

Symetra Claims Department
P.O. Box 1230
Enfield, CT 06083

For purposes of the Plan's claims procedures, you will be considered to have filed your claim under the Plan when your claim form or written statement is received at this address.

The Plan Administrator has appointed Symetra as the claims administrator of the Plan for adjudicating claims for benefits under the Plan and for deciding any appeals of denied claims. Symetra shall have the authority, at its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All benefits decisions made by Symetra shall be final and binding to the full extent permitted by law.

Symetra has 45 days from the date your claim is filed to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Plan, and, if so, the amount of benefits. If more time is needed to review your claim due to circumstances beyond the Plan's control, Symetra must notify you in writing that the review period has been extended. The extension notice will describe the circumstances requiring the extension, the expected date of a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. This extension may be for up to 30 days beyond the end of the normal 45-day review period. A second 30-day extension may apply if, for reasons beyond the Plan's control, additional time, beyond the first 30-day extension, is needed to review your claim. In this case, Symetra will notify you in writing that the review period has been further extended. Symetra will provide the same information required in the first notice of extension.

If an extension of the review period is made because you must furnish additional information in order for Symetra to decide your claim, Symetra will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to Symetra. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period or the extended 75- or 105-day period. For example, if Symetra advises you on the 20th day after your claim was filed that your claim is incomplete because it lacks a physician's statement regarding your ability to perform various tasks, the number of days from the date of Symetra's request for the physician's statement until you provide the physician's statement will not count as part of the review period. In this example, the day you provided the physician's statement will be treated as the 21st day of the review period.

If needed in order to decide your claim, Symetra may require you to submit to a medical examination, at Symetra's expense. If a medical examination is required, Symetra will notify you of the date and time of the examination and the physician's name and location. This will be treated as a request for additional information, as described above, and the review period will be tolled until Symetra receives the results of the examination. It is important that you keep any appointments made for you by Symetra, since rescheduling examinations will delay the claim process.

If your claim is approved, you will receive the appropriate benefit from Symetra.

If your claim is denied, in whole or in part, you will receive a written notice from Symetra within the review period. The written notice of claim denial must include the following information:

1. The specific reason(s) the claim was denied, including an explanation of the basis for disagreeing with or not following:

    - the views that you presented to Symetra of health care professionals that treated you and vocational professionals that evaluated you;
    - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether Symetra relied upon the advice in denying your claim; and
    - the disability determination made by the Social Security Administration, if you presented such a disability determination to Symetra.

2. Specific reference to the Policy provision(s) on which the denial was based.

3. A description of any additional material or information necessary to perfect your claim, and the reason this material or information is necessary.

4. If your claim was denied 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, Symetra did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.

6. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

7. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

**Appeal procedure for denied disability claims**

Whenever a claim is denied in whole or in part, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request to appeal Symetra's decision within 180 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. This request for review should be directed to Symetra at the address given above for claims submissions. When requesting a review, you should state the reasons you believe the claim denial was improper, and you should submit any additional information, material, or comments which you consider appropriate. You may also review and, upon request, obtain copies of any documents that have a bearing on the claim, including the documents which establish and control the Plan.

Once your request has been received by Symetra, a full and fair review of your claim must take place. This review will give no deference to the original claim decision and will not be made by the person who made the initial claim decision, nor a subordinate of that person. Any medical or vocational experts consulted by Symetra in reviewing your claim will be identified. If your claim was denied in whole or in part based on a medical judgment, Symetra, in deciding your appeal of that determination, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. In no case will such health care professional be an individual who was consulted in connection with the original claim decision. In conducting the review, Symetra will take into account all comments, documents, and other information that you submit, whether or not it was submitted at the time of the initial claim decision.

In conducting the review, Symetra will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Symetra (or at the direction of Symetra) in connection with your claim. Symetra will provide you with this evidence as soon as possible and sufficiently in advance of the date on which the review period expires, as further described below, in order to give you a reasonable opportunity to respond to the new or additional evidence prior to that date.

Before Symetra can deny your appeal based on a new or additional rationale, Symetra must provide you, free of charge, with the new or additional rationale. Symetra will provide you with the new or additional rationale as soon as possible and sufficiently in advance of the date on which the review period expires, as further described below, in order to give you a reasonable opportunity to respond to the new or additional rationale prior to that date.

Symetra has 45 days from the date it receives your appeal to review the original claim decision for your claim and notify you of its decision. Under special circumstances, Symetra may require more time to review your claim. If this should happen, Symetra must notify you, in writing, that its appeal review period has been extended for an additional 45 days, noting the special circumstances requiring the extension and the date by which a decision on the appeal is expected.

If an extension of the appeal review period is made because you must furnish additional information in order for Symetra to decide your appeal, Symetra will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to Symetra. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period.

Once its review is complete, Symetra must notify you, in writing, of the results of the review and must include in its notice the following information:

1. The specific reason(s) the appeal was denied, including an explanation of the basis for disagreeing with or not following:

    - the views that you presented to Symetra of health care professionals that treated you and vocational professionals that evaluated you;
    - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether Symetra relied upon the advice in denying your claim; and
    - the disability determination made by the Social Security Administration, if you presented such a disability determination to Symetra.

2. Specific reference to the Policy provision(s) on which the denial was based.

3. A statement that you are entitled to receive, upon request and free of charge, all documents, records, and copies of all documents, records, and other information relevant to your claim for benefits under the Plan.

4. If your claim was denied 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, Symetra did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.

6. The written notice will include a statement regarding your right to file suit in federal or state court to recover benefits under the terms of the Plan, including pursuant to ERISA Section 502(a) as applicable, together with a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for your claim.

* You may have an authorized representative, such as a guardian or an individual having a valid power of attorney, act on your behalf in pursuing a claim for benefits under this Plan. The Plan will take reasonable steps to determine whether an individual claiming to be acting on your behalf is, in fact, validly empowered to do so under the circumstances. Throughout this description of the Plan's claims and appeals procedures, the word "you" is used to refer to you and/or any representative acting on your behalf in claiming benefits under the Plan.

## Symetra Non-Disability Plan Claim Procedures (including Group Life Claims)

The Plan's claims procedures are set forth in the attached certificate of insurance, as supplemented by the Symetra Non-Disability Claim Procedures set forth below. The Symetra Non-Disability Plan Claim Procedures are followed by Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York when processing group life claims and any claims other than claims for group short term disability benefits, group long term disability benefits and group life waiver of premium benefits. These Symetra Non-Disability Plan Claim Procedures are being furnished to you automatically, without charge, as a separate document accompanying the Summary Plan Description.

**What you should do and what you should expect if you have a non-disability claim, including a Group Life Claim**

To claim benefits other than disability benefits under the Plan (including Group Life Claims), you must first complete Symetra's claim form according to Symetra's requirements. You may request the claim form from Symetra by calling (877) 377-6773 or from the Plan Administrator by contacting your benefits coordinator. If Symetra's claim form or instructions for completing it are not available, you must submit to Symetra a written statement of the reasons you are entitled to benefits, and you must include your name, address and contact information, and your employer's name, address and contact information. After you have completed the claim form or written statement, you must submit it to Symetra at the following address:

Symetra Claims Department
P.O. Box 1230
Enfield, CT 06083

For purposes of the Plan's claims procedures, you will be considered to have filed your claim under the Plan when your claim form or written statement is received at this address.

Symetra has 90 days from the date your claim is filed to decide your claim. If more time is needed to review your claim due to circumstances beyond the Plan's control, Symetra must notify you in writing that the review period has been extended. The extension notice will describe the circumstances requiring the extension, the expected date of a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. This extension may be for up to 90 days beyond the end of the normal 90-day review period.

**If your claim is approved, you will receive the appropriate benefit from Symetra.**

If your claim is denied, in whole or in part, you must receive a written notice from Symetra within the review period (which may have been extended beyond 90 days, as described above). The written notice of claim denial must include the following information:

1. The specific reason(s) the claim was denied.

2. Specific reference to the Policy provision(s) on which the denial was based.

3. A description of any additional material or information necessary to perfect your claim, and the reason this material or information is necessary.

4. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

**Appeal procedure for denied non-disability claims (including Group Life Claims)**

Whenever a claim is denied in whole or in part, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request to appeal Symetra's decision within 60 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. This request for review should be directed to Symetra at the address given above for claims submissions. When requesting a review, you should state the reasons you believe the claim denial was improper, and you should submit any additional information, material, or comments which you consider appropriate. You may also review and, upon request, obtain copies of any documents that have a bearing on the claim, including the documents which establish and control the Plan.

Once your request has been received by Symetra, a full and fair review of your claim must take place. This review will give no deference to the original claim decision and will not be made by the person who made the initial claim decision, nor a subordinate of that person.

Symetra has 60 days from the date it receives your request to review the original claim decision for your claim and notify you of its decision. Under special circumstances, Symetra may require more time to review your claim. If this should happen, Symetra must notify you, in writing, that its appeal review period has been extended for an additional 60 days, noting the special circumstances requiring the extension and the date by which a decision on the appeal is expected.

Once its review is complete, Symetra must notify you, in writing, of the results of the review and must include in its notice the following information:

1. The specific reason(s) the appeal was denied.

2. Specific reference to the Policy provision(s) on which the denial was based.

3. A statement that you are entitled to receive, upon request and free of charge, all documents, records, and copies of all documents, records, and other information relevant to your claim for benefits under the Plan.

4. The written notice will include a statement regarding your right to file suit in federal or state court to recover benefits due to you under the terms of the Plan, including pursuant to ERISA Section 502(a) as applicable.

Suit may be filed only after the plan's review procedures described above have been exhausted and only if filed within the limitations set forth in the certificate of insurance.

SYMETRA
RETIREMENT | BENEFITS | LIFE

# Symetra Life Insurance Company

## Group Life Insurance

## CERTIFICATE

Accelerated benefit payments from this policy may qualify for special tax status if the benefits are for terminal illness. However, under certain circumstances the benefits may be taxable. We recommend that you contact a tax advisor when making tax-related decisions about electing accelerated benefits.

The limitations of the Employee Accelerated Benefit are set forth in policy form LGC 13500/MA-BEN.

This policy may be eligible for conversion. Please refer to policy forms LGC 13500/MA-BEN.

Class 1

SYMETRA
RETIREMENT | BENEFITS | LIFE

## CERTIFICATE OF INSURANCE

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200
Bellevue, Washington 98004-5135
(An insurance company)

| | |
|---|---|
| **Policyholder:** | Trustees of Teamsters Local 170 Health and Welfare Fund |
| **Policy Number:** | 01 020443 00 |
| **Policy Effective Date:** | June 1, 2022 |
| **Policy Anniversary Date:** | June first of each year beginning in 2023 |

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us. The Policy may be inspected at the office of the Policyholder.

Signed for The Company

Jacqueline M. Veneziani, Secretary

Margaret Meister, President

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*A note on capitalization in this certificate:*
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

**Table of Contents**

## Schedule of Insurance

**The benefits described herein are those in effect as of:** June 1, 2022

**Cost of Coverage:**
**Non-Contributory Coverage:**
Basic Life Insurance
Basic Accidental Death and Dismemberment Insurance

**Eligible Class(es) for Coverage:** All Full-time active Plan Participants covered by a Collective Bargaining Agreement and all Full-time active Plan Participants working for Teamsters Union Local 170, Teamsters Local 170, Health & Welfare Fund who have accumulated 500 hours of credited employment within a 6 month continuous period, provided the appropriate contributions have been made to the fund, who are citizens or legal residents of the United States.

Class 1 All Eligible Full-Time Plan Participants

**Eligibility Waiting Period for Coverage:**
If You are a Plan Participant with a Participating Employer on or after the Policy Effective Date, Your coverage will become effective on the first of the month following the month You complete the participation requirements as defined in the Trustees of Teamsters Local 170 Health and Welfare Fund's plan document.

The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a full-time active Plan Participant with the Participating Employer under the Prior Policy.

To maintain eligibility after the initial eligibility period, You must have contributed 400 hours per eligibility period as defined below:

| Eligibility Period<br>400 credited hours in: | Insurance Period<br>Gives full coverage in: |
|---|---|
| March, April and May | July, August and September |
| June, July and August | October, November and December |
| September, October and November | January, February and March |
| December, January and February | April, May and June |

### Life Insurance Benefit

**Plan Participant**

| Basic | Benefit Amount | Benefit Maximum Amount | Guaranteed Issue Amount |
|---|---|---|---|
| Class 1 | $50,000 | $50,000 | $50,000 |

### Accidental Death and Dismemberment Insurance Benefit (AD&D)

**Plan Participant**

| Basic | Principal Sum | Principal Maximum Sum |
|---|---|---|
| Class 1 | $50,000 | $50,000 |

## Schedule of Insurance

## Additional Accidental Death and Dismemberment Insurance Benefits

**Seat Belt and Air Bag Coverage**

| | |
|---|---|
| Seat Belt Benefit Amount: | 100% of Basic AD&D Principal Sum |
| Seat Belt Maximum Amount: | $25,000 |
| Seat Belt Minimum Amount: | $1,000 |
| | |
| Air Bag Benefit Amount: | 5% of Basic AD&D Principal Sum |
| Air Bag Maximum Amount: | $5,000 |

**Repatriation Benefit**

| | |
|---|---|
| Benefit Amount: | 5% of Basic AD&D Principal Sum |
| Maximum Amount: | $5,000 |

**Child Education Benefit**

| | |
|---|---|
| Benefit Amount: | 100% of Basic AD&D Principal Sum |
| Maximum Amount: | $3,000 |
| Minimum Amount: | $1,250 |

### Reduction in Amount of Life Insurance

We will reduce the amount of Life Insurance for You by any amount:

1) of individual Life Insurance issued in accordance with the Conversion Right; or
2) of Life Insurance in force, paid or payable under the Prior Policy.

### Reduction in Coverage Due to Age

No reduction.

## Definitions

**Airworthiness Certificate**
means:
1) the “Standard” Airworthiness Certificate issued by the United States Federal Aviation Administration (FAA); or
2) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

**Civil or Public Aircraft**
means a Civil or Public Aircraft which:
1) has a current and valid Airworthiness Certificate;
2) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
3) is not operated by the militia, or armed forces of any state, national government or international authority.

**Common Carrier**
means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

Common Carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

**FAA**
means:
1) the Federal Aviation Administration of the United States; or
2) the equivalent aviation authority for the country of the aircraft's registry, if the governmental authority is recognized by the United States.

**Guaranteed Issue Amount**
means the amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

**Injury**
means bodily Injury resulting:
1) directly from an accident; and
2) independently of all other causes;
which occurs while You are covered under The Policy.

Loss resulting from:
1) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2) medical or surgical treatment of a sickness or disease;
is not considered as resulting from Injury.

**Military Transport Aircraft**
means a transport aircraft operated by:
1) the United States Air Mobility Command (AMC); or
2) a national military air transport service of a governmental authority recognized by the United States.

## Definitions

**Motor Vehicle**
means a self-propelled, four or more wheeled:

1) private passenger: car, station wagon, van or sport utility vehicle;
2) motor home or camper; or
3) pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

**Non-Contributory Coverage**
means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

**Normal Retirement Age**
means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

| Year of Birth | Normal Retirement Age | Year of Birth | Normal Retirement Age |
|---|---|---|---|
| 1937 or before | 65 | 1955 | 66 + 2 months |
| 1938 | 65 + 2 months | 1956 | 66 + 4 months |
| 1939 | 65 + 4 months | 1957 | 66 + 6 months |
| 1940 | 65 + 6 months | 1958 | 66 + 8 months |
| 1941 | 65 + 8 months | 1959 | 66 + 10 months |
| 1942 | 65 + 10 months | 1960 or after | 67 |
| 1943 through 1954 | 66 | | |

**On**
means, when used with reference to any conveyance (land, water or air), in or On, boarding or alighting from the conveyance.

**Participating Employer**
means an employer who agrees to participate in the Trust, pays the required contribution and is a participant in accordance with the provisions of The Policy.

**Physician**
means a legally qualified Physician or surgeon other than a Physician or surgeon who is Related to You by blood or marriage.

**Plan Participant**
means an eligible participant who is employed by a Participating 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 Plan Participant shall also mean Plan Participant of the Local 170 Health and Welfare Fund and Plan Participant of the Teamsters Local Union 170 for whom contributions are made to the Fund.

**Prior Policy**
means, if applicable, the group life insurance policy carried by the Policyholder on the day before the Policy Effective Date.

## Definitions

**Related**
means Your Spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

**Scheduled Aircraft**
means a Civil or Public Aircraft operated by a scheduled airline which:

1) is licensed by the FAA for the transportation of passengers for hire; and
2) publishes its flight schedules and fares for regular passenger service.

**Spouse**
means Your Spouse who is not legally separated or divorced from You.

**The Policy**
means The Policy which We issued to the Policyholder under the Policy Number shown on the face page.

**Trust**
means the Policyholder stated on the face page of The Policy.

**We, Us or Our**
means the insurance company named on the face page of The Policy.

**You or Your**
means the person to whom this certificate is issued.

## Eligibility and Enrollment

**Eligible Persons:** *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

**Eligibility for Coverage:** *When will I become eligible?*
You will become eligible for coverage on the latest of:

1) the Policy Effective Date;
2) the date on which You complete the Eligibility Waiting Period for Coverage; or
3) the date You become a member of an Eligible Class.

**Enrollment:** *How do I enroll for coverage?*
The Policyholder will automatically enroll You. However, You will need to complete a beneficiary designation form.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may only enroll during an Annual Enrollment Period if designated by the Policyholder.

Any enrollment may be subject to the Evidence of Insurability Requirements provision.

**Evidence of Insurability Requirements:** *When will I first be required to provide Evidence of Insurability?*
We do not require Evidence of Insurability.

**Evidence of Insurability:** *What is Evidence of Insurability?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

1) a completed and signed application approved by Us;
2) a medical examination;
3) attending Physicians' statement; and
4) any additional information We may require.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You are insurable for initial coverage or an increase in coverage under The Policy.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

## Period of Coverage

**Effective Date:** *When does my coverage start?*
Coverage, for which Evidence of Insurability is not required, will start on the date You become eligible.

Any coverage, for which Evidence of Insurability is required, will become effective on the later of:
1) the date You become eligible; or
2) the date We approve Your Evidence of Insurability.

However, all Effective Dates of coverage are subject to the Deferred Effective Date provision.

**Deferred Effective Date:** *When will my effective date for coverage or a change in my coverage be deferred?*
If, on the date You are to become covered:
1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

You are not a Plan Participant due to a physical or mental condition such coverage will not start until the date You are a Plan Participant.

**Continuity from a Prior Policy:** *Is there continuity of coverage from a Prior Policy?*
Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were insured under the Prior Policy, but on the Policy Effective Date You were not a Plan Participant and would otherwise meet the Eligibility requirements of The Policy. However, Your amount of Insurance will be the lesser of the amount of Life Insurance and Accidental Death and Dismemberment Principal Sum:
1) You had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:
1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:
1) the last day of a period of 12 consecutive months after the Policy Effective Date;
2) the date Your insurance terminates for any reason shown under the Termination provision;
3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) the date You are a Plan Participant.

However, if the coverage provided through this provision ends because You are a Plan Participant, You may be covered under The Policy.

**Effective Date for Changes in Coverage:** *When will changes in coverage become effective?*
Any decrease in coverage will take effect on the first of the month following the date of the change.

Any increase in coverage will take effect on the latest of:
1) the first of the month following the date of the change;
2) the date requirements of the Deferred Effective Date provision are met; or
3) the date Evidence of Insurability is approved, if required.

## Period of Coverage

**Termination:** *When will my coverage end?*
Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the last day of the month following the date You are no longer in a class eligible for coverage, or the class is cancelled;
3) the date the required premium is due but not paid;
4) the last day of the month following the date You or the Policyholder terminates Your participation;
5) the last day of the month following the date You are no longer a Plan Participant;
6) the last day of the insurance period that Your combined credited and banked hours do not qualify You for the next insurance period, except that You may continue Your insurance, provided You pay directly to the Fund prior to the insurance period, the balance of the required hours under Your Bargaining Agreement.

**Waiver of Premium:** *Does coverage continue if I am Disabled?*
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.

If You qualify for Waiver of Premium, the amount of continued coverage:

1) will be the amount in force on the date You became Disabled;
2) will be subject to any reductions provided by The Policy; and
3) will not increase.

**Eligible Coverages:** *What coverages are eligible under this provision?*
This provision applies only to Your Basic Life Insurance.

**Disabled:** *What does Disabled mean?*
Disabled means You are prevented by Injury or sickness from doing any work for which You are, or could become, qualified by:

1) education;
2) training; or
3) experience.

In addition, You will be considered Disabled if You have been diagnosed with a life expectancy of 24 months or less.

**Conditions for Qualification:** *What conditions must I satisfy before I qualify for this provision?*
To qualify for Waiver of Premium You must:

1) be covered under The Policy and be under age 60 when You become Disabled;
2) be Disabled and provide Proof of Loss that You have been Disabled for nine consecutive months, starting on the date You first became Disabled; and
3) provide such proof within one year of the date You became Disabled.

In any event, You must have been a Plan Participant under The Policy to qualify for Waiver of Premium.

## Period of Coverage

**When Premiums are Waived:** *When will premiums be waived?*
If We approve Waiver of Premium, We will notify You of the date We will begin to waive premium. In any case, We will not waive premiums for the first nine months You are Disabled. We have the right to:

1) require Proof of Loss that You are Disabled; and
2) have You examined at reasonable intervals during the first two years after receiving initial Proof of Loss, but not more than once a year after that.

If You fail to submit any required Proof of Loss or refuse to be examined as required by Us, then Waiver of Premium ceases.

However, if We deny Waiver of Premium, You may be eligible to convert coverage in accordance with the Conversion Right.

If You cease to be Disabled and return to work for a total of five days or less during the first nine months that You are Disabled, the nine month waiting period will not be interrupted. Except for the five days or less that You worked, You must be Disabled by the same condition for the total nine month period. If You return to work for more than five days, You must satisfy a new waiting period.

**Benefit Payable before Approval of Waiver of Premium:** *What if I die before I qualify for Waiver of Premium?*
If You die within one year of the date You became Disabled, but before You qualify for Waiver of Premium, We will pay the amount of Life Insurance which is in force for You provided:

1) You were continuously Disabled;
2) the disability lasted or would have lasted nine months or more; and
3) premiums had been paid for coverage.

**Waiver Ceases:** *When will Waiver of Premium cease?*
We will waive premium payments and continue Your coverage, while You remain Disabled, until the date You attain Normal Retirement Age if Disabled prior to age 60.

*What happens when Waiver of Premium ceases?*
When the Waiver of Premium ceases:

1) if You return to work in an Eligible Class, as an active Plan Participant, then You may again be eligible for coverage as long as premiums are paid when due; or
2) if You do not return to work in an Eligible Class, coverage will end and You may be eligible to exercise the Conversion Right if You do so within the time limits described in such provision. The amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right.

**Effect of Policy Termination:** *What happens to the Waiver of Premium if The Policy terminates?*
If The Policy terminates or a Participating Employer ceases to be a Participating Employer before You qualify for Waiver of Premium:

1) You may be eligible to exercise the Conversion Right, provided You do so within the time limits described in such provision; and
2) You may still be approved for Waiver of Premium if You qualify.

If The Policy terminates or a Participating Employer ceases to be a Participating Employer after You qualify for Waiver of Premium, Your coverage under the terms of this provision will not be affected.

## Benefits

**Life Insurance Benefit:** *When is the Life Insurance Benefit payable?*
If You die while covered under The Policy, We will pay Your Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

**Accelerated Benefit:** *What is the benefit?*
In the event that You are diagnosed as Terminally Ill, and You request in writing that a portion of Your amount of Life Insurance be paid as an Accelerated Benefit while You are:

1) covered under The Policy for an amount of Life Insurance of at least $10,000; and
2) under age 60;

We will pay the Accelerated Benefit Amount as shown below, provided We receive proof of such Terminal Illness.

The amount of Life Insurance payable upon Your death will be reduced by any Accelerated Benefit Amount paid under this benefit.

You may request a minimum Accelerated Benefit Amount of $3,000, and a maximum of $40,000. However, in no event will the Accelerated Benefit Amount exceed 80% of Your amount of Life Insurance. This option may be exercised only once for You.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of $10,000 and are Terminally Ill, You can request any portion of the amount of Life Insurance Benefits from $3,000 to $8,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only $3,000 now, You cannot request the additional $5,000 in the future.

A person who submits proof satisfactory to Us of his or her Terminal Illness will also meet the definition of Disabled for Waiver of Premium.

Any benefits received under this benefit may be taxable. You should consult a personal tax advisor for further information.

In the event:

1) You are required by law to accelerate benefits to meet the claims of creditors; or
2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

**Terminal Illness or Terminally Ill** means a life expectancy of 24 months or less.

**Proof of Terminal Illness and Examinations:** *Must proof of Terminal Illness be submitted?*
We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You do not submit proof of Terminal Illness satisfactory to Us, or if You refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

## Benefits

**No Longer Terminally Ill:** *What happens to my coverage if I am no longer Terminally Ill?*
If You are diagnosed by a Physician as no longer Terminally Ill and:

1) are in an Eligible Class, coverage will remain in force, provided premium is paid;
2) are not in an Eligible Class, but You continue to meet the definition of Disabled, coverage will remain in force, subject to the Waiver of Premium provision; or
3) are not in an Eligible Class, but You do not continue to meet the definition of Disabled, coverage will end and You may be eligible to exercise the Conversion Right, if You do so within the time limits described in such provision.

In any event, the amount of coverage will be reduced by the Accelerated Benefit paid.

**Conversion Right:** *If coverage under The Policy ends, do I have a right to convert?*
If Life Insurance coverage or any portion of it under The Policy ends for any reason, You may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for:

1) the Accidental Death and Dismemberment Insurance Benefits; or
2) any amount of Life Insurance for which You were not eligible and covered;

under The Policy.

If coverage under The Policy ends because:

1) The Policy is terminated;
2) coverage for an Eligible Class is terminated; or
3) Your Participating Employer is no longer a Participating Employer;

then You must have been insured under The Policy for five years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

1) $10,000; or
2) the Life Insurance Benefit under The Policy less any amount of Life Insurance for which You may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, the full amount of coverage which ended may be converted.

**Insurer**, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

**Conversion:** *How do I convert my coverage?*
To convert Your coverage, You must complete a Notice of Conversion Right form. The Insurer must receive this within 31 days after Life Insurance terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:

1) complete and return the request form in the proposal; and
2) pay the required premium for coverage;

within the time period specified in the proposal.

Any individual policy issued to You under the Conversion Right:

1) will be effective as of the 32nd day after the date coverage ends; and
2) will be in lieu of coverage for this amount under The Policy.

## Benefits

**Conversion Policy Provisions:** *What are the Conversion Policy Provisions?*
The Conversion Policy will:

1) be issued on one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

1) the same terms and conditions of coverage as The Policy;
2) any benefit other than the Life Insurance Benefit; and
3) term insurance.

However, Conversion is not available for any amount of Life Insurance which was, or is being, continued in accordance with the Waiver of Premium provision until such coverage ends.

**Death within the Conversion Period:** *What if I die before coverage is converted?*
We will pay the amount of Life Insurance You would have had the right to apply for under this provision if:

1) coverage under The Policy terminates;
2) You die within 31 days of the date coverage terminates; and
3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

**Effect of Waiver of Premium on Conversion:** *What happens to the Conversion Policy if Waiver of Premium is later approved?*
If You apply and are approved for Waiver of Premium after an individual Conversion Policy has been issued, any benefit payable at Your death under The Policy will be paid only if the individual Conversion Policy is surrendered.

**Accidental Death and Dismemberment Insurance Benefit:** *When is the Accidental Death and Dismemberment Insurance Benefit payable?*
If You sustain an Injury which results in any of the following Losses within 365 days of the date of accident, We will pay Your amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss, after We receive Proof of Loss in accordance with the Proof of Loss provision.

This Benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum, to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance.

For Loss of:

| | |
|---|---|
| Life | Principal Sum |
| Both Hands or Both Feet or Sight of Both Eyes | Principal Sum |
| One Hand and One Foot | Principal Sum |
| Speech and Hearing in Both Ears | Principal Sum |
| Either Hand or Foot and Sight of One Eye | Principal Sum |
| Movement of Both Upper and Lower Limbs (Quadriplegia) | Principal Sum |
| Movement of Both Lower Limbs (Paraplegia) | Three-Quarters of Principal Sum |
| Movement of Three Limbs (Triplegia) | Three-Quarters of Principal Sum |

| | |
|---|---|
| Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia) | One-Half of Principal Sum |
| Either Hand or Foot | One-Half of Principal Sum |
| Sight of One Eye | One-Half of Principal Sum |
| Speech or Hearing in Both Ears | One-Half of Principal Sum |
| Movement of One Limb (Uniplegia) | One-Quarter of Principal Sum |
| Thumb and Index Finger of Either Hand | One-Quarter of Principal Sum |

**Loss** means with regard to:
1) hands and feet, actual severance through or above wrist or ankle joints;
2) sight, speech and hearing, entire and irrecoverable loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
4) movement, complete and irreversible paralysis of such limbs.

**Seat Belt and Air Bag Benefit:** *When is the Seat Belt and Air Bag Benefit payable?*
If You sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Seat Belt and Air Bag Benefit if the Injury occurred while You were:
1) a passenger riding in; or
2) the licensed operator of;

a properly registered Motor Vehicle and were wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:
1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

If a Seat Belt Benefit is payable, We will also pay an Air Bag Benefit if You were:
1) positioned in a seat equipped with a factory-installed Air Bag; and
2) properly strapped in the Seat Belt when the Air Bag inflated.

The Seat Belt Benefit is the lesser of:
1) an amount resulting from multiplying Your amount of Principal Sum by the Seat Belt Benefit Percentage; or
2) the Maximum Amount for this Benefit.

The Air Bag Benefit is the lesser of:
1) an amount resulting from multiplying Your amount of Principal Sum by the Air Bag Benefit Percentage; or
2) the Maximum Amount for this Benefit.

If it cannot be determined that You were wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

**Accident**, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which You were wearing a Seat Belt.

**Air Bag** means an inflatable supplemental passive restraint system installed by the manufacturer of the Motor Vehicle or its proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

## Benefits

**Seat Belt** means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

**Repatriation Benefit:** *When is the Repatriation Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Repatriation Benefit, if the death occurs outside the territorial limits of the state or country of Your place of permanent residence.

This Benefit will be paid:
1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

The Repatriation Benefit will pay the least of:
1) the actual expenses incurred for:
   a) preparation of the body for burial or cremation; and
   b) transportation of the body to the place of burial or cremation;
2) the amount resulting from multiplying Your amount of Principal Sum by the Repatriation Benefit Percentage; or
3) the Maximum Amount for this Benefit.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

**Child Education Benefit:** *When is the Child Education Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Child Education Benefit to Your Child.

This Benefit will be paid:
1) after We receive proof that Your Child qualifies as a Student, as defined in this Benefit; and
2) according to the General Provisions of The Policy.

If You die, the Child Education Benefit provides an annual amount equal to the lesser of:
1) the amount resulting from multiplying Your amount of Principal Sum by the Child Education Percentage; or
2) the Maximum Amount for this Benefit.

The Child Education Benefit is payable to each of Your Children:
1) on the date; and
2) for whom;
We have received proof satisfactory to Us that he or she is a Student.

If he or she is a minor, We will pay the benefit to the Student's legal guardian.

We will pay the Child Education Benefit to a qualifying Student until the first to occur of:
1) Our payment of the fourth Child Education Benefit to or on behalf of that person; or
2) the end of the 12$^{th}$ consecutive month during which We have not received proof satisfactory to Us that he or she is a Student.

We will not pay more than one Child Education Benefit to any one Student during any one school year.

## Benefits

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision of The Policy if:

1) a Principal Sum is payable because of Your death; and
2) no person qualifies as a Student.

**Student** means Your Child who on the date of Your death:

1) is a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning on the date of Your death; or
2) became a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning within 365 days after Your death and was a student in the 12th grade on the date of Your death.

If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student qualifies as a Student.

**Child** means Your unmarried child, stepchild, legally adopted child, child in the process of adoption or foster child who is less than age 21 who:

1) regularly attends an accredited institution of learning; and
2) is primarily dependent on You for financial support and maintenance.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

**Exclusions:** *What is not covered under The Policy?* (Applies to Accidental Death and Dismemberment Insurance only)

The Policy does not cover any Loss caused by:

1) for members of the military, war or act of war; or
2) Injury sustained while on active duty as a member of the armed forces of any country or international authority.

The Policy does not cover any Loss caused or contributed by:

1) intentionally self-inflicted Injury;
2) suicide or attempted suicide, whether sane or insane;
3) Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
4) Injury sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds;
5) Injury sustained while committing or attempting to commit a felony;
6) the insured's being Intoxicated or under the influence of any narcotic;
7) Injury sustained while Intoxicated; or
8) Injury sustained while driving while Intoxicated.

**Intoxicated** means:

1) the blood alcohol content;
2) the results of other means of testing blood alcohol level; or
3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

## General Provisions

**Notice of Claim:** *When should I notify The Company of a claim?*
You, or the person who has the right to claim benefits, must give Us written notice of a claim within 30 days after:

1) the date of death; or
2) the date of Loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address and the Policy Number.

**Claim Forms:** *Are special forms required to file a claim?*
Within 15 days of receiving a Notice of Claim, We will send forms to the claimant to provide Proof of Loss. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.

**Proof of Loss:** *What is Proof of Loss?*
Proof of Loss may include, but is not limited to, the following:

1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your enrollment form;
4) Your beneficiary designation (if applicable);
5) if applicable, documentation of:
    a) the date Your disability began;
    b) the cause of Your disability; and
    c) the prognosis of Your disability;
6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
7) the names and addresses of all:
    a) Physicians or other qualified medical professionals You have consulted;
    b) hospitals or other medical facilities in which You have been treated; and
    c) pharmacies which have filled Your prescriptions within the past three years;
8) Your signed authorization for Us to obtain and release medical, employment and financial information; or
9) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

**Sending Proof of Loss:** *When must Proof of Loss be given?*
Written Proof of Loss should be sent to Us:

1) with respect to the Life Insurance Benefits, within 365 days; and
2) with respect to the Accidental Death and Dismemberment Insurance Benefits, within 90 days;

after the Loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than one year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

**Physical Examination and Autopsy:** *Can We have a claimant examined or request an autopsy?*
While a claim is pending We have the right at Our expense:

1) to have the person who has a Loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

## General Provisions

**Claim Payment:** *When are benefit payments issued?*
When We determine that benefits are payable, We will pay the benefits due in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

**Claims to be Paid:** *To whom will benefits for my claim be paid?*
Life Insurance Benefits and benefits for Loss of life under the Accidental Death and Dismemberment Insurance Benefits will be paid in accordance with the life insurance beneficiary designation.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:
1) the executors or administrators of Your estate;
2) all to Your surviving Spouse;
3) if Your Spouse does not survive You, in equal shares to Your surviving children; or
4) if no child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:
1) $200 at Your death; and
2) monthly installments of not more than $200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will make any payments, other than for Loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:
1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to $1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

**Beneficiary Designation:** *How do I designate or change my beneficiary?*
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Policyholder. Only satisfactory forms sent to the Policyholder prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Policyholder.

In no event may a beneficiary be changed by a power of attorney.

**Claim Denial:** *What notification will my beneficiary or I receive if a claim is denied?*
If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:
1) give the specific reason(s) for the denial;
2) make specific reference to the provisions upon which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

## General Provisions

**Claim Appeal:** *What recourse will my beneficiary or I have if a claim is denied?*
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

**Policy Interpretation:** *Who interprets policy terms and conditions?*
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

**Incontestability:** *When can The Policy be contested?*
Except for non-payment of premiums, the Life Insurance Benefit of The Policy cannot be contested after two years from the Policy Effective Date. This provision does not apply to the Accidental Death and Dismemberment Insurance Benefits.

In the absence of Fraud, no statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

**Assignment:** *Are there any rights of assignment?*
Except for the dismemberment benefits under the Accidental Death and Dismemberment Insurance Benefit, You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to, the following:

1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

**Legal Actions:** *When can legal action be taken?*
Legal action cannot be taken against Us:

1) sooner than 60 days after the date written Proof of Loss is furnished; or
2) three years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

## General Provisions

**Workers' Compensation:** *How does The Policy affect Workers' Compensation coverage?*
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

**Insurance Fraud:** *How does The Company deal with fraud?*
Insurance fraud occurs when You, Your dependent and/or the Policyholder provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your dependent and/or the Policyholder commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You, Your dependent and/or the Policyholder perpetrate insurance fraud.

**Misstatements:** *What happens if facts are misstated?*
If material facts about You were not stated accurately:

1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

# Trustees of Teamsters Local 170 Health and Welfare Fund

## Group Life Insurance Benefits
### Summary Plan Description

LG-12128 04/18

**PLEASE READ THIS IMPORTANT NOTICE**

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the Plan Sponsor provide a Summary Plan Description to Plan Participants.

This document, together with the attached Certificate of Insurance ("Certificate") issued by Symetra Life Insurance Company ("Symetra") to the Plan Sponsor, is your Summary Plan Description. It provides you an overview of the Plan and addresses certain information that may not be included in the attached Certificate.

This document is not intended to give a Plan Participant any substantive rights to benefits that are not already provided by the attached Certificate. If the terms of this summary document conflict with the terms of the insurance contract, then the terms of the insurance contract will control, unless superseded by applicable law.

**Plan Name**
Group Basic Term Life and AD&D Plan for Trustees of Teamsters Local 170 Health and Welfare Fund

**Plan Effective Date**
June 1, 2022

**Policyholder**
Trustees of Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff, Suite 202
Worcester, Massachusetts 01604

**Plan Sponsor, EIN and Number**
Trustees of Teamsters Local 170 Health and Welfare Fund
Plan EIN: 04-2219623
Plan Number: 501

**Type of Plan Administration**
Symetra and Plan Administrator

**Plan Administrator and Named Fiduciary**
Trustees of Teamsters Local 170 Health and Welfare Fund
330 Southwest Cutoff, Suite 202
Worcester, Massachusetts 01604
Telephone Number: (508) 791-3416

**Plan Year**
June 1 to May 31

**Type of Plan**
Fully Insured Group Term Life Plan

**Policy Number**
01 020443 00

**Insurance Company and Contact Information**
Symetra Life Insurance Company
P. O. Box 2993
Hartford, CT 06104-2993
Toll Free Number: 1-800-943-2107
Fax Number: 1-860-392-3672

**Claims Administrator**
Claims administration for life insurance benefits under your Plan is provided by Symetra Life Insurance Company (Symetra) according to the terms of a Group Life Insurance policy. The Plan Administrator has designated Symetra as a Named Fiduciary for benefit claims.

**If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.**

## Funding Medium and Type of Plan Administration

The Plan is fully insured. Benefits are provided under the terms of a Group Life Insurance policy entered into between Trustees of Teamsters Local 170 Health and Welfare Fund and Symetra. Claims for benefits are sent to the Insurance Company. Symetra (not Trustees of Teamsters Local 170 Health and Welfare Fund) is responsible for paying benefits. Trustees of Teamsters Local 170 Health and Welfare Fund is the Plan Administrator. As the Plan Administrator, Trustees of Teamsters Local 170 Health and Welfare Fund is responsible for satisfying certain legal requirements under ERISA with respect to the Plan (for example, distributing SPDs and filing an annual report about the Plan with the U.S. Department of Labor).

Insurance premiums for covered individuals are paid by the Plan Sponsor out of its general assets.

Trustees of Teamsters Local 170 Health and Welfare Fund provides a schedule of the applicable premiums; contact the Human Resources Manager of Trustees of Teamsters Local 170 Health and Welfare Fund if you need another copy.

## Plan Interpretation

The Plan Administrator has delegated to Symetra the exclusive right, power, and authority, in its sole and absolute discretion, to interpret the Plan (including the terms of the Plan set forth in the attached Certificate) including (but not limited to) the sole and absolute discretionary authority to take all actions and make all decisions regarding questions of coverage, eligibility, and entitlement to benefits, and benefit amounts, and to process and approve or deny all claims for benefits.

## Amendment or Termination

Trustees of Teamsters Local 170 Health and Welfare Fund, as the sponsor of the Plan, has the general right to amend or terminate the Plan or any component benefit program under the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Trustees of Teamsters Local 170 Health and Welfare Fund or any of its delegates who are authorized to amend or terminate the Plan.

## No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Trustees of Teamsters Local 170 Health and Welfare Fund to the effect that you will be employed for any specific period of time.

## Information in Attached Certificate of Insurance

Benefits under the Plan are described in the attached Certificate issued by Symetra to the Plan Sponsor. The Certificate contains important information about your coverage, including:

- Eligibility and Participation Requirements
- Enrollment Requirements
- Description of Benefits
- Definitions
- Termination Provisions
- Continuation of Coverage
- Effective Date of Coverage
- Benefit Reductions, Exclusions and Limitations

In order to understand your benefits under the Plan, you must read the attached Certificate.

## Claims Procedures

The Plan's claims procedures are set forth in the attached certificate of insurance, as supplemented by the Symetra Disability Plan Claim Procedures and Symetra Non-Disability Plan Claim Procedures (including Group Life Claims). The Symetra Disability Plan Claim Procedures and Symetra Non-Disability Plan Claim Procedures (including Group Life Claims) are being furnished to you automatically, without charge, as a separate document accompanying this Summary Plan Description.

## Statement of ERISA Rights

**Your Rights**

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

**If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.**

**Receive Information About Your Plan and Benefits**
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

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

**Enforce Your Rights**
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance With Your Questions**
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory), or contact 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.

**Your Certificate of Insurance, issued by Symetra Life Insurance Company, is attached.**

**This Certificate is furnished to you automatically without charge.**

**If you have questions regarding the Plan, please contact the Policyholder or Plan Administrator.**

# Symetra Disability Plan Claim Procedures

Symetra's Disability Plan Claim Procedures are set forth in the attached certificate of insurance, as supplemented by the procedures set forth below. The Disability Plan Claim Procedures are followed by Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York when processing group short term disability claims, group long term disability claims, and waiver of premium claims under a group life insurance plan.

These Disability Plan Claim Procedures are being furnished to you automatically, without charge, as a separate document accompanying the Summary Plan Description.

**What you should do and what you should expect if you have a disability claim?**

To claim benefits under the Plan, you* must first apply for the benefit according to Symetra's requirements. Claims can be submitted telephonically, electronically, or via paper application. You may request the claim form from Symetra by calling (877) 377-6773 or from the Plan Administrator by contacting your benefits coordinator. If Symetra's claim form or instructions for completing it are not available, you must submit to Symetra a written statement of the reasons you are entitled to benefits, and you must include your name, address and contact information, and your employer's name, address and contact information. After you have completed the claim form or written statement, you must submit it to Symetra at the following address:

Symetra Claims Department
P.O. Box 1230
Enfield, CT 06083

For purposes of the Plan's claims procedures, you will be considered to have filed your claim under the Plan when your claim form or written statement is received at this address.

The Plan Administrator has appointed Symetra as the claims administrator of the Plan for adjudicating claims for benefits under the Plan and for deciding any appeals of denied claims. Symetra shall have the authority, at its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All benefits decisions made by Symetra shall be final and binding to the full extent permitted by law.

Symetra has 45 days from the date your claim is filed to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Plan, and, if so, the amount of benefits. If more time is needed to review your claim due to circumstances beyond the Plan's control, Symetra must notify you in writing that the review period has been extended. The extension notice will describe the circumstances requiring the extension, the expected date of a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. This extension may be for up to 30 days beyond the end of the normal 45-day review period. A second 30-day extension may apply if, for reasons beyond the Plan's control, additional time, beyond the first 30-day extension, is needed to review your claim. In this case, Symetra will notify you in writing that the review period has been further extended. Symetra will provide the same information required in the first notice of extension.

If an extension of the review period is made because you must furnish additional information in order for Symetra to decide your claim, Symetra will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to Symetra. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period or the extended 75- or 105-day period. For example, if Symetra advises you on the 20th day after your claim was filed that your claim is incomplete because it lacks a physician's statement regarding your ability to perform various tasks, the number of days from the date of Symetra's request for the physician's statement until you provide the physician's statement will not count as part of the review period. In this example, the day you provided the physician's statement will be treated as the 21st day of the review period.

If needed in order to decide your claim, Symetra may require you to submit to a medical examination, at Symetra's expense. If a medical examination is required, Symetra will notify you of the date and time of the examination and the physician's name and location. This will be treated as a request for additional information, as described above, and the review period will be tolled until Symetra receives the results of the examination. It is important that you keep any appointments made for you by Symetra, since rescheduling examinations will delay the claim process.

If your claim is approved, you will receive the appropriate benefit from Symetra.

If your claim is denied, in whole or in part, you will receive a written notice from Symetra within the review period. The written notice of claim denial must include the following information:

1. The specific reason(s) the claim was denied, including an explanation of the basis for disagreeing with or not following:

    - the views that you presented to Symetra of health care professionals that treated you and vocational professionals that evaluated you;
    - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether Symetra relied upon the advice in denying your claim; and
    - the disability determination made by the Social Security Administration, if you presented such a disability determination to Symetra.

2. Specific reference to the Policy provision(s) on which the denial was based.

3. A description of any additional material or information necessary to perfect your claim, and the reason this material or information is necessary.

4. If your claim was denied 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, Symetra did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.

6. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

7. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

**Appeal procedure for denied disability claims**

Whenever a claim is denied in whole or in part, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request to appeal Symetra's decision within 180 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. This request for review should be directed to Symetra at the address given above for claims submissions. When requesting a review, you should state the reasons you believe the claim denial was improper, and you should submit any additional information, material, or comments which you consider appropriate. You may also review and, upon request, obtain copies of any documents that have a bearing on the claim, including the documents which establish and control the Plan.

Once your request has been received by Symetra, a full and fair review of your claim must take place. This review will give no deference to the original claim decision and will not be made by the person who made the initial claim decision, nor a subordinate of that person. Any medical or vocational experts consulted by Symetra in reviewing your claim will be identified. If your claim was denied in whole or in part based on a medical judgment, Symetra, in deciding your appeal of that determination, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. In no case will such health care professional be an individual who was consulted in connection with the original claim decision. In conducting the review, Symetra will take into account all comments, documents, and other information that you submit, whether or not it was submitted at the time of the initial claim decision.

In conducting the review, Symetra will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Symetra (or at the direction of Symetra) in connection with your claim. Symetra will provide you with this evidence as soon as possible and sufficiently in advance of the date on which the review period expires, as further described below, in order to give you a reasonable opportunity to respond to the new or additional evidence prior to that date.

Before Symetra can deny your appeal based on a new or additional rationale, Symetra must provide you, free of charge, with the new or additional rationale. Symetra will provide you with the new or additional rationale as soon as possible and sufficiently in advance of the date on which the review period expires, as further described below, in order to give you a reasonable opportunity to respond to the new or additional rationale prior to that date.

Symetra has 45 days from the date it receives your appeal to review the original claim decision for your claim and notify you of its decision. Under special circumstances, Symetra may require more time to review your claim. If this should happen, Symetra must notify you, in writing, that its appeal review period has been extended for an additional 45 days, noting the special circumstances requiring the extension and the date by which a decision on the appeal is expected.

If an extension of the appeal review period is made because you must furnish additional information in order for Symetra to decide your appeal, Symetra will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to Symetra. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period.

Once its review is complete, Symetra must notify you, in writing, of the results of the review and must include in its notice the following information:

1. The specific reason(s) the appeal was denied, including an explanation of the basis for disagreeing with or not following:

    - the views that you presented to Symetra of health care professionals that treated you and vocational professionals that evaluated you;
    - the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether Symetra relied upon the advice in denying your claim; and
    - the disability determination made by the Social Security Administration, if you presented such a disability determination to Symetra.

2. Specific reference to the Policy provision(s) on which the denial was based.

3. A statement that you are entitled to receive, upon request and free of charge, all documents, records, and copies of all documents, records, and other information relevant to your claim for benefits under the Plan.

4. If your claim was denied 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 your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

5. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying your claim or, alternatively, a statement that in denying your claim, Symetra did not rely upon any specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan in existence.

6. The written notice will include a statement regarding your right to file suit in federal or state court to recover benefits under the terms of the Plan, including pursuant to ERISA Section 502(a) as applicable, together with a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for your claim.

* You may have an authorized representative, such as a guardian or an individual having a valid power of attorney, act on your behalf in pursuing a claim for benefits under this Plan. The Plan will take reasonable steps to determine whether an individual claiming to be acting on your behalf is, in fact, validly empowered to do so under the circumstances. Throughout this description of the Plan's claims and appeals procedures, the word "you" is used to refer to you and/or any representative acting on your behalf in claiming benefits under the Plan.

## Symetra Non-Disability Plan Claim Procedures (including Group Life Claims)

The Plan's claims procedures are set forth in the attached certificate of insurance, as supplemented by the Symetra Non-Disability Claim Procedures set forth below. The Symetra Non-Disability Plan Claim Procedures are followed by Symetra Life Insurance Company and First Symetra National Life Insurance Company of New York when processing group life claims and any claims other than claims for group short term disability benefits, group long term disability benefits and group life waiver of premium benefits. These Symetra Non-Disability Plan Claim Procedures are being furnished to you automatically, without charge, as a separate document accompanying the Summary Plan Description.

**What you should do and what you should expect if you have a non-disability claim, including a Group Life Claim**

To claim benefits other than disability benefits under the Plan (including Group Life Claims), you must first complete Symetra's claim form according to Symetra's requirements. You may request the claim form from Symetra by calling (877) 377-6773 or from the Plan Administrator by contacting your benefits coordinator. If Symetra's claim form or instructions for completing it are not available, you must submit to Symetra a written statement of the reasons you are entitled to benefits, and you must include your name, address and contact information, and your employer's name, address and contact information. After you have completed the claim form or written statement, you must submit it to Symetra at the following address:

Symetra Claims Department
P.O. Box 1230
Enfield, CT 06083

For purposes of the Plan's claims procedures, you will be considered to have filed your claim under the Plan when your claim form or written statement is received at this address.

Symetra has 90 days from the date your claim is filed to decide your claim. If more time is needed to review your claim due to circumstances beyond the Plan's control, Symetra must notify you in writing that the review period has been extended. The extension notice will describe the circumstances requiring the extension, the expected date of a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. This extension may be for up to 90 days beyond the end of the normal 90-day review period.

**If your claim is approved, you will receive the appropriate benefit from Symetra.**

If your claim is denied, in whole or in part, you must receive a written notice from Symetra within the review period (which may have been extended beyond 90 days, as described above). The written notice of claim denial must include the following information:

1. The specific reason(s) the claim was denied.

2. Specific reference to the Policy provision(s) on which the denial was based.

3. A description of any additional material or information necessary to perfect your claim, and the reason this material or information is necessary.

4. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

**Appeal procedure for denied non-disability claims (including Group Life Claims)**

Whenever a claim is denied in whole or in part, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request to appeal Symetra's decision within 60 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. This request for review should be directed to Symetra at the address given above for claims submissions. When requesting a review, you should state the reasons you believe the claim denial was improper, and you should submit any additional information, material, or comments which you consider appropriate. You may also review and, upon request, obtain copies of any documents that have a bearing on the claim, including the documents which establish and control the Plan.

Once your request has been received by Symetra, a full and fair review of your claim must take place. This review will give no deference to the original claim decision and will not be made by the person who made the initial claim decision, nor a subordinate of that person.

Symetra has 60 days from the date it receives your request to review the original claim decision for your claim and notify you of its decision. Under special circumstances, Symetra may require more time to review your claim. If this should happen, Symetra must notify you, in writing, that its appeal review period has been extended for an additional 60 days, noting the special circumstances requiring the extension and the date by which a decision on the appeal is expected.

Once its review is complete, Symetra must notify you, in writing, of the results of the review and must include in its notice the following information:

1. The specific reason(s) the appeal was denied.

2. Specific reference to the Policy provision(s) on which the denial was based.

3. A statement that you are entitled to receive, upon request and free of charge, all documents, records, and copies of all documents, records, and other information relevant to your claim for benefits under the Plan.

4. The written notice will include a statement regarding your right to file suit in federal or state court to recover benefits due to you under the terms of the Plan, including pursuant to ERISA Section 502(a) as applicable.

Suit may be filed only after the plan's review procedures described above have been exhausted and only if filed within the limitations set forth in the certificate of insurance.

SYMETRA
RETIREMENT | BENEFITS | LIFE

# Symetra Life Insurance Company

## Group Life Insurance

## CERTIFICATE

Accelerated benefit payments from this policy may qualify for special tax status if the benefits are for terminal illness. However, under certain circumstances the benefits may be taxable. We recommend that you contact a tax advisor when making tax-related decisions about electing accelerated benefits.

The limitations of the Employee Accelerated Benefit are set forth in policy form LGC 13500/MA-BEN.

This policy may be eligible for conversion. Please refer to policy forms LGC 13500/MA-BEN.

Class 2

SYMETRA
RETIREMENT | BENEFITS | LIFE

## CERTIFICATE OF INSURANCE

**Symetra Life Insurance Company**
777 108th Avenue NE, Suite 1200
Bellevue, Washington 98004-5135
(An insurance company)

| | |
|---|---|
| **Policyholder:** | Trustees of Teamsters Local 170 Health and Welfare Fund |
| **Policy Number:** | 01 020443 00 |
| **Policy Effective Date:** | June 1, 2022 |
| **Policy Anniversary Date:** | June first of each year beginning in 2023 |

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us. The Policy may be inspected at the office of the Policyholder.

Signed for The Company

Jacqueline M. Veneziani, Secretary

Margaret Meister, President

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*A note on capitalization in this certificate:*
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

**Table of Contents**

## Schedule of Insurance

**The benefits described herein are those in effect as of:** June 1, 2022

**Cost of Coverage:**
**Non-Contributory Coverage:**
Basic Life Insurance
Basic Accidental Death and Dismemberment Insurance

**Eligible Class(es) for Coverage:** All Part-time active Plan Participants covered by a Collective Bargaining Agreement and all Part-time active Plan Participants working for Teamsters Union Local 170, Teamsters Local 170, Health & Welfare Fund who have accumulated 400 hours of credited employment within a 6 month continuous period, provided the appropriate contributions have been made to the fund, who are citizens or legal residents of the United States.

Class 2 All Eligible Part-Time Plan Participants

**Eligibility Waiting Period for Coverage:**
If You are a Plan Participant with a Participating Employer on or after the Policy Effective Date, Your coverage will become effective on the first of the month following the month You complete the participation requirements as defined in the Trustees of Teamsters Local 170 Health and Welfare Fund's plan document.

The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a full-time active Plan Participant with the Participating Employer under the Prior Policy.

The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a part-time Plan Participant with the Participating Employer.

To maintain eligibility after the initial eligibility period, You must have contributed 250 hours per eligibility period as defined below:

| Eligibility Period | Insurance Period |
|---|---|
| 250 credited hours in: | Gives full coverage in: |
| March, April and May | July, August and September |
| June, July and August | October, November and December |
| September, October and November | January, February and March |
| December, January and February | April, May and June |

### Life Insurance Benefit

**Plan Participant**

| Basic | Benefit Amount | Benefit Maximum Amount | Guaranteed Issue Amount |
|---|---|---|---|
| Class 2 | $25,000 | $25,000 | $25,000 |

### Accidental Death and Dismemberment Insurance Benefit (AD&D)

**Plan Participant**

| Basic | Principal Sum | Principal Maximum Sum |
|---|---|---|
| Class 2 | $25,000 | $25,000 |

## Schedule of Insurance

## Additional Accidental Death and Dismemberment Insurance Benefits

**Seat Belt and Air Bag Coverage**

| | |
|---|---|
| Seat Belt Benefit Amount: | 100% of Basic AD&D Principal Sum |
| Seat Belt Maximum Amount: | $25,000 |
| Seat Belt Minimum Amount: | $1,000 |
| | |
| Air Bag Benefit Amount: | 5% of Basic AD&D Principal Sum |
| Air Bag Maximum Amount: | $5,000 |

**Repatriation Benefit**

| | |
|---|---|
| Benefit Amount: | 5% of Basic AD&D Principal Sum |
| Maximum Amount: | $5,000 |

**Child Education Benefit**

| | |
|---|---|
| Benefit Amount: | 100% of Basic AD&D Principal Sum |
| Maximum Amount: | $3,000 |
| Minimum Amount: | $1,250 |

### Reduction in Amount of Life Insurance

We will reduce the amount of Life Insurance for You by any amount:

1) of individual Life Insurance issued in accordance with the Conversion Right; or
2) of Life Insurance in force, paid or payable under the Prior Policy.

### Reduction in Coverage Due to Age

No reduction.

## Definitions

**Airworthiness Certificate**
means:
1) the “Standard” Airworthiness Certificate issued by the United States Federal Aviation Administration (FAA); or
2) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

**Civil or Public Aircraft**
means a Civil or Public Aircraft which:
1) has a current and valid Airworthiness Certificate;
2) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
3) is not operated by the militia, or armed forces of any state, national government or international authority.

**Common Carrier**
means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

Common Carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

**FAA**
means:
1) the Federal Aviation Administration of the United States; or
2) the equivalent aviation authority for the country of the aircraft's registry, if the governmental authority is recognized by the United States.

**Guaranteed Issue Amount**
means the amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

**Injury**
means bodily Injury resulting:
1) directly from an accident; and
2) independently of all other causes;
which occurs while You are covered under The Policy.

Loss resulting from:
1) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2) medical or surgical treatment of a sickness or disease;
is not considered as resulting from Injury.

**Military Transport Aircraft**
means a transport aircraft operated by:
1) the United States Air Mobility Command (AMC); or
2) a national military air transport service of a governmental authority recognized by the United States.

## Definitions

**Motor Vehicle**
means a self-propelled, four or more wheeled:

1) private passenger: car, station wagon, van or sport utility vehicle;
2) motor home or camper; or
3) pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

**Non-Contributory Coverage**
means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

**Normal Retirement Age**
means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

| Year of Birth | Normal Retirement Age | Year of Birth | Normal Retirement Age |
|---|---|---|---|
| 1937 or before | 65 | 1955 | 66 + 2 months |
| 1938 | 65 + 2 months | 1956 | 66 + 4 months |
| 1939 | 65 + 4 months | 1957 | 66 + 6 months |
| 1940 | 65 + 6 months | 1958 | 66 + 8 months |
| 1941 | 65 + 8 months | 1959 | 66 + 10 months |
| 1942 | 65 + 10 months | 1960 or after | 67 |
| 1943 through 1954 | 66 | | |

**On**
means, when used with reference to any conveyance (land, water or air), in or On, boarding or alighting from the conveyance.

**Participating Employer**
means an employer who agrees to participate in the Trust, pays the required contribution and is a participant in accordance with the provisions of The Policy.

**Physician**
means a legally qualified Physician or surgeon other than a Physician or surgeon who is Related to You by blood or marriage.

**Plan Participant**
means an eligible participant who is employed by a Participating 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 Plan Participant shall also mean Plan Participant of the Local 170 Health and Welfare Fund and Plan Participant of the Teamsters Local Union 170 for whom contributions are made to the Fund.

**Prior Policy**
means, if applicable, the group life insurance policy carried by the Policyholder on the day before the Policy Effective Date.

## Definitions

**Related**
means Your Spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

**Scheduled Aircraft**
means a Civil or Public Aircraft operated by a scheduled airline which:
1) is licensed by the FAA for the transportation of passengers for hire; and
2) publishes its flight schedules and fares for regular passenger service.

**Spouse**
means Your Spouse who is not legally separated or divorced from You.

**The Policy**
means The Policy which We issued to the Policyholder under the Policy Number shown on the face page.

**Trust**
means the Policyholder stated on the face page of The Policy.

**We, Us or Our**
means the insurance company named on the face page of The Policy.

**You or Your**
means the person to whom this certificate is issued.

## Eligibility and Enrollment

**Eligible Persons:** *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

**Eligibility for Coverage:** *When will I become eligible?*
You will become eligible for coverage on the latest of:

1) the Policy Effective Date;
2) the date on which You complete the Eligibility Waiting Period for Coverage; or
3) the date You become a member of an Eligible Class.

**Enrollment:** *How do I enroll for coverage?*
The Policyholder will automatically enroll You. However, You will need to complete a beneficiary designation form.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may only enroll during an Annual Enrollment Period if designated by the Policyholder.

Any enrollment may be subject to the Evidence of Insurability Requirements provision.

**Evidence of Insurability Requirements:** *When will I first be required to provide Evidence of Insurability?*
We do not require Evidence of Insurability.

**Evidence of Insurability:** *What is Evidence of Insurability?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

1) a completed and signed application approved by Us;
2) a medical examination;
3) attending Physicians' statement; and
4) any additional information We may require.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You are insurable for initial coverage or an increase in coverage under The Policy.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

## Period of Coverage

**Effective Date:** *When does my coverage start?*
Coverage, for which Evidence of Insurability is not required, will start on the date You become eligible.

Any coverage, for which Evidence of Insurability is required, will become effective on the later of:
1) the date You become eligible; or
2) the date We approve Your Evidence of Insurability.

However, all Effective Dates of coverage are subject to the Deferred Effective Date provision.

**Deferred Effective Date:** *When will my effective date for coverage or a change in my coverage be deferred?*
If, on the date You are to become covered:
1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

You are not a Plan Participant due to a physical or mental condition such coverage will not start until the date You are a Plan Participant.

**Continuity from a Prior Policy:** *Is there continuity of coverage from a Prior Policy?*
Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were insured under the Prior Policy, but on the Policy Effective Date You were not a Plan Participant and would otherwise meet the Eligibility requirements of The Policy. However, Your amount of Insurance will be the lesser of the amount of Life Insurance and Accidental Death and Dismemberment Principal Sum:
1) You had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:
1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:
1) the last day of a period of 12 consecutive months after the Policy Effective Date;
2) the date Your insurance terminates for any reason shown under the Termination provision;
3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) the date You are a Plan Participant.

However, if the coverage provided through this provision ends because You are a Plan Participant, You may be covered under The Policy.

**Effective Date for Changes in Coverage:** *When will changes in coverage become effective?*
Any decrease in coverage will take effect on the first of the month following the date of the change.

Any increase in coverage will take effect on the latest of:
1) the first of the month following the date of the change;
2) the date requirements of the Deferred Effective Date provision are met; or
3) the date Evidence of Insurability is approved, if required.

## Period of Coverage

**Termination:** *When will my coverage end?*
Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the last day of the month following the date You are no longer in a class eligible for coverage, or the class is cancelled;
3) the date the required premium is due but not paid;
4) the last day of the month following the date You or the Policyholder terminates Your participation;
5) the last day of the month following the date You are no longer a Plan Participant;
6) the last day of the insurance period that Your combined credited and banked hours do not qualify You for the next insurance period, except that You may continue Your insurance, provided You pay directly to the Fund prior to the insurance period, the balance of the required hours under Your Bargaining Agreement.

**Waiver of Premium:** *Does coverage continue if I am Disabled?*
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.

If You qualify for Waiver of Premium, the amount of continued coverage:

1) will be the amount in force on the date You became Disabled;
2) will be subject to any reductions provided by The Policy; and
3) will not increase.

**Eligible Coverages:** *What coverages are eligible under this provision?*
This provision applies only to Your Basic Life Insurance.

**Disabled:** *What does Disabled mean?*
Disabled means You are prevented by Injury or sickness from doing any work for which You are, or could become, qualified by:

1) education;
2) training; or
3) experience.

In addition, You will be considered Disabled if You have been diagnosed with a life expectancy of 24 months or less.

**Conditions for Qualification:** *What conditions must I satisfy before I qualify for this provision?*
To qualify for Waiver of Premium You must:

1) be covered under The Policy and be under age 60 when You become Disabled;
2) be Disabled and provide Proof of Loss that You have been Disabled for nine consecutive months, starting on the date You first became Disabled; and
3) provide such proof within one year of the date You became Disabled.

In any event, You must have been a Plan Participant under The Policy to qualify for Waiver of Premium.

## Period of Coverage

**When Premiums are Waived:** *When will premiums be waived?*
If We approve Waiver of Premium, We will notify You of the date We will begin to waive premium. In any case, We will not waive premiums for the first nine months You are Disabled. We have the right to:

1) require Proof of Loss that You are Disabled; and
2) have You examined at reasonable intervals during the first two years after receiving initial Proof of Loss, but not more than once a year after that.

If You fail to submit any required Proof of Loss or refuse to be examined as required by Us, then Waiver of Premium ceases.

However, if We deny Waiver of Premium, You may be eligible to convert coverage in accordance with the Conversion Right.

If You cease to be Disabled and return to work for a total of five days or less during the first nine months that You are Disabled, the nine month waiting period will not be interrupted. Except for the five days or less that You worked, You must be Disabled by the same condition for the total nine month period. If You return to work for more than five days, You must satisfy a new waiting period.

**Benefit Payable before Approval of Waiver of Premium:** *What if I die before I qualify for Waiver of Premium?*
If You die within one year of the date You became Disabled, but before You qualify for Waiver of Premium, We will pay the amount of Life Insurance which is in force for You provided:

1) You were continuously Disabled;
2) the disability lasted or would have lasted nine months or more; and
3) premiums had been paid for coverage.

**Waiver Ceases:** *When will Waiver of Premium cease?*
We will waive premium payments and continue Your coverage, while You remain Disabled, until the date You attain Normal Retirement Age if Disabled prior to age 60.

*What happens when Waiver of Premium ceases?*
When the Waiver of Premium ceases:

1) if You return to work in an Eligible Class, as an active Plan Participant, then You may again be eligible for coverage as long as premiums are paid when due; or
2) if You do not return to work in an Eligible Class, coverage will end and You may be eligible to exercise the Conversion Right if You do so within the time limits described in such provision. The amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right.

**Effect of Policy Termination:** *What happens to the Waiver of Premium if The Policy terminates?*
If The Policy terminates or a Participating Employer ceases to be a Participating Employer before You qualify for Waiver of Premium:

1) You may be eligible to exercise the Conversion Right, provided You do so within the time limits described in such provision; and
2) You may still be approved for Waiver of Premium if You qualify.

If The Policy terminates or a Participating Employer ceases to be a Participating Employer after You qualify for Waiver of Premium, Your coverage under the terms of this provision will not be affected.

## Benefits

**Life Insurance Benefit:** *When is the Life Insurance Benefit payable?*
If You die while covered under The Policy, We will pay Your Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

**Accelerated Benefit:** *What is the benefit?*
In the event that You are diagnosed as Terminally Ill, and You request in writing that a portion of Your amount of Life Insurance be paid as an Accelerated Benefit while You are:

1) covered under The Policy for an amount of Life Insurance of at least $10,000; and
2) under age 60;

We will pay the Accelerated Benefit Amount as shown below, provided We receive proof of such Terminal Illness.

The amount of Life Insurance payable upon Your death will be reduced by any Accelerated Benefit Amount paid under this benefit.

You may request a minimum Accelerated Benefit Amount of $3,000, and a maximum of $20,000. However, in no event will the Accelerated Benefit Amount exceed 80% of Your amount of Life Insurance. This option may be exercised only once for You.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of $10,000 and are Terminally Ill, You can request any portion of the amount of Life Insurance Benefits from $3,000 to $8,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only $3,000 now, You cannot request the additional $5,000 in the future.

A person who submits proof satisfactory to Us of his or her Terminal Illness will also meet the definition of Disabled for Waiver of Premium.

Any benefits received under this benefit may be taxable. You should consult a personal tax advisor for further information.

In the event:

1) You are required by law to accelerate benefits to meet the claims of creditors; or
2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

**Terminal Illness or Terminally Ill** means a life expectancy of 24 months or less.

**Proof of Terminal Illness and Examinations:** *Must proof of Terminal Illness be submitted?*
We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You do not submit proof of Terminal Illness satisfactory to Us, or if You refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

## Benefits

**No Longer Terminally Ill:** *What happens to my coverage if I am no longer Terminally Ill?*
If You are diagnosed by a Physician as no longer Terminally Ill and:

1) are in an Eligible Class, coverage will remain in force, provided premium is paid;
2) are not in an Eligible Class, but You continue to meet the definition of Disabled, coverage will remain in force, subject to the Waiver of Premium provision; or
3) are not in an Eligible Class, but You do not continue to meet the definition of Disabled, coverage will end and You may be eligible to exercise the Conversion Right, if You do so within the time limits described in such provision.

In any event, the amount of coverage will be reduced by the Accelerated Benefit paid.

**Conversion Right:** *If coverage under The Policy ends, do I have a right to convert?*
If Life Insurance coverage or any portion of it under The Policy ends for any reason, You may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for:

1) the Accidental Death and Dismemberment Insurance Benefits; or
2) any amount of Life Insurance for which You were not eligible and covered;

under The Policy.

If coverage under The Policy ends because:

1) The Policy is terminated;
2) coverage for an Eligible Class is terminated; or
3) Your Participating Employer is no longer a Participating Employer;

then You must have been insured under The Policy for five years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

1) $10,000; or
2) the Life Insurance Benefit under The Policy less any amount of Life Insurance for which You may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, the full amount of coverage which ended may be converted.

**Insurer**, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

**Conversion:** *How do I convert my coverage?*
To convert Your coverage, You must complete a Notice of Conversion Right form. The Insurer must receive this within 31 days after Life Insurance terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:

1) complete and return the request form in the proposal; and
2) pay the required premium for coverage;

within the time period specified in the proposal.

Any individual policy issued to You under the Conversion Right:

1) will be effective as of the 32nd day after the date coverage ends; and
2) will be in lieu of coverage for this amount under The Policy.

## Benefits

**Conversion Policy Provisions:** *What are the Conversion Policy Provisions?*
The Conversion Policy will:

1) be issued on one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

1) the same terms and conditions of coverage as The Policy;
2) any benefit other than the Life Insurance Benefit; and
3) term insurance.

However, Conversion is not available for any amount of Life Insurance which was, or is being, continued in accordance with the Waiver of Premium provision until such coverage ends.

**Death within the Conversion Period:** *What if I die before coverage is converted?*
We will pay the amount of Life Insurance You would have had the right to apply for under this provision if:

1) coverage under The Policy terminates;
2) You die within 31 days of the date coverage terminates; and
3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

**Effect of Waiver of Premium on Conversion:** *What happens to the Conversion Policy if Waiver of Premium is later approved?*
If You apply and are approved for Waiver of Premium after an individual Conversion Policy has been issued, any benefit payable at Your death under The Policy will be paid only if the individual Conversion Policy is surrendered.

**Accidental Death and Dismemberment Insurance Benefit:** *When is the Accidental Death and Dismemberment Insurance Benefit payable?*
If You sustain an Injury which results in any of the following Losses within 365 days of the date of accident, We will pay Your amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss, after We receive Proof of Loss in accordance with the Proof of Loss provision.

This Benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum, to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance.

For Loss of:

| | |
|---|---|
| Life | Principal Sum |
| Both Hands or Both Feet or Sight of Both Eyes | Principal Sum |
| One Hand and One Foot | Principal Sum |
| Speech and Hearing in Both Ears | Principal Sum |
| Either Hand or Foot and Sight of One Eye | Principal Sum |
| Movement of Both Upper and Lower Limbs (Quadriplegia) | Principal Sum |
| Movement of Both Lower Limbs (Paraplegia) | Three-Quarters of Principal Sum |
| Movement of Three Limbs (Triplegia) | Three-Quarters of Principal Sum |

| | |
|---|---|
| Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia) | One-Half of Principal Sum |
| Either Hand or Foot | One-Half of Principal Sum |
| Sight of One Eye | One-Half of Principal Sum |
| Speech or Hearing in Both Ears | One-Half of Principal Sum |
| Movement of One Limb (Uniplegia) | One-Quarter of Principal Sum |
| Thumb and Index Finger of Either Hand | One-Quarter of Principal Sum |

**Loss** means with regard to:
1) hands and feet, actual severance through or above wrist or ankle joints;
2) sight, speech and hearing, entire and irrecoverable loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
4) movement, complete and irreversible paralysis of such limbs.

**Seat Belt and Air Bag Benefit:** *When is the Seat Belt and Air Bag Benefit payable?*
If You sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Seat Belt and Air Bag Benefit if the Injury occurred while You were:
1) a passenger riding in; or
2) the licensed operator of;

a properly registered Motor Vehicle and were wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:
1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

If a Seat Belt Benefit is payable, We will also pay an Air Bag Benefit if You were:
1) positioned in a seat equipped with a factory-installed Air Bag; and
2) properly strapped in the Seat Belt when the Air Bag inflated.

The Seat Belt Benefit is the lesser of:
1) an amount resulting from multiplying Your amount of Principal Sum by the Seat Belt Benefit Percentage; or
2) the Maximum Amount for this Benefit.

The Air Bag Benefit is the lesser of:
1) an amount resulting from multiplying Your amount of Principal Sum by the Air Bag Benefit Percentage; or
2) the Maximum Amount for this Benefit.

If it cannot be determined that You were wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

**Accident**, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which You were wearing a Seat Belt.

**Air Bag** means an inflatable supplemental passive restraint system installed by the manufacturer of the Motor Vehicle or its proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

**Seat Belt** means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

**Repatriation Benefit:** *When is the Repatriation Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Repatriation Benefit, if the death occurs outside the territorial limits of the state or country of Your place of permanent residence.

This Benefit will be paid:
1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

The Repatriation Benefit will pay the least of:
1) the actual expenses incurred for:
   a) preparation of the body for burial or cremation; and
   b) transportation of the body to the place of burial or cremation;
2) the amount resulting from multiplying Your amount of Principal Sum by the Repatriation Benefit Percentage; or
3) the Maximum Amount for this Benefit.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

**Child Education Benefit:** *When is the Child Education Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Child Education Benefit to Your Child.

This Benefit will be paid:
1) after We receive proof that Your Child qualifies as a Student, as defined in this Benefit; and
2) according to the General Provisions of The Policy.

If You die, the Child Education Benefit provides an annual amount equal to the lesser of:
1) the amount resulting from multiplying Your amount of Principal Sum by the Child Education Percentage; or
2) the Maximum Amount for this Benefit.

The Child Education Benefit is payable to each of Your Children:
1) on the date; and
2) for whom;
We have received proof satisfactory to Us that he or she is a Student.

If he or she is a minor, We will pay the benefit to the Student's legal guardian.

We will pay the Child Education Benefit to a qualifying Student until the first to occur of:
1) Our payment of the fourth Child Education Benefit to or on behalf of that person; or
2) the end of the 12$^{th}$ consecutive month during which We have not received proof satisfactory to Us that he or she is a Student.

We will not pay more than one Child Education Benefit to any one Student during any one school year.

## Benefits

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision of The Policy if:

1) a Principal Sum is payable because of Your death; and
2) no person qualifies as a Student.

**Student** means Your Child who on the date of Your death:

1) is a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning on the date of Your death; or
2) became a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning within 365 days after Your death and was a student in the 12th grade on the date of Your death.

If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student qualifies as a Student.

**Child** means Your unmarried child, stepchild, legally adopted child, child in the process of adoption or foster child who is less than age 21 who:

1) regularly attends an accredited institution of learning; and
2) is primarily dependent on You for financial support and maintenance.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

**Exclusions:** *What is not covered under The Policy?* (Applies to Accidental Death and Dismemberment Insurance only)

The Policy does not cover any Loss caused by:

1) for members of the military, war or act of war; or
2) Injury sustained while on active duty as a member of the armed forces of any country or international authority.

The Policy does not cover any Loss caused or contributed by:

1) intentionally self-inflicted Injury;
2) suicide or attempted suicide, whether sane or insane;
3) Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
4) Injury sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds;
5) Injury sustained while committing or attempting to commit a felony;
6) the insured's being Intoxicated or under the influence of any narcotic;
7) Injury sustained while Intoxicated; or
8) Injury sustained while driving while Intoxicated.

**Intoxicated** means:

1) the blood alcohol content;
2) the results of other means of testing blood alcohol level; or
3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

## General Provisions

**Notice of Claim:** *When should I notify The Company of a claim?*
You, or the person who has the right to claim benefits, must give Us written notice of a claim within 30 days after:

1) the date of death; or
2) the date of Loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address and the Policy Number.

**Claim Forms:** *Are special forms required to file a claim?*
Within 15 days of receiving a Notice of Claim, We will send forms to the claimant to provide Proof of Loss. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.

**Proof of Loss:** *What is Proof of Loss?*
Proof of Loss may include, but is not limited to, the following:

1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your enrollment form;
4) Your beneficiary designation (if applicable);
5) if applicable, documentation of:
    a) the date Your disability began;
    b) the cause of Your disability; and
    c) the prognosis of Your disability;
6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
7) the names and addresses of all:
    a) Physicians or other qualified medical professionals You have consulted;
    b) hospitals or other medical facilities in which You have been treated; and
    c) pharmacies which have filled Your prescriptions within the past three years;
8) Your signed authorization for Us to obtain and release medical, employment and financial information; or
9) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

**Sending Proof of Loss:** *When must Proof of Loss be given?*
Written Proof of Loss should be sent to Us:

1) with respect to the Life Insurance Benefits, within 365 days; and
2) with respect to the Accidental Death and Dismemberment Insurance Benefits, within 90 days;

after the Loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than one year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

**Physical Examination and Autopsy:** *Can We have a claimant examined or request an autopsy?*
While a claim is pending We have the right at Our expense:

1) to have the person who has a Loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

## General Provisions

**Claim Payment:** *When are benefit payments issued?*
When We determine that benefits are payable, We will pay the benefits due in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

**Claims to be Paid:** *To whom will benefits for my claim be paid?*
Life Insurance Benefits and benefits for Loss of life under the Accidental Death and Dismemberment Insurance Benefits will be paid in accordance with the life insurance beneficiary designation.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:
1) the executors or administrators of Your estate;
2) all to Your surviving Spouse;
3) if Your Spouse does not survive You, in equal shares to Your surviving children; or
4) if no child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:
1) $200 at Your death; and
2) monthly installments of not more than $200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will make any payments, other than for Loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:
1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to $1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

**Beneficiary Designation:** *How do I designate or change my beneficiary?*
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Policyholder. Only satisfactory forms sent to the Policyholder prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Policyholder.

In no event may a beneficiary be changed by a power of attorney.

**Claim Denial:** *What notification will my beneficiary or I receive if a claim is denied?*
If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:
1) give the specific reason(s) for the denial;
2) make specific reference to the provisions upon which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

## General Provisions

**Claim Appeal:** *What recourse will my beneficiary or I have if a claim is denied?*
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

**Policy Interpretation:** *Who interprets policy terms and conditions?*
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

**Incontestability:** *When can The Policy be contested?*
Except for non-payment of premiums, the Life Insurance Benefit of The Policy cannot be contested after two years from the Policy Effective Date. This provision does not apply to the Accidental Death and Dismemberment Insurance Benefits.

In the absence of Fraud, no statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

**Assignment:** *Are there any rights of assignment?*
Except for the dismemberment benefits under the Accidental Death and Dismemberment Insurance Benefit, You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to, the following:

1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

**Legal Actions:** *When can legal action be taken?*
Legal action cannot be taken against Us:

1) sooner than 60 days after the date written Proof of Loss is furnished; or
2) three years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

## General Provisions

**Workers' Compensation:** *How does The Policy affect Workers' Compensation coverage?*
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

**Insurance Fraud:** *How does The Company deal with fraud?*
Insurance fraud occurs when You, Your dependent and/or the Policyholder provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your dependent and/or the Policyholder commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You, Your dependent and/or the Policyholder perpetrate insurance fraud.

**Misstatements:** *What happens if facts are misstated?*
If material facts about You were not stated accurately:

1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

## EXHIBIT "B" TO PLAN DOCUMENT

## MEDICAL CLAIMS & APPEALS PROCEDURE

### 1. INTRODUCTION

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 "effective internal claims and appeals processes" "ACA Rules" enacted under the Patient Protection and Affordable Care Act (ACA) and DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

The following procedures apply to any claim for medical benefits (including health, dental, vision and prescription drug). If you believe you are entitled to a benefit under the Teamsters Local 170 Health & Welfare Fund program, you may have to file a claim for such benefit. The procedures for filing a claim may vary with the benefit. If the claim procedure is not explained in the appropriate benefit section, call the Fund Office for an explanation.

### APPEALS & GRIEVANCES

The Fund has established an internal and external claims appeal process. You have the right to a full and fair review if you disagree with a decision to deny coverage or payment for services you have received. Also, if you have a complaint regarding the care or service you received from a health care provider who participates in your health care network; or you are denied coverage in this health plan or your coverage is cancelled or discontinued for reasons other than non-payment of your cost for coverage in this plan.

You shall have the right to review your file, and present evidence and testimony as part of the appeals process. Further, the Fund will allow enrollees to receive continued coverage pending the outcome of the appeal process. Claim determinations are made in accordance with Plan Documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

Authorized Representative. You may choose to have another person act on your behalf during the grievance review process. You must designate this person in to the applicable claim reviewer. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. (When you are an inpatient, a health care provider may act as your authorized representative to ask for an expedited grievance review. In this case, you do not have to designate the health care provider in writing.) Once an authorized representative is appointed, the care reviewer shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notification regarding decisions, unless the claimant provides specific written direction otherwise.

## 2. DEFINITIONS

Adverse Benefit Determination: includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit can include both pre-service claims (for example, a claim resulting from the application of any utilization review), as well as post-service claims. Failure to make a payment in whole or in part includes any instance where plan pays less that the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding co-payments, deductibles, or other cost sharing requirements.

An adverse benefit determination also includes any rescission of coverage as defined in the regulations restricting rescissions whether or not there is an adverse effect on any particular benefit at that time. The regulations restricting rescissions generally define a rescission as 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. Rescissions of coverage must also comply with requirements of the regulations restricting rescissions.

Claim: A claim is any request for a plan benefit(s) made in accordance with these claim procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.

Claimant: You become a claimant when you make a request for a plan benefit(s) in accordance with these claim procedures.

Day: When used in these claim procedures, the term day means calendar day.
Incorrectly-Filed Claim: Any request for benefits that is not made in accordance with these claim procedures is called an incorrectly-filed claim.

Claim Reviewers: Claim reviewers shall include Blue Cross Blue Shield of MA ((1-800-217-7878); Fallon Community Health Plan (1-800-333-2535); Envision Rx Options (1-800-361-4542); Davis Vision (1-800-999-5431).

## 3. TYPES OF CLAIMS

There are four categories of claims, each with somewhat different claim appeal rules. The Department Of Labor regulations set different requirements based on the type of claim involved. The primary difference is the timeframe within which claims and appeals must be determined.

Pre-Service Claim: A claim is a pre-service claim if receipt of the benefit, in whole or part is conditioned upon an authorization in advance of obtaining the medical care - unless the claim involves urgent care.

Urgent Care Claim: An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would – in the opinion of a physician with knowledge of the claimant's medical condition – subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

On receipt of a pre-service claim, the claim reviewer will make a determination of whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

Post-Service Claim: A post-service claim is any claim for a benefit under this Plan that is not pre-service claim or an urgent care claim.

Concurrent Care Claim: A concurrent care decision occurs where the plan authorizes an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (1) where reconsideration of the authorization results in a reduction or termination of the initially authorized period of time or number of treatments; and (2) where an extension is requested beyond the initially authorized period of time or number of treatments.

The claim type is determined initially when the claim is filed. However, if the nature of the claim changes as it proceeds through these claim procedures, the claim may be re-characterized. If you have any questions regarding the type of claim and /or what claim procedure to follow, contact:

Teamsters Local 170 Health & Welfare Fund
330 Southwest Cutoff Suite 202
Worcester, MA 01604
1-800-447-7730 or (508) 791-3416

## 4. HOW TO FILE A CLAIM FOR BENEFITS

If you have a problem or concern regarding benefits you may call the applicable claim reviewer. Most problems or concerns can be handled with just one phone call. A customer service

representative will work with you to help you understand your coverage or to resolve your problem or concern as quickly as possible. Please keep a record of the representatives who assist you.

Claims determinations are made in accordance with Plan Documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

When resolving a problem or concern the applicable claim reviewer will consider all aspects of the particular case. This includes looking at: all of the provisions of this health plan; the policies and procedures that support this health plan; the health care provider's input; and your understanding and expectation of coverage by this health plan. The applicable claim reviewer may use an individual consideration approach when it is judged to be appropriate. The applicable claim reviewer will follow its standard guidelines when it resolves your problem or concern.

If after speaking with the applicable claim reviewer's customer service representative, you still disagree with the decision that is given to you, you may request a review through the applicable claim reviewer's internal formal claim review program. All claims, grievances and/or appeals should include the following:

- Member's Name
- Identification Number
- Description of issue
- All relevant dates
- Names of Physicians, other medical providers, or administrative staff involved with the case
- Details of any attempts to resolve the case
- Names of customer service representatives who assist you
- Comments, documents, records & other information to support your claim

How to Request an Internal Claim Review. To request a formal review from the applicable medical care provider, you or your authorized representative have three options.

- Write or Fax. The preferred option is for you to send your claim/grievance in writing to: Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your grievance to 1-617-246-3616. Blue Cross Blue Shield will let you know that your request was received by sending you a written confirmation within 15 calendar days.

- Write. Member Appeals and Grievances Department, Fallon Health & Life Assurance Company, 10 Chestnut Street, Worcester, MA 01608.

- Write: Envision Pharmaceutical Services, Inc. 2181 East Aurora Road, Suite 201, Twinsburg, Ohio 44087.

- Write: Davis Vision, Inc. Customer Relationship and Information Technology Center, Capital Region Health Park, Suite 301, 177 Troy-Schenectady Road, Latham, New York 12210.

- E-mail. Or, you may send your grievance to the Blue Cross Blue Shield Member Grievance Program internet address grievances@bcbsma.com or Member Relations Department at Fallon Life & Assurance Company grievance@fchp.org.

- Telephone. Or, you may call the Blue Cross Blue Shield Member Grievance Program at 1-800-472-2689; Fallon Community Health Plan Customer Service at 1-800-333-2535, (extension 69959; Envision RX Options Helpdesk 1-(800) 361-4542; Davis Vision
  1-(800) 999-5431.

Once your request is received, the applicable claim reviewer will research the case in detail. They will ask for more information if needed. The claim reviewer will let you know in writing of the decision or the outcome of the review. All appeals must be received by the applicable claim reviewer within 180 days of the date of treatment, event, or circumstance, such as the date you were told of the service denial or claim denial.

**5.** TIMEFRAME FOR INITIAL BENEFITS CLAIMS DECISIONS

Urgent Care Claim: The claim reviewer shall decide an initial urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims: The claim reviewer shall decide an initial pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request: If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least twenty-four (24) hours prior to the end of the initially authorized period of time or number of treatments, the claim shall be decided within no more that twenty-four (24) hours after receipt of the claim. Any other request to extend a concurrent care decision shall be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Concurrent Care Early Termination: A decision by the claim reviewer to reduce or terminate an initially-authorized course of treatment is an adverse benefit decision that may be appealed by the claimant under these procedures. Notification to the claimant of a decision by the claim reviewer to reduce or terminate an initially-authorized course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

Post-Service Claim: The claim reviewer shall decide an initial post-service claim within reasonable time but no later than thirty (30) days after the receipt of the claim.

Timeframe Extensions: Despite the specified timeframes, nothing prevents the claimant from voluntarily agreeing to extend the above timeframes. If the claim reviewer is not able to decide a pre-service or post-service claim within the above timeframes, due to matters beyond its control, one fifteen (15) day extension of the applicable timeframe is permitted, provided that the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The extension notice shall include a description of the matters beyond the claim reviewer's control that justify the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

Incomplete Claims: If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

Incomplete Urgent Care Claims: If an urgent care claim is incomplete, the claim reviewer shall notify the claimant as soon as possible, but no later than twenty-four (24) hours following receipt of the incomplete claim The notification may be made orally to the claimant, unless the claimant request written notice, and it shall describe the information necessary to complete the claim and shall specify a reasonable time, no less that forty-eight (48) hours, within which the claim must be completed. The claim reviewer shall decide the claim as soon as possible but not later than forty-eight (48) hours after the receipt of the specified information or the end of the period of time provided to submit the specified information.

Other Incomplete Claims: If a pre-service or post-service claim is incomplete, the claim reviewer may deny the claim or may take an extension of time, as described above. If the claim reviewer takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than forty-five (45) days, in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided, the medical care provider shall decide the claim within the extension period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

## 6. NOTIFICATION OF INITIAL BENEFIT DECISION

Once the claim review is completed, the claim reviewer will let you know in writing of the decision or the outcome of the review. This document is often referred to as an EOB or Explanation of Benefits. If the claim reviewer continues to deny coverage for all or part of a healthcare service or supply, the claim reviewer will send an explanation to you. This notice will include: information related to the details of you grievance; the reasons that the claim reviewer has denied the request and applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which the medical care provider has denied the request; any alternative treatment or health care services and supplies that would be covered; the medical care provider's clinical guidelines that apply and were used and any review criteria; and how to request an further review.

In addition, written notification shall be provided to the claimant of the claim reviewer's adverse decision on a claim and shall include the following:

- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific plan provision(s) on which the decision is based;
- A description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the claim reviewer providers procedures and time limits for appeal of the decision, and the right to obtain information about those procedures and the right to sue in federal court;
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, disclose either an explanation of the scientific or clinical judgment applying the terms of the claim reviewer to the claimant's medical circumstances or a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available of such claims.

Notification of the claim reviewer's adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished not later that one (1) day after the oral notice.

## 7. HOW TO APPEAL AN ADVERSE BENEFIT DECISION

A claimant ( or authorized representative) or the attending physician on behalf of the claimant has the right to request an appeal to an adverse benefit decision and that such review is full and fair. All medical claims are subject to both internal and external appeal processes. An initial appeal must be filed in writing on a Request for Review form within 180 days following the receipt of the notification of an adverse benefit decision, or else you will lose you right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

A Request for Review form can be requested from and must be submitted to: Benefits Appeals, at the address specified in the initial notification of benefit decision or on the Explanation of Benefits (EOB). Any request for appeal should state why the benefit decision is incorrect. A claimant has the right to submit documents, written comments, or other information in support of an appeal. Once a request for appeal is received, the claimant or the provider may be advised if additional information is needed to finalize the decision. If this additional information (e.g. medical records, etc.) is not received within forth-five (45) days of request for use in making a decision on an appeal, the medical care provider has the right to deny any appeal.

In the light of the shortened timeframes for decisions of urgent care claim, the claimant (or authorized representative) or attending physician may request an expedited single level appeal by telephone, or by any similarly rapid communication method. The appeal should include the identity of the claimant, a specific medical condition or symptom, a specific treatment, service or product for which authorization is requested, and any reasons why the appeal should be processed on a more expedited basis. The appeal determination for an expedited appeal shall be made over the phone within one (1) working day. Expedited appeals which do not resolve a difference of opinion may be submitted through the standard appeal process.

Claims/Grievance Records. You have the right to look at and get copies of the claim file, records and criteria that the applicable claim reviewer has and that are relevant to your appeal. You shall have a reasonable opportunity to present evidence in the course of the internal claims and external appeals process. In addition, you have the right to copies of these records and criteria free of charge, with any new or additional evidence considered, relied on or generated by (or at the direction of) the plan or insurer. Further, the plan or insurer must provide the claimant, free of charge, with a written statement of any new or additional rationale underlying the adverse benefit determination. This information must be provided as soon as possible and with sufficient time to allow the claimant a reasonable opportunity to respond before the date the adverse determination is made. The applicable claims reviewer will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services. In place of the formal grievance review described above, you have the right to request an "expedited" review right away when your grievance review concerns claims reviewer or treatment for which waiting for a response under the grievance review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by the applicable medical care provider or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance review, the claims reviewer will review your grievance and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.

Pre-service- and Urgent Care: Written notification of the claim reviewer's decision on a pre-service or urgent care claim shall be provided to the claimant whether or not the decision is adverse.

Who Handles the Initial Claim Review. All claims are reviewed by professionals who are knowledgeable about the medical plan and the issues involved in the grievance. The professionals who will review your grievance will be, those who did not participate in any of the applicable claims reviewer's prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When grievance is related to a medical necessity denial, at least one grievance reviewer is an individual who is actively practicing health care professional in the same or similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your grievance.

## 8. RIGHT TO REQUEST EXTERNAL REVIEW

Requesting External Review

A Claimant may request external review of an adverse benefit determination by filing a request for external review within four (4) months after the date of receipt of a notice of an adverse benefit determination. The request for external review must be made in writing to the Teamsters Local 170 Health and Welfare Fund Administrator at 330 Southwest Cutoff, Worcester, Massachusetts 01604 or to the applicable claim reviewer.

Standard External Review

Within five (5) business days following the date of receipt of the external review request, a preliminary review of the request will be performed to determine whether the claim is eligible for external review. Claims eligible for external review are only those that involve (a) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; or (b) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). Furthermore, a claim is not eligible for external review if:

- The Claimant is (or was) not covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Claimant was not covered under the Plan at the time the health care item or service was provided;
- The adverse benefit determination is based on the fact that the Claimant was not eligible for coverage under the Plan (except where the Claimant relates to a rescission of coverage);
- The Claimant has not exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); or
- The Claimant has not provided all the information and forms required to process an external review.

The Claimant will be notified of the results of the preliminary review within one business day after completion of the preliminary review. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request, and set forth the time limit for the Claimant to provide the additional information needed (the longer of the initial four-month period within which to request an external review or, if later, forty-eight (48) hours (or such longer period specifically identified in the notice) after the receipt of the notice).

If the Claim is eligible for external review, an Independent Review Organization (IRO) will be assigned to conduct the external review.

Expedited External Review

Expedited external review may be requested when:

- An adverse benefit determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or
- A final internal adverse benefit determination involves (a) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Claimant's life, health or ability to regain maximum function; or (b) an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged from a facility.

The request for an expedited external review must be made in writing to the Teamsters Local 170 Health and Welfare Fund Administrator or the applicable claim reviewer at the address indicated above. Immediately upon receipt of the request for an expedited external review, a determination will be made as to whether the request meets the requirements described above for a standard external review, the Claimant will be notified of the determination, and, if the request meets the requirements, an IRO will be assigned as described above for a standard external review.

## 9. EXTERNAL REVIEW BY IRO

Providing Information to IRO

The Teamsters Local 170 Health and Welfare Fund or applicable claims reviewer will timely (in the case of an expedited external review, expeditiously) provide to the IRO documents and any information considered in making the adverse benefit determination. The Claimant may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the request for external review.

IRO Review

The IRO will review all of the information and documents timely received. In making its decision, the IRO is not bound by the Plan's prior determination. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

- The Claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, the Claimant, or the Claimant's treating health care provider;
- The terms of the Claimant's summary plan description;
- Evidence-based practice guidelines;

- Any applicable clinical review criteria developed and used by the Plan; and
- The opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

Notification of IRO Decision

The IRO will provide written notice of the final external review decision to the Claimant and the plan within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rational for its decision and any evidence-based standards that were relied on in making its decision. To the extend the final external review decision reverses the Plan's decision (as was reflected in the notice of adverse benefit determination), the Plan shall follow the final external review decision of the IRO.

In the case of an expedited external review, the IRO will provide the notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within48 hours.

Upon completion of these procedures, either the Claimant or the Plan may request judicial review of the final decision on the Claim. Any action brought by, or on behalf of, a Claimant for the Plan benefits must be filed not later than 24 months after completion of the Plan's internal claims procedures (and external review, if applicable).

ERISA Rights Following Review A claimant has the right to sue if 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.

IN WITNESS WHEREOF, THE PLAN DOCUMENT IS EXECUTED AS OF THE _____ DAY OF COTOBER 2024, TO FIRST BECOME EFFECTIVE JANUARY 1, 2025.

EMPLOYER TRUSTEES

_____
Monica J. Chester
Dated:

_____
Ronald J. Bevens
Dated:

_____
Robert Robinson
Dated:

UNION TRUSTEES

_____
Shannon R. George
Dated:

_____
Sean M. Foley
Dated:

_____
Elias M. Gillen
Dated: