

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 ArticleIV, Section 2(a)(k)(m) and ArticleVI, 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, 2018 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, stepdaughter, 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 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 1.35 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 1.36 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 1.37 Room and Board

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

Section 1.38 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 “Schedule of Benefits” is further defined to include the benefits set forth in the member handbook for participants and their dependents who are enrolled in a Fallon

Plan; 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 1.39 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 1.40 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 1.41 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 1.42 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 1.43 Gender

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

Section 2 Eligibility

Section 2.1 General Provisions - Active Employees

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.

Section 2.2 - Initial Eligibility of Participants

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

1. Eligibility – Retired Employees

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 65^h 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; (eg. 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 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
- 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 (2nd) 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 Hartford Life and Accident Insurance Company (the “Hartford”), 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 the Hartford 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 the Hartford 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 the Hartford 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 the Hartford 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 the Hartford policy.

Section 3.2 Accidental Death and Dismemberment Benefit

The Fund has procured group Accidental Death and Dismemberment coverage from the Hartford. The Fund shall pay those benefits in accordance with the terms and conditions of the Hartford 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 the Hartford policy.

D. Additional Provisions There is coverage for additional benefits, including a repatriation benefit or education benefit, subject to the terms and conditions of the Hartford 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 (8th) 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, initially 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 – 3.22 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 and applicable handbook as provided by Fallon Health Plan, 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 Article4 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 full 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 Fallon Health Plan formulary or 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 or medicines as set forth as exclusions established by Fallon Health for Participants and Dependents enrolled in a Fallon Plan;
 - Drugs dispensed without first receiving prior authorization, when required, by the Fund's Prescription Benefit Manager, Blue Cross Blue Shield Express Scripts for Participants and their Dependents enrolled in a Blue Cross Blue Shield Plan;
 - Drugs dispensed without first receiving prior authorization, when required, by the Fallon Health Plan Pharmacy Manager, for Participants and their Dependents enrolled in a Fallon Plan;
 - Drugs or medicines in excess of fill limitations established by Blue Cross Blue Shield Express Scripts for participants and their dependents enrolled in a Blue Cross Blue Shield Plan;
 - Drugs or medicines in excess of fill limitations established by Fallon Health Plan for participants and their dependents enrolled in a Fallon Health Plan;
 - Drugs dispensed without following the step therapy requirements established by Blue Cross Blue Shield/Express Scripts for participants and their dependents enrolled in the Blue Cross Blue Shield plan;
 - Drugs dispensed without following the step therapy requirements established by Fallon Health Plan for participants and their dependents enrolled in a Fallon Health 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 by Fallon Health for participants and dependents enrolled in a Fallon 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 both Fallon and 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. These expenses are subject to maximums as set forth under the Participant’s Schedule of Benefits.

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 entitled “Vision Care Plan Benefit Description”. As used in the preceding sentence, the term “Allowable Vision Care Expenses” means expenses for charges made by a licensed personnel for eye exams, eye glass, lenses or contact lenses.

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 eye glasses (frames and lenses) or contact lenses during any one (1) year cycle, and subject to exclusions for special lens designs or coatings as described in the Davis Vision 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 Article 4 ("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 Article 4 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 are 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 are 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").

3.23 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 or Fallon Health. 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 health 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”:

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

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

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

Active/Inactive Employee: The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a 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, Fallon Health Plan, Blue Cross Blue Shield of Massachusetts and or Express Scripts 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, Fallon Health Plan, Blue Cross Blue Shield of Massachusetts and or Express Scripts 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 Express Scripts, Fallon Health Plan 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 Express Scripts 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 the Hartford Life and Accident Insurance Company. Claims filed regarding life insurance and the accidental death and dismemberment benefit shall be forwarded to the Hartford 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 you 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 advice 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 than 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, 2018.

Notice of Claim

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

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

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

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

Timing of Notice of Adverse Benefits Determination

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

If a claim under the Plan is denied in a whole or in part, you or your representative will receive written notification of the adverse benefit determination within a reasonable period of time, but no later than 45 days after the Fund’s receipt of the claim. The Fund may extend this period for up to 30 additional days provided the Fund determines that the extension is necessary due to matters beyond the Fund’s control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date 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 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 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;
- 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; 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 formally 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 the Hartford Life and Accident Insurance Company. Claims filed regarding life insurance and the accidental death and dismemberment benefit shall be forwarded to the Hartford for benefit determination in accordance with the Hartford Life Insurance Company’s procedures found in Attachments #10, #11 to this SPD. The Hartford Life and Accident Insurance Company has sole and complete discretion and authority to administer and interpret the provisions of the plans it insures. The Hartford 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 or Express Scripts, Fallon Health 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 the Hartford). 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 (Charles H. Aubuchon, Paul E. Dauphinais, Ronald J. Bevens) and three (3) Union Trustees (Shannon R. George, Edward J. Adley and Sean M. Foley). 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 the Hartford 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, Blue Cross Blue Shield or Fallon Health. However, the medical networks are very similar in size; the standard of care is equally comprehensive. 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 three (3) 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 three (3) 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. Fallon Health Plan
Chestnut Place
10 Chestnut Street
Worcester, Massachusetts 01608
1-800-868-5200
www.fallonhealth.org

3. Davis Vision, Inc.
Davis Vision Live Support: 1-800-999-5431
175 East Houston Street
San Antonio, Texas 78205
1-800-328-4728
www.davisvision.com

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

None of these organizations serve as an insurer, but rather, serve as claims processors. Claims for benefits or services are sent to these organizations. They process the claims, then request and receive funds from the Plan to pay these claims, and they in turn, make payment to doctors, hospitals and other providers. Each of 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 Fallon Health Plan Select Care Supreme Plan (a Fallon Health 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 three plans; namely Network Blue New England Option (Network Blue) through Blue Cross/Blue Shield; Fallon Health Direct Care Premium Value Plan (Fallon Health Plan) and Fallon Health Select Care Premium Value Plan (Fallon Health Plan). The Network Blue 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 and/or Handbooks for these Plans. 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.

Fallon Health provides three Plans: Supreme, Select and Direct. The Supreme and Select Plans have the same network. The Select Program has less generous benefits than the Supreme Plan (i.e. higher co-pays, deductibles, etc.). The cost sharing arrangements under the Direct Plan are more favorable to the Participant than the Select plan, but the network is smaller. Deductibles, co-pays, etc. are generally the same or less. Incorporated by reference are the Fallon Health Handbooks which provide extensive descriptions regarding covered services and members rights as well as the Schedule of Benefits.

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 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 and irrespective as to whether the member is enrolled at Blue Cross Blue Shield or Fallon Health.

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

Fallon Health

The Fallon Health Network is comparable to the Blue Cross Blue Shield Network. In the absence of an emergency situation, or in the absence of receiving prior authorization from Fallon Health, no coverage or payment is generally made for services provided outside the Fallon Direct, Select, or Supreme networks. Access to the Network can be made at the Plan's website at www.fallonhealth.org. The Fallon Direct Care Network is smaller than the Fallon Select Care Network. Members may call Customer Service to obtain or select a provider.

Fallon Health has agreed to perform services similar, if not identical, to Blue Cross Blue Shield. Fallon Health provides a number of health care services, including utilization management and administrative services. Fallon Health processes all medical and prescription drug programs in its network. The following is a summary of its services:

- a. Administrative services to comply with applicable statutory and regulatory requirements
- b. Acts as claims fiduciary. Fallon Health does not provide an external appeals process. The Plan has contracted three independent review organizations to fulfill this need pursuant to DOL mandates or guidelines.
- c. Arranges to provide covered services through the Fallon Health Provider Networks
- d. Ensures participating providers are credentialed
- e. Fallon Health administers the payment of participating providers (in-network) and non-participating providers (out-of-network). Fallon Health provides and administers a claims payment and management program
- f. Provides claims and utilization reports
- g. Issues "Certificate of Group Health Plan Coverage" as required by law.

Participants in the Fallon Health program have access to prescription drugs via the Fallon Health Pharmacy Network at www.fallonhealth.org/members/Pharmacy/pharmacy-network.aspx or you may view the Fallon Health drug formulary at www.fallonhealth.org/members/Pharmacy/online-drug-formulary.aspx. Mail order prescriptions are administered by CVS Caremark may be obtained by calling 1-800-237-2767 or at www.fallonhealth.org/members/Pharmacy/mail-order-prescriptions.aspx. Specialty drugs are administered by CVS Caremark. Please contact Customer Service at 1-800-237-2767 or at www.fallonhealth.org/members/Pharmacy/specialty-pharmacy.aspx.

Davis Vision

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 and contact lenses.

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 of Massachusetts and or Express Scripts

Blue Cross Blue Shield of Massachusetts and or Express Scripts is the Fund’s Pharmacy Benefit Manager for the Plan’s prescription drug program (except as provided by Fallon Health Plan). Blue Cross Blue Shield of MA and or Express Scripts is 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.

The Fund uses the Blue Cross Blue Shield of MA and or Express Scripts three Tier open formulary also known as a preferred drug list. Participants are provided access to the Blue Cross Blue Shield MA website at www.bluecrossma.com select the “Member” option, followed by “Using My Plan” then “Pharmacy Coverage”, and the select “Pharmacy Networks”. On the Pharmacy Networks page you will find a link to Express Scripts pharmacy locator tool. You may also call BCBSMA Member Services at 1-800-217-7878 to identify pharmacies within the network.

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

The mail order drug program is provided by Express Scripts Home Delivery Service. On-line enrollment can be made at www.starhomedelivery.com. Click on REGISTER NOW and fill in the requested information to create a new profile. Make sure you include the member identification number on your BCBSMA I.D card. Or you can call Express Scripts at 1-800-892-5119 to speak to a representative.

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.com select the “Member” option followed by “Using my Plan”, then “Pharmacy Coverage” and then select the “Specialty Networks” option for a current 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.cvscaremarkspecialtyrx.com
1-866-846-3096

Onco360, Oncology Pharmacy Solutions
www.onco360.com
1-877-662-6633

Walgreens Specialty Pharmacy
www.walgreens.com/specialty
1-800-649-2872

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

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

Fertility Pharmacy Network

A list of fertility medications can be found on the BCBSMA website. Visit the BCBSMA website, www.bluecrossmas.com select the “Member” option, followed by “Using my Plan”, then “Pharmacy” Coverage”, and then select the “Specialty Pharmacy Networks” option for a current list. Or, contact BCBSMA Member Services at 1-800-217-7878 for additional information.

If you are taking a fertility medication, the BCBSMA pharmacy benefit plan requires that your fertility medication be filled through one of the pharmacies in the BCBSMA Fertility Pharmacy Network. Contact one of the fertility pharmacies listed below to arrange for dispensing of your fertility medication and patient education/counseling services:

BriovaRx
www.briovax.com
1-800-850-9122

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

Metro Drugs
www.metrodrugs.com
1-888-258-0106

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

Walgreens
www.walgreens.com/specialty
1-800-424-9002

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

Section 14 Reciprocity

A. You may have contributions made on our behalf reciprocated (forwarded) to the employee Health & Welfare Fund when you work in an area where employer contributions are made to another Health & Welfare Fund if: (a) there exists a reciprocal agreement between the Teamsters Local 170 Health & Welfare Fund and the other fund; and (b) you have provided both funds with a written request to have the contributions reciprocated (made on your behalf). You will not receive credit for hours worked in another area until reciprocated contributions are received by the Teamsters Local 170 Health & Welfare Fund, see “Continuing Eligibility with Reciprocal Contributions”. However, you may continue eligibility by making self-payments, if necessary. See Pay-in-Provision under Full or Part-Time Participation. You should complete the proper form immediately upon working in another Fund’s area so that you do not lose credit for any time worked. Contact the Local 170 Union Business Office or the administration office of the other plan or call Teamsters Local 170 Health & Welfare Fund office for help. Most reciprocal agreements have deadlines concerning the transferring of contributions. If you wait too long to apply, benefits may be lost. Reciprocal agreements are established so that members can have hours and contributions transferred back to their home Health & Welfare Fund. The home Health & Welfare Fund as defined in the reciprocal agreement is the Fund to which your Home Local Union is a party. Reciprocal agreements are not intended to allow anyone to pick and choose which Health & Welfare Fund they want their contributions to be transferred to or remain in.

B. Continuing Eligibility With Reciprocate Contributions

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

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

Section 15 Source of Financing

The Fund receives contributions from participating employers, income from investments, rent, self-payments by participants, including retired employees, dependents and COBRA. Consistent with these sources, and mindful of their obligations as fiduciaries under ERISA, the Board seeks to establish appropriate rates of contribution in all Collective Bargaining Agreements; seeks to prudently invest assets in accordance with ERISA and the Fund's Investment Policy; set appropriate self-pay rates for COBRA and retired employees; and obtain fair market rentals. The Board of Trustees may also utilize professional investment consultants and managers to ensure proper investments. The Board periodically evaluates the cost of benefits and administrative expenses and based upon actual and projected costs, determines a minimum hourly contribution rate which must be paid in order to finance future expenses.

Section 16 HIPAA Compliance

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

Special Enrollment Rights

If you do not enroll yourself and your eligible dependents in the Plan after you become eligible or during annual open enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual initially declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you initially declined coverage because you had other health care coverage that you have now lost through no fault of your own, or (ii) since declining coverage initially, you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. When you have previously declined coverage, you must have given (in writing) the alternative coverage as your reason for waiving coverage when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents within 30 days after you lose your alternative coverage or the date of your marriage or the birth, adoption, or placement for adoption of your child.

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

Contact the Fund for details about special enrollment.

Section 17 PPACA Compliance

The Trustees have elected “non-grandfathered” status for purposes of complying with the Patient Protection Affordable Care Act and have taken all measures in accordance therewith. For example, the Fund does not impose any lifetime or annual limits on essential health benefits nor does the Plan contain or impose any preexisting exclusions. The Plan provides preventative health services, including women’s preventative health services, as required by the PPACA.

Section 18 Mental Health Parity

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

Section 19 Newborns and Mothers’ Health Protection Act (NMHPA)

Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with NMHPA. Federal law requires the following statement be included in the Plan document:

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

Section 20 Women’s Health and Cancer Rights Act of 1998 (WHCRA)

Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with WHCRA. Specifically, the plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymph edema.

Section 21 Genetic Information Nondiscrimination Act

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

Section 22 Tax Treatment

The Plan is self-insured (for almost all benefits) and is intended to meet the requirements of the Internal Revenue Code so that the cost of coverage paid by a contributing employer or self-payer, and any benefit received by a covered individual through the Plan are not taxable. The Plan does not guarantee any particular tax treatment. Covered individuals are solely responsible for any and all federal, state and/or local taxes attributable for their participation in this plan and the Plan hereby expressly disclaims any liability for such taxes.

Section 23 Plan Name

Teamsters Local 170 Health and Welfare Fund

Section 24 Plan Year

The Plan year is January 1st through December 31st

Section 25 Plan Number

The Plan number is 501

Section 26 Employer Identification Number

The Plan's EIN number is 04-2219623

Section 27 Type of Plan

The Plan is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1). The benefits provided thereunder are intended to be eligible for exclusion from income, to the extent permitted by law. The Short Term Disability Income Benefit is intended to provide partial income replacement in the event of an employee's disability.

Section 28 Distribution of Plan Assets Upon Termination

This Plan may be terminated at any time in the sole discretion of the Board of Trustees.

In the event of the termination of this Plan, the Trustees shall apply the Fund to pay or to provide for the payment of any and all obligations of the Plan and shall distribute and apply any remaining surplus in such a manner as will in the opinion best effectuate the purpose of the Plan; provided however, that no part of the corpus or income of said Fund shall be divided for or diverted to for purposes other than for the exclusive benefit of the employees (Active and/or Retired) and their Dependents, or the administrative expenses of the Fund or for other payments in accordance with the provisions of the Plan. Under no circumstances, shall any corpus or income of the Fund, directly or indirectly revert or accrue to the benefit of any contributing employer of the Fund.

Section 29 Guaranteed Renewability for Employers

In accordance with ERISA section 703 and Internal Revenue code section 9803 the Fund may not deny an employer whose employees are covered under the plan continued access to coverage except for

- Nonpayment of contributions;
- Noncompliance with material plan provisions;
- Ceasing to offer any coverage in a geographic area;
- Fraud or other intentional misrepresentation of material fact;
- Failure to comply with or renew a collective bargaining agreement or other agreement requiring or authorizing plan contributions, or ceasing to employ persons covered by such an agreement; and
- In a network plan, no longer having any individual enrolled through the employer who lives, resides, or works in the network service area, provided that the plan applies this rule uniformly and without regard to any health status related factors.

Section 30 Changes in Law

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

Section 31 Plan Authority

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

- Who is eligible for benefits
- The amount of benefits payable
- The meaning and applicability of Plan provisions

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

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

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

Section 32 Right to Amend, Modify or Discontinue the Plan or Benefits

Nothing in this Plan is meant to interpret, extend or change in anyway the provisions expressed in any insurance policies purchased by the Fund. The Trustees reserve the right to amend, modify or discontinue all or part of the Plan and or benefits, in the sole opinion of the Trustees by affirmative votes of two (2) Union Trustees and two (2) Employer Trustees.

IN WITNESS WHEREOF, THE PLAN DOCUMENT IS EXECUTED AS OF THE 8th
DAY OF SEPTEMBER 2017, TO FIRST BECOME EFFECTIVE JANUARY 1, 2018.

EMPLOYER TRUSTEES

UNION TRUSTEES

Charles H. Aubuchon
Charles H. Aubuchon
Dated: 9/8/17

Shannon R. George
Shannon R. George
Dated: 9/8/17

Paul E. Dauphinais
Paul E. Dauphinais
Dated: 9/8/17

Edward J. Adley
Edward J. Adley
Dated: 9-8-17

Ronald J. Bevens
Ronald J. Bevens
Dated:

Sean M. Foley
Sean M. Foley
Dated: 9-8-17