Warehouse Employees Union Local No. 730
Health and Welfare Trust Fund

SUMMARY PLAN DESCRIPTION

December 2022

Administrative Manager

Associated Administrators, LLC

Fund Offices
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(800) 730-2241

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-6102
(301) 459-3020 or (800) 730-2241

Hours
8:30 a.m. to 4:30 p.m., Monday through Friday

Legal Counsel
Blank Rome LLP
Morgan, Lewis & Bockius, LLP

Accountant
Novak Francella, LLC

Website
www.associated-admin.com

Dear Participant:

This Summary Plan Description ("SPD") describes the comprehensive benefits provided to eligible employees and their eligible dependents under the Warehouse Employees Union Local No. 730 Health & Welfare Trust Fund (the "Fund" or "Plan") and also serves as the Fund's Plan document.

The benefits the Fund provides include coverage for hospital, surgical, and medical bills, and payment of dental, vision, and prescription drug expenses. Death benefits and disability income benefits also are provided for employees as specified in this SPD.

This SPD is a detailed summary of the Plan provisions. It is not a contract. The Fund is jointly administered by a Board of Trustees, half of whom are appointed by Warehouse Employees Union Local No. 730 ("Local 730") and half of whom are appointed by employers that pay contributions ("Contributing Employers") to the Fund. The Trustees have delegated the day-to-day administrative functions to Associated Administrators, LLC which acts as the Fund's Administrative Manager. The Trustees are required to interpret the Plan in accordance with the written terms of this SPD. **No oral statement from any of the Fund's Trustees, or any of the Administrative Manager's employees, or anyone else can override the written terms of this SPD.**

We urge you to read this SPD carefully so that you will be familiar with the benefits to which you may be entitled and the Fund's eligibility requirements. We hope that you will share our pride in your Plan and the measure of security it provides to those who work in the industry.

Sincerely,

BOARD OF TRUSTEES

TABLE OF CONTENTS

GENERAL INFORMATION	
Facts About The Plan	6
Board of Trustees	9
Contributing Employers	10
No Fund Liability	11
Board of Trustees Has Final Discretion	11
If the Plan Terminates	11
Automated Benefit Information System	12
DEFINITION OF TERMS	**13**
ELIGIBILITY	
Initial Eligibility	18
Continuing Eligibility	18
Calendar Work Quarter	19
Special Eligibility	20
Personal Contributions (“Self-Pay”)	20
Dependent Eligibility	20
Coverage for Newly Eligible Dependents (Newborn, New Spouse, Adopted Child)	21
Enrolling Dependents	22
Loss of Eligibility	23
SUMMARY SCHEDULE OF BENEFITS	26
HEALTH CARE BENEFITS	
Cigna HEALTHCARE PPO	33
CERTIFICATION PROCEDURES FOR HOSPITAL ADMISSIONS	
CareAllies Utilization Management Provider	35
Chiropractic Care	37
Comprehensive Medical Benefits	37

Doctors' Visits 38
Durable Medical Equipment Network – "CareCentrix" 39

HOSPICE CARE BENEFITS
Bereavement Counseling 40

HOSPITAL EXPENSE BENEFITS
Anesthesiologist 40
Hospital Admissions 40
Hospital Services (Inpatient) 41
Intensive Care Unit 41
Non-Emergency Admissions 41
Outpatient Emergency Accident or Illness 41
Outpatient Illness 41
Outpatient Surgery 42
Midwife Coverage 43
CVS Minute Clinics 44
Organ Transplants 45
Outpatient Diagnostic Lab & X-Ray 46
Surgical Benefits 46
Temporomandibular Joint Treatment (TMJ) 47
COVID-19 47

EXCLUSIONS UNDER COMPREHENSIVE MEDICAL BENEFITS
Exclusions Under Comprehensive Medical Benefits 50

PRESCRIPTION DRUG BENEFITS
Cigna HealthCare Coverage 52
Reimbursement 52
Diabetic Supplies 53
Exclusions/Restrictions 53

MENTAL HEALTH AND SUBSTANCE USE DISORDERBENEFITS
Mental Health and Substance Use
Disorder Benefits 55

DENTAL BENEFITS
Dental Health Centers & Associates 56
Covered Services 56
Emergency Care 57
Charge for Non-Covered Services 58
Excluded Services 58

OPTICAL BENEFITS – Group Vision Services
How to Use the Program 59
Available Benefits 59
Locating a Network Provider 60
Claim Filing and Appeal Procedures 61

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE 63

WEEKLY ACCIDENT & SICKNESS BENEFITS 68

HOW TO FILE A CLAIM
Medical Benefits 71
Weekly Accident & Sickness Benefits 72

APPEAL PROCEDURES
If Your Claim Is Denied 75
Where to Send Your Appeal 75

COORDINATION OF BENEFITS 84

SUBROGATION 88

REQUIRED NOTICES AND POLICIES
Your Rights and Protections Against Surprise Medical Bills 96
Continuation of Coverage - (“COBRA”) 99
Notice of HIPAA Privacy Practices (“HIPAA”) 103
Qualified Medical Child Support Orders (“QMCSO”) 110

Uniformed Services Employment and Re-Employment Rights Act ("USERRA") **111**
Continuation of Coverage under Family Medical Leave Act ("FMLA") **113**
Newborns' And Mothers' Health Protection Act **114**
Women's Health and Cancer Rights Act ("WHCRA") **114**
Statement of ERISA Rights **115**

GENERAL INFORMATION

Plan Name:
Warehouse Employees Union Local No. 730
Health & Welfare Trust Fund

Plan Sponsor: Board of Trustees of the Fund

Employer Identification Number:	**Plan Number:**
52-6058419	501

Plan Administrator: Board of Trustees, Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund

Type of Plan:
This Fund provides coverage for Medical, Dental, Optical, and Prescription Drug expenses and provides benefits for Weekly Accident & Sickness, Life Insurance, and Accidental Death & Dismemberment as specified in the Plan documents.

Type of Administration:
This employee benefit plan is administered by the Board of Trustees, who has contracted with Associated Administrators, LLC to provide administrative management services to handle the day-to-day administration of the Fund.

Contributions, Assets, and Benefit Payments:
Contributions to the Fund are made by Contributing Employers and are held and accumulated in the Fund. Benefits are payable by the Fund, Dental Health Centers, Group Vision Services or MetLife. All benefits are self-funded except for life insurance, accidental death and dismemberment benefits, vision, and dental benefits, which are underwritten and provided in accordance with policies issued to the Trustees by Dental Health Centers, Group Vision Services, and MetLife. Prescription Drug benefits are provided through a contract with Cigna HealthCare.

Agent of Service of Legal Process:
Associated Administrators, LLC or any Trustee at this address:

Warehouse Employees Union Local No. 730
Health & Welfare Trust Fund
911 Ridgebrook Road
Sparks, Maryland 21152-9451
(800) 730-2241

Sources of Contribution:
The Fund is maintained pursuant to collective bargaining agreements. Contributions to the Fund are made by Contributing Employers that are signatory to collective bargaining agreements with Warehouse Employees Union Local 730. Under certain circumstances, participants are also permitted to make contributions.

Funding Medium:
All assets are held in trust by the Trustees. Insurance premiums are paid by the Fund, and insurance companies pay part of the benefits. Benefits are also partially paid from the accumulated assets of the Fund. A current Summary Annual Report (available from the Administrative Manager) gives details of the funding of benefits. The Fund's assets are held by PNC Bank, National Association.

Documents:
The Fund is maintained pursuant to collective bargaining agreements between Warehouse Employees Union Local 730 and Contributing Employers that are contractually obligated to pay contributions to the Fund. The Fund also is governed by an Agreement and Declaration of Trust ("Trust Agreement"). Copies of the Collective Bargaining Agreements and the Trust Agreement may be obtained by participants and beneficiaries upon written request to the Administrative Manager at 911 Ridgebrook Road, Sparks, Maryland 21152-9451. The Collective Bargaining Agreements are also available at the office of Warehouse Employees Union Local 730 and at each Contributing Employer establishment where a minimum of 50 participants who are covered under the Fund customarily work.

Employers:
Upon written request to the Trustees, you may obtain information concerning whether a particular employer or employee organization is a Contributing Employer to the Fund and, if so, the address of that sponsor.

Plan Year: January 1 – December 31

BOARD OF TRUSTEES

Union Trustees

Ritchie Brooks, Chairman
Warehouse Employees Union
Local No. 730
2001 Rhode Island Ave., NE
Washington, D.C. 20018

Jason Lacy
Warehouse Employees Union
Local No. 730
2001 Rhode Island Ave., NE
Washington, D.C. 20018

Franklin Myers
Warehouse Employees Union
Local No. 730
2001 Rhode Island Ave., NE
Washington, D.C. 20018

Tyrone Richardson, Alternate
Warehouse Employees Union
Local No. 730
2001 Rhode Island Ave., NE
Washington, D.C. 20018

Employer Trustees

Jason Paradis, Secretary
Ahold, USA
c/o Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451

Frank Stegman
c/o Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451

Hanna Sehbat
Eight O'Clock Coffee
3300 Pennsy Drive
Landover, MD 20785

Michael Goble, Alternate
Giant Food, LLC
8301 Professional Place
Landover, MD 20785

CONTRIBUTING EMPLOYERS

Adams Burch
Eight O'Clock Coffee
Giant Recycling
Giant Warehouse
Warehouse Employees Union Local No. 730 Staff
Washington Food & Supply

NOTICE: No Fund Liability

Use of the services of any hospital, clinic, doctor, or other provider rendering health care, whether designated by the Fund or otherwise, is the voluntary act of the participant or dependent. Some benefits may only be obtained from providers designated by the Fund. This is not meant to be a recommendation or instruction to use the provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Fund. Providers are independent contractors, not employees of the Plan. The Fund makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission of any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

NOTICE: Board of Trustees Has Final Discretion

The Trustees or any committee of the Trustees have the absolute authority to take all actions necessary to administer the Fund. The Trustees have the right to interpret and apply the rules set forth in this SPD. The Trustees are empowered and authorized to make all decisions concerning the eligibility for and the amount of benefits payable under the Fund. The Trustees further have the right to resolve and clarify any ambiguities, inconsistencies, and omissions which may arise under this SPD.

If the Plan Terminates

The Trustees intend for the benefits provided by the Fund to be in effect permanently. However, the Trustees reserve the right to amend, modify, or discontinue all or part of the Fund's benefits. Should the Trustees terminate the Fund, any remaining assets will be used first to provide benefits under the terms of this SPD to participants and beneficiaries until all assets are exhausted. If there are any surplus assets, they will be used to provide health benefits to participants and beneficiaries in a manner determined by the

Trustees, consistent with the provisions of this SPD and with applicable law.

AUTOMATED BENEFIT INFORMATION SYSTEM

The Fund Office has an Automated Benefit Information System available to participants to check on medical claims 24 hours a day, seven days a week. Dial (800) 730-2241, press #1, and then follow the prompts.

DEFINITION OF TERMS

ELIGIBLE DEPENDENT. "Eligible Dependent" means any one of the following persons who is not employed by any Contributing Employer whose employees are covered by the Fund:

1. The participant's legal spouse.

2. The participant's child or children under 26 years of age (see page 22 for more details). “Child” shall mean the child, step-child, legally adopted child, or a child living with the participant who is under the participant’s legal guardianship and who is dependent on the participant for at least one-half of his/her support. For purposes of this provision, the Trustees may rely on evidence that a child has been claimed as a dependent on the participant’s tax return. In the absence of such evidence or if there is information which raises questions about the accuracy of such evidence, the Trustees may rely on any other information which establishes that the participant provides at least one-half of the child’s support.

EMERGENCY MEDICAL CONDITION/SERVICES. “Emergency Medical Condition/Services” means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy. Emergency Services includes: (1) an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency depart-

ment to evaluate such emergency medical condition; (2) such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and (3) services provided by an out-of-network provider or facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the emergency visit, until: (a) The provider or facility determines the patient is able to travel using nonmedical transportation or nonemergency medical transportation; (b) The patient is supplied with a written notice, as required by federal law, that the provider is an out-of-network provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any in-network providers at the facility who are able to treat the patient, and that the patient may elect to be referred to one of the in-network providers listed; and (c) The patient gives informed consent to continued treatment by the non-participating provider, acknowledging that she or he understands that continued treatment by the out-of-network provider may result in greater cost to the patient.

CONTRIBUTING EMPLOYER. A Contributing Employer who has agreed to make contributions to the Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund in accordance with the terms and conditions of a Collective Bargaining Agreement with the Warehouse Employees Union Local No. 730 Union.

FUND. Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund.

HOSPICE. A hospice is a licensed facility primarily engaged in providing a coordinated program of home and inpatient care for terminally ill individuals.

HOSPITAL. A lawfully operated institution accredited by the American Hospital Association, which maintains and operates organized facilities for major surgery, diagnosis, care and treatment,

and which provides facilities for overnight stay and which is not, other than incidentally, a clinic, nursing, or convalescent home, or similar establishment. A "hospital" may also be a lawfully operated institution specifically accredited by the Joint Commission on Accredited Hospitals for the treatment of alcoholism or mental illness.

ILLNESS. Sickness or disease for which the participant or eligible dependent is not entitled to benefits under Workers' Compensation or Occupational Disease Act or other laws and which causes loss beginning while the benefits of the participant or eligible dependent are in force.

INJURY. An accidental bodily injury occurring while the participant or eligible dependent is eligible for benefits and which did not occur as a result of employment for wage or profit or criminal activity.

MAXIMUM ALLOWED AMOUNT. “Maximum Allowed Amount” means the charge that is used to calculate payment of your benefits. The Maximum Allowed Amount depends on the type of health care provider that furnishes a covered service to you, and on the type of service provided.

The Maximum Allowed Amount for Cigna HealthCare providers is based on the provisions of that provider’s network payment agreement. You pay your copayment and/or coinsurance if it applies. For all out-of-network providers, the Maximum Allowed Amount (other than for No Surprises Services) is based on the usual, customary and reasonable fees for the provider’s geographic region. You pay the deductible and coinsurance and any amount above the allowed amount.

For “No Surprises Services,” the Maximum Allowed Amount is defined as the “Qualifying Payment Amount” (“QPA”). The QPA, as defined under regulations implementing the No Surprises Act, is based on the median of the in-network rates payable for the same or similar service in the same geographic region, adjusted for inflation.

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS. Mental Health and Substance Use Disorder Benefits are benefits to treat a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

NO SURPRISES SERVICES. “No Surprises Services” means the following services: (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) services ancillary to non-Emergency Services (such as anesthesiology, pathology, radiology, and diagnostic services, and other services defined as ancillary under the No Surprises Act and its implementing regulations) when performed by out-of-network providers at in-network facilities; and (4) other out-of-network non-Medical Emergency services performed at in-network facilities for which the provider does not comply with federal notice and consent requirements.

PARTICIPANT. "Participant" means an employee of a Contributing Employer who has met the eligibility requirements established by the Board of Trustees and is actively eligible for benefits.

PREVENTIVE SERVICES. This Plan provides coverage for certain preventive services as required by the Patient Protection and Affordable Care Act of 2010 (“ACA”). Coverage for you and your dependents is provided on an in-network basis only, with no cost sharing (for example, no deductibles, coinsurance, or copayments). For a complete list of preventive services, please contact the Fund Office or visit www.uspreventiveservicestaskforce.org

PHYSICIAN. A legally qualified physician or surgeon (as recognized by the state in which treatment takes place).

SECOND SURGICAL OPINION. An opinion by another surgeon, Doctor of Internal Medicine, or other Specialist not associated with the surgeon who first recommended the surgery.

SUBROGATION. The process by which a participant or dependent, who has been involved in an accident or sustains an illness for which a third-party may be liable, agrees to the Fund's Right of Recovery.

TOTAL DISABILITY. A disability that completely prevents the participant from engaging in any business or occupation for remuneration or profit.

TOTAL & PERMANENT DISABILITY. A "Total Disability" (as defined above) that is expected to last the remainder of the participant's lifetime as determined by the Social Security Administration.

ELIGIBILITY

Initial Eligibility

You will first become eligible for benefits when a single Contributing Employer has reported that you worked at least 600 hours in six consecutive months with the Contributing Employer in a position represented by the Union. On the first day of the seventh month, you will become eligible for benefits, and you will remain eligible for a maximum of three months.

If you are an employee of a new Contributing Employer and (1) you are actively employed in an eligible class of employees **on the date the new Contributing Employer becomes signatory to a Collective Bargaining Agreement with Warehouse Employees Union Local 730;** and (2) you remain eligible for not less than 30 days after the date such Employer became a party to the Trust Agreement, you are eligible for benefits. All other employees must satisfy the initial eligibility requirements listed above.

If you lose your eligibility for benefits, you can earn it again only by meeting the initial eligibility requirement of 600 hours in six consecutive months of employment with the same Contributing Employer.

Continuing Eligibility

Once you become eligible for benefits, you can continue your eligibility in later three-month periods (called "Benefit Quarters") if you have either 300 hours of credited employment in the preceding Calendar Work Quarter (see the chart on page 21), or 600 hours of credited employment in the preceding two Calendar Work Quarters.

Calendar Work Quarter	Benefit Quarter
January, February, March	June, July, August
April, May, June	September, October, November
July, August, September	December, January, February
October, November, December	March, April, May

"Credited employment" for continuing eligibility is the SUM of:

1. All hours reported by a Contributing Employer, plus
2. Credit of 28 hours for each week of non-work-related disability, limited to a 26-week maximum per year for any continuous disability, as long as Weekly Accident & Sickness benefits are payable; **OR**
3. Credit of 28 hours for each week of work-related disability up to a maximum of 52 weeks for each single continuous disability as long as you are receiving Workers' Compensation benefits.

Once you become eligible for benefits, you do not have to continue to work for the same Contributing Employer who reported your initial eligibility, but you will have to work for **one of** the Contributing Employers in a job that is represented by the Union in order to continue your eligibility.

Eligibility Ends on Last Day of Month Contributions Were Made

If your Employer decides it will no longer participate in the Fund, your eligibility for benefits will end on the last day of the month for which contributions were paid. For example, if at the time your Employer terminates its participation in the Fund and has paid contributions for the month of March; your benefits will terminate on March 31st If you are enrolled as a participant in the Fund and your Employer determines it will no longer be a Contributing Employer in the Fund, you will receive notice from the Fund Office informing you that you are no longer eligible for benefits.

Special Eligibility

When a Giant Food, Inc. Vacation Relief employee moves to "Regular Employee" status, the employee is not required to go through another 6-month eligibility waiting period as set forth in Fund rules for new participants, but shall be eligible for Fund benefits on the first day of the month following the move to Regular Employee status, except in the following situation:

- If a Vacation Relief Employee moves to Regular Employee status prior to completing 6 months from date of employment, that employee will not become eligible for benefits until the first day of the month after 6 months from date of employment in the bargaining unit.

Benefit eligibility for these participants will end on the date of their termination of employment.

Personal Contributions ("Self-pay")

If you fail to earn either 300 hours in the current Calendar Work Quarter, or 600 hours in the preceding two Calendar Work Quarters, you may make personal contributions for up to 300 hours for the current Calendar Work Quarter only, for a maximum of two consecutive Calendar Work Quarters. If you are eligible to make these personal contributions, known as the "self-pay" option, the Fund Office will notify you of the amount due. Any amount due for continuing eligibility **must be paid before the Benefit Quarter begins.**

Dependent Eligibility

Eligible Dependent

"Eligible Dependent" means any one of the following persons who is not employed by any Contributing Employer whose employees are covered for benefits provided by the Fund:

1. The participant's legal spouse.
2. The participant's child or children under 26 years of age. "Child"

shall mean the child, step-child, legally adopted child, or a child living with the participant who is under the participant's legal guardianship and who is dependent on the participant for one-half of his/her support. For purposes of this provision, the Trustees may rely on evidence that a child has been claimed as a dependent on the participant's tax return. In the absence of such evidence or if there is information which raises questions about the accuracy of such evidence, the Trustees may rely on any other information which establishes that the participant provides at least one-half of the child's support.

Coverage for Newly Eligible Dependent (Newborn, New Spouse, Adopted Child)

Once you have satisfied the waiting period for coverage (worked at least 600 hours in six consecutive months for a Contributing Employer), you may add a newly eligible dependent to your benefit coverage by notifying the Fund Office and completing a new Enrollment Form. In order for coverage to begin right away, you must enroll your new dependent (new spouse, newborn child, or adopted child) **within 30 days** from the date he or she became your dependent.

For example, in the case of a newborn, you must enroll the newborn within 30 days from the date of birth for coverage to begin at birth. For a new spouse, you must enroll the new spouse within 30 days from the date of marriage for coverage to begin on the date of your wedding.

To ensure that your dependent has coverage from the first possible date, request a new Enrollment Form from your Employer or the Fund Office ***before*** you have the baby (or get married, or whatever the situation may be) so you can mail it with supporting certifications to the Fund Office as soon as the event occurs.

How Do I Enroll My New Dependent?

- You can obtain an Enrollment Form by logging onto www.associated-admin.com and click on "Your Benefits." Next, select "Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund" which will bring you to Local 730's homepage. Under the heading entitled "Downloads," you can print the Enrollment Form. You can also call the Fund Office at (800) 730-2241 and ask for an Enrollment Form.

- Complete the form and return it to the Fund Office along with supporting documentation (baby's birth certificate, adoption papers and/or marriage certificate). Be sure to include your dependent's Social Security Number on the enrollment form.

NOTE: Enrollment will not be processed until we receive both the Enrollment Form (with your dependent's Social Security Number*) and the required proof of dependent status.

*Fund *benefits may be suspended if we do not receive a Social Security Number for your dependent(s), as required by law. Reinstatement will not be retroactive.*

When You Do Not Enroll Within 30 Days

If you fail to enroll your new dependent when he/she is first eligible, coverage will begin on the first day of the month following the date the Fund Office receives the Enrollment Form and all required documentation. Enrollment will not be retroactive.

Send Information To:

Associated Administrators, LLC
Warehouse Employees Union Local 730
Health and Welfare Trust Fund
Eligibility Department
911 Ridgebrook Road
Sparks, MD 21152-9451

Loss of Eligibility

Eligibility for you and your eligible dependents will end on the first day of a Benefit Quarter when the requirements of credited employment or personal contributions have not been met in the corresponding Calendar Work Quarter. If you die while eligible for benefits, your eligible dependents will continue to be eligible for benefits until the end of the Benefit Quarter for which you were eligible. See page 101 for information on continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

If you are a Giant Food, LLC employee who obtained initial eligibility through the "Special Eligibility" rule defined herein, your benefit eligibility will end on the date of your termination of employment. If any benefits are paid on a claim in violation of the terms and conditions of this SPD, you will be advised by mail of the improper payment and requested to make restitution to the Fund. If you refuse to make restitution within 10 days of the date on such notice, you and your eligible dependents shall be denied all further benefits under the Fund (referred to as "suspended" or "suspension") until full restitution of the money improperly obtained is made to the Fund.

The Fund will notify you by mail that your benefits and those of any of your eligible dependents have been suspended. Upon complete restitution to the Fund (including without limitation, interest calculated at the prime interest rate), your benefits and your eligible dependent's benefits will be reinstated as of the date your payment clears the Fund's bank account. Under no circumstances shall the Fund provide retroactive medical benefits to you or your dependents dependent during any period of suspension.

Loss of Medicaid or CHIP Coverage

If your dependents lose eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage, or if your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP coverage, and you return an Enrollment Form and all required documentation (such as, notice from the state regarding eligibility for Medicaid or CHIP coverage) to the Fund Office within 60 days of such event, your dependents' coverage will begin immediately. Otherwise, if you do not return the Enrollment Form and necessary documentation within 60 days, your dependents will be enrolled for coverage on the first day of the month following receipt of your completed Enrollment Form and all required documentation.

Emergency Continuations of Eligibility:
Illness or Injury

If you are not working because of a non-work-related illness or injury, and you have filed a claim for **Weekly Accident & Sickness benefits** with the Fund Office, your eligibility can be extended for up to 26 weeks in a calendar year as long as you were eligible for benefits when the illness or injury began.

If you are not working because of a work-related illness or injury and you have submitted written proof (such as Workers' Compensation paystubs) to the Fund Office that you are receiving **Workers' Compensation benefits**, your eligibility can be extended for up to 52 weeks for any one continuous disability provided you were eligible at the time of the illness or injury and provided that you continue to receive Workers' Compensation benefits.

Strike or Lockout

If you were eligible when a strike or lockout involving your Employer began, your eligibility for benefits (excluding Weekly Accident & Sickness disability benefits) can be extended through the first 90 days of the strike or lockout.

Leave of Absence or Layoff

If you are not working because of an approved leave of absence or a layoff, and your Employer has stopped contributing to the Fund on your behalf, you may be able to make personal contributions to extend your eligibility (see section on COBRA, page 101).

Hospital Extension

If you or your dependents are confined to a hospital on the date you would otherwise become covered, such coverage is not effective until the date following your (or your dependent's) final discharge from the hospital.

Reciprocity

Initial eligibility requirements for health benefits will be waived for any new participant transferring into the Fund from another Health Trust Fund whose Union Sponsor is affiliated with the Teamsters Joint Council No. 55, providing such action is reciprocated, and such new participant was eligible with the Health Trust Fund from which he/she transferred.

SUMMARY SCHEDULES OF BENEFITS

Note: The following information is a summary. For more detailed information about applicable benefits, refer to the applicable section of this SPD.

SCHEDULE OF BENEFITS

Accidental Death & Dismemberment Benefits	
Eligible	**Benefit**
Participant Only	$50,000.00 Maximum
Life Insurance Benefits	
Eligible	**Benefit**
Participant Only	$50,000.00 Maximum
Weekly Accident & Sickness Benefits	
Eligible	**Benefit**
Participant Only	Weekly Benefit amount shown for your Employer in the table on page 72. See page 70 for special circumstances which may extend the time for which benefits are paid.

SCHEDULE OF BENEFITS (Continued)

	Ambulance Fees
Eligible	**Benefit**
Participant & Eligible Dependents	Covered under Comprehensive Medical Benefits (see below) (hereinafter "Comprehensive coverage") up to the Maximum Allowed Amount
	Bereavement Counseling
Eligible	**Benefit**
Participant & Eligible Dependents	Bereavement Counseling – Comprehensive coverage up to Maximum Allowed Amount; maximum of $200.00.
	Comprehensive Medical Benefits
Eligible	**Benefit**
Participant & Eligible Dependents	$800.00 deductible per person per calendar year; maximum family deductible is $1,600.00 per calendar year. 80% of eligible Maximum Allowed Amount paid; maximum out-of-pocket expense is $6,250.00 per person per calendar year; $12,500.00 per family after which benefits are paid at 100%.
	Dental Benefits
Eligible	**Benefit**
Participant & Eligible Dependents	Provided by Dental Health Centers. See page 58 for details.

	Doctor Visits - Inpatient
Eligible	**Benefit**
Participant & Eligible Dependents	Comprehensive coverage up to Maximum Allowed Amount to a maximum of 90 visits per year.
	Doctor Visits - Outpatient
Eligible	**Benefit**
Participant & Eligible Dependents	$35.00 basic payment per visit; balance under Comprehensive coverage up to Maximum Allowed Amount. Maximum of 90 visits (excluding preventive visits).
	Hospital Care Benefits
Eligible	**Benefit**
Participant & Eligible Dependents	Inpatient – Comprehensive coverage up to Maximum Allowed Amount. Outpatient – Comprehensive coverage up to Maximum Allowed Amount.
	Hospital Admissions
Eligible	**Benefit**
Participant & Eligible Dependents	Daily Room & Board – 180 days under Comprehensive coverage up to semi-private room rate. $100.00 deductible per stay. Intensive Care Unit – Full charges (up to Maximum Allowed Amount under

	Comprehensive coverage). Included in 180-day maximum. Coverage is provided for both inpatient and outpatient MH/SA up to the limits of the Plan. The 180-day hospital stay limit applies to a combination of MH/SA and medical/surgical. The 90-day inpatient visit limit applies to a combination of both MH/SA and medical/surgical.
	Hospital Services
Eligible	**Benefit**
Participant & Eligible Dependents	Comprehensive coverage up to Maximum Allowed Amount.
	Mental Health Benefits
Eligible	**Benefit**
Participant & Eligible Dependents	Hospital Room & Board – 180 days per calendar year under Comprehensive coverage up to semi-private room rate. $100.00 deductible per stay up to annual maximum (included in regular room & board maximums). Inpatient Hospital Services – Comprehensive coverage up to Maximum Allowed Amount. The 180-day hospital stay limit applies to a combination of MH/SA and medical/surgical. The 90-day inpatient visit limit applies to a combination of both MH/SA and medical/surgical.

SCHEDULE OF BENEFITS (Continued)

Mental Health and Substance Use Disorder Benefits	
Eligible	**Benefit**
Participant & Eligible Dependents	$35.00 basic payment per visit; balance under Comprehensive coverage up to Maximum Allowed Amount. Both inpatient treatment and outpatient treatment for Mental Health/Substance Use Disorder ("MH/SA") is available through Cigna Healthcare Network Providers. Coverage is provided for both inpatient and outpatient MH/SA up to the limits of the Plan. The 180-day hospital stay limit applies to a combination of MH/SA and medical/surgical. The 90-day inpatient visit limit applies to a combination of both MH/SA and medical/surgical.

	Optical Benefits
Eligible	**Benefit**
Participant & Eligible Dependents	Exam, lenses, frames, & contacts covered as provided on page 61.

SCHEDULE OF BENEFITS (Continued)

Organ Transplant Benefits	
Eligible	**Benefit**
Participant & Eligible Dependents	Comprehensive coverage up to Maximum Allowed Amount.
Outpatient Diagnostic Lab and X-ray Benefits	
Eligible	**Benefit**
Participant & Eligible Dependents	Comprehensive coverage up to Maximum Amount.
Prescription Drug Benefits	
Eligible	**Benefit**
Active Participant & Eligible Dependents	$15.00 co-pay per generic prescription; $40.00 co-pay per preferred prescription; $75.00 per non-preferred prescription, maximum out-of-pocket expense is $1,100.00 per person per calendar year; $2,200.00 per family after which benefits are paid at 100%. Generic drugs must be used if available. See page 54.
Surgical Benefits	
Eligible	**Benefit**
Participant & Eligible Dependents	Comprehensive coverage up to Maximum Allowed Amount.

Temporomandibular Joint (TMJ) Treatment	
Eligible	**Benefit**
Participant & Eligible Dependents	Comprehensive coverage up to Maximum Allowed Amount.

Note: Certain benefits may require pre-authorization. Always contact the Fund Office before scheduling a procedure to confirm that the procedure is a covered benefit.

Cigna HEALTHCARE
PREFERRED PROVIDER ORGANIZATION ("PPO")

Cigna HealthCare Preferred Provider Organization is a network of hospitals, physicians, and other health care providers which offers services at reduced rates. When you use a Cigna HealthCare ("Cigna") provider for your medical benefits, you'll get lower out-of-pocket expenses, and the Fund's costs will also be lower.

Cigna *discounts* claims when you use one of their participating providers, but Cigna **is NOT your insurance company.** Your coverage is provided and paid for by the Fund.

Locating A Cigna HealthCare Provider

To locate current providers in the Cigna network, log on to its website at www.myCigna.com. At the bottom of that site, click on Provider Directory: hcpdirectory.cigna.com. The names of providers are updated regularly. If you wish to receive a Cigna Provider Directory, call the Fund Office toll free at (800) 730-2241 and we will mail one to you.

After discounting, Cigna will send the claim to the Fund Office to be processed. If you do not use a Cigna HealthCare provider, still send your claim to Cigna HealthCare for potential savings through the Out-of-Network Savings Plan at CIGNA HealthCare, P.O. Box 182223, Chattanooga, TN 37422-7223.

Your covered benefits do not change whether or not you use a Cigna Healthcare provider; only your out-of-pocket expense may change. The amount you pay will likely be higher if you don't use a Cigna Healthcare provider. What is excluded under your coverage continues to be excluded even if a Cigna Healthcare provider provides that service.

If a Healthcare provider leaves the Cigna HealthCare network, and you are a “**Continuing Care Patient”** who is receiving care with that provider you may continue to receive such care at the same in-network *Co-Payment* for up to 90 days after the provider leaves the network.

A Continuing Care Patient is a patient who is (1) receiving a course of treatment for a “serious and complex condition,” defined as an acute illness requiring specialized treatment to avoid the reasonable possibility of serious harm, and which requires treatment over a prolonged period of time; (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; or (4) determined to be terminally ill and receiving treatment for the illness.

CERTIFICATION PROCEDURES FOR HOSPITAL ADMISSIONS

CareAllies Utilization Management Provider

CareAllies (a subsidiary of Cigna HealthCare) is a Utilization Management ("UM") provider which helps the Fund control the cost of hospital admissions and other care by reducing unnecessary admissions and other costs and by finding alternative treatment settings which are effective and medically sound.

You and your eligible dependents **MUST** contact CareAllies toll free at (800) 768-4695 to precertify **ALL out-of-network** non-emergency or elective hospital stays and within 48 hours after an Emergency Illness admission. **If you (or a family member or the provider of service) do not contact CareAllies prior to your hospital admission, the Fund will NOT pay for any of your stay.**

CareAllies will verify that the admission is medically necessary according to standard medical practices and send you a letter of certification noting the number of days which are approved. CareAllies certification of medical necessity does not mean your claim is covered by the Fund. In addition to a CareAllies certification of medical necessity, you must also confirm that the hospital admission and procedure are covered benefits under the Fund. To do this, you must contact the Fund Office at (800) 730-2241.

To Certify Your Out-of-Network Admission:

- Before your admission, call CareAllies at (800) 768-4695 between 8:00 am to 8:00 pm EST, Monday - Friday. You should call at least two weeks before a scheduled inpatient hospital stay.
- CareAllies will send you an approval letter. Bring the letter with you when you go to the hospital.
- If your medical condition requires an extension of your hospital stay, you or your healthcare provider must first contact CareAllies to authorize the extension.

- **Remember: Non-emergency or elective admissions** must be certified prior to admission in order to be covered.

If Certification Is Denied:
CareAllies may request that you obtain a second opinion before they will certify your admission. In such a case, the Fund will cover the charges for the second opinion provided you use a Cigna Healthcare provider.

Enhancement Programs Offered by CareAllies:
CareAllies offers participants enhancements such as the following programs:

- **24-hour Health Information Line,** where you can receive helpful information from registered nurses, anytime, day or night. The telephone number for the Health Information Line is (800) 768-4695.
- **Case Management Program** is a patient-focused program intended to provide assistance and care coordination to chronically or critically ill patients (i.e., cancer, serious spinal cord injury, diabetes, heart disease, etc.).
- **Maternity Management Program** allows participants and eligible dependents to receive valuable prenatal guidance and high-risk maternity screening.
- **LifeSource Organ Transplant Program** provides care coordination in transplant centers across the country as well as case management to participants and eligible dependents.
- **Healthy Rewards Program** is a discount program for weight management, nutrition, tobacco cessation, fitness, and a wide range of other common health and wellness issues.

  To learn more about any of the above-mentioned enhancement programs and secure, convenient fast access to your personal health and wellness, log on to www.myCigna.com.

CHIROPRACTIC CARE

CareAllies must certify extended chiropractic care. The first eight visits in a calendar year will be covered without precertification, but the 9th visit, and any additional visits must be pre-authorized to be covered. All treatment performed by a chiropractor will be considered chiropractic care, even if the chiropractor submits a bill as physical therapy or other treatment.

COMPREHENSIVE MEDICAL BENEFITS

Comprehensive medical benefits are provided for participants and eligible dependents for covered charges incurred in connection with illness or injury. Before coverage begins, you must meet the $800.00 deductible per person, per calendar year (family deductible is $1,600.00 per calendar year). After the deductible has been met, payment will be made at 80% on eligible Maximum Allowed Amounts paid. The maximum out-of-pocket expense is $6,250.00 per person, or $12,500.00 per family per calendar year, after which benefits are paid at 100%.

If this benefit is increased at any time, the increased maximum benefit will not include any charges incurred in connection with conditions which began before the effective date of the increase, unless those charges are incurred **after** a period of three consecutive months or longer, beginning with the effective date of the increase, during which time no care or treatment is received in connection with the illness or injury.

If you lose eligibility for benefits under the Fund and you or an eligible dependent is totally disabled at the time, benefits may be extended by providing the Fund with a statement from the physician certifying that you or your eligible dependent are totally disabled. This coverage extension applies **only** to charges related to the illness or injury which caused the total disability. Benefits may be extended only until the end of the calendar year in which the participant lost his/her eligibility for benefits.

Covered Expenses
Treatment, services, and supplies recommended by a physician or surgeon may be covered for you or an eligible dependent provided they are medically necessary (i.e., you obtain certification from CareAllies), such treatment, services, or supplies are a covered benefit through the Fund (i.e., not excluded), and the amount charged does not exceed the Maximum Allowed Amount.

DOCTOR VISITS

Available to you and your eligible dependents, this benefit category includes both inpatient and outpatient visits.

Office & Home Visits
Payment is provided for medically necessary doctor visits, up to a maximum payable per visit, and up to a maximum number of visits (for all causes) per calendar year (excluding preventive care visits). Well baby visits may be included for children up to three years of age. Up to eight immunizations are covered from birth to age 6 at 100% of the Maximum Allowed Amount. The annual deductible still applies.

Inpatient Hospital Visits
The fee for an inpatient hospital consultation for an **initial** inpatient history and physical, or a **first visit** on the day of admission to the hospital will be paid up to the scheduled maximum, limited to one visit per admission. Thereafter, payment is provided up to a maximum amount per visit and a maximum number of visits (for all causes) per calendar year.

Exclusions
No benefits will be paid to the attending surgeon for visits on the day of any surgical procedure, nor for six weeks afterward, because post-operative visits are already paid for (i.e., included) in the surgical allowance. The Fund will **not** pay for any treatment not personally performed by the physician in the presence of the patient. Dentistry, eye refractions or fitting of glasses, and vision or speech therapy, are

not covered under "Doctor Visits," although they may be covered under a different benefit. Notwithstanding the foregoing speech therapy treatment associated with an autism diagnosis is covered for up to 26 visits in a calendar year without precertification, but the 27th visit and any additional visits must be pre-authorized to be covered under the Mental Health and Substance Abuse Disorder Benefit.

DURABLE MEDICAL EQUIPMENT NETWORK

If you or your eligible dependents require Durable Medical Equipment, you must use CareCentrix (Cigna's Durable Medical Equipment provider).

CareCentrix provides the following services:

- Durable medical equipment (e.g., beds, wheelchairs, walkers),
- Respiratory equipment (e.g., oxygen, CPAP, ventilators),
- Enteral nutrition (e.g., pumps and nutritional support),
- Home health care (e.g., nursing, therapies, social work, and home health aides),
- Home infusion products, and
- Other specialty services (e.g., insulin pumps and supplies, CPM machines and supplies, wound vacuums and supplies).

Because Cigna has a contract with certain suppliers, Cigna offers this equipment at a significant savings. Durable medical equipment is covered under your Comprehensive Medical benefits at 80%, which means these savings also reduce **your** out-of-pocket expenses.

With one call to Cigna, you can coordinate complete care and services. Call Member Services toll free at (800) 244-6224 (the telephone number is also on the back of your Cigna ID card).

HOSPICE CARE BENEFITS

Hospice care benefits are provided to cover the expense of a terminally ill participant or eligible dependent whose life expectancy is six months or less ("period of care").

For this purpose, one period of care is a continuous period of time in which a hospice provides services, whether inpatient or outpatient, to the terminally ill patient for up to six months. Coverage will end after six months. However, if the hospice provides no service of any kind for three months or longer, any later hospice expenses would be considered to start a new period of care.

Bereavement Counseling
Charges for bereavement counseling for the participant and/or eligible dependents of a terminally ill patient are payable up to a maximum of $200.00 so long as received within three months of the patient's death.

HOSPITAL BENEFITS

Hospital benefits that cover hospital rooms and related hospital services are available to you and your eligible dependents. Coverage for hospital benefits begins either on the first day of admission or on the day before an approved non-emergency surgery.

Anesthesiologist - The Anesthesiologist's fee will be covered under Comprehensive coverage up to the Maximum Allowed Amount.

Hospital Stays
Room & Board - Benefits are provided up to the actual hospital semi-private room rate for a maximum number of days (see the Schedule of Benefits) for all causes in a calendar year. You have a $100.00 deductible per admission.

Hospital Services

Inpatient Services - During a period of admission, benefits are payable and all necessary hospital expenses incurred are covered, up to the day maximum for all hospital admission benefits in a calendar year.

Intensive Care Unit ("ICU") - Benefits are provided up to the ICU Maximum Allowed Amount rate. You have a $100.00 deductible per stay.

Non-Emergency Admissions

If you plan to be admitted to the hospital for any non-emergency procedure, you or your physician must contact CareAllies at (800) 768-4695 for advance approval of the hospital stay. **Uncertified non-emergency hospital stays will not be covered by the Fund.**

Organ Transplant Benefits

Participants and eligible dependents may receive Comprehensive coverage up to the Maximum Allowed Amount (see page 47 for more information).

Outpatient Emergency Accident or Illness - Hospital expenses incurred at a hospital emergency room or ambulatory care center within 72 hours of an accident or emergency illness are covered up to the day maximum for all hospital stay benefits in a calendar year.

Outpatient Non-Emergency Illness - Hospital expenses incurred at a hospital emergency room or ambulatory care center are NOT payable for a non-emergency illness. See section on Doctor Visits and Outpatient Diagnostic X-ray & Lab Benefits, and the Definition of Terms section, for further details.

Outpatient Surgery
The Fund maintains a list of surgical procedures, which **do not** require hospital admissions and will only approve such surgeries on an outpatient basis unless prior approval is obtained through CareAllies based on one of the following:

- The surgery will be performed at the same time as or immediately prior to a surgical procedure that requires a hospital stay;

- There are technical problems in the procedure that require a hospital stay; or

- Special post-operative medical care will be required which cannot be done if outpatient surgery is performed.

The list of applicable surgical procedures is maintained at the Fund Office. If you are planning to be admitted to the hospital for any of the surgeries on the list, have your physician contact CareAllies at least two weeks before the scheduled admission. Pre-certification is required for outpatient procedures through CareAllies.

If you use an in-network provider, you do not need to do anything for pre-certification. The provider is responsible for getting the pre-certification for all required non-emergency in-network services.

If you use an out-of-network provider for non-emergency services, you are responsible for pre-certification. To do this, call the customer service phone number on the back of your Cigna ID card. A service representative will walk you through the pre-certification process. If a hospital stay is approved for the surgery, benefits will begin on the day before surgery is scheduled, unless your physician has provided evidence that an earlier admission is medically necessary. Normally, the Fund expects all pre-admission testing to be done on an outpatient basis (covered under your Outpatient Diagnostic X-Ray and Laboratory Benefits).

When a hospital stay is not necessary, and surgery is performed either in a hospital or an ambulatory care center, all related hospital service charges will be covered, as long as the 180-day maximum for all hospital stay benefits has not been exhausted.

If a hospital stay is not approved for the surgery or you are hospitalized without pre-authorization and hospitalization cannot later be justified, no room and board charges will be payable. The only benefits available will be for the surgeon's fee and any hospital service charges directly related to the surgical procedure itself. The surgeon's fee and any hospital service charges directly related to the surgical procedure will be considered as if the procedure had been done on an outpatient basis.

Verification of Eligibility

The hospital may request advance verification of your eligibility prior to your admission. Eligibility for inpatient hospital benefits can be verified by telephone up to seven days in advance. Give the hospital the full names of the participant and the patient, the participant's Social Security number, Local Union affiliation and/or number, as well as the Fund's telephone number. It is your responsibility to verify your eligibility prior to hospital admission.

Locating a Provider

To locate a provider in the Cigna Healthcare Network, log onto www.myCigna.com. At the bottom of that site, click on Provider Directory: hcpdirectory.cigna.com.

MIDWIFE COVERAGE
Participant & Legal Spouse Only

The services of a midwife are covered for deliveries at home, in a birthing center, or in a hospital on the same basis as a medical doctor, provided that the midwife is certified by the American College of Nurse Midwives. If complications arise and/or a doctor is called in to handle the birth, the physician's fees would be considered for

payment first, and then the midwife's fees would be considered, if applicable. Benefits payable on the combined fees will in no case exceed the Maximum Allowed Amount for a delivery.

CVS MINUTE CLINICS

Cigna HealthCare provides convenience care clinics throughout the country where you can receive high quality, affordable health care services. In our Mid-Atlantic area, these centers are called Minute-Clinics and are conveniently located in select retail grocery stores and drug stores, as well as certain corporate office buildings and college campuses. As a Cigna HealthCare member, you and your eligible dependents have the opportunity to receive treatment for common ailments and injuries by going to a CVS MinuteClinic health care center.

NOTE: Not all services offered at MinuteClinics are covered. Call the Fund Office at (800) 730-2241 before receiving treatment to be sure services are covered. Use of a MinuteClinic is subject to the same terms and conditions set forth in your Plan of benefits, where appropriate co-payments and deductibles apply.

To find a participating MinuteClinic near you:

- Log on to www.myCigna.com
- Select "Medical PPO Provider Directory," and then the category called "Cigna Facility and Ancillary Directory."
- Enter the Zip code of the area you choose and click on "Continue Search." Scroll down the screen and select "Specialty." After you click on "Convenient Care Centers," you will be able to view all the various MinuteClinics in your area.

ORGAN TRANSPLANTS

Organ transplants for participants and eligible dependents are divided into three categories. The level of benefits depends upon the category in which the procedure falls.

1. Benefits are payable at the same level as any other illness or surgery for common, non-experimental transplant and replacement procedures including:
   a. Cornea transplants,
   b. Kidney transplants,
   c. Artery or vein transplants,
   d. Joint replacements,
   e. Heart valve replacements,
   f. Implantable prosthetic lenses in connection with cataracts, and
   g. Other non-experimental transplants such as skin grafts.

2. Benefits are payable at the same level as for any other illness or surgery, up to a lifetime maximum benefit which covers ALL charges incurred as a result of the transplant, for each type of procedure in the second category including:
   a. Heart transplants,
   b. Heart and lung transplants, and
   c. Liver transplants.

3. No benefits will be paid for the third category or for experimental transplant procedures that are not payable under the first or second categories. Some excluded procedures are:
   a. Implants of artificial hearts, and
   b. Pancreas transplants.

OUTPATIENT DIAGNOSTIC LABORATORY X-RAY

Benefits are provided for outpatient laboratory services if the benefits are performed at a Quest Diagnostics or LabCorp facility. The Fund will not pay benefits for services performed at any other facility. Benefits are paid under major medical, applying to the deductible and out-of-pocket maximum.

OUTPATIENT X-RAY

Benefits are provided for outpatient X-ray examinations, including but not limited to X-rays, MRIs and CT scans. Most of these services require pre-authorization. Benefits are paid under major medical, applying to the deductible and out-of-pocket maximum.

SURGICAL BENEFITS

Surgical benefits are provided to cover surgical procedures performed for participants and eligible dependents. If two or more surgical procedures are performed at the same time, payment will only be made for the operation with the higher value. If two or more surgical procedures are performed at the same time but in different operative fields for different causes, payment will be made for each operation.

Non-Emergency Surgery - If your doctor is planning to admit you to the hospital for non-emergency surgery, please have him/her contact the Fund Office in advance. The Fund Office has a list of surgical procedures, which will be approved only on an **outpatient** basis and will not cover related inpatient hospital expenses except under special circumstances (see page 98 for more information).

No benefits are payable for elective cosmetic surgery. Benefits are not payable for reconstructive surgery except for sterilization for the participant or participant's eligible spouse, and for reconstructive surgeries performed under the WHCRA (see page 116 for more

information). However, cosmetic surgery to repair the effect of an accidental injury incurred while eligible will be covered for you and your eligible dependents if you are still eligible when the surgery is performed.

TEMPOROMANDIBULAR JOINT TREATMENT (TMJ)

The Fund has a special limitation on the benefit it will pay for treatment of Temporomandibular Joint Treatment ("TMJ") syndrome. The Fund will pay a participant and eligible dependent up to $1,500.00 as an annual maximum benefit for the treatment of TMJ Syndrome, whether the treatment is by a physician or a dentist. Claims for treatment of TMJ Syndrome will only be paid by the Fund under this special benefit category and **cannot** be considered under any other benefit (for example, the dental benefit) under the Fund.

COVID – 19

The following services will be covered with no cost sharing (including deductibles, co-payments, and coinsurance) and no requirement of prior authorization:

- diagnosis products for the detection of SARS-CoV-2 or COVID-19 that are approved by the FDA, and the administration of such diagnostic products;

- items and services furnished to a participant or dependent during health care provider office visits (which includes in-person visits and telehealth visits), urgent care visits, and emergency room visits that result in an order for, or administration of, a diagnosis product, but only to the extent that the item or service relates to the furnishing or administration of the diagnostic test or the evaluation of whether an individual needs a diagnostic test; and

~ the COVID-19 vaccine(s) and related administration charges, regardless of whether the vaccine is administered by an in-network or out-of-network provider.

OVER THE COUNTER COVID-19 Tests

The Fund will reimburse eligible participants and dependents for the purchase of at-home COVID-19 test kits. In order to receive a reimbursement, the tests kits must be authorized by the Food and Drug Administration. The most common test kits are FlowflexTM, EllumeTM, InteliSwabTM, BinaxNOWTM and On/GoTM. The Fund will reimburse up to 8 individual tests per covered member and dependent(s) each month.

The reimbursement limit is based on individual tests and not test kits -- most test kits include two individual tests. Also, reimbursement is limited to personal use of tests. Tests related to employment or for resale by a participant/dependent are not eligible for reimbursement.

The reimbursements will be processed by Cigna. If you paid out-of-pocket for a test, you may submit the enclosed claim form for reimbursement. You must submit your claim for reimbursement within one year of the purchase date to be eligible for reimbursement. The reimbursement will be available through the end of the National Emergency period.

To submit for a reimbursement, visit https://www.cigna.com/assets/docs/Cigna%20notices-of-privacy-practices/pharmacy-claim-form.pdf or send in a claim form. A copy of your purchase receipt in addition to the reimbursement claim form is required. Claim forms can be mailed to:

Cigna Pharmacy Service Center
P.O. Box 188053
Chattanooga, TN 37422-8053

You also may be eligible free, at home tests through the U.S. Department of Health and Human Services (HHS). Please visit www.CovidTests.gov for more information.

EXCLUSIONS UNDER COMPREHENSIVE MEDICAL BENEFIT

The Fund does not provide coverage for the following:

1. Charges for, contributed to, or resulting from dental care or treatment, dental X-rays, eye examinations for correction of vision or fitting of glasses, vision therapy, speech therapy, furnishing or replacing hearing aids, drugs, biologics, vaccines or medicines provided on an outpatient basis.
2. Cosmetic or elective surgery or treatment (except sterilization for the participant or participant's eligible spouse, reconstructive surgery under the WHCRA, or to repair the effect of an accident or injury incurred while you are eligible, if you are still eligible at the time the surgery is performed).
3. Charges resulting from occupational injuries or illnesses.
4. Suicide, attempted suicide, or self-inflicted injury except if those actions or the injury are the result of a mental condition such as clinical depression.
5. Treatments, services, or supplies deemed unreasonable or unnecessary.
8. Charges in excess of the Maximum Allowed Amount for any treatment, service, or supply.
9. Injuries or losses resulting from war (declared or undeclared), acts of war, or any injury or sickness contracted while in the Armed Forces.
10. Charges resulting from an aircraft accident, unless the participant is a fare-paying passenger on a regularly scheduled, commercial airline flight.
11. Maternity benefits for anyone other than the participant or the participant's legal spouse.
12. Charges related to injuries sustained while in the commission of a felony except if the participant or eligible dependent is the victim of an act of domestic violence.
13. Confinement in a nursing home.
14. Services provided by a licensed social worker.

15. **Vaccinations, except for those listed under the ACA preventive care guidelines. For a list of immunizations included in the ACA preventive care guidelines, please contact the Fund Office.**
16. **Supplies or services for which no charge is made, or which are furnished by or at the expense of the United States government or any of its agencies.**
17. **Charges for supplies, services or procedures that are not specifically listed as covered in this SPD.**

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits are provided through Cigna HealthCare. As an eligible participant, you receive a Cigna ID card, which you may use at participating pharmacies.

To get a prescription filled, give your card to the pharmacist. There is a $15.00 co-pay per generic prescription; $40.00 co-pay per preferred prescription; and $75.00 per non-preferred prescription. The maximum out-of-pocket expense is $1,100.00 per person per calendar year and $2,200.00 per family, after which benefits are paid at 100%. The Fund will cover 100% of the remaining balance (provided the prescription is related to an illness or injury) up to the Maximum Allowed Amount for that drug or medicine. There are no claim forms to complete--the pharmacist will process your claim and send it directly to Cigna HealthCare. Should you become ineligible, your card will be deactivated.

Generic Drugs

Generic drugs are drugs that go by their chemical names and are required to meet the same government standards as brand name drugs. Brand name drugs are **much** more expensive than generic drugs. **You must request a generic drug, if available.** If you purchase a brand name drug when a generic drug was available, you must pay the difference in cost between the generic and the brand name drugs.

Reimbursement

If you need a prescription filled when you do not have your ID card with you, you will have to pay for the prescription in full and request reimbursement from the Fund. Contact the Fund Office for the reimbursement form. Reimbursement for the amount that would have been paid to the pharmacy (minus your co-payment) will be mailed to you directly from Cigna provided the prescription is covered and you were eligible at the time the prescription was filled. **You are still required to request generic drugs, if available.** If you do not, your reimbursement will only be for the difference in cost between the brand name and the generic drugs.

Please note that the amount of the reimbursement when you do not use your card will not be for the full cost of the drug minus your co-payment, because the discounted cost of the drug will not apply when you do not use the card. It is best to always have your card with you when you go to the pharmacy.

Claims for reimbursement will only be considered for prescriptions, which were filled within one year of the date of submission for reimbursement to the Fund Office.

Covered Prescriptions

Prescription drug benefits will be paid only if the prescription is an order issued by a physician or other authorized healthcare provider to a licensed pharmacist for a "legend drug" or for diabetic supplies. The physician must issue such written order individually for each participant or eligible dependent. A "legend drug" is a drug or medicine that the law requires to be labeled with a warning such as "Caution: Federal Law Prohibits Dispensing without A Prescription."

Diabetic Supplies

Covered diabetic supplies include insulin, glucose test strips, lancets, insulin needles and syringes, insulin pens and cartridges.

Exclusions/Restrictions

The Fund does not pay for:

- Non-prescription drugs or medicines
- Diet drugs, even if prescribed by a physician
- Birth control or fertility drugs
- Drugs taken by injection (except insulin, blood or blood plasma, biological sera, or a prescription that cannot be taken orally)
- Drugs prescribed for more than a 34-day supply or 180 tablets* (whichever is greater) without requiring a refill.
- More than eight (8) Erectile Dysfunction pills per month.
- Compound drugs.

****In accordance with standard dispensing limits, participants can fill a prescription for a 34-day supply up to 180 tablets before authorization is required. Drugs which are prescribed for more than a 34-day supply, or 180 tablets require pre-authorization. In order to obtain a pre-authorization, please contact the number on the back of your Cigna ID card or call (800) 244-6224.***

The Fund also does not pay for drugs under your Prescription Drug Benefit under the following conditions:

- **When you get the drugs free of charge,**
- **When you receive the drugs while in a hospital, nursing home, or mental health facility,**
- **When the cost of the drugs is covered under a government plan or law, such as Social Security or Workers' Compensation,**
- **When you get the drugs after your eligibility for benefits from the Fund has ended, or**
- **When the drugs are prescribed for injury or sickness due to war or acts of war.**

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Participants are not required to obtain pre-authorization before receiving outpatient Mental Health/Substance Use Disorder treatment. Inpatient Mental Health/Substance Use Disorder treatment requires pre-authorization through the Cigna (CareAllies) Mental Health/Substance Use Disorder network.

Both inpatient treatment and outpatient treatment for Mental Health/Substance Use Disorder ("MH/SA") are available to participants and eligible dependents through Cigna Healthcare Network Providers. Benefits for hospital room and board are up to 180 days per calendar year, under Comprehensive coverage limited to a semi-private room rate.

Both inpatient and outpatient MH/SA Coverage is provided for participants and eligible dependents up to the limits of the Plan. The 180-day hospital stay limit applies to a combination of MH/SA and medical/surgical. The 90-day inpatient visit limit applies to a combination of both MH/SA and medical/surgical.

In order to obtain MH/SA services in-network, contact Cigna/CareAllies toll free at 800-768-4695 and select the prompt for Behavioral Health.

DENTAL BENEFITS

Dental benefits for you and your eligible dependents are provided through Dental Health Centers & Associates, and certain covered expenses are paid in full when performed by a participating dentist. (See the list of covered services below). **Be sure to make your appointment with a dentist that participates with Dental Health Centers & Associates. If you contact the provider (dentist) yourself, make sure you confirm that he/she still participates with Dental Health Centers.** This is very important! If the dentist no longer participates, you may be required to pay for services. You are required to pay for any services not covered by the Plan. As long as you use a Dental Health Centers & Associates provider, you will receive a 25% discount off the cost of non-covered services.

Services that are covered at 100% when performed by a participating dentist include the following:

Covered Services

1. Routine examinations and emergency examinations,
2. X-rays (except for excluded services set forth in the Exclusions section),
3. Consultations,
4. Cleaning with fluoride paste and routine plaque removal,
5. Sealants on children 14 and under,
6. Restorative dentistry--silver and tooth-colored fillings, with local anesthesia.
7. Children's restorations by a general dentist or a pediatric dentist, including nerve treatment and stainless steel crowns when needed.

8. Emergency gum treatment for infection, and emergency treatment for toothaches, and oral pain not requiring hospitalization,
9. Oral surgery under local or general anesthesia by a general dentist or oral surgeon to include extractions, impactions, bone reshaping for dentures, biopsies, and other surgical procedures not requiring hospitalization,
10. Prosthetic procedures required to make new full and partial dentures every five years, and
11. Unlimited repair and relining of dentures when necessary.
12. Endodontic benefits are included with a 25% co-payment at any participating general dentist or specialist who participates in the endodontia program. Services covered with the co-payment include exam/consultation with the endodontist, endodontic therapy (root canals), apicoectomy, retrograde amalgams, and root amputations.
13. Reimbursement of charges for emergency care, performed anywhere in the United States and paid for by the participant, up to a maximum of $50.00 per person, per year upon presentation of the paid bill to Dental Health Centers.

Locating a Participating Dentist

To locate a participating dentist, call Dental Health Centers at (301) 583-1400 Tuesday through Saturday. You can also check the list of participating dentists on the web at www.dhcandassociates.com.

Emergency Care

For 24-hour emergency service, call your regular participating Dental Health Centers & Associates affiliated dentist, or call Dental Health Centers at (301) 583-1400. If you are unable to contact and be treated by any of the participating dentists or the emergency staff at Dental Health Centers, see any dentist you can.

Send a copy of **the itemized ADA claim form and paid receipt, along with** a note explaining why you were unable to be treated by a participating dentist to:

Dental Health Centers & Associates
1450 Mercantile Lane Suite 131
Largo, MD 20774

You will be reimbursed up to $50.00 for the emergency treatment.

Charge for Non-Covered Services

Participating general dentists and specialists have agreed to provide services not covered under the Fund at a 25% reduced rate (from their usual fee) to Fund participants. The list of participating specialists will be provided by the Fund upon request. If you need to see a participating specialist, let him/her know about your Fund affiliation **before** you have any work done.

Exclusions

Unless specifically covered elsewhere in this SPD, the following procedures are not covered under your Dental Benefits:

1. Inlays and onlays,
2. Crowns, implants,
3. Bridges,
4. Space maintainers,
5. Periodontia,
6. Hospital dentistry,
7. Plastic surgery,
8. Temporomandibular Joint Syndrome (TMJ) treatment,
9. Orthodontia, and
10. Any other services not listed under Dental Benefits "Covered Services."

Dental Complaints – For problems or complaints send to Dr. Robert P. Cohen, Director of Dental Health Centers, 1450 Mercantile Lane Suite 131, Largo, and MD 20774. Telephone: (301) 583-1400.

OPTICAL and HEARING AID BENEFITS

Vision benefits are provided through Group Vision Service ("GVS"). The GVS Select Network has many providers available through its relationship with EyeMed Vision Care, including independent optometrists and ophthalmologists as well as retail locations such as LensCrafters®, Target Optical®, and participating Pearle Vision® locations. By using a network provider, you minimize your out-of-pocket costs and receive the benefit of paperless claims processing.

When you use a participating vision provider in the GVS network, you are entitled to:

(1) An exam once every 12 months. When rendered by a participating GVS provider you will be responsible for a $10.00 co-payment per visit which is payable to the provider rendering the services.

(2) Single vision or standard multi-focal lenses (for glasses) once every 12 months. Standard Scratch Coating and Polycarbonate Lenses for dependent children under 19 (only) are covered. All other cosmetic options are cost controlled or discounted through the network provider.

(3) Frames are available, once every 12 months, up to a retail allowance of $130.00. For frames costing more than the allowance, members receive a 20% discount on the difference between the actual cost of the frame and the $130.00 retail allowance.

(4) Contact lenses in lieu of spectacle lenses, once every 12 months. A $130.00 allowance is available for the purchase of any prescription contact lens. You are responsible for any cost above $130.00.

If you choose to go to a non-network provider, you must pay the provider his or her full charges at the time of service. You will be responsible for submitting a claim for reimbursement for the amount indicated in the member reimbursement schedule. Members can access the non-network provider reimbursement claim form and reimbursement schedule at www.groupvisionservice.com

Locating a Network Provider

- Find network providers at www.groupvisionservice.com. Click on "Find A Provider."

- Schedule an exam with the provider of your choice. When scheduling your appointment, inform the provider that you are a GVS/EyeMed member and provide your name and date of birth. The provider will verify your eligibility and plan benefits prior to your appointment.

- Members will be responsible to pay the provider at the time of service for any applicable co-payment /costs that exceed the plan coverage.

Out-of-Network Providers

1. Visit non-network provider
2. Members are required to pay the entire amount for exam and eyewear at the time of service.
3. Members must obtain an out-of-network claim form from the GVS website at www.groupvisionservice.com. (click "Members" click "OON Form Download").
4. Members must submit out-of-network claim form and provider receipt to the Claims Address indicated on the form.

Reimbursement is based on the out-of-network benefits indicated in the benefit summary.

Call GVS for Assistance

If you need help regarding your vision coverage, contact GVS customer service or use the Interactive Voice Recognition ("IVR") system at (866) 265-4626 between 8:00 a.m. to 11:00 p.m. EST, Monday through Saturday, and 11:00 a.m. to 8:00 p.m. EST on Sunday.

General Claims Filing

In general, in-network providers handle the claims process for you. If you receive services or materials out-of-network because you have been permitted to do so by GVS, you will have to pay the provider and seek reimbursement through the claims process. Claims must be filed no later than 12 months from the date of service. Claims will generally be paid within 30 days of receipt. For reimbursement for out-of-network services, you must submit The GVS/EyeMed Out-of-Network Claim form and all applicable receipts to GVS' claims department via facsimile 866-293-7373, or mail to:

EyeMed Vision Care
Attn: OON Claims
P.O. box 8504
Mason, OH 45040-7111

Telephone inquiries concerning claims should be directed to: Group Vision Services Claims/Appeals Department at (866) 723-0514.

If a claim is partially paid, you will receive a written notice explaining how the claim was processed and giving notice of your appeal rights as to the unpaid portion. If a claim is denied in whole, a written Notice of Benefit Determination will be sent to you.

Appeal Procedure

You or your authorized representative may appeal a denial via facsimile at (513)-492-3259 or by sending a letter to GVS at the following address:

EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040

Appeals must be in writing and received by GVS within 180 days after your receipt of Notice of Benefit Determination. If this Notice is not received by you within 30 days of submission of the original claim, you may submit an appeal within 180 days after this 30-day period has expired.

Appeals will be decided within 30 days after receipt by GVS. If an appeal is denied, a written Notice of Benefit Appeal Determination will be sent to you. Telephone inquiries concerning appeals should be made to: GVS Claims Appeals Department at (866) 723-0514.

HEARING AID BENEFIT

Routine hearing exams and hearing aids are covered under the Plan's optical benefit. This benefit is provided by EPIC Hearing Healthcare ("EPIC"), an affiliate of GVS, your optical provider. The benefit allows a specific payment, not to exceed $2,500.00 per ear, per every five years, toward your choice of hearing aids. If you have any questions regarding the hearing aid products, including the cost, please call EPIC at 866-956-5400.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Life Insurance

Participants are eligible for Life and Accidental Death & Dismemberment benefits provided through MetLife under Group Policy Number 5394249 in the amount shown in the Schedule of Benefits (see information on page 28). The amount shown is a maximum. If you are still actively employed on your 65th birthday, the amount of insurance decreases according to a schedule shown in the annual benefit summary provided to you by MetLife.

If you die while eligible for benefits, the amount of your death benefit may be paid to the beneficiary(ies) designated on your Enrollment Form. You may name any person(s) you choose to be your beneficiary. Be advised that any beneficiary named that is under the age of 18 must have a court appointed guardian to handle all matters related to the death benefit. Even a child's surviving parent must obtain court appointed guardianship.

Changing Beneficiary(ies)

You may change your named beneficiary (ies) at any time, without the beneficiary's consent. If you name more than one beneficiary without indicating a specific share for each, the benefits may be paid in equal shares or to the survivor.

To designate or change a beneficiary(ies), follow the steps below.

1. Go to www.associated-admin.com and click on "Your Benefits." Next, select "Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund" which will bring you to Local 730's homepage. Under the heading entitled "Downloads," you can print the "Enrollment Form" to name a beneficiary(ies) or you can print the "Change in Beneficiary for Life Insurance Benefit" to change your beneficiary(ies).
2. You also can call the Fund Office at (800) 730-2241 and ask for either an Enrollment Form or Change in Beneficiary for Life Insurance Benefit Form.

3. Complete all sections of the form and sign it.
4. Return the Form to:

    Fund Office
    Warehouse Employees Union Local No. 730
    Health and Welfare Trust Fund
    Attn: Eligibility Dept.
    911 Ridgebrook Road
    Sparks, MD 21152-9451

Beneficiary should call Fund Office soon after your death.
The person(s) you name as beneficiary(ies) should call the Fund Office within 20 days of your death to file a Life Insurance claim. The Fund Office needs to receive written proof of death (a certified copy of the death certificate) within 90 days of the date of death. You may not assign your Life Insurance Benefits to any debtor.

If the beneficiary(ies) you designate dies before you and/or you fail to designate a beneficiary, the death benefits will be paid to the first survivor in the following order:

1. Your spouse.
2. Your natural and adopted children.
3. Your parents.
4. Your siblings.
5. Your estate.

Only those forms (the Enrollment Form, or if completed, the Change in Beneficiary for Life Insurance Benefit Form) that have been properly completed, signed, and received by the Fund Office prior to a participant's death will be honored.

If You Become Permanently and Totally Disabled:
MetLife may waive your insurance premiums under the Group Policy while you are totally disabled if you satisfy certain conditions. The disability must begin before your 60th birthday and you must provide proof of your total disability within one year of the date the total disability begins.

Premiums are waived until the earliest of the following:

- the date you are no longer disabled,
- the date you do not give MetLife proof of total disability when asked, or
- the date you turn age 65.

Other rules are applicable to this provision; contact the Fund Office for details and to obtain the proper forms.

If You Become Terminally Ill (Accelerated Death Benefit)
If the participant becomes terminally ill, meaning has a life expectancy of twelve months or less due to a specific medical condition, the participant may receive 80% of his or her death benefit after submitting proof of the terminal illness. This does not apply to the Accidental Death and Dismemberment benefits. Contact the Fund Office for forms required to seek this benefit.

Life Conversion Privilege
If you lose your life insurance because of disability or termination of employment, you may convert your insurance (without double indemnity or disability riders) to any type of individual life insurance policy then customarily issued by MetLife, except a term insurance policy.

If you lose your life insurance because the Master Policy is replaced or amended, and if you have been insured under the policy for at least five years, you may convert your insurance for an amount equal to the **difference between** your former policy and the amount of life insurance for which you may be eligible under any new policy.

You will have 31 days after termination of your insurance to apply for conversion and pay the required premium. If your death occurs within the grace period and had not yet applied for conversion, your beneficiary(ies) will be paid the amount to which you were entitled to convert.

If your life insurance benefit is paid under your previous Group Policy, your beneficiary(ies) will receive no payment under the converted policy. Any premiums you may have paid for the converted policy will be refunded.

Contact the Fund Office for further details on the Life Conversion Privilege.

Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment ("AD&D") benefits are provided through MetLife. The full amount is payable for losses occurring within twelve months of an accident, as the result of accidental bodily injury and independent of all other causes, for loss of life, two limbs or eyes, or any combination thereof. Half the full amount is payable for the loss of one hand, one foot, or the sight of one eye. No more than the full amount can be paid for losses resulting from a single accident. Dismemberment benefits are only payable to the participant (not to a beneficiary).

Accidental Dismemberment claims should be filed with the Fund Office as soon as possible. Within 20 days after your accident, you must notify the Fund Office; written proof of your injury should be sent the Fund Office within twelve months of your accident. Contact the Fund Office to obtain the proper forms.
Accidental Death claims are filed like any other Life Insurance claims. Follow the procedures outlined under "Life Insurance" on the preceding pages.

Under the Accidental Death benefit, the Fund will **not** pay for losses that occur as a result of suicide or self-inflicted injury, physical or

mental illness, bacterial infection unless from a cut or wound caused by an accident, riding in or descending from an aircraft as a pilot or crew member, armed conflict, injury sustained in the military service, injury occurring during the commission of a felony, voluntary use of any drug, narcotic, or hallucinogen which is illegal and not prescribed by a doctor or taken as directed.

There are many details of the Fund's group insurance plan for death and AD&D benefits which are not shown here. For the benefit description provided by MetLife, please contact the Fund Office. The certificate from MetLife takes precedence and governs over the information in this SPD. A copy of the MetLife insurance certificate can be obtained by contacting the Fund Office.

WEEKLY ACCIDENT & SICKNESS BENEFITS

The Fund provides disability income benefits to a participant if you are totally disabled and unable to work.

Weekly Accident & Sickness Benefits may be payable to you if you sustain an injury or illness due to **non**-work-related causes.

You are entitled to a total of 52 weeks of Weekly Accident & Sickness Benefits per injury in a calendar year if you have sustained a non-work-related injury or illness which prevents you from performing any and every duty pertaining to your employment. Although you do not need to be confined to your home, you must be under the care of a physician. If you exhaust your 52-week entitlement in a calendar year, you will become eligible for another 52 weeks of entitlement in the next calendar year as long as you have been actively employed again for at least two weeks. The maximum number of weeks for which you receive credited employment of 28 hours a week remains 26 weeks.

The amount of the weekly benefit and the waiting period required before you may file a claim varies, depending on your Employer. See the table on page 72 for the benefit rate and waiting period that apply to you.

To obtain these benefits, a Weekly Accident & Sickness form must be completed by you and your attending physician and must be submitted to the Fund Office after the appropriate waiting period (see chart on page 72). Contact the Fund Office at (800) 730-2241 if you need the form. Continuation of Disability forms should be filed periodically after that, as required by the Fund Office, during the time that you are away from work because of disability and while benefits remain to be paid. Send your claim to the Fund Office:

Warehouse Employees Union Local No. 730
Health & Welfare Trust Fund
P.O. Box 1064
Sparks, Maryland 21152-1064

You may pick up your check in person, with photo ID, if your claim is payable and if you notify the Fund Office by 4:30 p.m. on the Wednesday preceding when the payment is due. If you do not notify the Fund Office of your desire to pick up your check by Wednesday at 4:30 p.m., your check will be mailed to you.

WEEKLY ACCIDENT & SICKNESS BENEFITS

Company	Class	Weekly Benefit Amount	Day Benefit Begins		Max. Weeks Payable
			Accident	Sickness	
Eight O'Clock Coffee	E	$ 300.00	15th	22nd	52
Adams Burch, Inc.	E	$ 300.00	1st	8th	52
Giant Recycling	E	$ 300.00	15th	22nd	52
Giant Food--Warehouse	E	$ 300.00	15th	22nd	52
Warehouse Emps. Union Local No. 730 Staff	E	$ 300.00	15th	22nd	52
Washington Food & Supply	E	$ 300.00	15th	22nd	52
Maximum weeks payable are per calendar year per disability.					

HOW TO FILE A CLAIM

All claims for benefits must be made within one year of the date charges were incurred. If a claim is filed after one year has passed, the claim will be automatically denied. **Vision, Dental, or Prescription Drug claims are handled through the provider of the benefit (see the section describing that benefit). They are not processed through the Fund Office.**

Medical Claims

Claims for Medical Benefits are made by sending an itemized bill for services to Cigna Payor 62308, P.O. Box 188004, Chattanooga, TN, 37422-8004. This is generally a "1500 Form" standard claim form for physician services or a "1450 Form" for hospital services. The itemized bill must contain all the information required to process the claim. This includes the name of the participant (and, if applicable, the eligible dependent), alternate ID number of patient (located on your Medical ID card), name and alternate ID number of patient, if different, address, federal tax ID number of service provider, date of service, charge for each service, description of each service (procedure code), and diagnosis. The physician or facility may send the claim for you if you have assigned benefits to them. However, it is the participant's responsibility to be certain a claim is filed within the one-year period. Claims filed outside this period will be denied.

If you use a Cigna HealthCare ("Cigna") physician or facility, generally the Cigna physician or facility will send the claim directly to Cigna for discounting. The address is on the back of your ID card, which should be presented to the provider at the time of service.

If you do not use a Cigna HealthCare physician or facility, the claim should be mailed to the Fund Office at this address:

Warehouse Employees Union Local No. 730
Health & Welfare Trust Fund
911 Ridgebrook Road
Sparks, Maryland 21152-9451

When submitting your claim, you must submit an original of the bill. Photocopies are **only** acceptable under the following conditions:

a. Other group insurance is involved and the Fund is the secondary insurer;
b. The billing is a physician's itemized, ongoing list of all charges and payments; or
c. The original bill has been lost. If this occurs, the photocopy must be submitted with a signed statement by the participant stating that the original was lost.

If you are submitting a claim for "secondary" payment, you must attach a copy of the **other payer's** Explanation of Benefits ("EOB") to your claim form. This information is necessary to process your claim, and without it, your claim will be delayed and/or denied.

Claim Inquiries
If you have a question regarding coverage for services not specifically stated in this SPD, submit it in writing to the Fund Office. **Do not rely on an oral explanation or verification alone.** Request a written statement before proceeding with the contemplated medical service.

Weekly Accident & Sickness Disability Benefits
Complete and sign parts I and II of the Weekly Accident & Sickness claim form and have your attending physician complete and sign part IV. The initial claim for Weekly Accident & Sickness benefits should be filed after the appropriate waiting period (see page 72).

Claim forms should be filed at regular intervals, thereafter, as required by the Fund, for as long as you are disabled, and benefits remain to be paid. Claim forms for continuation of disability benefits must always be signed by you and your attending physician. Mail your disability claim to the Fund Office at:

Warehouse Employees Union Local No. 730
Health & Welfare Trust Fund
P.O. Box 1064
Sparks, Maryland 21152-1064

The Fund does not cover claims arising from routine work-related injuries or illnesses. Typically, the Fund Office will process work-related claims **only** under the following conditions:

- Your claim is denied by your Employer's Workers' Compensation carrier, and
- It is disallowed by the Workers' Compensation Commission.

See the section on Subrogation on page 90 for more information concerning work-related injuries or illnesses.

Steps to Follow for Work-Related Claims

If you have an illness or injury, which may be work-related, you must follow the steps below for your claim to be processed.

1. Submit your claim to the Fund Office as usual. Be sure to file within the time frame required (within 365 days from the date the injury/illness began).

2. At the same time, also file your claim with your Employer's Workers' Compensation carrier.

3. The Fund Office will deny the claim as work-related because it falls under the Workers' Compensation exclusion. Importantly, your claim will be on record as received on time by the Fund Office.

4. If your claim is denied by Workers' Compensation as "non-compensable under Workers' Compensation law," you may choose to file an appeal with the Workers' Compensation Commission***.*** ***Filing an appeal does not guarantee eligibility for benefits.*** In order to maintain eligibility, your claim must be paid by Workers' Compensation, or you have filed a claim with the Fund and are receiving Accident & Sickness benefits.

5. If your claim is approved by Workers' Compensation, the Workers' Compensation carrier will process your medical bills related to the Workers' Compensation injury.

6. **If the Workers' Compensation Commission denies your claim** on the grounds that the claim is non-compensable under Workers' Compensation (meaning the claim was determined NOT to be work-related), the Fund will process your claims. We must receive verification of this information, such as a copy of the denial by the Commission. The Fund will process any bills received in accordance with the Plan document.

7. **If the Commission awards benefits** because your claim is determined compensable, the Workers' Compensation carrier will process your claim.

APPEAL PROCEDURE

If Your Claim Is Denied:

1. If your claim is denied, you will be advised of the specific reason for the denial, the specific Plan provision on which the denial is based, if applicable, any additional information needed to reconsider the claim, a description of the Plan's appeal procedures and time limits, and your right to bring suit against the Plan under ERISA if your appeal is denied. If the Fund relied on an internal rule, guideline, or protocol in making the decision, you will receive either a copy of the rule, etc., or a statement that it was relied upon and is available upon request and free of charge. If the Fund based its decision on medical necessity, experimental treatment, or a similar exclusion or limit, you would receive either an explanation of the judgment related to your condition or a statement that such an explanation is available upon request and free of charge. If the Fund received the advice of any medical or vocational expert with respect to your claim, the Fund would identify the expert upon your request.

2. You or your authorized representative may appeal the claim denial directly to the Board of Trustees. If you decide to appeal, you must make a written request for review within 180 days after you receive written notice that your claim has been denied (within 60 days for non-medical, non-disability claims). **Only participants may file appeals for medical claims; providers of medical services may not.** Send your request for review to the Board of Trustees, Warehouse Employee Union Local No. 730 Health and Welfare Fund, Attn: Appeals Dept., 911 Ridgebrook Road, Sparks, MD 21152-9451. You must include in your written appeal all the facts relating to your claim as well as the reasons you feel the denial was incorrect. You may receive, upon request and free of charge, reasonable access to and copies of any documents relevant to your claim. You may submit issues and comments in writing, and documents relating to your claim.

3. **The Board of Trustees, in making its decisions on claims and appeals, will apply the terms of the Plan document and any applicable guidelines, rules, and schedules, and will periodically verify that benefit determinations are made in accordance with such documents and, where appropriate, are applied consistently with respect to similarly situated claimants. The Board of Trustees will also take into account all information you submit. If the initial decision was based in whole or in part on medical judgment, the Board of Trustees will consult with a health care professional in the appropriate field who was not consulted in the initial determination (or the subordinate of such person). As the Board of Trustees did not initially review your claim, the Board will not give deference to the initial decision.**

4. **The Board of Trustees will make its decision at the next regularly scheduled meeting following receipt of your appeal, unless there are special circumstances, such as the need to hold a hearing, in which case the Board of Trustees will decide the appeal at the second regularly scheduled meeting. If you submit your appeal within 30 days of the next scheduled Board meeting, the Board reserves the right to decide the appeal at the second regularly scheduled meeting, or, if there are special circumstances, the third meeting after it receives your appeal. If the Board requires a postponement of its decision to the next meeting, you will receive a notice describing the reason for the delay and an expected date of the decision.**

5. **The Board will send you notice of the decision within five days of the date the decision is made. If the Board denies your appeal, the notice will contain the specific reason for the decision, the specific plan provision on which the decision is based, notice of your right to receive, upon request and free of charge, reasonable access to and copies of all documents and records relevant to your claim, and a statement of your right to bring suit against the Fund under ERISA. The decision of the Board of Trustees is final and binding.**

6. In connection with an appeal of a denied claim, the claimant is entitled to be represented by a person of the claimant's choosing, including an attorney. If during a review proceeding, you choose to have someone act on your behalf, you must notify the Fund in writing of your representative's name, address, and telephone number. You may, at your own expense, have legal representation at any stage of these review procedures. Regardless of the outcome of your appeal, neither the Board nor the Fund will be responsible for paying any expenses, including legal expenses that you incur during the course of your appeal.

7. **Appeal Procedures – Weekly Disability Claims**

You (or your authorized representative) may appeal the claim denial directly to the Board of Trustees. If you decide to appeal, you must make a written request for review within 180 days after you receive written notice that your claim has been denied. You must include in your written appeal all the facts relating to your claim as well as the reasons you feel the denial was incorrect. You (or your authorized representative) may receive, upon request and free of charge, reasonable access to and copies of any documents relevant to your claim. You may submit issues and comments in writing, and documents, relating to your claim.

You may name a representative to act on your behalf. To do so, you must notify the Fund in writing of the representative's name, address and telephone number.

The Board of Trustees, in making its decisions on claims and appeals, will apply the terms of the Plan document and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, are applied consistently with respect to similarly situated claimants.

If, on appeal, the Board of Trustees relies upon, considers or

prepares new or additional evidence in connection with a claim, this evidence must be provided to you to the extent required by law. If the Board of Trustees denies your claim on a basis other than what is originally stated in your initial claim denial, the Fund must provide this basis to you to the extent required by law.

Preliminary Review. Within five business days of receiving your request for an external review, the Fund will complete a preliminary review of your request to determine whether it is eligible for external review (e.g., whether you have exhausted the Fund's claims and appeals procedures and provided all the necessary information).

Within one business day after the preliminary review is completed, you will be notified whether the claim is eligible for external review, except that to the extent required by law, the preliminary review may be referred to an independent review organization ("IRO") to determine whether the claim involves medical judgment. If your external review request is complete but your claim is not eligible for external review, you will receive a notice stating the reason(s) it is not eligible, and you will receive contact information for the Employee Benefits Security Administration. If your external review request is not complete, the notice will describe the information or materials needed to make your request complete. You may submit additional required information within the original four-month filing period or within the 48-hour period following your receipt of the decision regarding your eligibility for external review, whichever occurs later.

Referral to Independent Review Organization. If your external review request is complete and your claim is eligible for external review, the Fund will forward your claim to an IRO for review. The IRO will notify you in writing that your claim has been accepted for external review.

You are permitted to submit in writing to the assigned IRO, within ten business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten business days. If you choose to submit such information, within one business day, the assigned IRO will forward the information to the Fund. Upon receipt of any such information, your claim that is subject to external review may be reconsidered. Reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Fund decides, upon completion of its reconsideration, to reverse its denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

In making its decision, the IRO will review all of the information and documents it timely receives and will not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition, the IRO may consider additional information relating to your claim to the extent the information is available and the IRO considers it relevant.

The IRO will provide you will provide you with written notice of its decision within 45 days after it receives the request for review. The IRO's decision notice will contain:

- **A general description of the claim and the reason for the external review request;**

- **The date the IRO received the external review assignment and the date of its decision;**

- **Reference to the evidence considered in reaching its decision;**

- **A discussion of the principal reason(s) for its decision, and any evidence-based standards that were relied on in making its decision;**

- **A statement that the determination is binding except to the extent that other remedies may be available under state or federal law;**
- **A statement that judicial review may be available to you; and**

- **Contact information for any applicable consumer assistance office.**

Upon request, the IRO will make available to you its records relating to your request for external review, unless such disclosure would violate state or federal privacy laws.

Reversal of the Fund's decision. If the IRO issues a final decision that reverses the Fund's decision, the Fund will pay the claim.

Certain decisions concerning death and accidental dismemberment benefits are handled by MetLife. In the event your claim involves one of these decisions, you will be notified and provided with an address to which you may direct questions or an appeal of a denied claim.

Regulations from the Department of Labor's Employee Benefits Security Administration establish several categories of medical claims, including urgent, urgent concurrent care, pre-service, and post-service claims.

- **An urgent claim is one for treatment of an illness or injury which involves imminent danger to life, health, or function, or which causes the patient to be in extreme pain. In these**

cases, the Fund has 24 hours to tell the provider what information the Fund needs to determine whether the claim is covered under the benefit Plan. Within 72 hours of receiving the information, the Fund must determine whether the claim is covered. For these cases, the Fund Office has established a special dedicated fax line (877) 227-3536, in order to expedite handling. The Fund will also coordinate with CareAllies to determine medical necessity.

- An urgent concurrent care claim is a claim related to an ongoing course of treatment or a number of treatments over time. Decisions on urgent concurrent care claims must be made within 24 hours after receipt of the claim.

- A pre-service claim is one that requires pre-authorization, such as a hospital stay or transplant procedure. Decisions on pre-service claims must be made within 15 days unless the Fund requires an extension for reasons beyond its control. You are required to obtain pre-authorization from CareAllies in advance of elective or non-emergency hospitalization. CareAllies has 15 days to make the pre-authorization determination and the Fund has the same 15-day period to make the eligibility determination.

- A post-service claim is one for which the treatment or service has already been rendered and the Fund Office has received the provider's invoice (or the invoice and the participant's receipt if you paid for the service yourself). The Fund Office has 30 days (with a possible extension if necessary, for reasons beyond its control) to make the initial determination on a post-service claim from the time the claim is received in the Fund Office. There will be times when the Fund Office requires additional information to complete a claim, and if so, will send you or the provider a letter. If the claim requires review by the Fund's medical advisor or if a PPO discount should be applied to the claim, the Fund Office will also

handle that correspondence. Generally, the participant will be sent a copy so he or she knows the status of the claim. If a claim is not complete, the Fund Office will deny the claim within the 30-day period. In many cases, as long as there is still time under the submission period of one year from date of service, the claim may be reopened for consideration once the missing information has been received. An inquiry on the phone about whether a service is covered (except an urgent claim as described above) is not a claim.

8. External Review of Claims for Uninsured Benefits

If your claim for uninsured benefits has been denied and if you have exhausted the Fund's internal claims and appeal procedures as described above, you may be entitled to appeal the decision to an external independent review organization ("IRO"). External review is limited to claims involving "No Surprises Services," medical judgment (e.g., lack of Medical Necessity, or a determination that a claim is Experimental or cosmetic), or a retroactive rescission of coverage. No other denials will be reviewed by an IRO unless otherwise required by law.

A request for external review must be filed with the Fund Office within four months after you receive notice of the denial of your appeal (or if earlier, by the first day of the fifth month after receipt of the decision on your appeal).

9. Expedited External Review of Denied Claims

You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay, or emergency service, if the claimant has not yet been discharged from the facility. You may request an expedited external review at the same time an appeal is submitted to the Fund's Board of Trustees if the claimant requires urgent care or is receiving an on-going course of treatment.

Immediately upon receiving your request for expedited external review, a determination will be made as to whether your request is eligible for external review as described above. The Fund will immediately send you a notice of its eligibility determination.

If your claim is determined to be subject to external review, the IRO will provide a decision as soon as possible under the circumstances but no more than 72 hours after receiving the expedited request for review.

If your appeal is denied you have the right to bring a legal action against the Plan or the Trustees under Section 502(a) of the Employee Retirement Income Security Act ("ERISA"). Any such legal action must be filed no later than 1 year from the date of the Trustees' or IRO's final determination on appeal. All legal actions against the Fund and/or the Trustees must be filed in the United States District Court for the District of Maryland.

COORDINATION OF BENEFITS

The purpose of this Fund is to help pay your medical bills, but your benefits are not meant to exceed the medical expenses you incur. Therefore, if you are covered under another "Plan" (as defined below), and the total benefits payable by both Plans would exceed your total medical expenses, the benefits provided by this Fund will be "coordinated" with the benefits provided by the other Plan so your actual medical expenses are covered, but no more. **All benefits provided by this Fund are subject to this provision**.

Plan. Any plan providing benefits or services for or by reason of medical care or treatment, or dental care or treatment, under (1) group, blanket, or franchise insurance coverage; (2) hospital or medical service organizations and other group pre-payment coverage; (3) labor-management trusteed plans, union welfare plans and/or Employer organization plans; (4) governmental programs or plans required or provided by any statute; (5) schools or other educational institutions; (6) any Health Maintenance Organization; and (7) any other group plan or program or health benefits, regardless of whether funded by insurance or otherwise.

Allowable Expense. Any necessary, reasonable, and customary expense, at least a portion of which is covered under at least one of the Plans covering the person for whom the claim is made.

Claim Determination Period. A calendar year or that portion of a calendar year during which the person on whose expenses the claim is based has been covered under the Plan.

If any person covered by this Fund is also covered by one or more other Plans, and the sum of the benefits payable under all other Plans exceeds that person's allowable expenses during any claim determination period, the benefits otherwise payable with respect to that person shall be reduced, so that the benefits payable under all of the Plans involved will not exceed the allowable expense for each

period. Benefits payable under another Plan include the benefits that would have been payable if a proper claim had been made for them.

If a person is covered under two or more Plans, or if a person is covered by the Fund both as a participant and a dependent, the order in which benefits are paid will be determined as follows:

1. The benefits of a Plan which covers the person other than as a dependent shall be determined before the benefits of the Plan which covers the person as a dependent;

2. If a covered child is the patient, the Plan covering the parent whose birthday falls earlier in the year pays first (except children of legally separated or divorced parents--see below);

3. When rules (1) and (2) do not establish an order of benefit determination, the benefits of the Plan which has covered the person for the longer period of time shall be determined first.

If the covered person is a child whose natural parents are legally separated or divorced, the order in which benefits will be determined is as follows, **subject to the rules on dependent eligibility on page 22.**

1. If a court decree has determined financial responsibility for a child's health care expenses, the order of payments follows the court decree.

2. If there is no court decree specifically determining financial responsibility for a child's health care expenses, the order is:

   a. First, the Plan of the natural parent with legal custody pays, then
   b. The Plan of the spouse, if any, of the natural parent with legal custody pays, then
   c. The Plan of the natural parent without legal custody pays, then

d. The Plan of the spouse, if any, of the natural parent without legal custody pays last.

Release of Information

For the purpose of Coordination of Benefits, the Fund may:

- Release information to or obtain information from any person, organization, or insurance company and may require information to be furnished by any person claiming benefits under the Fund;
- Have the right to pay to any organization any amount determined to be warranted, if payments which should have been made under the Fund have been made by such other organization; and
- Have the right, if overpayment is made, to recover such overpayment from any person or any insurance company or organization.

For the purposes of the Coordination of Benefits provision, a person shall be deemed to be insured by the Plan if eligible for benefits, regardless of whether that person actually files a claim or otherwise applies for benefits from the Plan. If you or your eligible dependent has other coverage through a Health Maintenance Organization ("HMO"), and the HMO coverage is primary and you don't use an HMO provider, you will **not** be eligible for secondary benefits under the Fund, since, if used properly, most HMOs cover all charges.

PROHIBITION OF ASSIGNMENT OF BENEFITS

No benefit under the Fund or right under ERISA may be assigned or transferred to another party by a participant or beneficiary. No attempted assignment will be recognized by the Fund. Nothing in this SPD, or the Fund's Trust Agreement shall be construed to make the Fund, the Trustees, Warehouse Employees Union Local 730, or any Contributing Employer liable to any third-party to whom a participant or beneficiary may be liable for medical care, treatment, or services. The Fund may make direct payments to a medical provider. A direct payment by the Fund to a medical provider does not make the provider an assignee, and in no way confers upon the provider any rights that a participant has under the Plan or ERISA.

SUBROGATION

Reimbursement and Subrogation

Were you or your eligible dependent injured in a car accident or other accident for which someone else may be responsible? If so, that person (or his/her insurance) may be liable for paying your (or your eligible dependent's) medical expenses and these expenses would not be covered under the Fund.

Waiting for a third party to pay for these injuries may be difficult. Since recovery from a third party can take a long time (you may have to go to court) and your creditors will not wait patiently, as a service to you, the Fund will advance your (or your dependent's) benefits based on the requirement that you reimburse the Fund in full from any recovery you or your eligible dependent may receive, no matter how it is characterized (except an insurer on a policy of insurance issued to and in your name or your dependent's name). This means that you must reimburse the Fund if you obtain any recovery from any source, person or entity (except an insurer on a policy of insurance issued to and in your name or your dependent's name). This reimbursement and subrogation program is a service to you and your dependents. It provides for the early payment of benefits and also saves the Fund money (which saves you money too) by making sure that the responsible party pays the costs incurred as a result of your or your dependent's injuries.

You and/or your dependent are required to notify the Fund within ten days of any accident or injury for which someone else may be liable. Further, the Fund must be notified within ten days of the initiation of any lawsuit or settlement negotiations relating to the accident and of the conclusion of any settlement, judgment or payment relating to the accident to protect the Fund's claims (unless the foregoing relates to an insurer on a policy of insurance issued to and in your name or your dependent's name).

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

The Fund's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, Right of Recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the illness or injury, and regardless of whether you and/or your dependent actually receive the full amount of such judgment, award, settlement, compromise, insurance or order. The Fund's rights of reimbursement and subrogation provide the Fund with first priority to any and all recovery in connection with the illness or injury, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified.

The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your dependent in obtaining recovery. The Fund's right to full reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other defenses or

doctrines. The Fund Trustees may, however, reduce the amount you or your dependent must repay in special circumstances. Whether special circumstances exist is determined by the Trustees in their sole discretion. If you or your dependent believe there are special circumstances that should reduce the amount to be repaid to the Fund, you or your dependent must make a written request to the Trustees.

The amount you or your dependent must repay (and the amount of the assignment, constructive trust, lien, and/or equitable lien by agreement) is the full amount of all benefit payments made or to be made by the Fund on your or your dependent's behalf in connection with the illness or injury, but not more than the amount of the payment you or your dependent recover from any third party or parties in connection with the illness or injury (other than an insurer of a policy of insurance issued to and in your name or your dependent's name). For example, if the Fund pays $1,000.00 in benefits for an injury and you recover $5,000.00, you will have to repay the Fund the full $1,000.00. Alternatively, if the Fund pays $5,000.00 in benefits for an injury and you recover only $1,000.00, you will only have to repay the Fund $1,000.00. The Fund is not required to reduce the repayment (or the constructive trust, lien and/or equitable lien by agreement) for any reason, including, but not limited to, attorney's fees, lost wages, unpaid expenses or property damage.

The Fund has a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any amount received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. You and your dependent hereby consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any payment, amount and/or recovery from a third party. In accordance with that constructive trust, lien, and/or

equitable lien by agreement, you and your dependent agree to co-operate with the Fund in reimbursing it for Fund costs and expenses.

Consistent with the Fund's rights set forth in this Section, if you or your dependent submit claims for or receive any benefit payments from the Fund for an illness or injury that may give rise to any claim against any third party, you and/or your dependent will be required to execute a "Subrogation and Reimbursement Agreement" ("Subrogation Agreement") affirming the Fund's rights of reimbursement and subrogation with respect to such benefit payments and claims. This Subrogation Agreement also must be executed by your or your dependent's attorney, if applicable. However, even if you or your dependent or a representative of you or your dependent (including your or your dependent's attorney) do not execute the required Subrogation Agreement and the Fund nevertheless pays benefits to or on behalf of you or your dependent, you or your dependent's acceptance of such benefits shall constitute your or your dependent's agreement to the Fund's right to subrogation or reimbursement from any recovery by you or your dependent from a third party that is based on the circumstance from which the expense or benefit paid by the Fund arose, and your or your dependent's agreement to a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund on any payment amount or recovery that you or your dependent recovers from a third party (excluding an insurer on a policy of insurance issued to and in your name or your dependent's name).

Any refusal by you or your dependent to allow the Fund a right to subrogation or to reimburse the Fund from any recovery you receive, no matter how characterized, up to the full amount paid by the Fund on your or your dependent's behalf relating to the applicable injury or illness, will be considered a breach of the agreement between the Fund and you that the Fund will provide the benefits available under the Fund and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your

dependent affirmatively waive any defenses you may have in any action by the Fund to recover amounts due under this Section or any other rule of the Fund, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your dependent's claim will not be considered filed and will not be paid if the period for filing claims passes before your Subrogation Agreement is received.

Further, any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recovered by, or on behalf of, you or your dependent in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your dependent or your attorney may receive as a result of the accident, no matter how these amounts are characterized or who pays these amounts, as provided in this Section, are excluded under the Fund.

Under this provision, you and/or your dependent are obligated to take all necessary action and cooperate fully with the Fund in its exercise of its rights of reimbursement and subrogation, including notifying the Fund of the status of any claim or legal action asserted against any party or insurance carrier and of your or your dependent's receipt of any recovery (unless the foregoing relates to an insurer on a policy of insurance issued to and in the name of the covered person). If you are asked to do so, you must contact the Fund Office immediately. You or your dependent also must do nothing to impair or prejudice the Fund's rights without the express written consent of the Fund. For example, if you or your dependent chooses not to pursue the liability of a third party, you or your dependent may not waive any rights covering any conditions under which any recovery could be received. Where you or your eligible dependent choose not to pursue the liability of a third party, the

acceptance of benefits from the Fund authorizes the Fund to litigate or settle your claims against the third party. If the Fund takes legal action to recover what it has paid, the acceptance of benefits obligates you and your dependent (and your attorney if you have one) to cooperate with the Fund in seeking its recovery, and in providing relevant information with respect to the accident. You or your dependent must also notify the Fund before accepting any payment prior to the initiation of a lawsuit or in settlement of a lawsuit (unless the foregoing relates to an insurer on a policy of insurance issued to and in the name of the covered person). If you do not, and you accept payment that is less than the full amount of the benefits that the Fund has advanced you, you will still be required to repay the Fund, in full, for any benefits it has paid. The Fund may withhold benefits if you or your dependent waives any of the Fund's rights to recovery without the express written consent of the Fund or fail to cooperate with the Fund in any respect regarding the Fund's subrogation or reimbursement rights.

If you or your dependent do not fully cooperate with the Fund in seeking its recovery and in providing necessary information with respect to the accident, the Fund may suspend your coverage under the Fund until such time that you cooperate. Suspension of coverage also will apply to dependents in cases where the participant is not cooperating and will apply to participants in cases where the dependent is not cooperating. If coverage is suspended under this paragraph for lack of cooperation, any future reinstatement of coverage will not be retroactive (i.e. any claims incurred during a period of suspension will not be paid).

If you or your dependent refuse to reimburse the Fund from any recovery or refuse to cooperate with the Fund regarding its subrogation or reimbursement rights, the Fund has the right to recover the full amount of all benefits paid by any and all other methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your dependents' future benefit payments under the Fund. "Noncooperation" includes the

failure of any party to execute a Subrogation Agreement and the failure of any party to respond to the Fund's inquiries concerning the status of any claim or any other inquiry relating to the Fund's rights of reimbursement and subrogation.

If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you or your dependent shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

Overpayments

If the Fund pays benefits in error, such as when the Fund pays you or your dependent more benefits than you are entitled to, or if the Fund advances benefits that you or your dependent are required to reimburse because, for example, you have received a third party recovery (see the Reimbursement and Subrogation Section of this SPD), you are required to reimburse the Fund in full and the Fund shall be entitled to recover any such benefits.

The Fund has a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Fund under this Section, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the Fund until paid to the Fund. By accepting benefits from the Fund, you and your dependent consent and agree that a constructive trust, lien, and/or

equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

Any refusal by you or your dependent to reimburse the Fund for an overpaid amount will be considered a breach of your agreement with the Fund that the Fund will provide the benefits available under the Fund and you will comply with the rules of the Fund. Further, by accepting benefits from the Fund, you and your dependent affirmatively waive any defenses you may have in any action by the Fund to recover overpaid amounts or amounts due under any other rule of the Fund, including but not limited to a statute of limitations defense or a preemption defense, to the extent permissible under applicable law.

If you or your dependent refuse to reimburse the Fund for any overpaid amount, the Fund has the right to recover the full amount by any and all methods which include, but are not necessarily limited to, offsetting the amounts paid against your and/or any of your dependents' future benefit payments under the Fund. For example, if the overpayment or advancement was made to you as the Fund participant, the Fund may offset the future benefits payable by the Fund to you, or on your behalf and any of your dependents. If the overpayment or advancement was made to or on behalf of your dependent, the Fund may offset the future benefits payable by the Fund to you and any of your dependents.

The Fund also may recover any overpaid or advanced benefits by pursuing legal action against the party to whom the benefits were paid. If the Fund is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Fund, you or your dependent shall pay all costs and expenses,

including attorneys' fees and costs, incurred by the Fund in connection with the collection of any amounts owed the Fund or the enforcement of any of the Fund's rights to reimbursement. In the event of legal action, you or your dependent shall also be required to pay interest at the rate determined by the Trustees from time to time from the date you become obligated to repay the Fund through the date that the Fund is paid the full amount owed. The Fund has the right to file suit against you in any state or federal court that has jurisdiction over the Fund's claim.

REQUIRED NOTICES AND POLICIES

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "Balance Billing" or "Surprise Billing"?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care like when you have an emergency or when you schedule a visit at an in-network

facility but are unexpectedly treated by an out-of-network provider.

<u>You are protected from balance billing for:</u>

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the maximum those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- The Fund will generally:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Fund Office.

For more information about your rights under federal law, visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (“COBRA”)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) requires that the Plan offer eligible participants and their eligible dependents the opportunity to pay for a temporary extension of health coverage at group rates in instances where coverage under the Plan would otherwise end.

Eligible participants who lose eligibility or whose dependents lose eligibility as a result of reduction in hours of employment or termination of employment (except for gross misconduct) can continue coverage. An eligible spouse covered by the Fund can continue coverage if eligibility is lost because of the death of the participant, termination of the participant's employment, reduction in the participant's hours of work, divorce or legal separation from the participant, or the participant becomes eligible for Medicare. An eligible dependent child can continue coverage when eligibility is lost because of the death of the participant, termination of the participant's employment, reduction in the participant's hours of employment, the parents' divorce or legal separation, the participant becomes eligible for Medicare, or the dependent child ceases to be a dependent under the rules of the Fund.

The participant’s Contributing Employer must notify the Fund in writing within 30 days of a participant's death, termination of employment, eligibility for Medicare, reduction in hours, or of the Contributing Employer’s initiation of bankruptcy proceedings. The Contributing Employer’s failure to provide timely notice may subject the Contributing Employer to federal excise taxes. The participant or eligible dependent must inform the Fund in writing within 60 days in the event of divorce, legal separation, or dependent child's loss of dependent status under the Fund. The participant or eligible dependent who is determined to have been disabled at some time before the 60th day of COBRA continuation coverage must inform the Fund in writing within 60 days of the date that the Social Security

Administration determines that he or she is disabled, and within 30 days of any final determination that he or she is no longer disabled. If the participant or eligible dependent fails to notify the Fund Office within 60 days of the date that coverage would otherwise cease, the right to elect COBRA continuation coverage will be forfeited. Within 14 days of receipt of notification of any of these events, the Fund will notify the participant or participant's family of the right to continue coverage.

Coverage for the participant and eligible dependents can be continued for up to 18 months following the date on which coverage is lost due to termination or reduction in hours of employment.

The following situations may extend the 18-month period if they would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred. You must notify the Fund Office within 60 days of the occurrence of the second qualifying event and before the end of the 18-month COBRA continuation period.

1. **If the participant dies or becomes divorced/legally separated within the 18-month period or a dependent no longer qualifies as a dependent, the 18-month period may be extended up to a maximum period of 36 months for the affected spouse or dependents.**

2. **If the participant becomes eligible for Medicare, and within 18 months of becoming eligible for Medicare, becomes eligible for COBRA coverage because of the termination of employment (other than for gross misconduct) or reduction in work hours, coverage for the participant's dependents may be continued for up to 36 months from the date the participant became eligible for Medicare.**

3. **If any participant or dependent was disabled (as determined by Social Security) on the date of the qualifying event, the 18-**

month period may be extended up to a maximum period of 29 months for the disabled person. To be eligible for the extra 11 months of coverage, the Fund must be notified within 60 days of the Social Security Administration's disability determination. The self-payment premium for the last 11 months will be increased by about 50%. If the disability stops during the 29-month period, the Fund must be notified within 30 days of the cessation of the disability.

4. If the participant is eligible for Medicare at termination of employment, his spouse and covered dependent children will be eligible to continue coverage for a period of 36 months measured from the participant's Medicare eligibility, or 18 months measured from the termination of employment, whichever period is longer.

5. In the event of divorce, legal separation, death of the participant, or loss of dependent eligibility for dependent children, the dependents of a participant can continue coverage for up to 36 months.

To get an extension of the continuation coverage as described above, you must notify the Administrative Manager at the Fund Office. If you elect continuation coverage, please contact us whenever an important event occurs which could affect it.

Continuation of coverage may be cut short or changed under the following circumstances:

- The Contributing Employer ceases to provide coverage to all of its participants.
- The participant fails to pay premiums on time.
- The participant becomes covered by another health plan as an employee or otherwise.
- The participant becomes entitled to Medicare benefits.
- In the event of divorce, you remarry and are eligible for coverage under your spouse's plan.

- Should your former Employer alter the level of benefits provided through the Fund to similarly situated active employees, your coverage may change accordingly.

The eligible participant or family member can continue coverage for **medical and drug benefits only** or for **medical benefits, drug benefits, optical benefits, and dental benefits**. The cost that you must pay to continue benefits is determined annually and will be contained in the notice of right to elect continuation of coverage sent to you by the Fund Office. Timely retroactive payments must be made to the date of loss of eligibility either at the time of the election or within 45 days of the election. Ongoing payments must be made by the 30th day of the month following the month for which coverage is to be continued. Late payments can result in termination of coverage.

If a participant or dependent does not give written notice within 60 days of the date of a qualifying event, or a Contributing Employer within 30 days of a qualifying event, and as a result, the Fund pays a claim for a person whose coverage terminated due to a qualifying event, then that person or the Contributing Employer, as applicable, must reimburse the Fund for any claims that should not have been paid. If the person fails to reimburse the Fund, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the participant, if the person was his or her dependent. **It is very important that you contact the Fund Office whenever your address changes by calling toll free (800) 730-2241.**

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- Address Workers’ Compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may provide written notice of our denial if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways, – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Federal law requires group health plans to honor qualified medical child support orders ("QMCSOs"). In general, QMCSOs are state court or administrative agency orders requiring a parent to provide medical financial support to a child, for example, in case of separation or divorce. Upon receipt of a QMCSO, a plan is required to pay benefits directly to the child, the child's custodial parent or legal guardian, according to the order. You and the affected child will be notified if an order is qualified. You may obtain a copy of the Fund's procedures governing the determination of whether an order is a QMCSO by contacting the Fund Office at the address above. There is no charge for this document.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT

The Uniformed Services Employment and Re-Employment Rights Act of 1994 ("USERRA") requires that the Fund provide you with the right to elect continuous health coverage for you and your eligible dependent(s) for up to 24 months, beginning on the date your absence from employment due to military service begins, including Reserve and National Guard duty, as described below.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible dependent(s) under the provisions of USERRA. The period of coverage for you and your eligible dependent(s) ends on the earlier of:

1. the end of the 24-month period beginning on the date on which your absence begins; or

2. the day after the date on which you are required but fail to apply for or return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge).

You may be required to pay a portion of the cost of your benefits. If your military service is considered an approved Leave of Absence, your Contributing Employer must pay the cost of the premium for the first 12 months that you are eligible for coverage. If your military service is not considered an approved Leave of Absence, there is no charge for the cost of the premium for the first 31 days of coverage. Beyond 31 days, you must pay the cost of the coverage. The cost that you must pay to continue benefits will be determined in accordance with the provisions of USERRA.

You must notify your Contributing Employer or the Fund Office that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You must also notify the Fund Office that you wish to elect continuation coverage for yourself or your eligible dependent under the provisions of USERRA.

If you have satisfied the Plan's eligibility requirements at the time you enter the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service if you qualify for coverage under USERRA.

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The Family and Medical Leave Act of 1993 ("FMLA") requires Contributing Employers with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the employee to care for his/her own sickness or to care for a seriously ill child, spouse, or parent.

In compliance with the provisions of the FMLA, your Contributing Employer is required to maintain pre-existing coverage under the Plan during your period of leave under the FMLA as if you were actively employed. Your coverage under the FMLA will cease once the Fund Office is notified or otherwise determines that you have terminated employment, exhausted your 12-week FMLA leave entitlement, or do not intend to return from leave. Your coverage will also cease if your Contributing Employer fails to maintain coverage on your behalf by making the required contribution to the Fund.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect to continue your coverage under the COBRA continuation rules, as described on page 101. The qualifying event entitling you to COBRA continuation coverage is the last day of your FMLA leave.

If you fail to return to covered employment following your leave, the Fund may recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the FMLA. If you fail to return from FMLA for impermissible reasons, the Fund may offset payment of outstanding medical claims incurred prior to the period of FMLA leave against the value of benefits paid on your behalf during the period of FMLA leave.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

In accordance with the Newborns' and Mothers' Health Protection Act, the Fund will provide coverage for newborns and mothers to remain in the hospital after birth for a minimum of 48 hours for a normal, vaginal delivery and a minimum of 96 hours for a cesarean delivery.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (“WHCRA”)

The Women's Health and Cancer Rights Act (“WHCRA”) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, the Plan is required to provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes:

- all stages of reconstruction of the breast on which the mastectomy was performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses, and
- treatment of physical complications of the mastectomy, including lymphedema, subject to the Plan's coverage provisions.

Payment for the services of an assistant surgeon will be considered after the principal surgeon has been paid, up to the Fund's limits

STATEMENT OF ERISA RIGHTS

Your Rights under ERISA

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Fund or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for benefit under the Fund is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.