INTERNATIONAL BROTHERHOOD OF TEAMSTERS LOCAL 710

Pension Health & Welfare Fund

Summary Plan Description

February 2019

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TEAMSTERS LOCAL 710 HEALTH & WELFARE FUND FOR PENSIONERS

THIS PLAN IS ONLY AVAILABLE TO INDIVIUDALS WHO ARE NOT ELIGIBLE FOR MEDICARE ON ACCOUNT OF AGE OR DISABILITY. THE PLAN IS NOT SECONDARY TO MEDICARE OR A MEDICARE SUPPLEMENT.

INTRODUCTION

The Trustees of the Teamsters Local 710 Health & Welfare Fund are pleased to offer you this combined Plan Document and Summary Plan Description for Pensioners. Because the terms of the Fund's Plan of Benefits are complex, it is important that you take the time to acquaint yourself with its provisions. The Plan's governing documents, including this SPD, Rules and Regulations, procedures and policies, and those portions of the Fund's contracts with insurers and administrators that describe the Benefits provided to you, are incorporated by reference into this SPD.

The Fund Administrator shall make copies of the latest SPD, annual report, Trust Agreement, or other instruments under which The Plan was established or is operated available for examination by any Participant or Beneficiary in the Fund Office at the address below.

Only the entire Board of Trustees is authorized to interpret the Plan's governing documents. No Employer or Union, nor any representative of any Employer or Union, acting in that capacity, is authorized to interpret the Plan's governing documents. No Employer or Union, nor any representative of any Employer or Union, acting in that capacity, can act as an agent for the Board of Trustees. ***ACCORDINGLY, WE RECOMMEND THAT YOU DIRECT ALL QUESTIONS ABOUT THE PLAN AND THIS SPD TO THE FUND OFFICE.***

This SPD sets forth the provisions of the Plan in effect as of January 19, 2019. You and your Family should read this entire SPD. The Plan may be amended in the future by the Trustees. Under the Fund's governing documents, the Trustees have the right to modify or eliminate any Benefits provided under this Plan. Notice of amendments to the Plan will be provided to you.

If you have any questions about amendments to the Plan made by the Board of Trustees after the publication of this SPD, write or call the Fund Office.

The mailing address for the Fund Office, including for UPS Delivery, is:
IBT Local 710 Health Welfare Fund
9000 W. 187th Street
Mokena, IL 60448

The telephone and fax numbers of the Fund Office are:
T (773)254-2500
F (773)254-6528

Many words and terms are capitalized in this text, indicating that they have special meanings when used in this SPD. These terms are defined in detail in the "Glossary" section of this SPD.

BENEFITS PER CALENDAR YEAR

	In-Network **YOU PAY**	Non-Network **YOU PAY**
BENEFITS PER CALENDAR YEAR		
Deductible[1]	$250 per person to max of 3 Deductibles per family	$250 per person to a maximum of three Deductibles per family
Out of Pocket Annual Maximum ("OOP") Individual/Family	$2,000/$6,000	$6,000/ $13,100[2]
PHYSICIAN SERVICES		
Primary Care Office	After Deductible, 10% Coinsurance[3] to OOP Maximum; then Fund pays 100%	After Deductible, 20% of out-of-Network rate[4] as Coinsurance plus Physician's balance bill to Non-Network OOP Maximum; then Fund pays 100%
Specialist Office	Same as above	Same as above
Outpatient mental health care	After Deductible,10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% of out-of-Network rate as Coinsurance plus provider's balance bill to Non-Network OOP Maximum; then Fund pays 100%
Chiropractor / Naprapathic	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays maximum of 90% of $55.00 per visit to an annual maximum of $2,000.	After Deductible, 20% of out-of-Network rate as Coinsurance plus Physician's balance bill to Non-Network OOP Maximum; then Fund pays maximum of 80% of $55.00 per visit to an annual maximum of $2,000.
Preventive Care / Screening / Immunization	No charge	After Deductible, 20% of out-of-Network rate as Coinsurance plus Physician's balance bill to Non-Network OOP Maximum; then Fund pays 100%

[1] **Deductible** The amount you pay for covered health care services before the Fund starts to pay. With a $250 Deductible, for example, you pay the first $250 of covered services yourself.

[2] Subject to annual adjustment under federal law.

[3] **Coinsurance** means the percentage of costs of a covered health care Service for which you are responsible (for example, 10%) after you have paid your Deductible**.**

[4] For Non-Network providers, the Fund pays a Benefit equal to 100% of Medicare's Resource-Based Relative Value Schedule.

	In-Network **YOU PAY**	Non-Network **YOU PAY**
Physical Therapy (30 visits)	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% of out-of-Network rate as Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%
HOSPITAL/ OTHER MEDICAL SERVICES		
Inpatient Hospital	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%
Inpatient mental health care	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%
Emergency Room	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 10% Coinsurance plus any balance bill to Non-Network OOP Maximum, based on the median amount negotiated with Network Providers for comparable Emergency Services; then Fund pays 100%.
Urgent Care	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% of out-of-Network rate as Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%
Outpatient Surgery Facility Physician/Surgeon	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%
Ambulance – Emergency	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% of out-of-Network rate as Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%
Outpatient lab/pathology	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% of out-of-Network rate as Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%

	In-Network **YOU PAY**	Non-Network **YOU PAY**
Routine radiology/diagnostic	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% of out-of-Network rate as Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%
MRI/MRA/CT/PET scan	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% of out-of-Network rate as Coinsurance plus any balance bill after to Non-Network OOP Maximum; then Fund pays 100%
Biotech /Specialty Injectables	No Benefits unless administered in Hospital; After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	No benefits unless administered in Hospital; After Deductible, 20% of out-of-Network rate as Coinsurance plus any balance bill after to Non-Network OOP Maximum; then Fund pays 100%
Standard Injectables	"	"
Durable Medical Equipment: Note: Walkers provided only for knee and hip replacements	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100% to annual Maximum of $15,000	After Deductible, 20% of out-of-Network rate as Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100% to annual Maximum of $15,000.
SUBSTANCE ABUSE TREATMENT		
Inpatient Services	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%
Outpatient	After Deductible, 10% Coinsurance to OOP Maximum; then Fund pays 100%	After Deductible, 20% of out-of-Network rate as Coinsurance plus any balance bill to Non-Network OOP Maximum; then Fund pays 100%

SECTION 1
GENERAL INFORMATION

Name of the Plan: Your health and welfare plan is known as the Teamsters Local 710 Health and Welfare Fund Plan for Pensioners - The Plan. Throughout the rest of this SPD, it will be referred to as the "Plan" or the "Fund".

1. **Plan Administrator:** The Plan Administrator is the Board of Trustees. It is the Trustees' responsibility to administer the Plan exclusively for the benefit of all Participants and Dependents. The Trustees have established a Fund Office, and have retained Brian O'Malley, Administrator, and a staff to conduct the day-to-day operations of the Plan.
2. **Contacting the Fund:** You may contact the Trustees at the Fund Office as follows:

   Teamsters Local 710 Health and Welfare Fund
   c/o Brian O'Malley, Administrator
   IBT Local 710 Health Welfare Fund
   9000 W. 187th Street
   Mokena, IL 60448

   Fund Trustees: The Board of Trustees is made up of six individuals. There are three Trustees selected by Teamsters Local Union No. 710, and three Trustees are selected by remaining Employer Trustees in the event of a vacancy. As of January 1, 2019, the Trustees are:

UNION TRUSTEES:

Michael J. Cales
IBT Local 710 Health and Welfare Fund
9000 W. 187th Street
Mokena, IL 60448

Delmar Schaefer
IBT Local 710 Health and Welfare Fund
9000 W. 187th Street
Mokena, IL 60448

Bernard Sherlock
IBT Local 710 Health and Welfare Fund
9000 W. 187th Street
Mokena, IL 60448

EMPLOYER TRUSTEES:

Sam Pilger
VP Industrial Relations
Holland (YRC Worldwide)
9000 W. 187th Street
Mokena, IL 60448

Ryan Thibodeau
Director of Finance
United Parcel Services
9000 W. 187th Street
Mokena, IL 60448

Gary Caldwell
Senior Director for Participant Relations
ABF
9000 W. 187th Street
Mokena, IL 60448

1. **Plan Year:** The Plan Year is the calendar year beginning on February 1 and ending on January 31. The Plan Year is the time period the Fund uses for financial and accounting purposes, as well as for government reporting purposes.
2. **Benefit Year:** The Benefit Year, which is also the calendar year beginning on January 1 and ending on December 31, is the time period the Fund uses for measuring annual Benefit limits.
3. **Type of Plan; Available Benefits; Self-Insured Benefits; Self-Insured Externally Administered Benefits:** The Plan is a multiemployer self-insured health and welfare plan governed by the – Employee Retirement Income Security Act of 1974 (ERISA). The Plan provides for Hospitalization Services, Physician visits, physical therapy, immunizations and injections, surgical Services, diagnostic Services, mental health and substance abuse Services. The Fund administers the Benefits.
4. **Plan Identification Numbers for this Plan:** The Plan's Employer Identification Number assigned by the Internal Revenue Service is 23-2153764. The Plan Number is 501.
5. **Agent for Service of Process:** Legal process may be served on the Plan or any member of the Board of Trustees at the Fund Office located at 9000 W. 187th Street, Mokena, IL 60448.

SECTION 2
CREATION AND PURPOSE OF THE FUND

The Teamsters Local 710 Health and Welfare Fund and this Plan for Pensioners were created and are maintained for the exclusive purpose of providing such health and welfare Benefits to Participants and Eligible Dependents as are set forth in this Plan, as it may be amended from time to time by the Trustees and as may be required by applicable law. Fund assets may be used to provide such Benefits to Participants and their Eligible Dependents and to defray the reasonable expense of administering the Fund and the Plan. It is intended that the Fund shall be a "welfare plan" within the meaning of ERISA § 3(l) and a "multiemployer" plan within the meaning of ERISA § 3(37).

SECTION 3
ELIGIBILITY

1. **Eligibility Rules for You and Your Eligible Dependents:**

   a. **General:** You may be Eligible for Benefits from the Fund if:

      i. You have retired from employment with any Contributing Employer with a "Thirty and Out," Special Regular Pension or a Reciprocal Thirty and Out Pension or a Reciprocal Special Regular Pension (and has attained the minimum age of 50) or who has retired with a Normal Pension, a Survivor Pension, a Disability Pension or a Reciprocal Pension[5]; and

      ii. You were a Participant in the Health & Welfare Fund Plan for Active Participants at the time of your retirement; and

      iii. The IBT Local No. 710 Pension Plan is the terminal plan; and

      iv. You are not eligible or entitled to receive old age benefits under Medicare; and

      v. You have made the required self-payment as determined by the Fund's Trustees.

      If you elect to participate in the Plan, payments for coverage must begin with the effective date of your pension, or, if later, the date you cease to be covered under another group health plan, provided that coverage under that group health plan began when your eligibility terminated under the Plan for active employees.

   b. **Your coverage under this Pensioner Plan will end when:**

      i. You become eligible or entitled to receive old age benefits under Medicare; or

      ii. As of the date of expiration of the period for which the last Contribution was made on your behalf; or

      iii. Upon termination of the Plan; or

      iv. On the date you enter full-time military, naval, or air service.

   c. **Individuals Eligible for Enrollment**: **Participant, Spouse and Child/Children. General:** If you are Eligible for Benefits Coverage, you may generally enroll your Spouse and your Children up to age 26 in the Plan. Your Children may include your natural Children, your adopted Children, or your stepchildren (that is, the Children of your current spouse for whom you are not the natural parent). (See the definition of Spouse and Child/Children in the Glossary for a more detailed description of these important terms.)

   d. **Divorced Spouses:** You can only provide coverage under the Fund for your lawful Spouse, which includes only a husband or wife to whom you are currently married. **Your former husband or wife is not Eligible for Benefits as of the date of your divorce, unless your Spouse elects COBRA continuation coverage as described below.**

[5] Please see the Teamsters Local 710 Pension Plan Summary Plan Description and Plan Document for definition and further discussion of the terms that refer to a pension.

e. **Spouses Participating in Health Savings Accounts:** If your Spouse (or an Eligible Dependent) is covered under a high-deductible health plan with a "health savings account" ("HSA"), this Spouse or Dependent may not be covered under this Plan.

***IMPORTANT NOTE**: You should be aware that the Internal Revenue Code provides that in order to be eligible to contribute to an HSA, an individual may NOT have coverage that is not a high-deductible health plan. This Plan does not meet the requirements to be a high-deductible health plan.*

f. **Disabled Child:** Your mentally or permanently physically handicapped Child age 26 and over may remain Eligible for Benefits Coverage provided that he or she meets all of conditions listed below. You must submit a Physician's statement, on the Physician's letterhead, that details the severity of your Child's mental or permanent physical handicap. Other documentation may also be required by the Trustees, including on-going verification of your Dependent Child's continuing Disability. Benefits Coverage may be provided for a mentally or permanently physically handicapped Child while you are Eligible for Benefits Coverage provided the following conditions are met:

i. The Child is incapable of independent self-support;

ii. The Child is unmarried;

iii. The Child's Earned Income does not exceed a yearly maximum of $12,000;

iv. The Child was Eligible for Benefits Coverage before reaching age 26; and

v. The Child was mentally or permanently physically handicapped before reaching age 26.

2. Enrolling Yourself and Eligible Dependents in the Plan:

a. **Required Information:** In order to enroll yourself and your Eligible Dependents, you must complete all required enrollment materials and provide all applicable documentation, **for example**, a marriage certificate, birth certificate, or adoption documentation. The forms and documentation must be submitted to the Fund Office.

b. **Failure to Submit Required Information Timely:** If you or your Dependents are Eligible for Benefits but fail to provide the required information, the Fund will provide Benefit Coverage for you after you submit all required information, starting from the date that you would have been Eligible for Benefits had the required information been timely submitted to the Fund.

***IMPORTANT NOTE:** You must notify the Fund Office as soon as you are divorced. Once a divorce occurs, your ex-Spouse is not eligible for Benefits under your Coverage after the date of the divorce. Your ex-Spouse is only entitled to elect COBRA continuation coverage (see "Important Federal Laws Applicable to this Plan" below for the rules governing this coverage.). **If the Fund Office is not properly notified of a divorce and you continue to cover your Spouse as a Dependent, you will be responsible to reimburse the Plan for all Benefits paid on behalf of your ex-Spouse after the divorce became final.** The Fund reserves the right to take all action to recover Benefits that were paid on behalf of your*

ex-Spouse, including offsetting those Benefits against Benefits payable on behalf of any other Family member and taking any appropriate legal action.

3. **Contributions: General.** The Fund's rules require that in order to maintain Benefits Coverage, a Participant must make timely Contributions to the Fund in an amount and by such dates as are determined by the Fund's Trustees. If your Contribution is not taken out of your check, Contributions are due on the 1st day of the month.

   ***IMPORTANT NOTE**: You should update your list of Eligible Dependents on the Fund's Application and Beneficiary Form. These forms are available from the Fund Office. The Fund will mail a copy of the form to you upon your request. These forms must be signed and returned to the Fund Office in order for your Eligible Dependents to be covered and for your beneficiary designations to be effective.*

a. **Contributions:**

4. **Special Instances of Continued Eligibility:**

   a. **Hospitalization Benefits if Eligibility Lost during Hospitalization:** If **you** enter the Hospital while you are Eligible for Benefits but lose Eligibility while you are in the Hospital, the Fund will continue to pay Benefits for the duration of your stay in the Hospital.

   b. **COBRA:** Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), a federal law, your Dependents may be able to purchase continuation coverage from the Plan after the date your coverage would otherwise end. These COBRA rights are described in the "Important Federal Laws Applicable to this Plan" section of this SPD.

SECTION 4
MANAGED CARE PROGRAM
CLINICAL TRIAL COVERAGE
PREVENTIVE CARE COVERAGE

1. **Managed Care Program: General.** The Trustees of the Fund design and administer the Plan in order to provide excellent Benefits in a cost-effective manner. In order to protect the Fund's Participants and their Families, the Fund provides Benefits only for Medically Necessary Treatment and Services, as provided for under the terms of the Plan, and monitored through the Fund's Managed Care Program. The terms of the Fund's Managed Care Program are described below.

   ***IMPORTANT NOTE**: If the patient or his or her Provider does not cooperate with the Plan's Managed Care Program, the Plan may decline to pay any Benefits for your treatment from that Provider.*

   Elements of the Fund's Managed Care Program: The Plan's Managed Care Program has four key elements, which are described below.

   a. **Network Providers:** The Fund has contracted with a Network of Providers, or a Preferred Provider Network ("PPO"), to serve you and your Family. These Network Providers perform their Services at an advantageous cost to you and to the Plan and will generally not bill you the balance between the amount the Plan pays and the amount the Provider charges. Network Providers may also be referred to as "Participating Providers." "PPO" means Preferred Provider Organization, and is simply another way to describe a Provider that participates in the Plan's Network.

   b. **Limited Payment for Non-Network Providers:** The Plan limits the Benefits it pays for treatment by Non-Network Providers to the "Usual and Customary Rate" ("UCR"), which is a percentage of **Medicare's Resource-Based Relative Value Schedule**. While you are free to obtain medical treatment from these Providers, the Fund will not pay more than a percentage of the UCR rate for the Services or treatment and you will be responsible for any balance on charges not paid by the Plan (except for Emergency services for a *bona fide* Emergency). Of course, the Fund will only provide Benefits for Medically Necessary Services, regardless of whether the Services are from a Network or a Non-Network Provider.

   c. **Limits on Treatment that is not "Medically Necessary," not consistent with the terms of the Plan or is "Experimental or Investigational":** The Plan limits or may deny the Benefits for treatment in certain circumstances regardless of whether you treat with a Network or Non-Network Provider. **For example**, the Fund will not pay any Benefits for treatment that is not "Medically Necessary" or is "Experimental or Investigational" as those terms are defined in the Plan. In these circumstances, you will be responsible for any charges not covered by the Plan.

   d. **Utilization Review:** The Fund uses the "utilization review" guidelines developed and implemented by Blue Cross and Blue Shield of Illinois ("BC/BS IL") under which Treatment and Services are subject to review to make sure that they are consistent with the standards established under the Plan. **A determination under utilization review that a procedure is Medically Necessary is NOT a guarantee of payment.**

2. **Network Providers**: The Trustees have sole discretion to establish or contract with one or more Networks of Providers to provide Services to you and your Dependents.

Generally, if you receive Services from a Network Provider, the Plan will pay Benefits in full, less any required Copayments or Deductibles.

Providers join or leave Networks frequently. Therefore, the most current information is to be found on the electronic Provider Lists available on the website of Blue Cross and Blue Shield of Illinois. **You should contact the Fund Office or BC/BS IL at 800-810-BLUE to verify if a particular Provider is currently a Network Provider.**

IMPORTANT NOTE: *In some areas, not every Provider within a practice or Physician group listed in the Provider list is in the Network. Moreover, not every Provider in a Network Hospital is necessarily a Network Provider. Therefore, it is important that you make sure that the specific Provider or Physician you are seeing, and not just the practice or group, is a Network Provider. For the most up-to-date information, contact the Fund Office, or contact BC/BS IL at http://www.bcbsil.com.*

a. **Medical Networks:** The Fund's Network, or PPO Provider, is BC/BS IL.

IMPORTANT NOTE: *If you live in the Chicago area, the Fund will not provide Benefits for Treatment, care or Services that are provided outside of the greater Chicago metropolitan area, unless the patient provides documentation to the satisfaction of the Trustees that comparable Treatment, care or Services cannot be provided in this area and that the out-of-area care is Medically Necessary. Notwithstanding the foregoing, the Fund will provide Benefits for Medically Necessary Treatment, care or Services at the Cleveland Clinic and the Mayo Clinic. This provision does not apply to bona fide Emergency Services or to patients who reside outside the greater Chicago area.*

3. **Non-Network Providers:**

a. **Limited Payment for Non-Network Providers:** The Plan limits the Benefits it pays for treatment by Non-Network Providers. Typically, the Plan will pay only a percentage of the Usual, Customary and Reasonable rate ("UCR") for a Service performed by a Non-Network Provider, less any applicable Deductibles or Copayments.

b. **Percentage of UCR as Payment**: The Fund's UCR is based on the **Medicare Resource-Based Relative Value Schedule**. For Non-Network Providers, the Fund pays as follows:

- For outpatient surgery and/or facility charges, 80% of the UCR;
- For Physician visits, the Fund pays 80% of the UCR;

Contact the Fund Office if you need to determine in a specific situation what Benefits the Plan will pay for Services provided by a Non-Network Provider.

c. **Additional limits are described below:** If you need to determine whether there are Plan limits that apply to your particular situation, call the Fund office.

4. **Fund Provides Benefits Only For "Medically Necessary" Services, Treatments and Items:**

a. **General: "**Medically Necessary" care is care that the Trustees, in reliance upon the Plan's Medical Advisors, determine is appropriate to treat your injury or illness. In determining whether care is Medically Necessary, the

medical professionals advising the Trustees consider the standards of medical practice applicable to the particular treatment rendered.

b. **Medically Necessary Care Does Not Include Experimental or Investigational Treatments:** If the Trustees, in reliance upon the Plan's Medical Advisors, determine that a treatment is "Experimental or Investigational" as defined in the Plan, no Benefits shall be paid for that treatment.

5. **Utilization Review:** Utilization review is a process through which the Trustees, in reliance upon the Plan's Medical Advisors, determine whether treatment is Medically Necessary, as that term is defined in the Plan. **A determination under the utilization review that a procedure is Medically Necessary is NOT a guarantee of payment.**

   a. **Pre-Certification (Hospitalization and Surgery). All non-Emergency Hospitalization and surgery (inpatient, and both medical and mental health/substance abuse) must be pre-certified in advance** from Blue Cross/Blue Shield of Illinois**:** If you are using a Network Provider, it is the Provider's responsibility to contact the Fund Office and follow its instructions to obtain pre-certification. If you are using a Non-Network Provider, **YOU** are responsible for pre-certifying your Hospital stay with BCBS-IL. Call the numbers below for prior authorization:

      Medical Pre-Authorization: 1-800-635-1928
      M/SA Pre-Authorization: 1-800-851-7498
      Blue-Card Access 1-800-810-2583

      Outpatient surgery does not need to be pre-certified, except for bariatric surgery. Bariatric surgery must be pre-certified by Blue Cross/Blue Shield of Illinois.

      If you have Emergency surgery or an Emergency admission, you or your Provider must notify the Blue Cross/Blue Shield, IL within two business days after treatment/Hospitalization. Certain other Services must also be pre-certified. Contact the Fund Office if you have any questions about whether a procedure or Service must be pre-certified by using the phone numbers listed above.

      If you fail to pre-certify your Hospital stay or Service, the Fund may limit or deny Benefits for the claims incurred, unless the Pre-Certification cannot be required pursuant to the Affordable Care Act or other applicable federal law or regulation.

   b. **Pre-Certification: (Number of Days for Hospitalization).** Upon a patient's admission to the Hospital, the Fund's Managed Care Organization ("MCO") will inform the Fund of the number of days of admission for which the Fund should pay and either the Fund or the MCO will so inform the Provider. The Fund will not pay Benefits for additional Hospital days unless approved under the Managed Care Program.

   c. **Pre-Certification does not Guarantee Payment of Benefits:** The purpose of pre-certification is to determine whether the treatment or Service is "Medically Necessary" as that term is defined by the Plan. However, it is possible that the treatment may not be covered if, on review, the Fund determines, **for example**, that the individual was not Eligible for Benefits at the time the treatment is provided or that the treatment is subject to Plan exclusion.

For example, Jane Smith's doctor asked for and received pre-certification for removal of Ms. Smith's appendix and related surgical procedures. When Ms. Smith's doctor submits her claim, the Trustees discover that the "related procedures" included a "tummy tuck" unrelated to the appendectomy. Although the Fund would pay for the Medically Necessary appendectomy, it will not pay for those Services that were not Medically Necessary and instead were cosmetic surgery.

For example, John Jackson's doctor receives pre-certification for Medically Necessary surgery on June 1. Mr. Jackson's coverage lapses on July 1. The surgery is not performed until July 15. Even though the surgery was pre-certified as Medically Necessary, the Fund will not pay Benefits for the surgery because Mr. Jackson was not Eligible for Benefits at the time of the surgery.

d. Second Opinion May Be Required: If the Plan's Medical Advisors recommend a second opinion, you will have to get the second or third opinion. The Plan will pay Benefits in full for these additional opinions. If you elect to seek a second opinion on your own, the standard Deductible, Copayments and Coinsurance will apply.

6. Coverage for Clinical Trials

a. General: Effective January 1, 2014, the Affordable Care Act ("ACA") requires that the Plan provide Coverage for Services related to an "Approved Clinical Trial" for a "Qualified Individual." These related services include, **for example**, Hospitalization or monitoring in connection with the Approved Clinical Trial. The Plan is **not** required to cover treatments that fall outside the designated class of Approved Clinical Trials. The following terms are meant to have the same meaning as found in Section 2709 of the Public Health Services Act:

i. A "Qualified Individual" is a Plan Participant or Dependent who is eligible to participate in an "Approved Clinical Trial" because either the individual's doctor has concluded that patient is appropriate for the Approved Clinical Trial or the patient provides medical and scientific information establishing that his or her participation in the Approved Clinical Trial is appropriate.

ii. An "Approved Clinical Trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

iii. "Routine Patient Costs" for the purpose of this subsection include all Items and Services consistent with the Coverage provided in the Plan that is typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. Routine patient costs do **not** include (1) the investigational item, device or service itself; (2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (3) a service that is clearly

inconsistent with the widely accepted and established standards of care for a particular diagnosis.

iv. If a Network Provider is participating in an Approved Clinical Trial, the Plan may require the individual to participate in the trial through that Network Provider if the Network Provider will accept the individual as a participant in the trial.

7. Preventive Care Benefits: Under the Affordable Care Act, the Fund is required to provide certain "preventive care" services without imposing any cost sharing requirements, meaning that no Deductibles, Copayments or cost-sharing with respect to the required preventive care services will be imposed. While the Fund may not impose cost-sharing with respect to services provided by Network Providers, it is permitted to and may impose them with respect to Non-Network providers.

2. A listing of covered Preventive Care Services can be found on the U.S. Preventive Services Task Force website. A link to this website is: https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/uspstf/index.html. For a more detailed description of how these protections relate to the Physician office visit, outpatient diagnostic, and immunization Benefits provided by the Fund, see the "Preventive Care Services" Section of this Plan document.

SECTION 5
PHYSICIAN BENEFITS
PHYSICAL THERAPY BENEFITS
IMMUNIZATION AND INJECTIONS BENEFITS
PREVENTIVE CARE SERVICES PROVIDED BY YOUR PHYSICIAN

A. Physician Services

1. **Physician Office Visits:** The Plan will pay Benefits for Medically Necessary office visits to a doctor. The level of Benefits the Plan will pay depends on whether you use a Network or a Non-Network Provider. Note that your plan provides for one Annual physical examination, subject to the Copayment requirements set forth in this SPD.

    a. **Physician Office Visits: Network Provider.** For office visits to a Network Provider, after you meet your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses. There is no limit on the number of Medically Necessary office visits you can have with a Network Provider.

    IMPORTANT NOTE*: Chiropractors are not covered as a Non-Specialist Physician. See below for information about chiropractic Benefits.*

    b. **Physician Office Visits: Non-Network Provider.** For office visits to a Non-Network Provider after you meet your Annual Deductible, you will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Provider charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

    c. **Chiropractor / Naprapathic Services:** For Services by any licensed Chiropractor / Naprapathic services, including spinal manipulations and adjustments, as well as x-rays and other modalities and services performed to diagnose or treat the condition for which the spinal manipulations and / or adjustments are being provided, you will be responsible for the following:

        i. **Network Provider:** After you meet your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses. The maximum Benefit per visit is 90% of $55.00 and the Annual maximum per person per calendar year is $2,000.

        ii. **Non-Network Provider:** After you meet your Annual Deductible, you will be responsible for Twenty Percent (20%) of the UCR, plus any balance between UCR and the amount the Provider charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses. The maximum Benefit per visit is 80% of $55.00 and the Annual maximum per person per calendar year is $2,000.

2. **Physical Therapy.** The Fund pays Benefits for Medically Necessary Physical Therapy, including speech therapy, occupational therapy, and work hardening. For each injury or illness, the Plan will pay Benefits for up to 30 outpatient visits, starting with the first visit to the Physical Therapist, per Participant or Eligible Dependent. If you need Physical Therapy that requires more than 30 visits, such additional visits must be pre-certified by the Fund Office. The Plan's Benefits differ depending on whether you receive Services from a Network or Non-Network Provider. As used below, "modality" means Medically

Necessary physical therapy modalities and therapeutic procedures (for example, physical actions, applications, maneuvers and manipulation used to achieve a therapeutic goal).

a. **Network Provider:** If you use a Network Provider, after you meet your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses.

b. **Non-Network Provider:** If you use a Non-Network Provider, after you meet your Annual Deductible, you will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Provider charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

3. **Immunization and Injections:**

A. **Immunization and Injections** (ACA Preventive Care): Immunizations and injections required under the "Preventive Care" provisions of the ACA (see below) will be covered at no cost to patients who receive care from a Network provider. HOWEVER, you may still be charged for an Office Visit.

B. **Immunization and Injections** (Non-ACA Preventive Care): In addition to the Benefits that the Fund provides for immunization and injections with no Copayment required as Preventive Care under the ACA (see below), the Fund provides Benefits for Medically Necessary Immunizations and Injections (subject to the Plan's Managed Care Program). Benefits differ depending on whether you receive Services from a Network or Non-Network Provider.

i. **Network Provider.** If you receive a Medically Necessary immunization or injection that is not "Preventive Care" under the ACA and the Network Provider charges separately for an office visit and the immunization or injection, the Fund will pay Benefits for the Services as an office visit at the Network Rate.

ii. **Non-Network Provider.** If you receive a Medically Necessary immunization that is not "Preventive Care" under the ACA and the Non-Network Provider charges separately for an office visit and the immunization, the Fund will pay Benefits for the Services as an office visit at the Non-Network rate.

4. **Preventive Care Services:** The Affordable Care Act requires that the Fund provide Benefits for certain preventive care Services without requiring a Copayment from the patient who uses a Network provider.

***IMPORTANT NOTE**: The guidelines provide that these Services are to be rendered without a Copayment only for certain individuals with identified risk factors.*

a. **Representative Preventive Services Required by the ACA:** These Services could, but do not necessarily, include tests and screenings like the following:

Blood pressure, diabetes, and cholesterol tests;
Many cancer screenings;
Counseling on such topics as quitting smoking, losing weight, eating better, treating depression, and reducing alcohol use;
Routine vaccines for diseases such as measles, polio, or meningitis;
Flu and pneumonia shots;
Counseling, screening and vaccines for healthy pregnancies;
Regular well-baby and well-child visits, from birth to age 21; and
Well-woman visits and services.

b. **Copayments and Coinsurance for Services Related to Preventive Services:** Although no Copayments or Coinsurance are imposed for required "Preventive Care" Services, Copayments are imposed for certain preventive care services, as described below:

- First, if a recommended preventive Service is billed separately (or is tracked as individual encounter data separately) from an office visit, then the Plan or issuer will impose cost-sharing requirements with respect to the office visit.

- Second, if a recommended preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then the Plan or issuer will not impose cost-sharing requirements with respect to the office visit.

- Finally, if a recommended preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then the Plan or issuer will impose cost-sharing requirements with respect to the office visit.

5. Special Rules for Continuous Positive Airway Pressure ("CPAP") Devices and Supplies

A. Devices: In general, Benefits for CPAP devices will be paid for a replacement machine every five years. However, in the event the machine has become mechanically or electrically unreliable or unsafe to operate, the Fund may provide Benefits three years after the device was originally provided.

B. CPAP Supplies: Benefits for CPAP supplies, including masks, filters, hoses, reservoirs, etc., will be provided on the replacement schedule set forth in the Medicare Continuous CPAP Supplies Replacement Schedule.

SECTION 6
HOSPITAL BENEFITS

1. **Hospitalization Benefits:** The Plan pays for Medically Necessary Hospitalizations (subject to the Plan's Managed Care Program) as described below. The level of Benefits the Plan will pay depends on whether you are using a Network or Non-Network Hospital. Using a Network Hospital will limit your out-of-pocket costs for medical care. (See the "Mental/Nervous/Substance Abuse Benefits" section below for a fuller description of inpatient Benefits for mental health/substance abuse Hospital admissions.) Private rooms are not covered by the Plan unless they are determined to be Medically Necessary.

    A. **Inpatient Hospital Benefits; Hospital Room and Board:** The Plan pays a different level of Benefits for Inpatient Hospital Services, including Room and Board, Intensive Care, Surgical Services, Other Hospital Charges, and Physician Visits while Hospitalized depending on whether you use a Network or Non-Network Provider.

        i. **Network:** For Medically Necessary stays at a Network Hospital, after you have met your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses.

        ii. **Non-Network:** For Medically Necessary stays at a Non-Network Hospital, you will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Hospital charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

    B. **Outpatient Hospital Benefits:** The Plan pays a different level of Benefits for Outpatient Hospital Services depending on whether you use a Network or Non-Network Provider.

        i. **Network:** For Medically Necessary Outpatient Hospitalization Services, after you have met your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network Rate until you meet the Annual Out of Pocket Maximum for Network Expenses.

        ii. **Non-Network:** For Medically Necessary Outpatient Hospitalization Services, after you have met your Annual Deductible, you will be responsible for Twenty-Ten Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Hospital charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

    C. **Private Rooms:** Private Rooms Not Covered If Not Medically Necessary. Regardless of whether you use a Network or Non-Network Hospital, private rooms are not covered by the Plan unless they are determined to be Medically Necessary (if approved, they are paid at the same rate as a semi-private room).

        IMPORTANT NOTE*: If the Plan denies your room and board Benefits for a Non-Network Hospitalization because they are not Medically Necessary (as defined in this Plan) and you are retained in the Hospital by your Physician, YOU will be responsible for any Non-Network Hospital room and board Services and for any Services by that same Physician if he or she is a Non-Network Provider.*

    D. **Benefits for Birth Required Under Federal Law:** Under federal law, group health plans like the Plan and health insurers generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or

newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider (e.g., her Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Plan or the insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, plans may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

***IMPORTANT NOTE*:** The Plan does not and, under federal law, may not, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours) or that you use a particular Provider or facility. However, the Plan's general pre-certification rules do apply. Keep in mind that if you use a Non-Network Physician or a Non-Network facility, YOU are responsible for ensuring that your stay is pre-certified. Also, remember that you can reduce your out-of-pocket costs by using a Network Physician and a Network facility. For information on pre-certification, contact the Fund Office.

2. **Hospital Miscellaneous Benefits:** Network and Non-Network Miscellaneous Hospital Services include things like inpatient diagnostic Services (X-rays, lab tests, etc.), and outpatient treatments like chemotherapy.

   A. **Network Hospital:** For Medically Necessary miscellaneous inpatient or outpatient Hospitalization Services, the Plan will pay Benefits at the Network rate described above if you use a Network Hospital.

   B. **Non-Network Hospital:** If you use a Non-Network Hospital, the Plan will pay Benefits for Medically Necessary miscellaneous inpatient or outpatient Hospitalization Services at the Non-Network rate described above.

3. **Emergency Room Services:**

   A. **Definition of "Emergency":** The term "Emergency" under the Plan means an unforeseeable condition or complaint of pain that causes a reasonable person to fear serious injury, illness or death. You should think of emergencies as things like heart attacks, strokes, Accidental injuries, etc. Things like colds and the flu are not emergencies under the Plan. If you use an Emergency Room for a non-Emergency, the Plan will not pay any Benefits at all.

   B. **Emergency Room Coinsurance:**

      a. **Network:** If you use a Network Provider, after you meet your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses.

      b. **Non-Network:** If you use a Non-Network Provider, after you meet your Annual Deductible, you will be responsible for Twenty Percent (20%) of the median amount negotiated with Network Providers for comparable Emergency Services until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

      IMPORTANT NOTE: *If the condition for which you seek treatment from a Non-Network facility Emergency Department is* ***not*** *an "Emergency" as defined in the Plan, the Plan will not pay any Benefits at all.*

IMPORTANT NOTE: *The Trustees reserve the right to only pay for true medical Emergencies as defined above.*

4. Emergency / Hospital Transportation:

A. Ambulance: The Fund provides Benefits for Medically Necessary ambulance services, including Life Flights.

a. Network: After you meet your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses.

b. Non-Network: After you meet your Annual Deductible, you will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount charged, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

IMPORTANT NOTE: *The Fund will not provide Benefits for the ambulance Services described above if the patient does not meet the criteria required for Coverage under the Plan.*

SECTION 7
SURGICAL BENEFITS

1. **Inpatient Surgical Benefits:** The Plan will pay Benefits for Medically Necessary inpatient surgery (subject to the Plan's Managed Care Program). The level of Benefits will depend on whether you use a Network or Non-Network Provider:

    A. **Network Provider:** After you have met your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses.

    B. **Non-Network Provider:** You will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Provider charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

2. **Outpatient Surgical Benefits.**

    A. **Network Provider:** After you have met your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses.

    B. **Non-Network Provider:** You will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Provider charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

3. **Bariatric (Obesity) Surgery**. Benefits will be provided for bariatric surgery for the Participant and Spouse only if the following conditions are met:

    A. The surgery is pre-authorized by Blue Cross/Blue Shield of Illinois, which shall apply the appropriate criteria, which may be updated from time to time. Benefits will be subject to the same Co-payments and Deductibles applicable to other physical conditions covered under the Plan. These criteria include:

        - Patient's body mass index (BMI) is 40 kg/meter 2 or a BMI equal to or greater than 35 kg/meters 2
        - Patient must suffer from at least two of the following conditions:
            - Hypertension
            - Dyslipidemia
            - Diabetes Mellitus
            - Coronary Heart Disease
            - Sleep Apnea
            - Osteoarthritis
        - Patient must provide documentation from the prospective surgical program demonstrating that the patient has completed evaluation by a licensed professional counselor, psychologist or psychiatrist within the twelve months preceding a request for surgery indicating the absence of significant psychopathology that would hinder the ability of the individual to understand the procedure and comply with the recommendations and any psychological co-morbidity that could contribute to weight, mismanagement or a diagnosed eating disorder, and the patient's willingness to comply with preoperative and postoperative treatment.

4. **Gynecomastia:** The Fund will provide Benefits for gynecomastia procedures for males if the following criteria are met. These criteria are subject to revision. At least the following criteria are met:

    - Endocrine sources have been ruled out;
    - Other exogenous sources such as caffeine and anabolic steroids have been ruled out;
    - The breast tissue component is greater than 4 cm in diameter;
    - The condition has been present for more than two years; and
    - The patient has provided two medical opinions demonstrating the need for the surgery. One of these opinions must be from a qualified surgeon and the other from an endocrinologist.

5. **Preventive Care Surgical Procedures:** The Fund provides Benefits for certain procedures deemed "preventive care" by the U.S. Preventive Services Task Force. Patients who use Network providers will not be responsible for a copayment for "preventive care." These Services include, **for example**, a screening colonoscopy for adults between the ages of 50 and 75.

    A. **Network Provider:** If you use a Network Provider, the Plan will pay Benefits in full with no Copayment required from you.

    B. **Non-Network Provider:** If you use a Non-Network Provider after you have met your Annual Deductible, you will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Provider charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses

        a. Preventive Services include only **screening** services, NOT **diagnostic** Services. Therefore, if your doctor orders a colonoscopy as a diagnostic tool, **for example**, to determine the extent of your diverticulitis, the procedure is diagnostic and not preventive and you will be responsible for any remaining Deductible and Coinsurance. The amount you owe will differ depending on whether you use a Network or a Non-Network Provider.

6. **Mastectomy Benefits:** The Plan will pay surgical Benefits for reconstruction of the breast on which the mastectomy has been performed, and for the reconstruction of the other breast to produce a symmetrical appearance. The Plan also will pay Benefits for prostheses for mastectomies. Finally, the Plan also will pay Benefits for any complications arising from a mastectomy (including lymphedemas) under the relevant Plan provision (Hospital Benefits, Physician visits, surgical Benefits, etc.). The Plan will not deny a Patient Eligibility, or continued Eligibility, to avoid paying these Benefits. The Plan also will not penalize or otherwise reduce or limit the reimbursement of an attending Provider to avoid paying these Benefits, or induce such a Provider to provide care to a Patient in a manner to avoid paying these Benefits. **Nevertheless, the Hospitalization and medical Benefits are subject to the regular Plan provisions covering the use of Network and Non-Network Providers described above.**

SECTION 8
OUTPATIENT DIAGNOSTIC BENEFITS

IMPORTANT NOTE: *PRECERTIFICATION MAY BE REQUIRED! Regardless of whether you use a Network or Non-Network provider, certain outpatient diagnostic Services require precertification. The Fund's Benefits will be decreased or may not be available at all if you or your Provider do not precertify these procedures.*

1. **Outpatient Diagnostic Services.** The Plan will pay Benefits for Medically Necessary outpatient diagnostic Services (subject to the Plan's Managed Care Program). The level of Benefits the Plan will pay depends on whether you are treated by a Network or Non-Network Provider.

    A. **Network Provider:** If you use a Network Provider, after you meet your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses. This applies to all Services under this Section, except those diagnostic tests recommended by the U.S. Preventive Services Task Force.

    B. **Non-Network Provider:** If you use a Non-Network Provider, after you meet your Annual Deductible, you will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Provider charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

2. **Outpatient Diagnostic Services Provided Under Other Plan Sections:** The Plan will pay for Hospital pre-admission testing under the Hospital Benefit provisions of the Plan. Contact the Fund Office with any questions you have on when other provisions of the Plan cover outpatient diagnostic Services.

    IMPORTANT NOTE: *Certain preventive diagnostic procedures may be provided with no patient cost-sharing. See Section 5, the "Physician, Physical Therapy, and Immunization Benefits and Benefits for Preventive Care Services Provided by Your Physician" section.*

    A. **"Medical Intervention" Provided by a Dentist:** Where a dental procedure or treatment is considered a "medical intervention," the Fund will cover the cost of the procedure as set forth in this paragraph. A "medical intervention" means a procedure that is necessary for the safety or treatment of an individual with a significant medical condition that is not readily remediable through medical means. An example of "medical intervention" performed by a dentist include devices fabricated and fitted only by a dentist but that are prescribed by a pulmonologist to treat sleep apnea. Where the treatment is classified as a dental treatment, the dentist and the treatment will be payable under the claims payment amounts allowable under the Plan. Where the treatment is classified as a medical treatment but rendered by a dentist, the Fund will provide Benefits consistent with the Benefits available from BC/BS IL for the same service. Nothing in this policy will decrease or increase the Benefits available for treatment for Accidents as described in this SPD.

SECTION 11
MENTAL / NERVOUS/SUBSTANCE ABUSE BENEFITS

1. **Mental Health Benefits:** The Plan will pay Benefits for Medically Necessary mental illness or substance abuse treatments, subject to the Plan's Managed Care Program. The level of Benefits depends on whether you receive treatment from a Network or Non-Network Provider and whether the treatment is counseling or screening recommended by the U.S. Preventive Care Task Force (see below for additional information):

   A. Inpatient Treatment. The Plan will pay Benefits for Medically Necessary inpatient Benefits mental illness and substance abuse treatment, as follows.

   IMPORTANT NOTE: *Like all inpatient admissions, admissions for mental health and substance abuse treatment are subject to review by BC/BS IL. If you have an Emergency admission for mental health or substance abuse issues, you or your Provider must notify BC/BS IL within two business days after treatment/Hospitalization. If you fail to pre-certify your Hospital stay or treatment, the Fund may limit or deny Benefits for the claims incurred.*

   B. The Plan pays a different level of Benefits for in-patient Mental Health and Substance Abuse treatment depending on whether you use a Network or Non-Network Provider.

      i. Network Hospital: For Medically Necessary stays at a Network Hospital, after you have met your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses.

      ii. Non-Network Hospital: For Medically Necessary stays at a Non-Network Hospital, you will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Provider charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses.

   IMPORTANT NOTE: *If the Plan denies your room and board Benefits for a Non-Network Hospitalization because they are not Medically Necessary (as defined in this Plan) and you are retained in the Hospital by your Physician, you will be responsible for any Non-Network Hospital room and board Services and for any Services by that same Physician if he or she is a Non-Network Provider.*

   C. Outpatient Treatment: The Plan will pay outpatient Benefits for Medically Necessary visits for mental illness and substance abuse, as follows:

      i. Physician Office Visits: Network Provider. For office visits to a Network Provider, after you meet your Annual Deductible, you will be responsible for Ten Percent (10%) of the Network rate until you meet the Annual Out of Pocket Maximum for Network Expenses. There is no limit on the number of Medically Necessary office visits you can have with a Network Provider.

      ii. Physician Office Visits: Non-Network Provider. For office visits to a Non-Network Provider after you meet your Annual Deductible, you will be responsible for Twenty Percent (20%) of the UCR rate, plus any balance between UCR and the amount the Provider charges, until you meet the Annual Out of Pocket Maximum for Non-Network Expenses. There is no limit on the number of Medically Necessary office visits you can have with a Non-Network Provider.

2. **Preventive Care Services Provided Under this Section.** In accordance with the terms of the Affordable Care Act, the Fund will provide Benefits for screening and counseling for the "A" or "B" recommendations of the U.S. Preventive Services Task Force with no Copayment to you when you use a Network provider. If, however, the counseling or screening is provided in conjunction with other mental health or substance abuse Services or Treatment, you will be responsible for the Copayments for the additional Services or Treatment. Representative counseling and screening recommended by the U.S. Preventive Services Task Force include screening and counseling for alcohol misuse, and depression. The recommendations are tailored to certain groups and only at-risk patients as identified in the Guidelines are Eligible for Treatment with no Copayment. If you want to learn about the recommended screening and counseling, you can find more information from the Task Force's website at: https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/uspstf/index.html. If you wish to verify whether the treatment or counseling you receive will be subject to a Copayment, call the Fund Office.

SECTION 17
EXCLUSIONS

1. **Exclusions:** The Fund will not pay Benefits if the Trustees, in their sole discretion and in consultation with the Plan's professional advisors, determine that the payment of Benefits is inconsistent with the Plan's governing documents or with the best interests of the Plan, its Participants and Dependents. In addition, the Fund will not pay Benefits if the Claim is subject to any of the exclusions set forth below:

   A. **Medical Necessity**: The Fund will not pay Benefits if the Service is not Medically Necessary as determined by the Trustees in reliance upon the Plan's professional Medical Advisors.

   B. **Lack of Eligibility**: The Fund will not pay Benefits if the Service was rendered at a time when the individual was not Eligible for Benefits as described in the "Eligibility" section above.

   C. **Outside of Chicago Geographic Area**: The Fund will not provide Benefits for Treatment, care or services that are provided outside of the greater Chicago area, unless the patient provides documentation to the satisfaction of the Trustees that comparable treatment, care or services cannot be provided in this area and that the out-of-area care is Medically Necessary. This exclusion does not apply to the Cleveland Clinic or the Mayo Clinic. This provision does not apply to *bona fide* Emergency services or to patients who reside outside the greater Chicago area.

   D. **Certain Actions by the Participant or Eligible Dependent**.

      i. **False or Misleading Information:** The Fund will not pay Benefits if the Service is rendered as a result of the patient's submission to a Provider of incorrect, false or misleading information, or the Provider is paid as a result of the patient's submission (or the patient's Provider's submission) to the Plan of incorrect, false or misleading information. False or misleading information includes, but is not limited to, failing to inform the Fund of a change in status, **for example**, a divorce. (See the "Coordination of Benefits and Subrogation" section for a description of the Fund's rights if Benefits are paid pursuant to false, incorrect or misleading information.)

      ii. **Failure to Comply with Fund Rules:** The Fund may reduce or deny Benefits if the Service was rendered when the patient (or the patient's Provider) failed to comply with the Plan's Managed Care Program or other administrative and informational requirements of the Plan.

      iii. **Outside Employment for Wage or Profit:** The Fund will not pay Benefits if the Service is rendered as a result of injury or illness arising from any non-covered employment for wage or profit. For purposes of this paragraph, covered employment means employment for which Contributions are made to the Plan.

      iv. **Coordination of Benefits:** The Service is rendered and the patient attempts to make this Plan primary by failing to comply with the requirements of other primary insurance. See the Coordination of Benefit rules summarized in the "Coordination of Benefits and Subrogation" section.

E. Certain Item Condition or Service Exclusions.

i. **Personal Comfort Items:** The Fund will not pay Benefits if the Service is for Personal Comfort items. "Personal Comfort," means a Service that the Trustees, acting in reliance upon the Plan's Medical Advisors, find does not materially advance medical treatment of the patient's condition when compared to other Services, but is primarily prescribed or sought for the Patient's comfort or convenience. Examples of Personal Comfort Services include, without limitation, air conditioners, dehumidifiers, electronic controlled thermal therapy, and modifications to home, vehicle, etc.

ii. **Personal Care Items:** The Fund will not pay Benefits for equipment repairs or personal care items including but not limited to commodes, lift chairs, grab bars, scales, stethoscopes, pillows, mattresses, communication devices, blood pressure instruments and similar items.

iii. **Pregnancy of Non-Spouse Dependent:** The Fund will pay Benefits if the Service is for the pregnancy of an Eligible Dependent Child but will not pay Benefits for the child of this Eligible Dependent Child.

iv. **No Benefits for Surrogacy:** The Fund will not pay Benefits for any expenses related to a surrogate pregnancy.

v. **Cosmetic Services:** The Fund will not pay Benefits if the Service is for cosmetic purposes unless the claims arise from injuries sustained in an Accident that occurs while the Participant or Dependent is Eligible for Benefits and treatment begins within 90 days after the Accident. A Service is for cosmetic purposes if its purpose is to enhance appearance, rather than to correct a physical deformity caused by a congenital defect, Accident, trauma, or disfiguring disease.

vi. **Diet and Exercise (except bona fide wellness programs):** The Fund will not pay Benefits if the Service relates to a program or regimen, such as diet, exercise, rest, and obesity programs and regimens, even if it is Medically Necessary, unless specifically authorized by the Trustees as a bona fide wellness program adopted as a Plan Benefit or if the Services are "A" or "B" recommended Services, Treatment, counseling or screening as determined by the U.S. Preventive Services Task Force.

vii. **Visual Therapy:** The Fund will not pay Benefits if the Service is visual therapy.

F. Other Coverage.

i. **Workers Compensation Claims:** The Fund will not pay Benefits if the Service is compensable under workers' compensation or similar law.

ii. **Injury While Self-Employed:** A person who is self-employed and otherwise Eligible for coverage under the Plan must obtain liability insurance to provide the coverage that a Participant would obtain through worker's compensation insurance. In no event shall the Fund be liable to cover a self-employed person for any Service that

arises from an illness or injury incurred in the scope of self-employment.

iii. **Governmental or Other Coverage:** The Fund will not pay Benefits to the extent that the Service is payable by Other Insurance, including government-sponsored insurance.

G. Miscellaneous.

i. **Unqualified or Uncertified Provider:** The Fund will not pay Benefits if the Service is performed by a Provider that is unqualified, uncertified, or not licensed from the appropriate authority to perform the Service.

ii. **No responsibility for Claim:** The Fund will not pay Benefits if the Participant or Eligible Dependent does not have a legal responsibility to pay for the Service rendered.

iii. **Military Service or Act of War**: The Fund will not pay Benefits if the Service is rendered as a result of injury or illness from military Service or an act of war.

iv. **Trustee Discretion.** The Trustees, in their sole discretion and in consultation with the Plan's professional advisors, determine that the payment of Benefits is inconsistent with the Plan's governing documents or with the best interests of the Plan's Participants and Beneficiaries.

SECTION 18
COORDINATION OF BENEFITS AND SUBROGATION

COORDINATION OF BENEFITS

1. **General.** The Fund coordinates the Benefits available under the Plan with comparable Benefits that you or your Dependents may have under Other Insurance. This includes private insurance as well as Medicare, Medicaid or other governmental Benefits. The Fund will pay Benefits in accordance with the Medicare Secondary Payor statute and other applicable laws. In addition, this Section describes how the Fund will coordinate out of pocket costs with "Other" Coverage.

    A. The **key terms** in this section are "Primary" Insurance and "Secondary" or "Other" Insurance. When this Plan is "Primary," the Fund will pay on your claims first and then any remaining balance can be paid by the "Secondary" or "Other" Insurance.

IMPORTANT NOTE: *In no event will payment from the Fund, when combined with Benefits available under Other Insurance, exceed 100% of the amount payable under the Plan, regardless of whether this Plan is Primary or Secondary.*

2. **Primary Plan Determination Rules.** In determining whether Other Insurance is the Primary Plan, the Fund will apply the following rules:

    A. The Other Insurance will be the Primary plan when it is the Primary plan under the terms of that plan or if that plan does not include provisions for the coordination or nonduplication of Benefits.

    B. The plan that covers a Participant or Dependent as a Participant will be Primary; the plan that covers a Participant or Dependent as a dependent may be Secondary (depending on the Coordination of Benefits rules).

    C. If your Dependent Child under age 19 is covered under the plans of two parents, the Primary Coverage will be the coverage of the person whose birthday occurs first in a calendar year; except that,

        i. If the other plan does not have this rule, its alternate rule will govern; and

        ii. In the case of a Dependent Child of divorced or separated parents, the rules in the next subsection will apply.

3. **Dependent Children, including Adult Dependent Child**. Unless there is a valid Qualified Medical Child Support court decree stating otherwise, plans covering a Dependent Child shall determine the order of Benefits as follows:

    A. For a dependent Child under age 19 whose parents are married or are living together, whether or not they have ever been married:

        i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

        ii. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

    B. For a dependent Child under age 19 whose parents are divorced or separated or are not living together, whether or not they have ever been married:

        i. If a court decree states that one of the parents is responsible for the dependent Child's health care expenses or health care coverage, that plan is primary. If the parent with responsibility has no health care

coverage for the dependent Child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan;

ii. If a court decree states that both parents are responsible for the dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of Benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent Child, the provisions of Subparagraph (a) of this paragraph shall determine the order of Benefits; or

iv. If there is no court decree allocating responsibility for the Child's health care expenses or health care coverage, the order of Benefits for the Child are as follows:

a. The plan covering the custodial parent;
b. The plan covering the custodial parent's spouse;
c. The plan covering the non-custodial parent; and then
d. The plan covering the non-custodial parent's spouse.

C. Adult Dependent Child: In the case of an adult Dependent Child age 19 and over who is not the subject of any court order regarding the provision of health insurance coverage, and considering not only the plan of a non-Participant parent but also the plan of the Dependent's spouse, the plan that has covered the Dependent Child for the longest period shall be the Primary Coverage.

4. Coordination of "Out of Pocket" Costs: The Fund limits out of pocket costs to the statutory maximum. Effective January 2015, this amount is equal to the Deductible permissible under the Internal Revenue Code for "high-deductible health plans." The Fund will coordinate the "out of pocket" maximum expenditures with Other Coverage. The Fund will remit to the Participant or Dependent a refund of the amount that exceeds the out-of-pocket maximum only if you are actually left with an unpaid balance after the Benefits are coordinated with available Other Coverage.

5. Other COB Rules.

A. Automobile Insurance. In all cases, this Plan is Secondary to any automobile insurance. In addition, this Plan will not pay any Benefits until the automobile insurance has paid its full policy limit. If you are required by applicable state law to carry at least a minimum level of insurance but failed to do so, the Fund will pay Benefits as if it is paying Secondary to such coverage.

B. Supplemental Insurance Policies. If you or an Eligible Dependent purchase supplemental insurance (including, for motorcycle Accidents), this Plan shall be Primary as compared to the supplemental insurance. "Supplemental medical coverage" is coverage that can be purchased under a motorcycle or automobile policy but only provides medical insurance coverage and only to the driver and his passengers. This coverage is secondary to any medical coverage provided by the Fund. "Supplemental medical coverage" must be distinguished from "Uninsured bodily injury coverage," which is broader liability coverage that covers medical claims as well as pain and suffering claims. "Uninsured bodily injury coverage" will be treated as Primary Coverage and the Plan's coverage as Secondary Coverage.

C. payment as the Primary payer.

D. In any case in which the Plan is Secondary to Other Insurance (other than Medicare) pursuant to the Plan's coordination of Benefits rules, the Plan will pay Benefits for you or Eligible Dependent only as the Secondary payer of Benefits.

Coordination of Determinations of Medical Necessity. In the case where this Plan is Secondary to Other Insurance, and the Other Insurance has denied a claim on the ground that the Service is not Medically Necessary as defined under that Other Insurance, you or your Eligible Dependent must first exhaust the administrative remedies available under that Other Insurance before submitting the claim to this Fund to pay as the Secondary payor. If you or your Eligible Dependent exhaust the administrative remedies of the Other Insurance, the Fund will evaluate the claim by applying this Plan's Medical Necessity criteria.

SUBROGATION/REIMBURSEMENT

1. **General.** If you or an Eligible Dependent become ill or injured as a result of a third party's actions or if you are injured on the premises of another person, the Fund is given the broadest rights to recover any medical expenses paid on your behalf, including, but not limited to reimbursement, subrogation, constructive trust and any other applicable federal or state causes of action that may provide legal and/or equitable relief to the Fund. The Fund's rights survive your death and apply to any recovery subject to these subrogation and reimbursement provisions from a third party that is paid or payable to your estate, survivors, heirs or any other party.

2. **Make Whole and Common Fund Doctrines Do Not Apply.** Regardless of where the action is brought, neither the "make whole" nor the "common fund" doctrines apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related Benefits and are not offset by legal costs, fees or expenses incurred by the claimant or plaintiff, except as specifically set forth in this Section.

3. **Participant and Dependent Responsibilities.** If a Dependent Spouse or Child is the injured party and receives Benefits pursuant to these rules, the Participant, Dependent Spouse and/or Child is responsible to protect the Fund's interests as set forth in this Section. If the Dependent Spouse or Child is a plaintiff in an action to recover any monies, damages, etc. related to the Accident or injury for which the Fund has paid claims, the Participant agrees to be a party in that action for the purpose of protecting the Fund's subrogation rights.

4. **Fund Will Advance Payment on an Express and Automatic Condition that the Fund Will Be Reimbursed from Any Third Party Recovery.** The Fund will generally treat the third party as primarily liable for your medical expenses. However, the Fund will pay Benefits to you with the understanding that payment of these Benefits is expressly and automatically conditioned on the Fund being reimbursed for these Benefits if there is any recovery from that third party including, but not limited to, any recovery from your automobile (including "uninsured motorist coverage" under your policy) or Other Insurance carrier.

5. **Notice Requirements.** You and your attorney are required to provide the Fund with notice that a third party may be liable for an injury or illness for which the Fund has advanced claims, including the intent to initiate litigation, and must provide the Fund, no less often than quarterly, with notice of the status of the matter. You and your attorney further agree to provide the Fund with full documentation of any expenditures you make with money otherwise payable to the Fund so that the Fund may trace these expenditures and recover an amount equal to its subrogation lien or reimbursement interest.

6. **You Must Cooperate with the Fund's Right to Reimbursement.** You must not do anything that could interfere with the Fund's right to reimbursement from the third party. The Fund may ask you to assign to it your rights against that third party, or your recovery from that third party, to the extent of Benefits paid by the Fund.

   You must also contact the Fund before you settle the case and may not do so without the prior written consent of the Fund. The Fund may request that you authorize the Fund to sue on your behalf. In addition, as noted above, you and your attorney agree and are required, as a condition of the Fund providing any Benefits for you under this Fund, to hold all money you receive in constructive trust for the Fund, regardless of whether you sign a subrogation agreement.

   The Fund can and will deny Benefits to any Participant or Eligible Dependent who acts against the Fund's right to reimbursement from the third party. The Fund also can sue you, your attorney or any other person to recover the reimbursement owed to it if you or such person receives money from the third party and do not reimburse the Fund. Finally, the Fund can offset the amount that should have been reimbursed to it against other Benefits payable on behalf of the Participant or any Eligible Dependents.

   Cooperation with the Fund's Subrogation and Reimbursement provisions includes the timely completion of a Reimbursement Agreement as well as timely and accurate response to the Fund's inquiries relating to the status of any claim subject to the Fund's subrogation and reimbursement provisions.

7. **Constructive Trust.** You and your attorney agree and are required, as a condition of the Fund providing any Benefits for you, to hold all money you receive in constructive trust for the Fund, regardless of whether you execute a subrogation agreement. This means that you must treat all dollars you receive from the third party as if you are holding them to repay the Fund before you pay anyone else. Your attorney must place these funds in a restricted account and make payment first to the Fund before taking fees or providing payment to you. As noted above, by accepting these Benefits, you and your attorney agree not to dissipate any of the proceeds of the recovery before the Fund's subrogation lien or reimbursement interest is remitted to the Fund to the Fund's satisfaction. You and your attorney further agree to provide the Fund with full documentation of any expenditures you make with money otherwise payable to the Fund so that the Fund may trace these expenditures and recover an amount equal to its subrogation lien or reimbursement interest.

   It is the expectation that your attorney will act in a manner consistent with the applicable rules of professional responsibility regarding the Fund's lien. Specifically, the Fund understands that upon receiving funds or other property in which the Fund has an interest, the attorney shall promptly notify the Fund and shall promptly deliver to the Fund any monies due pursuant to the Fund's lien. The Trustees, at their discretion, will report any dereliction in this regard to the appropriate authorities.

8. **Fund May Be Subrogated to Your Rights Against a Third Party.** At the Fund's discretion, the Fund may choose to be subrogated to your rights against the third party, or to proceed with an action for reimbursement. If the Fund chooses to be subrogated, that means that it will take over your rights against the third party. If the Fund chooses to proceed with an action for reimbursement, that means that it looks to the third party for repayment of expenses it paid on your behalf. The Fund also can proceed with an action against you if you receive money from the third party and do not reimburse the Fund. The Fund's subrogation rights extend to any excess coverage that the Participant or Dependents may have purchased on his or her own. In addition to the above, the Fund may sue you, your attorney, or any other recipient of money from a third-party for imposition of a constructive trust or other legal and/or equitable remedy if you do not reimburse the Fund.

9. **Attorneys' Fees.** At its discretion, and upon receipt of an executed Dual Representation Agreement, the Fund may permit a certain percentage of the Fund's recovery to be applied to the claimant's attorney's fees, but shall not be greater than 33 1/3%, unless the Trustees have consented to a higher fee in writing and provided a Dual Representation Agreement (see below) is signed. You will be responsible for any attorneys' fees above this amount.

10. **Future Medical Expenses.** The Fund's right to reimbursement is an ongoing one. If you have future medical expenses that were the result of the third party's actions, the Fund's right to reimbursement continues.

11. **Workers Compensation Settlements (Lump Sum Commutation).** While you should consult your own attorney about whether to accept a workers' compensation settlement, you should note that any lump sum commutation should be limited to wages only, not medical care for your work-related injury. If you do waive your right to future medical care payments as part of a lump sum commutation, the Fund will not pay Benefits for any of your medical expenses, not just for your work-related injury expenses, until your medical expenses exceed your lump sum commutation.

12. **These Subrogation Rules apply to auto Accidents (as well as injuries or illness caused by a third party)**. The Fund will only cover medical expenses related to an auto Accident on a subrogated basis and only after the maximum liability has been paid by the motor vehicle insurance carrier. In other words, the Fund will consider the payment of medical expenses only after Benefits from the automobile insurance carrier have been exhausted. The subrogation rules above also apply if you are injured while repairing your car or by any other contact with your car.

13. **Reimbursement Agreement.** The Reimbursement Agreement is an agreement by which the injured person agrees to reimburse the Fund from any money you recover from another source. If the injured person is a minor, the Reimbursement Agreement must be signed by a person legally authorized to act on behalf of the minor. The Reimbursement Agreement must be on a form approved by the Trustees. It will require the injured person to repay the Fund for all Benefits paid on account of the injury, regardless of whether the recovery is sufficient to fully reimburse the person for his or her losses. The Fund is not responsible for legal fees and expenses incurred in obtaining a recovery from another source, unless the Fund has agreed in writing to assume a share of those fees and expenses. This can be done by "Dual Representation Agreement" (explained below), which must be signed by the injured person (or his/her representative), the injured person's attorney, and by a representative of the Fund.

14. **Dual Representation Agreements.** A "Dual Representation Agreement" is an agreement by which the attorney who represents the injured person also agrees to represent the interests of the Fund for the purpose of recovering monies the Fund expended in claims for you from a third party. If the Dual Representation Agreement is not signed, the Fund will not be responsible for any attorneys fees or costs incurred by the attorney in making a recovery on behalf of the injured person. Any Dual Representation Agreement signed on behalf of the Fund will have the following terms: (1) the attorney agrees to represent the interests of the Fund and to use his/her best efforts to recover the amounts the Fund has paid in medical and/or Loss of Time Benefits; (2) the Fund will pay the attorney the lesser of 33 1/3% or the contingency fee percentage agreed to between you and the attorney, of the amount the attorney recovers for the Fund; (3) any recovery obtained shall be applied as follows: first, to Fund second, to the Fund (less the agreed-upon deduction for attorney fees and costs); third, to the attorney for his or her agreed-upon fees and costs; and fourth, to the injured person. This priority shall not be affected by how the recovery is characterized (e.g., damages for pain and suffering, property damage, loss of future earnings, etc.); and (4) the injured person and

the Fund each agree to waive any potential conflict that may arise because the attorney is representing both parties.

15. **Use of "You" and "Your."** Under this Section, "you" and "your" shall refer to the Participant and/or the Eligible Dependent, or the estate, survivors, heirs or any other party entitled to receive a recovery of any monies subject to these subrogation and reimbursement provisions.

SECTION 19
AMENDMENT AND TERMINATION

1. **Plan and Trust Amendment.** The Trustees may amend this Plan, or any other plan of the Fund, in any manner and at any time, provided that the amendment is consistent with the provisions of the Trust Agreement, ERISA and other applicable federal or state law. Amendments may include, although are not in any way limited to, adding, modifying, or deleting Benefits provided under this Plan.

2. **Plan and Trust Termination.** The Trustees of the Teamsters Local 710 Health and Welfare Fund may terminate the Plan if the Trustees, by appropriate resolution, in a manner consistent with the applicable terms of the Fund's Agreement and Declaration of Trust. Any termination of the Plan shall be consistent with the applicable provisions of the Trust Agreement and with the requirements of IRC Code Section 501(c)(9).

SECTION 21
PLAN ADMINISTRATION

1. **Named Fiduciary and Plan Administrator**. The Trustees shall be the Named Fiduciary and Plan Administrator for the Fund and the Plan, except to the extent that the Trustees have properly delegated the responsibility for claim appeals brought under Section 503 of ERISA to another "named fiduciary."

2. **Final Authority of Trustees.** The Board of Trustees has final authority to make all determinations regarding the Plan's provisions, terms, rules, regulations, policies and procedures. The Board of Trustees has full authority and discretion to make factual findings regarding a claim or request for review and to interpret the terms of the Plan as they apply to the claim or request for review. The Board of Trustees will provide only those Benefits to which you are entitled under the terms of the Plan.

3. **Monies Held in Trust.** All monies contributed to the Fund shall be held in trust by the Trustees for the exclusive benefit of the Participants, their Dependents and Beneficiaries. In no event shall any assets of the Fund be used for, or diverted to, purposes other than those set forth in the Fund's Trust Agreement or this Plan. The Trustees shall have the right to commingle assets of the Plan with other Fund plans, so that all or any part of the assets of the Plan or plans are invested as a single trust.

4. **General Powers and Duties of the Trustees.** The Trustees shall, by way of illustration but not limitation, have the following powers and duties:

    A. All those powers and duties set forth in the Trust Agreement, or in this Plan.

    B. To do all acts, whether or not expressly authorized in the Trust Agreement or this Plan, that the Trustees may deem necessary or reasonable in the administration, operation, amendment, or termination of the Fund, this Plan, and the other plans comprising the Fund.

5. **Discharge of Duties.** Trustees and other Fiduciaries shall discharge their duties with respect to the Fund solely in the interest of the Participants, their Dependents and beneficiaries, and for the exclusive purpose of providing Benefits to such Participant or Dependents and defraying the reasonable expenses associated with administering this Plan. All actions shall be taken in a manner consistent with the requirements of the Fund's governing documents and applicable federal and state law.

6. **Fiduciary Responsibility.** The Trustees may allocate or delegate fiduciary responsibility to various Trustees and other Fiduciaries in accordance with applicable law. A Trustee or other Fiduciary may serve in more than one Fiduciary capacity hereunder.

7. **Actions Brought Under This Plan.** No action of any kind shall be brought in any forum with respect to any claim under this Plan unless the individual has exhausted the Claim Procedures described in the "Claim Appeals" section that follows. In any event, no action of any kind shall be brought against the Fund after one calendar year following receipt of the Claim Review Opinion. This limitations period will start to run as of (a) the actual date of receipt of the Claim Review Decision by the aggrieved party, as reflected either by a USPS "return receipt" card or UPS delivery receipt; or, if these documents are not available, (b) three days following the Fund's mailing of the Claim Review Decision, as documented in the Fund's records.

8. **Receipt of Benefits Not Evidence of Entitlement to Benefits or Entitlement to Participation in the Plan.** The establishment of the Fund and the Plan, the creation of any fund or account, or the payment of any Benefits under the Trust Agreement or Plan shall not create any right in or for any Participant, Dependent, Beneficiary or any other person or entity to receive or continue to receive any Benefits from the Fund or to continue to be a Participant, Dependent or Beneficiary under the Plan. If an individual

receives payment of Benefits because of a mistake of fact or mistake of law, the Fund reserves the right to require the individual to make full repayment to the Fund of the Benefits paid.

9. **Facility of Payment Provision.** The Plan may pay Benefits directly to the Participant, whether such Benefits are payable for Services to the Participant or his or her Dependent, and the Plan may pay Benefits directly to the Beneficiary of a Participant, as appropriate. The Plan also may pay Benefits due to or for a Participant, Dependent or Beneficiary to the person having legal custody of the payee, to the legal guardian of the payee, pursuant to a Qualified Medical Child Support Order ("QMCSO"), or to the person or entity who or that may be furnishing the Services to the individual. Disbursement made to payees as set forth in this Plan shall be sufficient to discharge the Plan's obligation to make payment of Benefits under the Plan.

10. **Nonassignment of Benefit Payments**. Except as required by applicable law, the right of any Participant or Dependent to receive any benefit payments under a self-insured Benefit under the Plan is personal to such Participant or Dependent and is not assignable in whole or in part to any person or entity, including a health care provider, nor may Benefits of coverage under the Plan be transferred at any time. Under no circumstances will the Plan's direct payment of any amounts to an In-Network Provider constitute a waiver of this nonassignment provision with respect to any party, including a Non-Network Provider.

11. **Separability and Saving Clause.** If a provision of this Plan is held to be invalid or illegal, in whole or in part, or as to any person or instance, such invalidity or illegality shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if the Provision had not been included.

12. **Spendthrift Clause - Alienation of Benefits**. Except as provided in the provisions of this Plan regarding QMCSOs or unless otherwise required by law, no individual shall have any right to assign, anticipate or transfer any assets held by the Fund or Benefits due under the Plan. To the extent permitted by law, the assets of the Fund shall not be subject to seizure by legal process or be, in any way, subject to the claims of the creditors of a Participant, Dependent, or Beneficiary for any reason including, but not limited to, the following: contracts, debts, torts, alimony, support, divorce, domestic relations orders, insolvency, or bankruptcy.

13. **Agent for Service of Process.** The Trustees or the Administrator of the Plan are the agents for acceptance of service of process of any action or proceeding regarding this Plan. Service shall be made at their place of business or at the Fund Office during normal business hours.

14. **Notices-Presentment of Invoices for Payment.** Any notice required under this Plan, unless otherwise specified in the Plan, shall be sufficient if in writing and forwarded by mail or hand delivery to the last address, as filed with the Fund, Participant, Local Union, Participant, Dependent, Beneficiary, or other person or entity to whom notice must be given. No invoice shall be honored for Benefit payment purposes unless it has been presented to the Fund at the Fund Office and date stamped by the Fund on or before the last date allowed under the Plan for invoice presentment. Mailing or other substitutes for presentment shall not be deemed presentment.

15. **Submission of Claims.** The Fund will not pay medical Benefits for claims that are not presented within one year from the date on which the Services were rendered.

16. **Status of Spouse.** The status of a Spouse shall be determined on the basis of the laws in effect in the state of the celebration of the marriage at the time the marriage was celebrated. The Fund requires that a Participant submit to the Fund a divorce decree entered by a court of competent jurisdiction before deleting a Spouse from the list of

Eligible Dependents on account of a divorce or separation. The Participant shall be responsible for any and all claims paid by the Fund on behalf of the spouse following the date of the entry of divorce, regardless of whether the Participant has submitted the divorce decree to the Fund.

17. **Payment and Other Procedures.** Payment and other procedures for all Benefits shall be governed by the rules and regulations of the Fund. At the Trustees' discretion, these rules and regulations may include rules and regulations established by Network Providers.

18. **Physical Examination and Autopsy.** The Fund shall have the right to examine an individual claiming Benefits or for whom Benefits are claimed, as well as the circumstances giving rise to the injury, illness, or conditions for which Benefits are claimed. Such examinations shall be performed by Physicians or other appropriate persons and may occur more than one time during the pendency of a claim. The Fund also shall have the right to require an autopsy when an individual for whom Benefits are payable has died.

19. **Right of Recovery:**

    A. **Against the Participant, Dependent, or Other Payee.** If the Fund has made an erroneous payment to a Participant, Dependent, or other payee (including a Provider), the Fund shall be entitled to recover such excess payment, including attorneys' fees expended in connection with such recovery, by proceeding directly against the Participant, Dependent, or payee for such amount, or by offsetting such erroneous payment against any other Benefits payable to the Participant, Dependent, Family, payee, or any of them, in the future.

    B. **Against a Provider.** If the Fund has made a payment on behalf of a Participant, Dependent, or other payee to a Provider in an amount in excess of the amount due under the Plan, the Fund shall be entitled to recover such excess payment, including attorneys' fees, expended in connection with such recovery, by proceeding directly against the Provider for such amount and against any other individuals for whom the Benefits are payable under the Plan. The Fund may also, to the extent permitted under applicable law and existing contracts, deduct such overpayment from balances otherwise owed to the Provider.

20. **Alternative Benefits.** The Trustees reserve the right to pay Benefits for an alternative Service that is equivalent in utility or quality to, but is less costly to the Fund than, the Service requested. The Trustees also reserve the right to pay Benefits not otherwise authorized in this Plan when the payment of such Benefits would be less costly to the Fund, in the near term or in light of long-term potential costs, than authorized Benefits.

21. **Change in Family Status.** Each Participant shall give prompt written notice, pursuant to the format established by the rules and regulations of the Fund, of any change in Family status, including marriage, divorce, birth of a Child, marriage of a Child, addition or deletion of a new Dependent, death of a Dependent, or otherwise. Failure to furnish such notice in a timely manner may result in a denial of Benefits, unless the Participant is able to show that he or she could not have timely furnished the notice, that the notice was furnished as soon as reasonably possible, and that the Fund was not prejudiced by the delay. In addition, should a Participant or Dependent fail to notify the Fund of a change in Family status, and the Fund thereafter pays Benefits for an individual who is no longer Eligible for Benefits after the change in Family status, the Fund may hold the Participant and Dependent jointly and severally liable for any and all such Benefits as well as all costs, including attorneys' fees and other professional fees, incurred by the, Fund in recovering such Benefits. At the discretion of the Trustees, the amount of such Benefits may be offset against future Benefits payable for the Participant or any other Family member.

22. **Timing of Payment for Covered Services and Items.** The Fund will pay Benefits only after the Participant or Dependent has received the Service and after the Fund has received a proper invoice for payment or reimbursement, as applicable.

23. **Information Required for Coordination of Benefits.** The Fund may require certification from any Participant or Dependent that Benefits claimed are not payable under Other Insurance. The Fund may also request, and the Participant or Dependent shall not decline to provide, permission for the Fund to receive confirmation from a Dependent's employer about the whether the Dependent has or is eligible for health benefits coverage from the Dependent's employer. Failure to provide this information, or cooperate with the Fund's obtaining the information, or the failure to provide correct information, may result in a denial of Benefits or in an action for reimbursement, as applicable.

24. **Cooperation of Participant and Others.** The Fund may require that a Participant, Dependent, Provider or other payee, or the legal counsel of any of these individuals, provide certain information necessary to process a claim for Benefits. Any party's failure to cooperate with the Fund by failing to provide information or by providing false information may result in the denial of the claim for Benefits, or an action for reimbursement, as applicable.

25. **Withholding Payment of Benefits.** If any dispute arises as to the proper person or persons to whom any payment of Benefits shall be made out of the Fund, the Fund may, to the extent permitted by applicable law, withhold such payment until a final adjudication of the dispute by a court of competent jurisdiction or until the Fund, its Trustees, Participants, or agents shall have been protected fully against loss by means of an indemnification agreement or bond that the Trustees, in their sole judgment, determines to be adequate.

26. **Uniformity.** All provisions hereof shall be interpreted and applied in a uniform and non-discriminatory manner. All similarly-situated individuals in the same bargaining unit shall have the same level of Benefits.

27. **Construction.** The Teamsters Local 710 Health and Welfare Fund, The Plan, was established pursuant to, inter alia, the laws of the State of Illinois. All issues pertaining to the validity and construction hereof, and of the acts and transactions of the parties hereto and hereunder, shall be determined in accordance with the laws of the State of Illinois, except to the extent such laws are preempted by ERISA or other applicable federal or state law.

28. **Lost Participant, Dependent, or Beneficiary.** If a Benefit is due to a Participant, Dependent, or Beneficiary under the terms of the Plan, but the Fund is unable to make the payment because the Fund is unable, after reasonable efforts, to locate the individual for a period of six years after the Benefit becomes payable, the Benefit shall be forfeited to the Fund and used for general Fund administration purposes. If the Participant, Dependent, or beneficiary is subsequently located, the Benefit may be restored by the Fund as a charge against the Fund, at the discretion of the Trustees. The Fund shall not pay any interest on a restored amount, unless such interest is required by law. These provisions shall not be interpreted to require the Fund to pay claims that are over one year old.

SECTION 22
CLAIM APPEALS

WHAT INFORMATION IS IN THIS SECTION? This Section sets forth the protections the Fund has in place so you can appeal the denial of a claim for Benefits.

Q. What are the rules for claims submission to the Plan?

A. Network claims will be submitted for you by the Provider. All Non-Network claims should be submitted to BC/BS IL. All claims for payment of Benefits from the Plan must be submitted within one year from the date the Service was rendered or they will not be processed.

Q. I have a complex health condition and need my wife or personal representative to help me work through the claims. Can the Plan accommodate this?

A. Yes. You may designate an "authorized representative" to act on your behalf with respect to processing claims or appealing the denial of a claim. Contact the Fund Office for the appropriate form designating your authorized representative. After you have properly designated an "authorized representative," the Fund will communicate directly with your authorized representative unless you tell the Fund on your authorization form that you would like the Fund to continue to communicate directly with you. (If you have an "urgent care claim," the health professional with knowledge of your medical condition may act as your authorized representative without an executed authorization form from you.).

Q. How does the Fund categorize claims?

A. There are four types of claims:

- Post-Service Claim: If you have already received the Service or treatment, the claim is a "post-service" claim. Post-service claims will likely be the majority of claims that you or your Providers submit. For certain treatment or Services, the Fund may limit the number of visits (**for example**, for Physical Therapy) or days of Hospitalization based on Medical Necessity.
- Concurrent Claims: Once you begin a course of treatment, your health professional may determine that you need additional services or treatment. A claim for extended visits or care are called "concurrent claims."
- Pre-Service Claim: Certain Services and procedures require pre-authorization or precertification. These claims are called "pre-service claims."
- Urgent Care Claim. The different types of claims, and the time limits for processing these claims, are described below.

Q. What is an "urgent care" claim and how long does the Fund have to respond? Are there special rules that apply?

A. Urgent Care Claims: An urgent care claim is a claim for treatment that the treating Physician believes must be provided immediately or the Patient's health or life could be jeopardized or the Patient will suffer severe pain that cannot otherwise be managed. Your claim must be certified as an "urgent care" claim by a Physician.

If your claim includes all of the information the Fund needs to process your claim, you will receive a response as soon as possible but no later than 72 hours after your request for review is received. If your claim does not include all of the information needed, you will be contacted within 24 hours and told what information you need to submit to support your claim. You will have up to 48 hours to submit the requested information. You will receive a response, including the reason for the decision as soon as possible but no later than 48 hours after you submit the required information or the expiration of the period you were given to provide additional information. The Fund may initially provide response orally, including by telephone, if the situation so warrants.

Q. What is a "concurrent care" claim and how long does the Fund have to respond? Are there special rules that apply?

A. Concurrent Care Claim: A concurrent care claim arises when the Fund has approved an ongoing course of treatment to be provided over a period of time or a number of treatments. **For example**, a concurrent care claim is one for additional visits to the physical therapist or for additional Hospital days for an already Hospitalized Patient. If the Fund determines that the course of treatment, the number of treatments or the amount of Service is going to be reduced or terminated, it must notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the Benefits are reduced or terminated. If your concurrent care claim is for "urgent care" and you notify the Fund, at least 24 hours before the expiration of the period or number of treatments, the Fund will notify you within 24 hours of the receipt of your claim. If the request is made less than 24 hours prior to the end of the course of treatment, the Fund will notify you of its decision within 72 hours of receipt of the claim. If the concurrent care claim is not an urgent care claim, the Fund will treat it as a pre-Service claim or post-Service claim and will process it according to the applicable deadlines described below.

Q. What is a "pre-service" claim and how long does the Fund have to respond? Are there special rules that apply?

A. A pre-service claim must be submitted when the Fund requires advance approval or certification prior to receiving medical treatment or Services. In many instances, pre-service claims may be submitted directly by the medical Provider. The Fund will provide a response not later than 15 days after it receives your request, unless it cannot respond because you (or your Provider) have not submitted all of the information it needs to process the claim or for other reasons beyond its control. If the delay is caused by circumstances beyond its control, the Fund shall notify you in advance of the expiration of the first 15-day period that an additional 15 days are required. If you (or your Provider) have not submitted the information needed to process your claim, the Fund will inform you of the specific information needed to process your claim. At that point, consideration of your claim will be suspended. You will have 45 days to submit this information. After you submit the required information, your claim will be processed during the balance of time remaining before consideration of your claim was suspended.

Q. What is a "post-service" claim and how long does the Fund have to respond? Are there special rules that apply?

A. Post-Service Care Claim: A post-service claim is a claim for Benefits for treatment or Services that you have already received. In many instances, post-Service claims may be submitted directly by the medical Provider to the Fund. The Fund will provide a response not later than 30 days after it receives your request, unless it cannot do so because you (or your Provider) have not submitted all of the information needed to process the claim or for other reasons beyond the Fund's control. If the delay is caused by circumstances beyond the control of the Fund you will be notified in advance of the expiration of the first 30-day period that an additional 15 days are required. If you (or your Provider) have not submitted the information needed to process your claim, the Fund will inform you of the specific information needed to process your claim. At that point, consideration of your claim will be suspended. You will have 45 days to submit this information. After you submit the required information, consideration of your claim will resume and it will be processed within the balance of time remaining before consideration of your claim was suspended.

Q. What information will the Fund provide if my claim is denied?

A. If your claim is denied, you will receive a written notice that will include the following information, regardless of whether your claim is processed and denied by the Fund. In the case of an urgent claim, the information may initially be provided orally but will be followed with

written confirmation no later than three days after the original decision is rendered. The information will include:

(1) The specific reasons for the denial (for example, you were not Eligible for Benefits at the time you applied for Benefits);

(2) The specific plan provisions under which your claim was denied;

(3) If an internal rule, guideline or protocol was relied upon to make the decision, you will be provided with the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;

(4) If the decision turned on medical necessity or whether a treatment was Experimental, you will be provided with either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or a statement that it will be provided to you free of charge upon request;

(5) A description and explanation of the information you must submit in order to perfect your claim;

(6) A description of the procedures you must follow to appeal the denial of your claim to the Board of Trustees.

Q. What can I do if I disagree with the Fund's decision on a claim?

A. If you are dissatisfied with the denial of your claim, or of a portion of your claim, you may appeal to the Board of Trustees. You must submit your written request for review to the Board of Trustees no later than 180 days after the denial or partial denial of your claim. Your request for review must include the reasons for your request for review. If you fail to appeal your claim, you waive your right to dispute the Fund's determination on this claim.

***IMPORTANT NOTE**: Appeal of the denial of an urgent care claim may initially be submitted by telephone or email.*

You may also request an "external review," as detailed in the following pages.

Q. Does the Fund have to continue coverage for my claim while my appeal is pending?

A. The Fund is required to provide continued coverage pending the outcome of an appeal, provided that you remain Eligible for Benefits. However, if your appeal is regarding the Fund's decision to rescind coverage, the Fund will not continue coverage during the pendency of this appeal.

Q. What are my rights on appeal?

A. Your rights when you request a review of the denial of a claim:

(1) Your claim will be considered by the Board of Trustees. The Board of Trustees does not participate in the processing and denial of claims at the initial stage. The Board of Trustees will not defer to the original decision of the Fund staff who originally denied your claim. You have the right to appeal in person, by telephone, or by email and at least one Trustee will participate in the hearing on appeal.

(2) In support of your request for review, you are permitted to submit written comments, documents, records and other information relevant to your request for review. The Board of Trustees will review this information in making a determination about your request for review.

(3) At your request and free of charge, you will be provided reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

(4) If consideration of your request for review requires that the Board make a medical judgment (**for example**, if the Trustees must consider whether a prescription drug was medically appropriate or Experimental), the Trustees shall consult with an appropriate health care professional. If the Trustees consult medical experts with respect to your request for review, they will provide for the identification of these experts. The medical expert consulted by the Board of Trustees on appeal shall be different from any medical professional consulted with respect to the original claim for Benefits.

Q. If the Trustees deny my claim, what information will the Fund provide to me?

A. If the Board of Trustees denies your appeal of the denial of a claim, you will be provided with the following information:

(1) The specific reasons for their determination;

(2) The Plan provisions on which the Trustees based their determination;

(3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for Benefits;

(4) If an internal rule, guideline or protocol was relied upon to make the decision, the Board of Trustees will provide either the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;

(5) If the decision turned on medical necessity or whether a treatment was Experimental, the Board of Trustees will provide either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or will provide the explanation to you free of charge upon request;

(6) You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.

(7) You have the right to bring an action against the Fund under Section 502(a) of ERISA, as amended, after you have exhausted all levels of appeal required under this claim procedure.

Q. When Will the Board of Trustees Provide a Decision on Appeal?

A. It depends on the type of claim:

(1) Urgent Care Claims: The Board of Trustees will provide a response no later than 72 hours after the Fund receives your appeal of the denial of a claim.

(2) Pre-Service Claims: The Board of Trustees will provide a response no later than 30 days after the Fund receives your appeal of the denial of a claim.

(3) Post-Service Claims: The Board of Trustees will generally provide a response to an appeal after the regular meeting of the Board of Trustees that follows the submission of your request for appeal. If your request for appeal was filed less than 30 days before the meeting, the Trustees may defer consideration of the appeal until the next regular meeting. If, due to special circumstances (**for example**, that the Board believes that a hearing would be appropriate), the Board of Trustees will provide a response no later than following the third meeting after your request for appeal was submitted. If the Board of Trustees requires an extension due to special circumstances, the Board will provide you with a description of the special circumstances and the date on which a determination will be made before the extension of time begins. The Board of Trustees will provide you with a response no later than five days after the decision is made.

IMPORTANT NOTE: *If you (or your Provider) have not submitted the information needed for the Board to consider your appeal, you will be informed of the specific information needed to process your claim. At that point, the Fund's consideration of your claim will be suspended. After you submit the required information, the Board of Trustees will resume consideration of your appeal within the balance of time remaining before consideration of your appeal was suspended. During the period that the Trustees are awaiting the requested information, the deadlines for rendering a decision will be suspended.*

Q. What happens if the Board of Trustees fails to make a decision within the time deadlines for my type of claim?

A. If the Board of Trustees fail to act within the time lines set forth above or fails to provide you with the information described above, your request for review is deemed denied. This means that you will be considered to have exhausted the Fund's review procedures and may proceed to take action against the Fund in federal district court, should you so choose.

Q. What if I wish to have my claim evaluated by an independent party following an adverse benefit decision by the Fund?

A. If you have received an adverse benefit determination from the Fund, you (or your authorized representative) may request an "external review" of the plan's final decision. This is a review of the Fund's denial of a payment or the Fund's refusal to authorize care that you have sought. The external review will be performed by an "independent review organization," ("IRO") engaged by the Fund.

Q. What is an "independent review organization"?

A. An "independent review organization" ("IRO") uses qualified individuals to undertake a review process, independent of all affected parties, to determine whether a health care service is Medically Necessary and appropriate or experimental/investigational. Under federal law, the IRO must be properly accredited; not be owned by or have material professional, financial or familial relationships with the Fund or its personnel.

Q. Who pays the fees to the IRO for the external review?

A. The Fund is responsible for paying the IRO's fees.

Q. Can I request an external review for any type of Fund adverse determination?

A. No. The external review can be requested only for adverse benefit determinations that involve:

- Medical necessity;
- Appropriateness;
- Health care setting;
- Level of care;
- Effectiveness of a covered Benefit;
- Whether a treatment is experimental or investigational; or
- Any other matter that involves medical judgment.

In addition, if your health insurance is retroactively cancelled, you may also request an external review. Retroactive cancellation is sometimes called rescission of coverage. It means that the plan cancelled your coverage back to an earlier date.

Q. If the IRO reverses the Fund's adverse determination, does the Fund have to cover my claim?

A. Yes. The IRO's determination is binding on the Fund. It is binding on you only to the extent that other remedies are not available under state or federal law (**for example**, you are still permitted to sue the Fund under ERISA Section 502(a)(1)(B)) in the event the IRO upholds the Fund's denial of your claim.

Q. Are there different kinds of external review, depending on the urgency of my claim?

A. Yes. There is a standard external review and, for urgent cases, an expedited (faster than usual) external review.

Q. How do I request a standard external review?

A. You may submit a standard external review request via mail or fax for an external review no later than four months after you receive the final internal adverse benefit determination notice. To request an external review, a person must provide the information listed below. For your convenience, the Fund will provide you with a form on which to make your request. Using the form will also help ensure that you submit all information needed to consider your request for external review:

- Name;
- Address;
- Phone;
- Email address;
- Patient's signature if person filing the appeal is not the patient; and
- A brief description of the reason you disagree with your plan's denial decision. In addition, you may also submit documents to support the claim, such as Physicians' letters, reports, bills, medical records, and explanation of Benefits (EOB) forms; Letters sent to the Fund or to your providers about the denied claim; and Letters received from the Fund or your providers regarding your claim.

Q. What address should I use to submit my External Review Request?

You may mail a request for external review to:

By Postal Mail:
Teamsters Local 710 Health & Welfare Fund
9000 187th St, Mokena, IL 60448

By Phone: (773) 254-2500

By Fax: 773-254-6528

By email: local710funds@710hwp.org

Q. What happens after I submit my request?

Within five business days of receiving your request, the Fund will turn over to the independent reviewer all documents and information used to make the final internal adverse benefit determination. If the plan fails to timely provide the documents and information, the IRO will suspend the review and shall reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify the claimant and the Plan.

After the IRO receives the documentation from the Fund, the IRO will timely notify you in writing of acceptance for external review eligibility. You will be able to submit, in writing, within ten business days following the date of receipt of the notice, information that the IRO

must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Q. Is the IRO required to share the information I submit to the IRO with the Fund?

A. Yes. Upon receipt of any information submitted by the claimant, the IRO will, within one business day, forward the information to the Fund. Upon receipt of any such information, the Fund may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. However, the Fund's 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 adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Fund must provide written notice of its decision to the claimant and to the IRO, at which time, the IRO will terminate the external review.

Q. Does the IRO accept the Fund's decision or make its own determination about my claim?

A. For both a standard and an expedited external review, the IRO will review all of the information and documents timely received, will review the claim "de novo," that is, the IRO takes a completely fresh look at your claim, and will not be bound by any decisions or conclusions reached during the Fund's internal claims and/or appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

Q. When will I receive the determination of the IRO?

A. The IRO will then provide you with written notice of the final external review decision as soon as possible, but no later than 45 days after the examiner receives the request for an external review.

Q. What will be included in the decision of the IRO?

A. The written decision of the IRO for both the standard and expedited external review will include the following information. (If in response to a request for an expedited external review the IRO provides an initial oral response, this information will not be included in the oral response. However, the IRO will provide it in the written response that will follow.) The IRO response will include:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding on the Plan except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

(6) A statement that judicial review may be available to the claimant;

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

Q. When can I request an "expedited" external review?

A. You may request an "expedited" external review when:

The patient has asked for an expedited internal appeal and an expedited external review at the same time, and the timeframe for an expedited internal appeal (72 hours) would place the person's life, health or ability to regain maximum function in danger.

OR

The patient has completed an internal appeal with the Fund and the decision was not in his or her favor, and:

- The timeframe for a standard external review (45 days) would place the person's life, health or ability to regain maximum function in danger, or
- The decision is about admission, care availability, continued stay, or Emergency health care services where the person has not been discharged from the facility.

Q. What information must I submit in order to request an "expedited" external review?

A. For your convenience, the Fund can provide you with a form on which to make your request. Using the form will also help ensure that you submit all information needed to consider your request for external review. You must include the following information:

- Name and Address;
- Phone;
- Email address;
- Why the request is urgent;
- Patient's signature if the person filing the appeal is not the patient; and
- A brief description of the reason you disagree with the Fund's denial decision.

Q. Do I have to submit my request for an expedited external review in writing?

A. No. A patient may also request an expedited review by calling (773) 254-2500. The 72-hour timeframe for an expedited request begins when the Fund receives a written request (e.g. via fax) or when a phone call ends.

Q. Where do I submit my request for an Expedited Review?

By Postal Mail:
Teamsters Local 710 Health & Welfare Fund
9000 187th St, Mokena, IL 60448

By Phone: (773) 254-2500

By Fax: 773-254-6528

By email: local710funds@710hwp.org

Q. When will I receive the independent reviewer's determination in my expedited external review?

A. The Fund will provide the IRO with all documents and information used to make the internal adverse benefit decision as expeditiously as possible. The IRO will give the claimant and the Fund the external review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request. The independent reviewer may give the external review decision orally, but it must be followed up by a written version of the decision within 48 hours of the oral notification.

Q. Are there other ways that I can use to appeal an adverse determination of the Fund?

A. No. The procedures specified in this section shall be the sole and exclusive procedures available to any individual who is dissatisfied with an Eligibility determination, Benefit award or denial, or any other action by the Fund.

Q. Do the Trustees have the authority to make determinations of my appeal?

A. Yes. The Trustees shall have full and exclusive discretionary authority to determine all questions regarding all such issues, including Coverage and Eligibility. The Trustees shall have full and exclusive discretionary authority to construe and interpret all Plan provisions, including ambiguous provisions, and to construe and interpret all rules and regulations and procedures of the Fund and this Plan. In addition, the Trustees shall have full and exclusive discretionary authority to determine the relevant facts, and to apply the facts to the law and to the terms of the Plan. Any such determination or construction made by the Trustees shall be binding upon all parties, and is entitled to the maximum deference permitted by law. No such determination or construction shall be subject to the grievance or arbitration procedures established in any Collective Bargaining Agreement.

***IMPORTANT NOTE**: Actions Brought Under This Plan. No action of any kind shall be brought in any forum with respect to any claim under this Plan unless the individual has exhausted the Claim Procedures described above. Any such litigation that challenges a claim review decision must be filed within one (1) calendar year of the Claimant's actual or constructive receipt of the claim review decision that the Claimant intends to challenge. Receipt of the Trustees' decision may be determined to occur on (a) the actual date of receipt of the Claim Review Decision by the aggrieved party, as reflected either by a USPS "return receipt" card or UPS delivery receipt; or, if these documents are not available, (b) three days following the Funds' mailing of the Claim Review Decision, as documented in the Funds' records. The Trustees reserve the right to adopt such policies and procedures as may be necessary to implement this section.*

SECTION 23
IMPORTANT FEDERAL LAWS APPLICABLE TO THIS PLAN

A. Continuation Coverage, or "COBRA"

If you lose coverage for health Benefits under this Plan, you may be Eligible to continue your health Benefits coverage by purchasing "COBRA" continuation coverage. This coverage is described in detail below. You may also have other health coverage alternatives that may be available to you through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

Your health Benefits Coverage under the Fund may be terminated because you have experienced a "qualifying event." This term is described below. The following sections explain that "qualified beneficiaries" have the legal right to continue group health care coverage, generally known as "COBRA Continuation Coverage," for a period of time even after a qualifying event. Under the law, a Qualified Beneficiary is any Participant, his or her Spouse or Dependent Child who was covered by the Plan when a qualifying event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A Child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Participant during a period of COBRA Continuation Coverage is also a qualified "beneficiary." A person who becomes the new Spouse of an Participant during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.

Each individual covered by the Fund will have the right to make his or her own decision about continuation coverage.

QUALIFYING EVENTS:

Qualified beneficiaries are entitled to COBRA Continuation Coverage when qualifying events (which are specified in the law and described below) occur, and as a result of the qualifying event, coverage of that Qualified Beneficiary ends. A qualifying event triggers the opportunity to elect COBRA when the covered individual loses health care coverage under this Plan. If a covered individual has a qualifying event but does not lose his or her health care coverage under this Plan, (e.g. Participant continues working even though entitled to Medicare) or loses his or her health coverage but does not have a qualifying event, then the individual is not entitled to COBRA Continuation Coverage.

Events that Apply to Spouses

- You die or become divorced or legally separated from your Spouse.

Events that Apply to Dependent Children

- Dependents include Eligible Dependent Children.

  IMPORTANT NOTE*: The definition of Dependent includes any newborn Child or Child adopted or placed with you for adoption if you have notified the Fund within 30 days of the birth, adoption or placement for adoption.*

  - The Child ceases to be a "Dependent" under the terms of the Plan.

TYPE OF COVERAGE

Generally, you can elect to receive the same type of coverage you had immediately prior to the qualifying event. However, you also may change coverage status by contacting the Fund Office. In addition, your Benefits will change if the Fund's benefit plans change.

Maximum Coverage Period

You may elect to continue coverage up to a maximum period as follows:

- Up to 18 months from the date coverage is lost in the event of the Participant's termination of employment or a reduction in working hours provided you were not reinstated during that time; or
- Up to 29 months if the Participant is found by the Social Security Administration to have been disabled within 60 days of the date he or she terminated employment, but only if the disabled person notifies the Plan Administrator of the determination within 60 days after he or she receives it and before the end of the 18-month coverage period; or
- Up to 36 months in all other cases.
- If you have elected continuation coverage following a termination of employment, reduction in hours, or resolution of grievance arbitration, and a second qualifying event occurs, your total period of continuation coverage may last up to 36 months from the date coverage would have been lost on account of the Participant's termination of employment or reduction in hours.

IMPORTANT NOTE: *COBRA Continuation Coverage begins on the date you otherwise would lose your medical coverage.*

COST OF COBRA CONTINUATION COVERAGE:

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. If there is a change in the health coverage provided by the Plan to similarly situated active Participants and their families, that same change will be made in your COBRA Continuation Coverage. The charge for the coverage is equal to the Fund's cost of providing group coverage plus two percent. The two percent charge covers a portion of the Fund's cost to provide you this coverage. If there is an increase or decrease in the Fund's cost, your future premiums will be adjusted accordingly.

NOTIFICATION REQUIREMENTS:

You Must Notify Us

- If you are divorced or become covered under Medicare, or one of your Children ceases to qualify as a Dependent under the Plan, or you experience a second qualifying event (as described later in this section) you must notify the Plan Administrator in writing as soon as possible, but no later than 60 days from the later of: (1) the date of the qualifying event; or (2) the date you would lose coverage due to the qualifying event.

We Will Notify You

- The Plan Administrator will notify you within 14 days of the date you advise us of one of the above events for any reason as well as death or entitlement to Medicare or of your reduction in hours.

ELECTION OF CONTINUATION COVERAGE:

You will have at least 60 days in which to elect continuation coverage. This election period will end on the later of (1) 60 days from the date you would otherwise lose coverage (except for making a COBRA election) or (2) 60 days from the date we mail you notice of your continuation coverage and provide you with an election form.

IMPORTANT NOTE*: If you incur covered expenses during the election period before you have made an election, your claims will not be processed until the Fund receives your election forms and payment of your first premium.*

IF YOU AND/OR ANY OF YOUR ELIGIBLE DEPENDENTS DO NOT CHOOSE COBRA COVERAGE WITHIN 60 DAYS AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

Grace Periods

Once you elect COBRA, the initial payment for the COBRA Continuation Coverage is due to the Fund Office 45 days after COBRA Continuation Coverage is elected. At that time, payment must be made for the full period back to the initial period of eligibility. If this payment is not made when due, COBRA Continuation Coverage will not take effect. Under this Plan, after the initial COBRA payment, monthly payments are due on the 1st day of the month for coverage in the same month but you will have a 30 day grace period to pay the monthly premiums. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Failure to Elect COBRA Continuation Coverage

In considering whether to elect COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law, as noted below:

- You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; and electing COBRA may help you not have such a gap; and
- You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you.

Special Enrollment Rights

If you elect COBRA, you have the same special and open enrollment rights as an active Participant. The special enrollment rights under federal law also allow you to request special enrollment under another group health plan for which you are otherwise Eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed in this section. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a qualifying event but the Fund Office determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, become entitled to Medicare, or if a covered Child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or Child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

Notifying the Plan: To extend COBRA when a second qualifying event occurs, you must notify the Fund Office in writing within 60 days of a second qualifying event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.

This extended period of COBRA Continuation Coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any Child(ren) born to, adopted by or placed for adoption with you during the 18-month period of COBRA Continuation Coverage.

In no case is an Participant whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Participant is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Participant experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Extended COBRA Continuation Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child become totally and permanently disabled so as to be entitled to Social Security Disability Income Benefits, the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare (whichever is sooner).

This extension is available only if: the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; and you or another family member notifies the Plan by sending a written notification to the Fund Office of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member (failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage); and that notice is received by the Fund Office before the end of the 18-month COBRA Continuation period. During the additional 11-month period COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% charge applicable to the COBRA family unit (but only if the disabled person is covered). The Fund Office must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

TERMINATION OF COBRA COVERAGE:

Your continuation coverage will end when one of the following occurs:

- The last day of the 18, 29, or 36 month period described above;
- You fail to pay the premium for your continuation coverage when it is due. However, there is a 30 day grace period before we will actually cut off coverage for failing to pay your premium;
- The date after you elect COBRA on which you first become covered under another group health plan;

1. Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act) requires the Fund to pay for at least a 48-hour Hospital stay following Childbirth (96-hour stay in the case of a cesarean section). The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's Benefits for a Hospital length of stay

that is connected to Childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a Physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn Child earlier. In addition, The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above. A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

2. Continuation Coverage Pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA)

In addition to COBRA, the Fund will provide continuation coverage pursuant to the terms of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) for all leaves while a Participant is serving in the uniformed services.

Service in the Uniformed Services. "Service in the uniformed services" generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Election Rights. You have 60 days to elect USERRA continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. A Participant "makes" his or her election as of the postmark date. If you elect USERRA continuation coverage within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If you do not elect USERRA continuation coverage within this period, your coverage under the Plan will end. If you do not make a timely election in a situation in which USERRA does not require you to provide advance notice of your service, your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

Maximum Continuation Period. The Fund will provide continuation coverage for a period of 24 months.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated Participants or Dependents that are not on service leave.

Cost. A person electing USERRA continuation coverage may be required to pay all or part of the cost of USERRA continuation coverage. If you perform service in the uniformed services for fewer than 31 days, you are not required to pay for the coverage. If your service exceeds 30 days, the amount charged cannot exceed 102% of the cost to the Plan of providing the coverage. Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. You will be given a grace period of 30 days within which to make the payment.

Termination of USERRA Continuation Coverage. The USERRA continuation coverage may be terminated before the end of the Maximum Continuation Period for any of the following reasons:

- you do not pay the premium for USERRA continuation coverage on time (including the grace period);
- you fail to return from service or apply for a position of employment as required under USERRA; or
- your coverage is terminated for cause under the generally applicable terms of this Plan.

Rights Upon Reemployment. If you are reemployed after service in the uniformed services and have met all of the conditions set forth in USERRA, you will be entitled to the same Benefits that you would be entitled had the service in the uniformed services not occurred.

A. Qualified Medical Child Support Orders ("QMCSOs").

The Fund shall provide Benefit Coverage in accordance with the applicable requirements of any Qualified Medical Child Support Order as set forth in the provisions that follow: The Fund requires submission of a Medical Child Support Order for determination of its qualification only if payments of Benefits for the Alternate Recipient are to be made to the non-Participant parent.

Definitions:

Alternate Recipient. Any Child of a Participant who is recognized by a Medical Child Support Order as having a right to enrollment as a Dependent of the Participant under this Plan.

Interested Party. Any Participant, any Alternate Recipient; or any custodial parent or non-custodial parent of an Alternate Recipient, if such parent is the petitioner in the Medical Child Support Order proceeding.

Medical Child Support Order. Any judgment, decree, order, or administrative order (including approval of a domestic relations settlement agreement), which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive Benefit Coverage as a Dependent of the Participant under this Plan, which Order is made pursuant to a state domestic relations law or medical Child support law enacted under the Social Security Act of 1935, as amended.

Qualified Medical Child Support Order. A Medical Child Support Order that meets all of the requirements set forth in this section.

Requirements for Qualification:

What the Order Must Include. A Medical Child Support Order meets the requirements of this section only if such order clearly specifies:

- the name and last-known mailing address (if any) of the Participant, and the name and mailing address of each Alternate Recipient covered by the Medical Child Support Order;
- the name of the Fund to which the Medical Child Support Order applies;
- the name of the plan of the Fund to which the Medical Child Support Order applies;
- a reasonable description of the type of Benefit Coverage to be provided under the Plan to an Alternate Recipient, or the manner in which such type of Benefit Coverage is to be determined; and
- the time-period to which such Medical Child Support Order applies.

What the Order Must Not Include. A Medical Child Support Order meets the requirements of this section only if such order clearly does not require:

- the Fund to provide any type or form of Benefit Coverage, or any option for Benefit Coverage. not otherwise provided under this Plan; or
- the Fund to provide increased Benefits of any type; or
- the Fund to provide for the payment of Benefits to an Alternate Recipient that Benefits are required to be paid to another Alternate Recipient under another Medical Child Support Order previously determined to be a Qualified Medical Child Support Order with respect to the Participant.

Procedures. In the case of any Medical Child Support Order received by the Fund, the Fund will notify promptly the Participant, Alternate Recipient and any other Interested Parties of the

receipt of such order, and of the Fund's procedure for determining the qualified status of Medical Child Support Orders. Within a reasonable period after receipt of such order, the Fund will determine whether such order is a Qualified Medical Child Support Order, and shall notify Interested Parties of such determination. The Fund has established written procedures for determining the qualified status of Medical Child Support Orders and for administering Benefit Coverage under such Qualified Medical Child Support Orders. Alternate Recipients may designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to such Medical Child Support Order. The Fund will furnish the Alternate Recipient with copies of appropriate Plan documents. Alternate Recipients and related Interested Parties are bound by the Trust Agreement, the provisions of this Plan, and the rules and regulations of the Fund.

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

Pursuant to the Women's Health and Cancer Rights Act of 1998, the Plan provides coverage for: All stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Such coverage may be subject to annual Deductibles and Coinsurance provisions as may be deemed appropriate and are consistent with those established for other Benefits under the plan or coverage.

C. HIPAA Privacy Notice.

Below is the Notice provided to all Participants regarding how the Fund cares for your "protected health information." This Notice is also available on the Fund's website. We are providing this Notice from the Teamsters Local 710 Health & Welfare Fund (referred to in this Notice as the "Fund") in order to inform you about the way that your health information may be used by the Fund. A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), provides your health information with important protection.

> ***IMPORTANT NOTE***: 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.

The Fund is required by federal law to maintain the privacy of your protected health information ("PHI"). The Fund is also required by federal law to provide you with this description of the privacy policies and practices adopted by the Fund. The Fund must follow these policies and practices, but as permitted by law, the Fund reserves the right to amend or modify these privacy policies and practices.

Changes in our policies and practices may be required by changes in federal and state laws and regulations. Regardless of the reason for the change, we will provide you with notice of any material changes within 60 days of the date the change is adopted.

For more information, see: https://www.hhs.gov/hipaa/for-individuals/index.html

Under HIPAA, how can the Fund use my protected health information ("PHI")? The Fund can use your PHI to facilitate your treatment, to make or obtain payment for your treatment and for health plan operations, including administration, oversight, and other legal purposes.

How may the Fund use my protected health information ("PHI") with respect to payment for my treatment? The Fund may use your PHI for the broad range of actions needed to make sure that the Fund can make payment for the services received by you and your family. The Fund may use your PHI for making payment to providers for services or treatment you received, for making arrangements for payment through one of the Networks of providers through which the Fund provides Benefits to you, as well as for coordinating payment to providers though other

health plans under the Fund's coordination of Benefits rule. **For example**, the Fund provides participants with access to a Network of providers outside of this immediate geographic area. The Fund may provide your PHI to the Network and directly to the provider in order to ensure that the provider receives the appropriate payment for the services that have been provided to you.

How does HIPAA permit the Fund to use my protected health information ("PHI") with respect to "health care operations?" The Fund may use your PHI for a broad range of actions required to assess the quality of the Fund's plan of Benefits as well as for its administration and operations. These activities include, but are not limited to, ensuring that participants or their beneficiaries are Eligible for Benefits prior to making payment; taking corrective action to recoup overpayments and assessing health plan performance; reviewing the Fund's plan of Benefits and determining whether a reduction in costs is possible; continuing case management and coordination of care; commissioning and reviewing actuarial studies relating to the cost of Benefits and management studies relating to the operation and administration of the plan; resolving internal grievances; and undertaking medical review, legal, and auditing functions.

For example, the Fund may use PHI to determine the most cost-effective manner of providing Benefits to its participants and beneficiaries.

May the Fund use my protected health information ("PHI") for purposes besides payment and health care operations? Yes. HIPAA permits the Fund to use your PHI for a number of other purposes, including informing you of treatment alternatives or other health–related Benefits that may be of interest to you.

Because I am always on the road, my Spouse often calls to find out the status of my health claims and to get other information about me or my Benefits. Can the Fund release information relating to payment of my claims to my Spouse? Unless you tell the Fund otherwise, the Fund will provide claims payment information to your Spouse **without** requiring an authorization from you. If you do NOT wish the Fund to provide your Spouse with this information, you must tell the Fund in writing that you do NOT wish the Fund to release claim payment information to your Spouse.

> ***IMPORTANT NOTE:*** *If you wish the Fund to release other information to your Spouse, you must file an authorization form with the Fund office. You can obtain release forms by calling the Fund office.*

May I call the Fund to get information about my Children's health claims? The Fund will provide a minor Child's parent, guardian (or person standing in *loco parentis* with respect to the Child) with payment information about the Child's claim. The Fund will carefully consider your written request for information other than claims payment information and will respond as permitted by these privacy policies and applicable state law.

> ***IMPORTANT NOTE****: If your Child is not a minor, the Fund generally cannot provide you with the Child's PHI, even if the Child is still covered under this Fund as your Dependent.*

Does HIPAA permit the Fund to disclose my protected health information ("PHI") to my Employer or insurer? Under HIPAA, the Fund generally cannot disclose your PHI to your Employer without your written authorization. It is important to note, however, that HIPAA does permit that the Fund disclose your PHI without your authorization to workers' compensation insurers, state administrators, or others involved in the workers' compensation systems to the extent the disclosure is required by state or other law.

May the Fund release my protected health information ("PHI") to the Fund's plan sponsor? HIPAA does permit the Fund to disclose information to the "plan sponsor" for administrative functions. Here, the "plan sponsor" is the Fund's Board of Trustees. The Fund may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids or modify, amend, or terminate the Plan.

May the Fund release my protected health information ("PHI") to law enforcement or other governmental entities? Your PHI may be disclosed to law enforcement agencies, without your authorization or permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting. The Fund may not disclose your PHI if you are the subject of an investigation that does not arise out of or is directly related to your receipt of health care or public Benefits. In addition, the Fund may disclose your PHI in the course of a judicial or administrative proceeding if the Fund receives a court order, subpoena, discovery request or other lawful process. Before releasing this information, the Fund will make reasonable efforts either to notify you or to obtain an order protecting your PHI.

Would the Fund release my protected health information ("PHI") if my health or safety or public health or safety would be jeopardized if it did not? If the Fund has a good faith belief that your health or safety or public health or safety would be jeopardized if it did not disclose the information, the Fund will do so, after consideration of appropriate legal and ethical standards.

Must the Fund have an authorization to release my protected health information ("PHI")?

Yes, in many circumstances. **For example**, the following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of PHI;

Any other disclosure or use of your PHI for any other purpose not described in this notice requires your written authorization. This means that if you want your friend, relative, or union representative to check on the status of a claim you submitted or to advise when or if payment will be made, you must sign an authorization form and submit it to the Fund Office. If you change your mind after authorizing a use or disclosure of your PHI, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to the Fund of your decision to revoke the authorization.

May the Fund use or disclose my genetic information for underwriting purposes? No. The Fund is prohibited from using or disclosing genetic information for underwriting purposes.

Do I have the rights under the federal privacy standards? Your rights to information under HIPAA include:

- the right to request restrictions on the use and disclosure of your PHI. The Fund will carefully consider, although is not required to honor, your request for restrictions;
- the right to restrict confidential communications concerning your medical conditions or treatment if you believe that disclosure of this information could endanger you (this means, **for example**, that you can make a written request that the Fund send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your PHI remains confidential). The Fund will attempt to honor reasonable requests;
- the right to opt out of receiving fundraising communications prepared the Fund;
- the right to inspect and copy your PHI. The Fund may charge a reasonable fee for copying, assembling and postage;
- the right to an electronic copy of electronic medical records. The Fund will make every effort to provide access to PHI in the form or format you request, if it is readily producible in such form or format;
- the right to get notice of a breach of any of your unsecured PHI;

- the right to amend or submit corrections to your PHI. If you believe that the information in your records is inaccurate or incomplete, you may submit a written request to correct these records. The Fund may deny your request if, **for example**, you do not include the reason you wish to correct your records or if the records were not created by the Fund;
- the right to receive an accounting of how and to whom your PHI has been disclosed if it was disclosed for reasons other than payment or health care operations. Your written request for information must be submitted to the Fund and should state the period of time for which you are requesting an accounting;
- the right to file a complaint that your privacy rights have been violated to the Fund and to the Secretary of U.S. Department of Health & Human Services.

  IMPORTANT NOTE*: you will not be penalized or otherwise retaliated against for filing a complaint;*
- the right to receive a printed copy of this notice.

Complaints? Comments? Requests? The Fund has designated Brian O'Malley, Administrator as the Privacy Officer. If you wish to request information that you have a right to receive, want to file a complaint with the Fund or if you have any comments or questions regarding this notice, contact Mr. O'Malley. The Fund can assess reasonable charges for copying and assembling documents you request as well as for postage.

D. Genetic Information Nondiscrimination Act Of 2008

The Fund takes the required measures to comply with Genetic Information Nondiscrimination Act of 2008 (GINA), to prohibit discrimination in health coverage based on genetic information. Pursuant this law and the applicable regulations promulgating this statute, the Fund does not collect genetic information for underwriting purposes (prior to or in connection with enrollment); request or require genetic testing; or for adjusting group insurance premium or Contribution rates.

E. THE U.S. DEPARTMENT OF LABOR STATEMENT OF YOUR RIGHTS UNDER ERISA

The U.S. Department of Labor requires that the following notice be provided to you.

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

1. Receive Information About Your Plan and Benefits

A. Examine, without charge, at the Fund Office and at other specified locations, such as worksites and your Local Union office, 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 Participant Benefit Security Administration.

B. Obtain, upon written request to the Trustees, copies of documents governing the Plan, including insurance contracts as they relate to your Benefits and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The Trustees may impose a reasonable charge for the copies.

C. Receive a summary of the Fund's annual financial report. The Board of Trustees is required by law to furnish each Participant with a copy of the summary annual report.

2. Continue Group Health Plan Coverage

   A. Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

3. Prudent Actions by Plan Fiduciaries.

   A. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and solely in the interest of you and the other Plan Participants and Dependents. 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 health and welfare benefit or exercising your rights under ERISA.

4. Enforce Your Rights.

   A. If your claim for a health and welfare benefit is denied 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.

   B. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Board of Trustees to provide the materials and pay you up to $110 a day (indexed for inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Board. 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 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 this Plan, you should contact the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in

obtaining documents from the Board of Trustees, 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.

The Teamsters Local 710 Health & Welfare Fund ("Fund") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Teamsters Local 710 Health & Welfare Fund:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Brian O'Malley, Administrator.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Brian O'Malley, Administrator. You can file a grievance in person or by mail or email. Teamsters Local 710 Health & Welfare Fund, 9000 187th St, Mokena, IL 60448 (Phone: (773) 254-2500); Email: local710funds@710hwp.org. If you need help filing a grievance, Mr. O'Malley is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://www.hhs.gov/ocr/index.html, or by mail or phone at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html .

Nondiscrimination statement for significant publications and signification communications that are small-size:

The Teamsters Local 710 Health & Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

GLOSSARY

The following words and phrases shall have the following meanings when used in this SPD unless their context clearly indicates otherwise. These words are capitalized throughout the text of the SPD.

Accident (Accidental). An event that is external, sudden, violent, by chance, and unexpected, and that causes injury.

Administrator. The person or persons appointed by the Trustees pursuant to the Trust Agreement to perform certain administrative or managerial duties for the Fund. The Administrator is not the Plan Administrator as that term is defined in ERISA § 3(16).

Benefits. The dollar amounts that the Fund will pay under the terms of the Plan. The Trustees establish the level of Benefits in their sole discretion.

Benefit Coverage. Coverage provided under the Plan for Eligible Participants or Dependents.

Benefit Period. A time period established by the Fund during which a Participant or his or her Dependent may be Eligible for Benefits under the Plan.

Benefit Year. A year-long period established by the Fund for tracking the payment of Benefits. The Benefit Year begins on January 1 and ends on December 31.

Child. May include the following individuals who are under age 26 and are:

A. A natural or adopted child of a Participant;

B. A stepchild, that is, the child of the Participant's Spouse;

C. A child who has been placed with the Participant for adoption. The term "placed for adoption," means the assumption and retention of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation. The Participant must provide the Fund with written updates about the progress of the adoption process at least once every six months.

D. A Disabled Child: For purposes of this Plan, a Disabled Child is a Child who is incapable of independent self-support; the Child is unmarried; the Child's Earned Income does not exceed a yearly maximum of $12,000; the Child was Eligible for Benefits Coverage before reaching age 26; and the Child was mentally or permanently physically handicapped before reaching age 26.

Code. The Internal Revenue Code of 1986, as amended, and the rules and regulation and guidance promulgated thereunder.

Coinsurance. The percentage of costs of a covered health care Service for which you are responsible (for example, 10%) after you have paid your Deductible**.**

Contribution. A payment made or required to be made by a Participant or on the Participant's behalf, in an amount and on a schedule determined by the Trustees.

Copayment. A charge for Services for which a Participant or Dependent is responsible and that is collected by a Provider.

Deductible The amount you pay for covered health care services before your insurance plan starts to pay. With a $250 Deductible, for example, you pay the first $250 of covered services yourself.

Dependent. A "Dependent" may include: your Spouse and your Child, as defined in this Plan.

Durable Medical Equipment. Equipment that can withstand repeated use, is not generally useful to the Participant or Dependent in the absence of an injury or illness, and is appropriate for use in the home. Examples of Durable Medical Equipment are wheelchairs, canes, and walkers.

Eligible (Eligibility). An Participant or his or her Dependent is Eligible for Benefits when the Participant has met the Eligibility requirements set forth in Section 3 of this SPD.

Emergency. "Emergency" means an unforeseeable condition or complaint of pain that causes a reasonable person to fear serious injury, illness or death. Emergencies include heart attacks, strokes, and gashes requiring treatment to stop or control bleeding and broken limbs. Conditions like colds and the flu are not considered "Emergencies" under the Plan.

ERISA. The Employee Retirement Income Security Act of 1974, as amended, and the rules and regulations and other guidance promulgated thereunder**.**

Experimental or Investigational. In determining whether a treatment is Experimental or Investigational under the Plan, the Fund's Medical Advisors will use the following process:

Step 1: The Fund's Medical Advisors will examine if the treatment has been formally studied and reported in the literature recognized as authoritative by the medical profession. If the answer is no, the Fund's Medical Advisors will conclude that the treatment is Experimental or Investigational, and the Fund will deny Benefits. If the answer is yes, the Fund's Medical Advisors will move to Step 2.

Step 2: The Fund's Medical Advisors will examine if the treatment has undergone government review by the National Institutes of Health or Medicare. If the answer is yes, the Fund's Medical Advisors will follow the conclusion of these agencies on the usefulness of the treatment. If the answer is no, the Fund's Medical Advisors will move to Step 3.

Step 3: The Fund's Medical Advisors will examine if the treatment is under a National Institutes of Health formal medical protocol, and if it has been cleared by an institutional review board as an experiment. If the answer is no, the Fund's Medical Advisors will conclude that the treatment is Experimental or Investigational, and the Fund will deny Benefits. If the answer is yes, the Fund's Medical Advisors will move to Step 4.

Step 4: The Fund's Medical Advisors will examine how an expert in the field evaluates this treatment as compared to more traditional treatments. If the expert selected by the Fund's Medical Advisors believes that the treatment is more effective than traditional treatments, the Fund's Medical Advisors will conclude that the treatment is not Experimental or Investigational. If the expert believes the treatment is not more effective than traditional treatments, the Fund's Medical Advisors will move to Step 5.

Step 5: The Fund's Medical Advisors will examine whether the treatment is Experimental or Investigational in their opinion. If, after reviewing all the Steps set forth above and any other relevant considerations, the Fund's Medical Advisors determine that the treatment is Experimental or Investigational, the Fund will deny Benefits.

Family. (Family Members). A Participant and all of his or her Eligible Dependents.

Fund. The Teamsters Local 710 Health and Welfare Fund, and its successors. *See also "Plan."*

Hospital. A facility that provides medical and diagnostic care for injured or ill persons on an inpatient basis; is supervised by a staff of Physicians and provides 24-hour-per-day nursing care under the supervision of registered nurses; provides diagnosis and treatment of surgical, medical, or mental (including substance abuse) conditions, and that is approved by The Joint Commission, or other appropriate accreditation body, or licensed to operate in the state in which it is located. The term Hospital includes an Ambulatory Surgical Center.

> ***IMPORTANT NOTE****: The term Hospital does* ***not*** *include residential or nonresidential treatment facilities; nursing homes; skilled nursing facilities or facilities that primarily provide custodial, domiciliary, or convalescent care, or that provide residential diet or exercise Services or care, except Medically Necessary sub-acute or hospice care that has been pre-certified by the Fund's Medical Advisor and/or is provided in a manner consistent with the Fund's policies, rules and regulations.*

Lifetime. A Participant or Dependent's Lifetime while covered under this Plan.

Local Union. A local union affiliated with the International Brotherhood of Teamsters that represents individuals Eligible for Benefits under this Plan, or a joint council or Conference of the international union with which such a local union is affiliated. This term will include

Teamsters Local No. 710, also known as Local No. 710, when not acting in its capacity as a Settlor of the Fund.

Medical Advisor. The Physician or other qualified individual or corporation that the Trustees engage to advise the Administrator and the Trustees on whether Services or Treatments are "Medically Necessary" or "Experimental or Investigational" as such terms are defined in this Plan as well as whether the Services or Treatments are consistent with the Fund's Plan of Benefits.

Medically Necessary. Services, Treatment and Items (collectively referred to as "Service") are "Medically Necessary" if they meet **all** of the criteria listed below:

A. The Service is provided in accordance with medical and surgical practices and standards prevailing in the community where the Service is provided at the time the Service is provided; and

B. The Service is commonly and customarily recognized throughout the Physician's specialty as appropriate in the treatment of the diagnosed disease, injury or illness; and

C. The Service is furnished to the Participant or Dependent at an appropriate level of care; and

D. The Service is not Experimental or Investigational or custodial in nature; and

E. The Service is not mainly for the purpose of medical or other research (except to the extent that Benefits for such Service must be provided under section 715(a)(1) of ERISA and section 9815(a)(1) of the Code relating to coverage while individuals are participating in a clinical trial); and

F. The Service must not be provided for the convenience of the Physician, Hospital or any other Provider or individual; and

G. The Service is determined, in the sole discretion of the Trustees acting upon the advice of the Fund's Medical Advisors, to be Medically Necessary.

Network. The individuals, organization, or organizations with which the Fund contracts to provide Services to Participants and Dependents at advantageous rates.

Network Providers. The Physicians, Hospitals and other Providers of health Services to Participants and Dependents who are affiliated with the Network.

Network Rate. The amount of Benefits for a Service negotiated with a Network Provider, which amount the Network Provider will accept as payment in full for the Service.

Non-Network Providers. The Physicians, Hospitals and other Providers of health Services to Participants and Beneficiaries who are not affiliated with the Network.

Other Insurance. "Other Insurance" includes any of the following types of coverage:

A. Any group insurance coverage, including any plan covering individuals as Participants of an Employer or as members of any other group that provides Hospital or medical care Benefits or Services on an insured or a prepayment basis;

B. "Other Insurance" does **not** include the coverage of a Spouse or Dependent under a "health savings account" as that term is defined under Code Section 223 and regulations thereunder. If (a) all of the plans covering the Spouse are high-deductible health plans or the Spouse elects a high-deductible health plan offered by the Spouse's employer and (b) the Spouse intends to contribute to a "health savings account" as that term is defined in the applicable federal law and regulations, this Plan cannot coordinate Benefits

with or provide any reimbursement for the primary high-deductible health plan's Deductible.

C. Any coverage under a labor-management Trustee plan or other welfare plan, Employer plan, Employer organization plan, or other arrangement for Benefits for individuals or a group, whether insured, partially insured, self-insured, non-insured, or otherwise;

D. Any coverage under any governmental program, including, but not limited to, worker's compensation, occupational disease, or similar programs; provided, however, that such coverage shall not be deemed Other Insurance for purposes of this Plan if applicable law mandates that the Plan provide Primary coverage;

E. Any Other Insurance, private or otherwise, carried by the Participant or an Eligible Dependent of a Participant, including, but not limited to, motor vehicle coverage (including fault, no-fault, financial responsibility, catastrophic, liability, collision or other coverage).

Participant. An individual who meets the Eligibility requirements of Section 3 who may be Eligible for Benefits for him or herself and his or her Dependents under the terms of the Plan.

Patient. A Participant or Eligible Dependent receiving medical care.

Personal Comfort. "Personal Comfort" refers to a Service or Treatment that the Trustees, acting in reliance upon the Plan's Medical Advisors, find does not materially advance medical treatment of the Patient's condition when compared to other Services, but is primarily prescribed or sought for the Patient's comfort or convenience (examples of Personal Comfort Services include, without limitation, air conditioners, dehumidifiers, and electronic controlled thermal therapy).

Physician. A practitioner of the healing arts who is appropriately qualified, properly licensed, and accredited or certified to practice such profession in accordance with the laws of the state governing his or her licensure and in accordance with all other applicable laws. The term Physician includes, **for example**, a Physician, surgeon, dentist, psychologist, nurse midwife, optometrist, podiatrist, or chiropractor.

Plan. The Teamsters Local 710 Health and Welfare Fund, including the Plan for Pensioners, as it may be amended from time to time. The Fund is a multiemployer self-insured health and welfare plan governed by ERISA. *See also* "Fund."

Provider. A person or organization that provides health care Services.

Qualified Beneficiary. An individual who was covered by the Plan on the day before a Qualifying Event occurred and who is either an Participant, the Participant's Spouse or former Spouse, or the Participant's Dependent Child.

Qualifying Event. Events that cause an individual to lose Coverage under the Plan and may trigger an individual's right to elect Coverage under COBRA.

Qualified Medical Child Support Order (QMCSO). A court or administrative order requiring the Fund to provide Benefit Coverage for a Dependent, which order the Trustees have determined complies with ERISA § 609(a).

Service(s). Any medical care, treatment, Hospitalization, or item provided to a Participant or Eligible Dependent.

Spouse. Your Spouse is the person to whom you are legally married under the laws of the state or country in which you were married.

Trustees. Those persons, including Employer Trustees and Participant Trustees appointed by the Teamsters Local 710 and the Employer Trustees, respectively, to administer the Fund.

Usual, Customary and Reasonable Rate (UCR). The rate that the Trustees may determine, in their sole discretion, is the appropriate compensation for various Services provided under the Plan. Unless otherwise indicated in this SPD, the percentile is 80%. The database is obtained from organizations that compile data on the fees that are paid for specific medical Services throughout the country. As of the effective date of this SPD, the Fund uses a database compiled by Fair Health. If there is no UCR for the particular Service rendered, the Plan will pay Benefits to Non-Network Providers a percentage of billed charges.

Construction.

1. The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender, unless the context clearly indicates otherwise.
2. The singular shall be deemed to include the plural, and the plural the singular, as the context may require.