

**TEAMSTERS JOINT COUNCIL NO. 83 OF VIRGINIA
HEALTH & WELFARE FUND**

**RETIREE HEALTH BENEFITS
Summary Plan Description**

Effective September 1, 2017

Chapter 1 General Information

The Summary Plan Description (SPD) describes your rights under the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund (the “Fund”) as a retired participant eligible for retiree health benefits under the Retiree Health Benefit Plan (“Plan” or “Retiree Plan”) and explains how you and your dependents become eligible for benefits, what the benefits are, and how to file a claim for benefits.

The SPD is divided into 11 chapters.

- Chapter 1 contains general information about the Fund;
- Chapter 2 explains the Fund’s eligibility rules for you and your dependents;
- Chapter 3 explains the types of benefits that are offered by the Fund;
- Chapter 4 explains the programs provided by the Fund’s Medical Consultant;
- Chapter 5 explains the Fund’s Preferred Provider Organization;
- Chapter 6 explains the limitations that apply to all your benefits;
- Chapter 7 explains how to file a claim and how a claim is paid. It describes how claims are paid if you are covered by other insurance, or if someone other than the Fund is responsible for your medical expenses;
- Chapter 8 explains what to do if you disagree with the payment or nonpayment of a claim;
- Chapter 9 addresses privacy issues and provides you with the Fund’s rules regarding the use or disclosure of your protected health information;
- Chapter 10 provides you with important information required by the Employee Retirement Income Security Act of 1974 (ERISA).
- Chapter 11 provides miscellaneous information regarding the Fund.

The questions and answers in the SPD are not intended to change in any way your rights under the Retiree Health Benefits Plan Document and most contain a reference to the Plan Document to assist you if needed. In the event there is a difference between the Plan Document and the SPD, the Plan Document will control. All benefits are determined under the terms of the Plan Document and your Schedule of Benefits. Therefore, you must consult the actual Plan Document, and your applicable Schedule of Benefits for a definitive answer to any question you have concerning your rights. Only the full Board of Trustees is authorized to interpret the Plan Document, your Schedule of Benefits and SPD. No employer, union, or any representative of any employer or union, is authorized to interpret the Plan Document, your Schedule of Benefits, or SPD, nor can any such person act as an agent of the Board of Trustees.

We urge you to read the SPD carefully in order to generally familiarize yourself with the benefits that are available to you under the Fund. If you have any questions after reading this document or if you would like to discuss the details further, contact the Fund Office. We will be glad to help you.

1. What is the name and purpose of the health & welfare fund?

The full name of the health and welfare fund is: Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund. Throughout this document it will be referred to as “the Fund” or “the Fund Office”. The purpose of the Fund is to collect contributions from retired participants and the numerous employers that are obligated to contribute to the Fund through collective bargaining and participation agreements. The contributions and premiums that are received are invested and used to provide the benefits listed in Chapter 3 for those meeting the eligibility requirements listed in Chapter 2. No other funding source is used to provide benefits, other than COBRA payments. Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund is a self-administered, self-insured fund.

2. Where is the Fund Office located?

8814 Fargo Road, Suite 200
Richmond, VA 23229

3. What telephone numbers do I use to contact the Fund Office?

804-282-3131 or toll free 800-852-0806

4. Who is the Fund administrator?

The Fund administrator is the Board of Trustees. You may contact the Trustees through the Fund Office as follows:

Board of Trustees
Teamsters Joint Council No. 83 of Virginia
Health & Welfare Fund
8814 Fargo Road, Suite 200
Richmond, Virginia 23229

5. Who are the Trustees?

The Board of Trustees is made up of six individuals, three Union Trustees and three Employer Trustees. The Union Trustees are appointed by Teamsters Joint Council No. 83 of Virginia and the Employer Trustees are appointed by Transport Employers Association. The Trustees are:

Union Trustees:

John D. Farrish
Teamsters Local Union No. 29

James R. Smith
Teamsters Local Union No. 592

James Wright
Teamsters Local Union No. 822

Employer Trustees:

W. Robert Davidson

William A. Nations
ABF Freight System

Jay Bowers
United Parcel Service

6. Who are the various employers and employee organizations that sponsor the plan?

A complete list of employers and employee organizations may be obtained upon written request. Please send your request to the address provided in Question 2.

7. Is the Plan maintained through collective bargaining and participation agreements?

No. The Retiree Health Benefit Plan was created when the traditional Health & Welfare Plan was divided into two separate plans – one for actives and one for retirees – effective January 1, 2011. The resulting Active Employee Health Benefit Plan is maintained through collective bargaining agreements while the resulting Retiree Health Benefit Plan was created in response to changes required by the Affordable Care Act as a “retiree-only” plan. Funding for the Retiree Health Benefit Plan comes from employer contributions to the Active Health Benefit Plan and monthly retiree premiums.

Chapter 2 Eligibility for You and Your Dependents

This Chapter explains how you and your dependents become covered, remain covered and lose coverage.

Eligibility For Retiree Health Benefits Coverage

8. How do I qualify for retiree health benefits coverage under the Fund? (Section 2.1)

In order to qualify for retiree health benefits coverage, you must

1. Be retired, and
2. Have at least 35 weeks of contributions to the Fund in five of the last seven 52 week periods immediately preceding retirement, and
3. Not be eligible for Medicare, and
4. Be at least 57 years of age and have 20.0 years of Vesting Service in the JC83 Pension Fund, OR
5. Be any age and have 25.0 but less than 30.0 years of Vesting Service in the JC83 Pension Fund, OR
6. Be any age and have at least 30.0 years of Vesting Service in the JC83 Pension Fund.

If meeting either condition 4 or 5, a maximum of 96 months of coverage is available. If meeting condition 6, coverage is available until meeting any of the termination provisions of Section 2.5.

9. How do I elect retiree health benefits? (Section 2.8)

The Fund Office will give you an election form to complete. The completed election form must be received by the Fund Office at least 30 days before your retirement date (except for a reinstatement explained in Question 19).

If Retiree Health Benefit Plan coverage is being elected for your spouse (with or without children) the election form must be received by the Fund Office no later than 30 days prior to the effective date of coverage. Failure to elect retiree health benefits timely may result in such coverage not being available to you or your dependents.

10. When are retiree health benefit premiums due? (Section 2.1.A.3)

Retiree health benefit premiums are due by the first day of the month that is two months in advance of the month for which coverage is purchased. You have a ten day grace period, so that premiums received in the Fund Office by the tenth of the month are considered timely paid. If you receive a monthly pension benefit from the Teamsters Joint Council No. 83 of Virginia Pension Fund, your monthly retiree health benefits premium may be automatically deducted from your monthly pension benefit.

IMPORTANT: Failure to pay your premium on time will result in the termination of your retiree health benefits coverage. Retiree health benefits coverage that terminates because of a late premium payment cannot be reinstated under any circumstances.

11. When does my retiree health benefits coverage start? (Section 2.1.A.4)

As a general rule, your retiree health benefits start on the first day of the month following the end of your coverage under the Active Employee Health Plan. This is usually two months after your retirement date. However, if you do not elect retiree health benefit coverage solely because you are eligible for health benefits from another employee benefit plan, you may elect coverage under the Retiree Health Benefit Plan to begin at a later date. In order to do so, you must meet all of the reinstatement rules as described in Question 19.

For example:

Sue's active employment ends on August 1, and her coverage under the Active Health Benefit Plan continues until October 1, 2016. Sue wishes to commence coverage under the Retiree Health

Benefit Plan on October 1 once her Active Health Benefit Plan coverage ends. Sue must commence paying premiums under the Retiree Health Benefit Plan on August 1 so that she is covered under the Retiree Health Benefit Plan commencing on October 1.

12. When does my retiree health coverage end? (Section 2.5)

Your retiree health benefits coverage will end on the earliest of the following dates:

- your 65th birthday;
- the date you first become eligible for health benefits from Medicare;
- the date of your death;
- the last day of the month two months following any period for which the premium is not timely paid;

For example:

To purchase September coverage, your premium payment is due no later than July 1, however a 10 day grace period applies. Your payment is received July 14. Because your payment was not received by July 10, your coverage will end August 30 and you are not eligible for September coverage.

- under certain circumstances, the date your former employer ceases contributing on active employees. See Section 2.9 of the Plan Document;
- if meeting the conditions 4 or 5 of Question 8; or
- the day before the day in which you are eligible for comprehensive medical coverage from your current employer at a cost to you that is less than the premium charged by the Fund.

Please note the following applicable to the last bullet point item above:

- It is your responsibility to monitor and enroll during the Fund's "Open Enrollment" or other sign-up opportunities available under the Fund. The Fund will not extend coverage due to missed enrollment opportunities;
- This rule is applied by comparing the amount you must pay per month for health care coverage from your current employer to the amount you must pay for the retiree benefit coverage from the Fund;
- If you desire "single" retiree benefit coverage under the Fund, the Fund compares this to the cost of "single" coverage from your current employer;
- If you desire "family" retiree coverage, the Fund compares this to the cost of "family" coverage from your current employer;
- Only your out-of-pocket cost, and not the level of coverage for each benefit plan compared, is considered when making the comparison;
- Retiree coverage through the Fund may be purchased as "secondary" coverage to another health plan treated as "primary".

13. Can my spouse qualify for retiree health benefits? (Section 2.1.B.1)

Yes. The person who is your legal spouse on the date of your retirement is eligible for retiree health benefits as long as your spouse is:

- younger than age 65; and
- not eligible for health benefits from Medicare.

14. When does my spouse's retiree health benefit coverage start? (Section 2.1.B.4)

As a general rule, your spouse's retiree health benefit coverage starts on the same day your retiree health benefits begin unless you elect to postpone your coverage. Refer to Question 19 to ensure you understand how to reinstate retiree coverage for yourself and dependents. There are two exceptions to this rule:

- if you never become eligible for retiree health benefits coverage because you retire at or after age 65, your spouse's coverage will start on the date that your coverage for retiree health benefits would otherwise have started (see Question 9);
- if you never become eligible for retiree health benefits coverage solely because you die before retiring, your spouse will become eligible for retiree health benefits the first day of the month following your death.

15. When does my spouse's retiree coverage end? (Section 2.6.A)

Your spouse's retiree health benefits coverage will end on the earliest of the following dates:

- your spouse's 65th birthday;
- the date your spouse becomes eligible for Medicare;
- the date that is 3 years after the date your coverage stops;
- if you never became eligible for benefits because you retired on or after the age of 65, or because you died before your effective date, your spouse's coverage terminates 3 years after the start of your spouse's retiree health benefits;
- the date you and your spouse divorce;
- the date of your spouse's death;
- the last day of the month two months following any period for which the premium is not timely paid (see example in question 12); or
- under certain circumstances, the date your former employer ceases contributing on behalf of active employees. See Section 2.9 of the Plan Document.

16. Can my dependent child qualify for retiree health benefits? (Section 1.13 and 2.1.B.2)

Yes, as long as they meet the requirements below.

A dependent child includes (a) a natural child, adopted child (or placed for adoption), a stepchild, a child for whom you have legal custody and who is living with you in a normal parent-child relationship and is not a tax dependent of any other taxpayer during the calendar year; and who is (b) under age nineteen, unmarried, living at your principal residence for more than half of the calendar year and not providing more than half of his or her own support during the calendar year.

Upon attaining age 19, a child may remain a dependent child while under age 23 if a student seeking a degree (as defined in the Plan section 1.13), or would have attended school but for a non-permanent Injury or Illness as set forth in the Plan.

A child who was eligible for benefits under the Retiree Health Benefit Plan as a dependent child may continue to be covered as a dependent child after attaining age 19, regardless of whether a student, if such child is physically or mentally incapacitated, as explained in Plan section 1.13.

Your dependent child may qualify for benefits upon satisfying the following requirements:

- either you, the retiree, or your lawful spouse is covered under the Retiree Health Benefit Plan;
- the child met the definition of a Dependent as listed in the Active Health Benefit Plan Document under Section 1.13 immediately prior to the retiree's pension or retirement effective date; and
- the child is not eligible for health benefits from Medicare.

17. When does my dependent child's retiree health benefit coverage start? (Section 2.1.B.4)

As a general rule, your dependent child's retiree health benefit coverage starts on the same day your retiree health benefits begin unless you elect to postpone your coverage. If you elect to postpone your coverage, refer to Question 19 to ensure you understand how to reinstate retiree coverage. There are two exceptions to this rule:

- if you never become eligible for retiree health benefits coverage because you retire at or after age 65, your dependent child's coverage will start on the date that your coverage for retiree health benefits would otherwise have started (see Question 9);
- if you never become eligible for retiree health benefits coverage solely because you die before retiring, your dependent child will become eligible for retiree health benefits the first day of the month following your death.

18. When does my dependent child's retiree health coverage end? (Section 2.6)

- the date that neither the retiree nor the retiree's spouse is covered by retiree health benefits under the Fund;
- the last day of the month 2 months following the month any period for which the premium is not timely paid (see example in Question 12);
- the date that a child is no longer an eligible dependent;
- the date that the dependent child becomes eligible for Medicare;
- under certain circumstances, the date your former employer ceases contributing to the Fund on behalf of active employees. See Section 2.9 of the Plan Document; or
- the date of the child's death.

19. Can retiree health benefits be reinstated? If yes, how? (Section 2.7)

Yes. Retiree health benefits can be reinstated if your, your spouse's and/or dependent child's coverage was deferred because of comprehensive medical coverage under another employee benefit plan, or you were unable to elect retiree health benefits as your primary coverage due to the availability of less expensive health coverage from any employer you work for after becoming eligible for retiree health benefits. When the other coverage ends, retiree health coverage will be reinstated if all eligibility requirements are met and

- the other coverage was maintained from the later of:
 - the date coverage was lost from the Retiree Health Benefits Plan, or
 - the date of your retirement with the Teamsters Joint Council No. 83 of Virginia Pension Fund.
- the Fund is notified of the desired reinstatement before the other coverage ends.

For Example: Harrison, a retired participant, and his wife, Cristin, did not elect retiree health benefits under the Fund because they were covered under Cristin's coverage through her employer. On June 1, Cristin retires and loses coverage under her employer's plan on that day. Can Harrison and Cristin now qualify for retiree health coverage under the Fund? Yes, if:

- they would have qualified for Retiree Health Benefit Plan coverage when Harrison retired under the Fund;
- they had continuously been covered under Cristin's employer's plan;
- they both are under age 65 and not covered by Medicare;
- Cristin's employer's plan was a comprehensive medical plan;
- Harrison notifies the Fund Office of his desire for Retiree Health Benefit Plan coverage prior to June 1, the date coverage ended under Cristin's employer's plan;
- the appropriate retiree premium is paid prior to the start of retiree coverage; and

- Harrison completes the proper Fund election forms prior to June 1, the date coverage ended under Cristin's employer's plan.

COBRA

20. What is "COBRA?" (Section 2.3)

The Consolidated Omnibus Budget Reconciliation Act, also known as COBRA, allows you to buy certain coverage with the Fund for certain periods of time if you or your dependents experience a "qualifying event."

21. I understand that the government has created a general notice that describes COBRA. What does the notice say?

The government's notice provides the following COBRA information:

Notice of COBRA Continuation Coverage Rights
** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Qualifying Children will become qualified beneficiaries under COBRA if they lose coverage under the Plan because of one of the following qualifying events:

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

When is COBRA continuation coverage available?

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. It is your obligation to notify the Fund of any qualifying event. However, the obligation to notify the Fund of the end of your employment or reduction in hours will also be satisfied if your employer provides the information in a timely filed contribution report covering the time frame in which the event occurred. In addition, the Fund is aware of your termination of Direct Pay benefits, so a notice is not required for this event.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care

Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information

For more information, contact the Fund's Senior Claim Analyst by phone at (804) 282-3131 or toll free at 800-852-0806, or in person at 8814 Fargo Road, Suite 200, Richmond, VA 23229.

22. What kind of COBRA benefits can my dependents and/or I buy from the Fund? (Section 2.3.B)

Your spouse and/or your dependents may choose the plan that covered them immediately prior to the qualifying event. They may choose dental (non-core) benefits in addition to medical (core) benefits.

23. Can my dependents purchase non-medical coverage on a COBRA plan? (Section 2.3.B)

They cannot elect non-medical coverage when purchasing COBRA benefits. They cannot purchase life insurance benefits, accidental death and dismemberment benefits, or short-term disability income benefits.

24. When does COBRA coverage end? (Section 2.3.E)

Your spouse and dependent child(ren) can continue COBRA coverage until a "Termination Event" occurs. "Termination Events" are:

- the end of the period of time as explained in Question 23;
- the date on which the Fund stops providing all health care coverage;
- the date on which your spouse or other dependents become covered by another group health plan. In some cases, COBRA coverage may be extended if the other plan has a waiting period or a pre-existing condition limitation;
- the date on which your spouse or other dependents qualifies for Medicare; or
- the first month for which a COBRA coverage premium is not paid in a timely manner.

IMPORTANT: Once your eligibility under COBRA terminates, it may not be reinstated.

25. How is COBRA coverage purchased? (Section 2.3.F & 2.3.G)

In order to purchase COBRA coverage:

- notify the Fund Office of a qualifying event within 60 days of the later of:
 - the date the qualifying event occurred; or
 - the date your dependents lose coverage due to the qualifying event;
- a qualified beneficiary must complete the COBRA coverage election form, which will be sent to qualified beneficiaries within 30 days of the Fund's notification of the qualifying event, and submit it to the Fund Office no more than 60 days after the later of the following dates:
 - the date that eligibility for benefits would have ended as a result of the qualifying event; or
 - the date of the notice from the Fund informing you of your right to elect COBRA coverage
- all COBRA coverage premiums must be received in a timely manner (see Question 26) .

26. When are COBRA premium payments due? (Section 2.3.G)

The first COBRA coverage premium includes payment for the current month plus the amount due for each month since you incurred a qualifying event. The first premium must be paid no later than 45 days after the date you elected COBRA coverage. A billing statement will be issued for this payment only.

Subsequent COBRA coverage premiums must be received by the Fund on the first day of the calendar month for which COBRA coverage is purchased. The Fund extends a grace period, however, so that you may keep your COBRA coverage as long as the premium is received by the Fund no later than the end of the month for which you are buying COBRA coverage.

****Please remember that you will not receive a bill for any of your COBRA premiums due after your first payment unless the premium changes. ****

27. Where do I send my notice of qualifying events?

Please send qualifying event information to:

Teamsters Joint Council No. 83 of VA Health & Welfare Fund
Attn: Senior Benefit Analyst
8814 Fargo Road Suite 200
Richmond, VA 23229

28. What should the notice contain?

The notice should contain your name, identification number, and the following additional information depending upon the qualifying event:

- divorce:
 - a copy of the divorce decree.

Qualified Medical Child Support Order

29. What is a Qualified Medical Child Support Order? (Section 2.4.B.1)

A Qualified Medical Child Support Order, QMCSO, is a legal document that establishes the right of a custodial parent or guardian, other than the Participant, to manage the health benefits available to your child. The person designated in the QMCSO is referred to as an Alternate Recipient.

30. What changes will occur if the Fund is in receipt of a QMCSO?

After receipt of a QMCSO, the following will occur:

- new health and prescriptions cards will be issued to the Alternate Recipient;
- future Explanation of Benefit (EOB) forms will be sent to the Alternate Recipient for health claims submitted on behalf of the child;
- if joint custody, Explanation of Benefit (EOB) form will be sent to both parents for health claims submitted on behalf of the child
- the Fund Office will record the Alternate Recipient as a person capable of discussing health related matters with the Fund Office either in person or by telephone; and
- Summary Plan Descriptions, Plan Documents, announcements, future newsletters, Summary Annual Reports, and other written material affecting the child's benefits will be sent to the Alternate Recipient.

31. To be qualified, what information must be provided in the order? (Section 2.4.C)

The following must be provided for a Medical Child Support Order to become qualified:

- 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 order. As an alternative, the name and mailing address of an official of a state or state agency may be used in place of the Alternate Recipient;

- a reasonable description of the coverage to be provided to each Alternate Recipient. If a description of the coverage is not available, the manner in which the type of coverage is to be determined will be acceptable; and
- the period of time covered by the order.

32. If the Fund received an order that required a change in the type of benefits provided by the Fund, would the order be qualified? (Section 2.4.D)

No. The order cannot change the type or form of benefits the Fund offers.

33. What are the Fund's responsibilities upon receipt of a medical child support order? (Section 2.4.E)

Within 5 business days after receipt of the order, the Fund must notify the Participant and each Alternate Recipient that the order has been received. It must also provide each person involved with a copy of the procedures used by the Fund to determine if the order can be considered qualified. The Fund must determine whether the order is a Qualified Medical Child Support Order within 15 business days after the receipt of the order.

34. Does the Fund have procedures available governing Qualified Medical Child Support Orders?

Yes, you may obtain a copy free of charge by submitting your request in writing to the following:

Coordination of Benefits Analyst

Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund

8814 Fargo Road, Suite 200

Richmond, VA 23229

Chapter 3 Benefits

This Chapter explains the types of benefits provided by the Fund.

The Trustees of the Fund reserve the absolute and sole right to terminate or change the benefits of any and/or all schedules at any time as they deem appropriate. In addition, the Trustees may terminate the health and welfare benefits at any time.

In the event the Fund is terminated, the available assets shall be used to pay the obligations of the Fund existing at the time of termination including but not limited to medical, dental, and administrative expenses. Remaining assets, if any, shall be used for the benefit of you and your families or beneficiaries and in no event, will remaining assets be provided back to contributing employers.

Comprehensive Rehabilitation Expense Benefit

35. What does the Comprehensive Rehabilitation Expense Benefit cover? (Section 3.12.B)

The Comprehensive Rehabilitation Expense Benefit covers the following services and supplies for necessary care and treatment, but only if the care and treatment is recommended by a physician or a qualified rehabilitation program specialist and approved by the Fund:

- charges by a registered physical therapist, registered occupational therapist, or registered speech therapist;
- treatment in an approved extended care or skilled nursing facility;
- charges by a registered nurse or licensed practical nurse (not a member of your family) for medically required professional services;
- physician's charges for professional services;
- charges for medically necessary durable equipment, prosthetic appliances, dressings, and prescription-only medicines that may not be covered by the Fund.

36. What is not covered by the Comprehensive Rehabilitation Expense Benefit? (Section 3.12.C)

The following charges are not covered by the Comprehensive Rehabilitation Expense Benefit:

- custodial care in any extended care facility, skilled nursing facility or nursing home;
- expenses that are not approved by the Fund's medical consultant for coverage under the Comprehensive Rehabilitation Expense Benefit; and
- expenses that are listed in Chapter 6, "General Limitations."

Dental Expense Benefit

37. What does the Dental Expense Benefit cover? (Section 3.8.A, 3.8.C and 3.8.D)

The Dental Expense Benefit covers payment of dental services, such as preventative care, treatment of dental problems, and replacement of missing teeth. It also provides for the payment of endosseous surgery in preparation for and including dental implants, and treatment of jaw-joint problems, including temporomandibular joint syndrome ("TMJ"), craniomandibular disorders, and other similar conditions.

38. How much is provided under the Dental Expense Benefit? (Section 3.8.A)

Each charge submitted under the Dental Expense Benefit is subject to the Fund's fee schedule which limits payment to amounts considered reasonable and customary. In addition, benefits are payable up to the yearly family maximum amount listed in your schedule of benefits.

39. What is not covered by the Dental Expense Benefit? (Section 3.8.E)

The Dental Expense Benefit does not cover any of the following expenses:

- more than 2 examinations during any calendar year;
- more than 2 prophylaxis (teeth cleaning) during any calendar year;
- more than 1 full mouth x-ray and panorex x-ray during any three-year period;
- more than 2 sets of bite wing x-rays in one calendar year;
- expenses for the replacement of any prosthetic appliance, gold restoration, crown or bridge within 5 years following the date of the last replacement;
- expenses for the replacement of any prosthesis by a different prosthesis within 5 years (if the second prosthesis cost more than the first, the cost difference may be considered for payment);
- expenses incurred for dental services rendered for cosmetic purposes such as bleaching;
- charges for special, nonstandard techniques in denture construction that exceed the cost of standard techniques;
- charges for replacing lost or stolen appliances or repairing appliances damaged when not in the mouth;
- expenses for any crown, other than a stainless steel crown, for children less than 14 years of age, unless the teeth involved are permanent;
- expenses incurred for a dental service that is not performed by or under the supervision of a physician or dentist;
- temporary restorations or prosthesis except when necessary to replace tooth numbers 6, 7, 8, 9, 10, and 11, or tooth numbers 22, 23, 24, 25, 26 and 27 in preparation for an implant;
- charges for supplies normally used at home (for example, toothpaste, toothbrushes, waterpiks, mouthwashes);
- charges incurred for readjustments and realignments of dentures during the six month period following placement in the month;
- any charges that are related to orthodontics;
- expenses not payable according to Chapter 6, "General Limitations."

Extension of Dental Expense Benefits

40. When is coverage for the Dental Expense Benefit extended? (Section 2.2.A)

Coverage for the Dental Expense Benefit is extended only for expenses that are incurred for treatment that started before coverage with the Fund ended.

If a dependent's coverage ends because he or she is no longer a dependent, he or she will not be eligible for an extension of the Dental Expense Benefit.

41. When does coverage under the extension of the Dental Expense Benefit end? (Section 2.2.B. and 2.2.C)

Coverage under extension of the Dental Expense Benefit ends on the earliest of the following dates:

- the date that is 3 months after the date your active coverage with the Fund ended;
- for a dependent, the date he or she no longer meets the definition of "dependent",
- the date coverage ends for all employees of the contributing employer you worked for immediately prior to your eligibility for extension.

Diagnostic X-ray and Laboratory Expense Benefit

42. What does the Diagnostic X-Ray/Lab Expense Benefit cover? (Section 3.6.A)

The Diagnostic X-Ray/Lab Expense Benefit covers charges for x-ray and/or lab work:

- performed/read at a facility outside the confines of a doctor's office; or
- performed/read at a hospital and is unrelated to an emergency room visit or inpatient stay.

43. What is not covered by the Diagnostic X-Ray/Lab Expense Benefit? (Section 3.6.B)

The following expenses are not included in the Diagnostic X-Ray/Lab Expense Benefit:

- dental x-rays, except in connection with an accident;
- examinations that are not recommended and approved by a legally qualified physician;
- radium, radioactive-isotope or x-ray therapy, and chemotherapy;
- charges incurred while confined in a hospital, which are considered under the Hospital Benefit;
- x-rays or laboratory work performed within a physician's office or urgent care center, which are considered under the Physician Office Visit Benefit;
- x-rays or laboratory work performed as part of an emergency room visit which are considered under the Emergency Room Benefit;
- expenses not payable in accordance with Chapter 6, "General Limitations."

44. Is the Diagnostic X-Ray/Lab Expense Benefit subject to any cost-sharing provisions? (Section 3.6.A)

Yes. The Diagnostic X-Ray/Lab Expense Benefit is subject to the following:

- deductible;
- co-insurance (the percentage is dependent upon whether the provider participates with Anthem Blue Cross Blue Shield);
- out-of-pocket limit;
- lifetime maximum.

Disease Management Program

45. What is provided by the Disease Management Program? (Section 3.2.A)

The Fund's Disease Management Program provides free and confidential assistance in the management of certain chronic conditions such as:

- Asthma
- Diabetes
- Arthritis
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD), or
- Coronary Artery Disease (includes Hypertension, Hypercholesterolemia, History of MI Angioplasty, Bypass Surgery and Stroke)

46. Is the Disease Management Program subject to any cost sharing provisions? (Section 3.2.A)

No, the Disease Management Program is provided free of charge.

47. How do I participate in the program?

A review of medical and prescription data is performed to identify chronic conditions you or your dependents may have, as listed in Question 45. You will receive a letter as well as a phone call from the Fund's Medical Consultant regarding participation in the program or you may contact the Fund's Medical Consultant to enroll.

Emergency Room Benefit

48. What is covered by the Emergency Room Benefit? (Section 3.4.A)

The Emergency Room Benefit covers the emergency room charge and any related charges incurred as a result of an emergency room visit. This can include, but is not limited to, attending physician charges, x-rays and radiologists' fees.

49. What is not covered by the Emergency Room Benefit? (Section 3.4.B)

The following expenses are not included in the Emergency Room Benefit:

- charges made by a professional ambulance service; or
- the expenses not payable according to Chapter 6, "General Limitations".

50. Is the Emergency Room Benefit subject to any cost sharing provisions? (Section 3.4.A)

Yes, the Emergency Room Benefit is subject to the following:

- co-payment; and
- lifetime maximum.

Inpatient Hospital Expense Benefit

51. What does the Inpatient Hospital Expense Benefit cover? (Section 3.3)

The Inpatient Hospital Expense Benefit covers charges incurred for an inpatient hospital admission. It covers the following expenses, up to the amount listed in your schedule of benefits:

- charges billed by a hospital for room and board; and
- necessary services and supplies that result from your confinement in a hospital.

52. How much does the Inpatient Hospital Expense benefit pay for room and board charges? (Section 3.1 & 3.3.A)

Your schedule of benefits lists the percentage payable for the hospital confinement. A penalty will apply if you do not follow the pre-certification requirement. If your stay is not deemed medically necessary by the Fund's designated medical consultant, no payment will be made. Your schedule of benefits also lists the maximum number of days payable per year under the Inpatient Hospital Expense Benefit.

53. What are necessary services and supplies as related to the Inpatient Hospital Expense Benefit? (Section 3.3)

Necessary services and supplies related to the Inpatient Hospital Expense Benefit include charges for services and supplies provided by the hospital other than room and board during the inpatient stay including, but not limited to:

- anesthesia and its administration;
- diagnostic x-ray and laboratory work;
- x-ray, radium and radioactive isotope treatment;
- chemotherapy;
- blood transfusions;
- oxygen and other gases and their administration;
- use of any durable equipment such as wheelchairs;
- physical therapy;
- prosthetic appliances;
- dressings;
- charges for drugs and medicines lawfully obtainable only upon written prescription of a physician that are not covered by the Fund's Prescription Drug Expense Benefit;
- required professional ambulance service.

54. If I have to travel to a hospital for an inpatient admission, will the Fund pay for lodging expenses? (Section 3.1.D)

The Fund will reimburse you for the cost of lodging for the night before the inpatient hospital admission at a pre-approved hotel if you must travel more than 50 miles to the hospital where you will be admitted.

55. Will the Fund pay any expenses for an early admission for surgery or weekend admission? (Section 3.1.C.1 & 3.1.C.2)

No, the Fund will not pay for an early admission for surgery or a weekend admission to the hospital, unless the admission is certified as medically necessary or a medical emergency.

56. What is not covered by the Inpatient Hospital Expense Benefit? (Section 3.3.B)

The following expenses are not payable under the Inpatient Hospital Expense Benefit:

- charges for inpatient days that are not certified by the Fund's medical consultant;
- charges for days over the maximum number of days listed in your schedule of benefits;
- take-home drugs;
- personal comfort items;
- expenses not payable according to Chapter 6, "General Limitations."

57. Is the Inpatient Hospital Expense Benefit subject to any cost-sharing provisions? (Section 3.3.A)

Yes. The Inpatient Hospital Expense Benefit is subject to the following:

- co-insurance (the percentage is dependent upon whether the hospital participates with Anthem Blue Cross Blue Shield PPO Network);
- annual deductible;
- out-of-pocket limits;
- lifetime maximum.

Major Medical Expense Benefit

58. What expenses are paid under the Major Medical Expense Benefit? (Section 3.9.B)

The following expenses are payable under the Major Medical Expense Benefit:

- charges made by a hospital, not to exceed the amount shown in your schedule of benefits;
- charges made by a physician, psychologist, psychiatrist or ophthalmologist in accordance with his/her license for professional services;
- charges made by a licensed counselor or social worker;
- charges made by a Registered Nurse or a Licensed Practical Nurse, other than a member of your or your family, for professional services;
- charges made for anesthesia and its administration; radium and radioactive isotope treatment, chemotherapy, blood transfusions; oxygen and other gases and their administration; use of any durable equipment; physical therapy, speech therapy or occupational therapy, prosthetic appliances and dressings, artificial limbs or artificial eyes. If any of these items are approved by the Fund's medical consultant for services in the your home, the maximum amount payable shall be determined by the Fund's preferred provider network's allowable charge;
- charges made for drugs lawfully obtainable only upon the written prescription of a physician by you or your dependent for whom the Fund is the secondary Plan;
- charges made for professional ambulance service, only when medically necessary and not merely for the convenience of the patient, used to transport you or your dependent:
 - directly from the place where you or your dependent is injured in an accident or stricken by illness to the nearest hospital where necessary care and treatment can be given;

- from one hospital to another hospital when medically necessary; or
- from a hospital to the patient's home when medically necessary;
- charges made for contact lenses or cataract glasses and lenses when cataract surgery has been performed and for contact lenses when contact lenses are used as a prosthetic appliance for other medically necessary reasons;
- charges for braces, crutches, or the rental of a wheelchair, hospital-type bed, or artificial respirator. If any of these items are approved by the Fund's medical consultant for home use, the maximum amount payable shall be determined by the Fund's preferred provider network's allowable charge;
- charges made by a dentist or dental surgeon for repair of damage to the jaw and/or natural teeth as the direct result of an injury, the removal of impacted teeth, osseous surgery not connected with dental implants, or medical procedures relating to the treatment of the lips, tongue or cheeks;
- charges made by a nursing home or a skilled nursing facility for skilled care. A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care and rehabilitation services as well as other related health services. The skilled nursing care can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist. The skilled rehabilitation services received must be under the general direction of a physician. Eligible charges will not include convalescent or custodial care;
- charges for the administration of allergy injections, without regard to the place of service;
- out-patient cardiac rehabilitation, if approved by the Fund's medical consultant;
- charges made by a hospital for room and board or necessary services and supplies related to dental treatment, if approved by the Fund's medical consultant.

59. How much is payable under the Major Medical Expense Benefit? (Section 3.9.A)

Refer to the section in your schedules of benefits titled "Other Allowable Major Medical Expenses".

60. What charges are not included in the Major Medical Expense benefit? (Section 3.9.C)

The following expenses are not payable under the Major Medical Expense Benefit:

- expenses for eyeglasses or examinations for prescriptions or fittings of eyeglasses (except cataract glasses needed after cataract surgery);
- charges for the treatment of TMJ or craniomandibular disorders except for TMJ surgery and TMJ related diagnostic tests, x-rays, therapy, treatment and other procedures for which an American Dental Association charge code does not apply;
- charges for cosmetic surgery, except to repair damage received from an injury and as required by the Women's Health Act;
- charges for marriage counseling;
- charges by an optometrist who is not licensed to prescribe and administer drugs;
- charges for weight loss programs;
- charges for hospital days that exceed the maximum number of days provided for in the schedule of benefits;
- charges for, or in connection with the treatment of teeth or periodontium unless the charges relate to dental work necessitated by injury to the natural teeth.
- any related hospital room and board and/or necessary services and supplies, for, or in connection with the treatment of teeth or periodontium unless approved by the Fund's medical consultant;
- charges related to the treatment of learning disabilities;
- charges for which benefits are not payable under the Fund according to Chapter 6, "General Limitations."

If, according to your schedule of benefits, any of the eligible expenses listed in this section are covered under another benefit provided under your schedule of benefits, payment will be made under that other benefit instead of under the Major Medical Expense Benefit.

61. Is the Major Medical Expense Benefit subject to any cost sharing provisions? (Section 3.9.A)

Yes. The Major Medical Expense Benefit is subject to the following:

- annual deductible,
- lifetime maximum,
- co-insurance,
- annual visit limit (physical therapy, speech therapy, occupational therapy),
- out-of-pocket limit.

Newborns' and Mothers' Health Protection Act of 1996

62. Does the Fund provide benefits under the Newborns' and Mothers' Health Protection Act of 1996 (NHPA)? (Section 3.1.E)

Yes. The Act requires the Fund to cover hospital stays related to childbirth for a mother and her newborn child. The Fund must provide benefits for at least 2 calendar days following a vaginal delivery and 4 calendar days following a Cesarean section. Further, the Fund may not require authorization from the Fund's medical consultant to receive coverage for admission within the above limits. Shorter stays are allowable if the doctor and mother determine an earlier discharge is appropriate.

Out-of-Pocket Expense Benefit

63. What is the Out-Of-Pocket Expense Benefit? (Section 3.11.A)

The term "out-of-pocket" is the amount you must pay excluding your annual deductible or co-payments. Once your "out-of-pocket" payments equal the amount listed in your schedule of benefits, the Fund pays eligible claims at 100% of the allowable charge for the remainder of the year.

64. What expenses are not covered by the Out-Of-Pocket Expense Benefit? (Section 3.11.C)

The following charges are not applied towards the Out-of-Pocket Expense Benefit:

- co-payment when utilizing a network doctor or the emergency room;
- dental charges;
- charges that exceed the allowable charge;
- charges for services and supplies that are not covered by the Fund;
- charges in excess of schedule of benefits maximums;
- prescription drug co-payments and co-insurances;
- charges incurred prior to the date you or your dependents become eligible for benefits;
- charges that are the result of a reduction in payment due to non-compliance with the Fund's pre-certification requirements;
- charges applied to the annual deductible;
- charges for which benefits are not payable under the Fund as listed in Chapter 6 "General Limitations."

For Example: Steve, an employee covered under schedule ZR has satisfied the out-of-pocket maximum. He is admitted to an in-network hospital for a 3 day stay. If Steve had not already reached his out-of-pocket maximum, the claims associated with the hospital admission would be paid at 90% of the allowable charge. However, because Steve has satisfied his out-of-pocket maximum, the Fund pays 100% of the allowable charge.

Organ Transplant Expense Benefit

65. What does the Organ Transplant Expense Benefit cover? (Section 3.13.A, 3.13.B & 3.13.C)

The Organ Transplant Expense Benefit includes:

- coverage for charges related to the transplant of an organ, patient screening, obtaining the organ, transportation of the organ, and live donor expenses. If, however, the live donor has other health coverage for these expenses, the Fund will pay the live donor's expense as a secondary carrier (see Chapter 7).

66. Is the Organ Transplant Expense Benefit subject to any cost-sharing provisions? (Section 3.13.A & 3.13.B)

Yes, the Organ Transplant Expense Benefit is subject to the following:

- deductible,
- co-insurance,
- out-of-pocket limit,
- lifetime maximum.

67. What expenses are not covered under the Organ Transplant Expense Benefit? (Section 3.13)

The following expenses are not payable under the Organ Transplant Expense Benefit:

- expenses for transplants considered experimental or investigational as determined by the Fund's medical consultant;
- expenses for the transportation of surgeons or family members;
- expenses related to an organ transplant that is not performed at a transplant facility approved by the Fund's medical consultant;
- any charges in connection with follow-up care. "Follow-up care" is defined as expenses for immunosuppressant drugs and medical care provided in the home or hospital;
- any limitations set forth in Chapter 6 "General Limitations".

Physician Office Visit Benefit

68. What is covered by the Physician Office Visit Benefit? (Section 3.10)

The Physician Office Visit Benefit covers the office visit charge, as well as all lab work, x-rays, drugs (i.e., chemotherapy, allergy), administration charges (i.e., vaccines) and all other products or services provided within the confines of and billed by the doctor's office. In addition, the Physician Office Visit Benefit covers charges submitted by a licensed psychologist, licensed optometrist or ophthalmologist, licensed counselor or social worker, midwife and a registered or licensed practical nurse (other than a member of your family or in the case of a dependent, his/her family) for services performed in a doctor's office.

69. What if my doctor does not provide lab or x-ray services within the office but sends me to another provider for lab and/or x-ray services?

If your doctor sends you, your x-rays or your lab work to an independent lab or radiologist, the Fund will pay the x-ray and lab bills under the Diagnostic X-ray and Laboratory Expense Benefit. (See Questions 42 and 43.)

70. What is not covered by the Physician Office Visit Benefit? (Section 3.10.C)

The following expenses are not included in the Physician Office Visit:

- charges for the administration of allergy injections; and
- expenses that are not payable according to Chapter 6, “General Limitations”.

71. Is the Physician Office Visit Benefit subject to any cost-sharing provisions? (Section 3.10)

Yes. The Physician Office Visit Benefit is subject to the following:

- co-payment;
- co-insurance;
- deductible;
- out-of-pocket limit; or
- lifetime maximum.

Prescription Drug Expense Benefit

72. What is the Prescription Drug Expense Benefit? (Section 3.7)

The Prescription Drug Expense Benefit provides you, your spouse and other eligible dependents benefits for drugs and other allowable supplies through participating retail pharmacies in the Prescription Solutions Network or the Prescription Solutions Mail Order Pharmacy. Information regarding pharmacy locations may be obtained by calling the toll free number found on your prescription ID card. In addition, you may request a provider directory at any time free of charge from the Fund Office.

73. What expenses are covered by the Prescription Drug Expense Benefit? (Section 3.7.B)

The Prescription Drug Expense Benefit covers acute, maintenance and specialty drugs that are prescribed by a physician and are not available over-the-counter. It also covers insulin and diabetic supplies, including syringes, needles, and necessary test materials.

74. What are “acute”, “maintenance” and “specialty” drugs?

“Acute” drugs are prescribed for a period of 30 days or less and can be obtained at an in-network retail pharmacy. “Maintenance” drugs are prescribed for more than 30 days and can be obtained at either an in-network retail pharmacy or Prescription Solutions’ Mail Order Pharmacy. “Specialty” drugs are injectable medications. Some specialty drugs can be obtained at an in-network retail pharmacy. Other specialty drugs are required to be purchased from Prescription Solutions’ Mail Order Pharmacy. Please contact the Fund Office to verify the requirements for the particular drug you are prescribed.

75. Is the Prescription Drug Expense Benefit subject to any cost-sharing provisions? (Section 3.7.A)

Yes. The Prescription Drug Expense Benefit is subject to the following:

- co-insurance; or
- co-payment; and
- lifetime maximum.

76. What expenses are not covered by the Prescription Drug Expense Benefit? (Section 3.7.E)

The following expenses are not payable under the Prescription Drug Program:

- drugs supplied by a hospital or convalescent facility during an in-patient confinement;
- dietary supplements, vitamins (except vitamins specifically included in the Prescription Drug Expense Benefit) and immunization agents, as well as appliances and other non-drug items;

- drugs that can be purchased over-the-counter, even if you have a written prescription;
- patent medicines, biologicals, sickroom supplies (i.e., medicines or supplies provided by a school or clinic), nose drops, and other nasal preparations;
- drugs and medicines administered or supplied in a doctor's office;
- fertility drugs prescribed for the promotion of pregnancy;
- glucometers and similar types of blood testing devices;
- drugs used for cosmetic purposes;
- drugs not approved by the Fund's Prescription Benefit Manager under the Fund's prior-authorization program;
- drugs and medicines not payable in accordance with Chapter 6 "General Limitations;
- Spiraza.

Procedures Requiring Pre-certification or Notification

77. What procedures require pre-certification from the Fund's Medical Consultant?

The following procedures require pre-certification from the Fund's Medical Consultant if performed on or after September 1, 2017 if such benefits are provided for in the Plan Document and Schedule of Benefits:

- A. All inpatient admissions. This includes admissions for surgeries, skilled nursing facilities and treatment centers for psychiatric conditions and/or substance abuse disorders;
- B. Durable Medical Equipment (DME) rentals and purchases exceeding \$1,000.

Refer to Question 85 for information regarding penalties for failure to pre-certify these items.

Surgical Expense Benefit

78. What is covered by the Surgical Expense Benefit? (Section 3.5.A & 3.5.B)

The Surgical Expense Benefit covers the surgeon's charge for services performed, up to the allowable charge for the procedure. The surgery must be the result of an illness or injury (except sterilization) and can be performed in a hospital, qualified outpatient facility or a doctor's office. If considered medically necessary, the benefit also covers the charges of a Certified Surgical Assistant. In cases where the allowable charge is unavailable, the Fund may utilize its medical consultant to determine the maximum payment.

79. How are multiple procedures performed during the same surgery considered for payment? (Section 3.5.C)

The following expenses are not payable under the Surgical Expense Benefit:

- if 2 or more surgical procedures are performed at the same time through the same incision or in the same operative field, the Fund will only pay for the procedure with the highest allowable charge;
- if 2 or more procedures are performed because of the same or related injury or illness and in separate operative fields, the Fund's maximum payment will be the amount paid as if processing each procedure separately; and
- the Fund reserves the right to allow additional payment for procedures based on the time and complexity of the procedures as determined by the Fund's medical consultant.

80. Is the Surgical Expense Benefit subject to any cost sharing provisions or limitations? (Section 3.5.A & 3.5.F)

Yes, the Surgical Expense Benefit is subject to the following cost sharing provisions:

- deductible,
- co-insurance,
- co-payment,
- out-of-pocket limit,
- lifetime maximum.

The Surgical Expense Benefit is limited by “General Limitations” listed in Chapter 6.

Women’s Health Care Act and Cancer Rights Act of 1998

81. Does the Fund provide benefits under the Women’s Health Act and Cancer Rights Act of 1998?

Yes. If you or one of your eligible dependents receive benefits in connection with a mastectomy and elect breast reconstruction, coverage will be provided for the following:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas;
- any physical complications at all stages of mastectomy, including lymphedemas.

Payment for breast reconstruction follows the same guidelines established for all surgical procedures performed while covered by the Fund. All deductibles and maximums contained in your schedule of benefits for surgical procedures and the related charges also apply to breast reconstruction surgery and the related charges.

General Preventative Services

The Fund encourages you and your family to utilize the Fund’s comprehensive benefits to prevent the onset of costly and debilitating medical conditions. You can do this by:

- having an annual physical. Early detection provides more cost effective and successful outcomes;
- utilizing the free services of the Fund’s Disease Management Program for the management of chronic diseases. As a reward for your participation, you will be eligible for free generic medication whether or not related to the chronic condition managed by the program. In addition, each year you have an annual physical, you will receive a gift card for use at a pharmacy in your area; and filling and taking prescriptions as directed by your doctor.

Chapter 4 Designated Medical Consultant

82. What is the Designated Medical Consultant?

The Designated Medical Consultant provides programs designed to ensure you and your dependents receive quality and cost effective healthcare that is appropriate for your needs.

83. What programs are provided by the Designated Medical Consultant?

The following programs are provided by the Designated Medical Consultant:

- pre-certification,
- utilization management,
- case management,
- disease management (as described in Chapter 3).

84. What are the requirements for the pre-certification of my in-patient admission to a hospital? (Section 3.1.A & 3.1.E)

You or your covered dependents must contact the Fund's Designated Medical Consultant at 866-253-3198 to satisfy the pre-certification requirement. Refer to the guidelines below for information regarding your specific type of admission. The Fund's Designated Medical Consultant must be contacted:

- before an elective admission to the hospital (elective admissions are those that are scheduled in advance because there is no medical emergency);
- within 2 calendar days of an inpatient hospital admission for emergency treatment; or
- within 3 calendar days after the initial 2 calendar days following a vaginal delivery, or 3 calendar days after the initial 4 calendar days following a Cesarean section in cases where a newborn or mother remains in the hospital.

85. If I don't notify the Fund's Designated Medical Consultant as described, will there be a penalty? (Section 3.1.B)

Yes. Failure to contact the Fund's Designated Medical Consultant as referenced in Question 84 will result in a \$500 reduction of the Fund's payment for benefits relating to the inpatient hospital.

86. What information needs to be provided to fulfill the pre-certification requirement?

Whenever you call for pre-certification, please have the following information available:

- your name, address, and unique identification number (UID) and phone number;
- the name of your employer;
- the patient's name;
- the diagnosis (reason for treatment);
- type of surgery, if any, to be performed;
- date of admission;
- the name and phone number of the hospital; and
- the physician's name, address, and phone number.

87. By contacting the Fund's Designated Medical Consultant, does that ensure my hospital admission will be considered medically necessary?

No. However, contacting the Fund's Designated Medical Consultant does start the process of determining medical necessity. Please be aware that if your in-patient hospital admission is not deemed medically necessary, you may be completely responsible for payment of all charges connected with your

admission.

88. What are Utilization Management and Case Management?

Utilization Management helps to avoid unnecessary medical services. This is primarily accomplished by the monitoring and planning of your care by licensed nurses.

Case Management is a program used to evaluate your medical needs, coordinate medical resources such as home healthcare, the rental of medical equipment, and provide flexible, cost-effective health options.

The goals of case management are to:

- help the patient navigate the healthcare system;
- ensure an appropriate treatment plan is followed;
- ensure all care incorporates proven, up to date medical practices; and
- help locate the appropriate nurse and/or doctor to provide services.

Chapter 5 Preferred Provider Organization

89. What is a Preferred Provider Organization (PPO)?

A Preferred Provider Organization is a group of doctors, laboratories, home health providers, hospitals, and other medical providers that have agreed to accept a reduced payment for the services they provide. They hope that by agreeing to a discount, more patients will want to utilize their services.

90. Which PPO does the Fund use?

The Fund uses the Anthem Blue Cross Blue Shield PPO Network.

91. Am I required to use a PPO doctor, laboratory, home health provider, hospital or other medical provider?

No. You may use any provider you wish. However, the plan will reduce the level of benefits it pays if the provider is not a member of the Anthem Blue Cross Blue Shield PPO Network. Please refer to your schedule of benefits and look for references to the term “out-of-network” to determine benefits available when not using a network provider.

92. How do I learn which doctors, laboratories, and outpatient facilities are in the network?

There are several ways to locate a network doctor or facility:

- call Anthem at 1-800-810-2583 (choose option 2, then option 1);
- visit Anthem on the internet at www.anthem.com; or
- you may request provider directories at any time, free of charge, from the Fund Office.

Chapter 6 General Limitations

This chapter explains the charges that the Plan does not cover. These limitations apply to all of your benefits. Each benefit explained in Chapter 3 has its own limitations in addition to those listed in this Chapter 6.

93. What is not covered under the Plan? (Section 4.1)

General Limitations are as follows:

- treatment of an injury or illness that is job-related or covered by a worker's compensation or similar law. However, if you or your dependent is denied worker's compensation benefits after providing a timely and valid application to the appropriate worker's compensation carrier, the Fund may pay benefits after receipt of denial from the carrier provided that you or your dependent:
 - appeal the denial in a timely manner through all levels of the worker's compensation appeal system including the final appeal body available to you in your state's worker's compensation program;
 - sign a written document providing that if any of your appeals are successful, you will pay the lesser of:
 - the amount of benefits paid by the Fund on your behalf; or
 - the amount received from the appeal
- charges for which the Fund is prohibited from paying by the law of the jurisdiction in which you and your dependents live at the time the expenses are incurred;
- charges that you or your dependent are not legally required to pay (except for services furnished by a department or agency of the United States);
- charges that are over the allowable charge for your schedule of benefits;
- charges due to a failure to keep a scheduled medical visit;
- charges for the completion of claim forms, administrative services and service charges;
- charges that are for, or in connection with, any treatment for cosmetic purposes or cosmetic surgery unless it is required by law such as the Women's Health Act of 1998 or to repair damage received from an injury;
- charges in connection with work-related examinations such as a Department of Transportation physical;
- charges for experimental and investigational procedures or drugs unless deemed necessary by the Fund's medical consultant or in the case of drugs, Pharmacy Benefit Manager;
- charges for services and supplies provided by a hospital, physician or other provider of health care services that is not consistent with standards of good medical practice;
- charges for any treatment, procedure, surgery, in-patient hospital days, service and supplies provided by a hospital, physician, or other health care provider that the Fund's designated medical consultant determines are not medically necessary;
- charges that are the result of a reduction in benefit payments due to noncompliance with pre-certification rules or failure to use the preferred provider programs;
- charges for any treatment or service not prescribed by a physician;
- charges in connection with the reversal of sterilization procedures;
- charges in connection with the artificial insemination or any other means to promote pregnancy;
- charges for custodial care;

- charges for or in connection with endosseous surgery in preparation of, and including, dental implants, except as provided under the Dental Expense Benefit;
- charges that are for services not listed or otherwise described in the Plan Document;
- charges that were incurred the day after the last day eligibility is provided to any employee of a contributing employer that has withdrawn from the Fund. This rule does not eliminate any participant access to COBRA benefits as described in Questions 22 through 28 or to participants who are receiving retiree benefits and worked for an employer who began participation with the Fund before January 1994;
- charges incurred by you or any dependent which resulted from the participation in any illegal act;
- no payment will be made for any unnecessary procedure, treatment or supplies as determined by the Fund's Medical Consultant;
- charges in connection with the treatment of mental illness or substance abuse when the patient undergoing the treatment is not present;
- all services, procedures and prescription drugs related to gender reassignment prior to August 25, 2015;
- no payment will be made for any charge for service rendered by a member of the Participant or the Dependent's family;
- no payment will be made for expenses relating to procedures listed in Question 77 as requiring precertification unless approved by the Fund's Medical Consultant;
- Spinraza.

Chapter 7 Claim Filing and Claim Payment

This chapter describes how to file a claim, explains the time limits for filing, how benefits are paid, and the Fund's method of collecting overpayments.

94. What is a "claim"?

A "claim" is a request to the Fund for the payment of health benefits. A claim must be filed with the Fund before benefits can be paid.

95. Who files claims with the Fund?

Your doctor, dentist, hospital, etc. will usually file a claim on your behalf for the treatment and/or services you have been provided. In most cases, medical claims will be filed electronically. Dental claims must be mailed or faxed to the Fund Office. If the provider does not file a claim, it is your responsibility to obtain a completed claim form or itemized statement of services and submit it to the Fund Office.

96. How do I file a claim when the Fund is my secondary carrier?

If, under the Fund's coordination of benefits provisions, the Fund is your secondary carrier, you must follow these steps:

- file a claim with the primary carrier;
- send a copy of the primary carrier's Explanation of Benefits along with the completed claim form. Please note, the claim form and/or the primary carrier's Explanation of Benefits may have already been submitted by the provider.

97. What is a "Notice of Claim?" (Section 6.2.A.1)

A "Notice of Claim" is the initial notification to the Fund that services were provided to you on a specific date. A "Notice of Claim" is a paper or electronic claim form, identifying the patient, the provider, the date(s) of service and the charges incurred.

98. Is there a time limit in which to file a Notice of Claim? (Section 6.2.A.1)

Yes. A Notice of Claim must be received by the Fund within 12 months after the claim has occurred. The Fund must receive Notice of Claim on claims for which the Fund is the secondary payer within 12 months of the primary carrier's final payment. The Notice of Claim time limit may be waived by the Fund if evidence is supplied showing it was not reasonably possible to provide Notice of Claim within 12 months and that such notice was supplied as soon as possible.

99. What is "Proof of Loss?" (Section 6.2.B)

"Proof of Loss" refers to the submission of any additional charges reasonably expected to be connected to a claim that has already been brought to the Fund's attention in a Notice of Claim. Charges for prescription drugs, office visits, and other services for which additional charges cannot be expected, will not be considered Proof of Loss.

100. Is there a time limit in which to file a Proof of Loss? (Section 6.2.B)

Yes. A Proof of Loss must be received by the Fund by the end of the calendar year that follows the calendar year in which the charges were incurred. The Fund must receive Proof of Loss on claims for which the Fund is the secondary payer by the end of the calendar year after the calendar year in which final payment is made by the primary carrier. The Proof of Loss time limit may be waived by the Fund if

evidence is supplied showing it was not reasonably possible to provide Proof of Loss within 12 months and that such notice was supplied as soon as possible.

For Example: Adam was admitted to the hospital from April 3, 2011 through April 6, 2011 for surgery. The Fund must receive Adam's Notice of Claim informing the Fund of his hospital stay and surgery by April 30, 2012. Other charges connected with his hospital stay such as radiology fees and surgeon's fees, must be submitted no later than December 31, 2012 under the Proof of Loss rules.

101. How will my benefits be paid? (Section 6.1.A)

Benefits will be paid directly to you, the provider or the individual designated in a Qualified Medical Child Support Order.

102. How long will it take my claims to be paid?

Since January 1, 2003, the Fund has been complying with the rules provided in the Department of Labor's Claim Regulation which requires the Fund to process claims within a certain amount of time based on the type of claim being processed. The following describes the different types of claims that may be filed with the Fund Office.

Pre-Service Claim - this is a claim in which the Fund provides that advance approval is required to obtain all or part of the benefits available. Examples related to the benefits offered by this fund include:

- a claim for prescription drugs requiring prior-authorization,
- home health care,
- cardiac rehabilitation therapy,
- speech, occupational or physical therapy taking place in the home,
- skilled nursing care,
- nutrition counseling, and
- use of the hospital or an outpatient facility for dental services.

Urgent Care Claim - this is a "Pre-Service Claim" that:

- if allowed to be addressed within the time frame allowed for a pre-service claim, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function;
- in the opinion of a physician with knowledge of the claimant's medical condition would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
- is deemed "urgent" by a physician with knowledge of the claimant's medical condition; or
- an individual acting on behalf of the Fund applying the judgment of a prudent layperson who possesses average knowledge of health and medicine, has determined could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function.

Post-Service Claim - a claim that does not fit the above description. Most claims will fall into this category.

Concurrent Care Claims - claims that are related to an approved ongoing course of treatment provided over a period of time or number of treatments.

Time Limitations for Different Claim Types

Once the type of claim is known, the following timeline applies:

Type of Claim	Time Limit for Claim to be Addressed	Extension Permitted
Medical, Prescription Drug, Dental, Mental Health Benefits or similar benefit		
- Urgent Claims (as medically determined)	3 days	2 days
- Pre-Service Claims	15 days	15 days
- Post-Service Claims	30 days	15 days
- Concurrent Care Claims	Prior to termination of care (if sufficient notice)	None

If the Fund Office needs more information to process your claim, you will be notified within the time frames listed in the Plan Document. Extensions are permitted if the Fund Office determines that special circumstances beyond its control require an extension of time for processing the claim. In such a case, you will be provided with written notice of the extension prior to the time noted in the “Extension Permitted” column above.

If all or a part of your claim is denied (“Adverse Benefit Determination”), your explanation of benefits will contain the following information:

- an explanation as to why the claim was denied or reduced;
- the plan provision for which the denial or reduction was based;
- a description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
- a description of the Plan’s appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after you have exhausted the appeals process;
- the identity of any medical or vocational expert(s) whose advice was obtained on behalf of the Plan in cases where the benefit was denied partially or fully;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Overpayment

103. What happens if the Fund makes an overpayment to me or to a provider on my behalf? (Section 6.7)

In cases where an overpayment is made by the Fund on behalf of a Participant or his Dependent, the Fund Office will attempt to recover the overpayment from whomever the benefit check was made payable except for overpayments to participants or dependents of \$25 or less. If the overpayment is made directly to a Participant or Dependent, the Fund will first advise the Participant in writing, and then withhold benefit payments on all

of the Participant's and Dependent's claims until payment in full is received, or a satisfactory written payment arrangement is made, including the payment of interest at the prime rate.

If the overpayment is made to an in-network service provider such as a doctor or hospital, and it was made less than 18 months prior to an attempt to recover the overpayment, the Fund will refer the matter to Anthem Blue Cross Blue Shield for collection. If the doctor, hospital or other service provider is out-of-network, the Fund will issue a repayment request letter to the provider. If the provider refuses to refund the money, it will be necessary to suspend benefit payments on all future claims submitted by the overpaid service provider on behalf of the Participant and/or Dependent until the debt is paid back. If necessary, the Fund will issue a second, third and final repayment request letter.

In any of the above situations, if the full overpayment is not received within the first 6 months of the first attempt, the Fund will refer the matter to the Board of Trustees.

Coordination of Benefits

104. What does "coordination of benefits" mean and are my spouse and I required to elect group health insurance if it's available free of charge? (Section 2.5.A.6, 5.3 & 5.4)

Effective June 1, 2003, if you are eligible for other comprehensive medical coverage from your employer, and the monthly premium is less expensive than the current premium charged by the Fund for retiree health benefits, you are required to enroll in the plan. The comparison of premiums will be based on whether you are enrolled in a single plan or a family plan. You may continue receiving benefits from the Fund if you are required to enroll in another comprehensive medical insurance program, however, the Fund will be your secondary carrier.

"Coordination of benefits" indicates that you or your dependents have health coverage with more than one group health plan, and the Fund will coordinate the payment of your health benefit expenses with your primary carrier. Coordination of benefits allows the provider to collect up to, but not more than, 100% of the "Allowable Charge." "Allowable Charge" is defined as the billed charge reduced by the greater of the discounts available with the primary carrier's Preferred Provider Organization or the Fund's Preferred Provider Organization. However, if required by contract, the allowed charge will be defined as the billed charge reduced by either the primary Plan's discount without regard to the Fund's discount or the Fund's discount without regard to the primary carrier's discount.

105. How do the Fund's coordination of benefits rules work? (Section 5.3)

The Fund determines which group plan has the primary responsibility for paying any health expenses you incur. The following rules are used to decide which carrier is primary:

- the other plan is primary if it has no coordination of benefits provision;
- the plan that covers the person as an employee or participant is primary, and the health plan that covers the person as a dependent is secondary;
- for a dependent child, the plan of the parent whose birthday (month and day) comes first during the calendar year will be primary, except as explained below;
- for a dependent child whose parents are divorced or separated, the plan of the parent, who by court order must provide health coverage, will be primary;
- for the dependent child whose parents are divorced or separated, if no court order exists, and if the parent with custody of the child has not remarried, the plan of the custodial parent will be primary and the plan of the noncustodial parent will be secondary. However, if the custodial

parent has remarried, his or her plan will be primary, the plan of the stepparent will be secondary the plan of the noncustodial parent will be third;

- for a dependent child whose parents are divorced, separated, and who have joint custody of the child, the parent who claims the dependent child for tax purposes will be primary;

Additional Coordination of Benefits Guidelines:

- under some plans, the coordination of benefits rules for dependent children require that the plan covering a child as a dependent of a male will be primary and that the program covering the child as a dependent of a female will be secondary. When that occurs, this Plan will follow those rules instead of those normally followed;
- if none of the above rules for dependent children establishes primary carrier, then the plan which has covered the person for the longer period of time will usually be primary;
- however, the plan covering a person (or a dependent of a person) under extension of benefits or as a laid off or retired person will be secondary to any plan covering the person as an active employee or as a dependent of an active employee.

For example: Alex, a Plan member, his wife Laura, and daughter Allison, are covered by the Fund. They are also covered by Laura's insurance through her employer. Whose coverage is primary on Allison?

Laura's insurance carrier uses the birthday rule for Coordination of Benefits. Alex's birthday is May 19, 1950, and Laura's birthday is February 1, 1952. Because February 1 comes before May 19 (the year of birth is not used), Laura's insurance is the primary carrier on Allison.

106. Are there situations for which the Fund will not pay benefits as a secondary payer? (Section 2.5.A.6, Section 5.2.D & Section 5.4.C)

Yes, as follows:

- the Fund will not pay the full benefit available if by doing so, the sum of the payments by the primary carrier and this Fund would be greater than the allowable charge;
- the Fund will not pay any benefit if the rules of the primary plan were not followed and charges were denied;
- the Fund will not pay any benefits if the election of other coverage is required as stated in Question 104;
- the Fund will not pay any benefits if other coverage would have been available had you or your dependent filled out the proper enrollment forms or enrolled during the proper enrollment period.

107. How are secondary payments calculated? (Section 5.4)

1. The billed charge will be reduced by the greater of the discounts available with the primary carrier's Preferred Provider Organization or the Fund's Preferred Provider Organization. However, if required by contract, the billed charge will be reduced by either the primary Plan's discount without regard to the Fund's discount or the Fund's discount without regard to the primary carrier's discount;
2. The resulting allowable charge will be processed in a manner consistent with the Fund's normal processing procedures; and
3. The related payment amount will be further reduced by the amount of any other plan's payment.

At no time, when added to the other plan's payment, will the Fund's payment exceed the allowable charge calculated in step 1 above.

Subrogation

108. What is subrogation? (Section 6.6)

Subrogation applies when you or your dependent is injured due to the wrongful act or negligence of someone else. When this happens, you or your dependent will receive the benefits that would normally be payable by the Fund as long as the steps mentioned in the next question are followed. However, the Fund will be allowed to recover medical and prescription benefits paid and/or fees charged by the Fund's Preferred Provider Organization related to the benefit payments in connection with the injury from a third party. A third party is considered to be an auto insurance company, a homeowner's insurance company, or anyone else who may be required to pay you or your dependent because of an injury.

109. What do I do if subrogation applies? (Section 6.6)

When subrogation applies, you must notify the Fund. You must supply all information needed, complete all forms required and agree to cooperate with the Fund before any benefits in connection with the injury will be paid.

110. Subrogation seems to apply to non-work related injuries or illnesses. What happens if I am injured on the job? (Section 4.1.A)

The Fund may cover your work related injury or illness claims as long as these steps are followed:

1. You must, in a timely manner, notify your employer of your work related injury and complete the proper forms necessary to apply for coverage with your employer's worker's compensation carrier;
2. Upon receipt of a denial of coverage letter from your employer or their worker's compensation carrier, you must supply a copy of the letter to the Fund Office and complete the "Worker's Compensation Benefits Assignment and Appeal Authorization" form indicating, that you will repay the Fund any money paid if ultimately you receive worker's compensation benefits through a timely appeal process.

Chapter 8 Appeals

111. What can I do if I disagree with the Fund's payment or nonpayment of my claim? (Section 6.2.D. & 6.2.E)

If you disagree with the Fund's decision, you may ask to have it reviewed. Your written request for review must be received by the Fund Office within 180 days from the date you receive an "Adverse Benefit Determination" or denial notice. Also, your request must be addressed to the Board of Trustees in care of the Fund Office and must state the following:

- your name and address;
- the fact that you are appealing a decision of the Fund Office and the date of the decision;
- the basis of your appeal, i.e., the reason why you feel that your claim should not be denied; and
- the provisions of the Plan on which you base your claim.

IMPORTANT: If your appeal is not filed within the required 180 day period, you lose your right to a review of the denial and the decision of the Fund Office will become final and binding.

There is one exception to the written request rule. If you are appealing an urgent care claim, your appeal request may be made by phone call, in person or in writing.

An urgent claim is a claim that, if not addressed within 15 days of receipt, could seriously jeopardize the life or health of the person for whom the appeal relates. An urgent care claim is also:

- a claim for which a medical provider that is familiar with the situation, believes would cause severe pain that cannot be adequately managed if the person for whom the appeal relates doesn't receive the care or treatment described in the appeal;
- an appeal deemed "urgent" by a physician familiar with the medical condition described in the appeal; or
- an appeal that is deemed "urgent" in the judgment of a person acting on the Fund's behalf that possesses average knowledge of health and medicine.

112. Can someone else submit an appeal on my behalf?

Yes, as long as you provide the Fund Office a letter naming your "authorized representative" in writing, the Fund's Trustees will accept their appeal on your behalf.

113. Do I have any rights to collect or supply information from or to the Fund Office related to the claim(s) for which I am appealing?

Yes, as follows:

- you may submit written comments, documents, records and other information you feel is important to your claim for which you are appealing;
- you or your authorized representative may request and receive reasonable access to all documents, records or other information related to you and the claim for which you are appealing. Copies of documents you desire will be provided free of charge.

114. What is considered a "document, record or other information" as referenced in Question 112?

If the item:

- was relied upon in making the original benefit payment decision;

- was submitted, considered or created during the claim review by the Fund Office whether or not the item was relied upon when processing the claim;
- shows that claim payment decisions are made as required by the Plan Document and that such requirements are consistently applied; or
- is a policy or guideline that covered the Fund Office's decision to deny,

then it will be considered a "document, record or other information."

115. Who reviews and rules on an appeal?

The Board of Trustees, or a subcommittee of Trustees, reviews and rules appeals. In doing so, they will take into account all comments, documents, records and other information submitted, whether or not such information was considered when the claim was originally processed by the Fund Office.

In some cases, the decision being appealed was reached by the Fund's medical consultant. For example, the determination of whether a medical procedure is medically necessary would be determined by the Fund's medical consultant. If an appeal is received related to such a decision it will first be addressed by the medical consultants' appeal process (Section 3.1.F). Ultimately, if you are still unsatisfied, you may pursue your appeal with the Board of Trustees.

In addition, the Trustees will not consider the original decision reached by the Fund Office when making a determination on the appeal.

116. The claim I am appealing required a medical judgment. How do the Trustees address this?

The Trustees will utilize an independent medical consultant specializing in the area for which the claim relates. In addition, if the Fund Office used a medical consultant when originally processing the claim, the medical consultant used for the appeal will not be affiliated with the original.

117. When should I expect a decision on my appeal from the Board of Trustees?

The Board will render a decision within 60 days unless their meeting schedule provides for quarterly meetings. In such a case, they will render a decision for all appeals received less than 30 days prior to the previous Trustee meeting date unless special circumstances require an extension.

118. Are there any special rules that would change the time frame listed in Question 116?

Yes.

Urgent Care Claims

In cases involving an urgent care claim, you will be notified of the Trustees' decision as soon as possible, but no later than 72 hours after receipt of your request for review.

Pre-service Claims

In the case of a pre-service claim, you will be notified of the Trustee's decision within a period of time that is appropriate to the medical situation under review, but no later than 30 days.

Please Note: If the Trustees deem an appeal to be incomplete because you failed to provide information necessary to make a decision, the time period for which claims must be decided will be stopped until the needed information is received.

119. Is the Board's decision concerning my appeal final and binding?

Unless you have additional information that was not initially submitted to the Board, or you elect to take the matter to court as described below, the Board's decision is final and binding.

120. If I don't agree with Board's decision, what can I do?

If you have followed the entire appeal process, and don't agree with the Board's decision, then you may take your claim denial to court, but you must do it within 180 days after the Board of Trustees' decision on your appeal. Refer to "Important Information Required by ERISA" for details.

Chapter 9 Privacy

The Fund makes every attempt to comply with the Department of Health and Human Services' Privacy Regulations, which were effective April 14, 2003. The following describes how the Fund Office may lawfully use or disclose your protected health information.

As part of its operations, Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund (the group health plan, hereinafter referred to as "the Fund") creates or receives certain information about you relating to your physical or mental health, the provision of healthcare to you, and the past, present, or future payments for the provision of healthcare to you. The privacy practices and procedures below often refer to "protected health information." Protected health information is information that is identifiable to an individual.

The Fund is required by law to maintain the privacy of your health information.

The Fund protects your information from inappropriate use or disclosure. Our employees, and those of companies that provide certain services on our behalf, are required to comply with our requirements that protect the confidentiality of your protected health information. They may use or disclose your information only as permitted, such as to administer claims.

We will not use your information, or disclose your information to other companies for marketing or fund-raising. However, we will use or disclose your information to another company or person for other reasons required or permitted by law. The following provisions describe how we may lawfully use or disclose your protected health information.

I. Uses and disclosures of your protected health information

A. Treatment, payment or healthcare operations

The Fund is permitted to use and disclose your protected health information for treatment, payment or healthcare operations, or to the Board of Trustees, as follows:

- (1) Treatment. The Fund may make disclosures of your protected health information to a healthcare provider for the healthcare provider's treatment purposes. For example, we may disclose the identity of an individual seeking approval of the drug Retin-A if over 26 years of age to ensure that it is not prescribed for cosmetic reasons;
- (2) Payment. The Fund may use or disclose protected health information to any person or entity for the purposes of carrying out the Fund's payment activities. The Fund receives or discloses your health information to doctors or other healthcare providers, other insurance carriers and occasionally other third parties for payment purposes. For example, the Fund receives information from your doctor's office about your visit to the office and the diagnosis in order to make payment to the doctor on your behalf. The Fund may also disclose your information to a healthcare provider, another health plan, or health care clearinghouse for the payment activities of the entity that receives the information. We may disclose your information to another health plan, for example, for the purpose of coordinating their and our benefits;
- (3) Health Care Operations. The Fund may disclose your protected health information for its health care operations. Health care operations include underwriting, contribution establishment and other activities relating to health insurance, arranging for legal services

and compliance programs, business planning and business management. For example, as part of the Fund's health care operations, it may receive information from its care management company about an inpatient hospital stay. The Fund may also disclose protected health information to another health plan, health care clearinghouse or health care provider for the health care operations activities of the entity that receives the information, if both the Fund and the other entity either has or had a relationship with you, the protected health information pertains to such relationship, and the disclosure is

- for the purpose of conducting quality assessment and improvement activities;
- for the purpose of health care fraud and abuse detection or compliance;

- (4) Board of Trustees. The Fund may disclose your protected health information to the Board of Trustees (the plan sponsor) in order to manage and administer the Fund, including for payment and health care operations purposes. For example, the Board of Trustees participates in underwriting, contribution establishment, arranging for legal services and auditing, business planning, conducting cost-management and planning related analysis for managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies. The Board of Trustees has certified that it will not use or disclose your protected health information other than as provided for in the Plan Document or as required by law. The certification is included in the Plan Document found in the appropriate section of this document.

B. Other uses and disclosures required or permitted by law

- (1) Secretary of Health and Human Services. The Fund will disclose your protected health information when required to do so by the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated;
- (2) Communications with You and Your Family. The Fund may disclose your information to you, or to your family members or close friends. If you are available, the Fund will ask for your oral agreement before it discloses information to family or friends, or, if you are unavailable, it will exercise its professional judgment in deciding whether it is in your best interest to discuss your information with family or friends. The Fund will only disclose information to family or friends to the extent of their involvement with your care;
- (3) Disclosures Required by Other Law. The Fund may use or disclose your protected health information to the extent that such use or disclosure is required by law. For example, we may disclose your information in the course of a worker's compensation claim in which you are involved;
- (4) Incidental Uses or Disclosures. The Fund may use or disclose protected health information as incident to a use or disclosure otherwise permitted or required by the HIPAA Privacy Standards;
- (5) De-Identified Information. The Fund may use protected health information to create information that is not individually identifiable health information or to create information that is only identifiable in a limited way, or it may disclose protected health information only to a business associate for such purposes, whether or not such information is to be used by the Fund. If the information is identifiable in a limited way, such limited information will only be used for the purpose of research, public health, or health care operations;

- (6) Business Associates. The Fund may disclose your protected health information to a business associate (such as the Fund's actuary, pharmacy benefit manager, and others) and may allow a business associate to create or receive your protected health information on its behalf, if the Fund has satisfactory assurance that the business associate will appropriately safeguard the information;
- (7) Disclosures to Law Enforcement Officials. The Fund may disclose your information to a law enforcement official under the following circumstances:
- if a member of the Fund's workforce is a victim of a criminal act;
 - in response to a court order;
 - as evidence of criminal conduct;
 - for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;
 - if you are a victim of a crime (if possible, the Fund will obtain your permission to use or disclose your information);
 - in compliance with laws requiring reporting of certain types of wounds or physical injuries;
- (8) Judicial or Administrative Proceedings. The Fund may also disclose information in the course of any judicial or administrative proceedings so long as it has satisfactory assurance that you have notice that your information is being sought;
- (9) Deceased Individuals. The Fund will protect your information even after you are deceased. The Fund may disclose your protected health information to a coroner or medical examiner, funeral director, or to an organ procurement organization in the event of your death;
- (10) Serious Threat to Health or Safety. The Fund may use or disclose your protected health information, if the Fund, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or is necessary for law enforcement authorities to identify or apprehend you. The Fund may not disclose your information if they learn about the threat to health or safety through a request by you to initiate or to be referred for treatment, counseling, or therapy;
- (11) Military. The Fund may use and disclose your protected health information if you are Armed Forces personnel or foreign military personnel for activities deemed necessary by appropriate military command authorities as published by notice in the Federal Register;
- (12) National Security and Heads of State. The Fund may disclose your protected health information to authorized federal officials for the conduct of lawful intelligence, counterintelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401 et seq.) and implementing authority (e.g., Executive Order 12333) and to authorized federal officials for the provision of protective services to the President or other persons authorized by 18 U.S.C. 3056, or to foreign heads of state or other persons authorized by 22 U.S.C. 2709(a)(3), or for the conduct of investigations authorized by 18 U.S.C. 871 and 879;
- (13) Correctional Institutions and Inmates. The Fund may disclose your protected health information to a correctional institution or a law enforcement official having lawful custody of you, if the correctional institution or such law enforcement official represents that such protected health information is necessary for the provision of health care to you,

the health and safety of you or other inmates, or the health and safety of the officers or employees involved with you while in lawful custody; (14) Disaster Relief. The Fund may disclose your protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. If you are present for, or otherwise available prior to, a use or disclosure for disaster relief and it does not interfere with the ability to respond to emergency situations, the Fund will give you the opportunity to agree or object to the use of your information;

(15) Public Health and Other Government Authorities. The Fund may disclose your health information to proper public health authorities and other government authorities in the following circumstances:

- a member of the Fund's workforce or a business associate may make a disclosure of protected health information to report unlawful conduct by the Fund;
- for reports of child abuse or neglect;
- if the Fund believes you to be a victim of domestic violence (if appropriate, the Fund will notify you before it reports this information);
- for public health activities or health oversight activities such as those regarding an FDA regulated product, or for the oversight of government benefit programs, such as Medicare.

II. Rights of the Participant, spouse and dependents 18 or over

(1) Inspect and Copy. You have the right to inspect and copy protected health information about yourself in a designated record set, except for psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding. The request for access to copy or inspect must be in writing. The Fund must act on a request for access no later than 30 days after receipt of the request (or 60 days if the information is kept off-site). If the Fund denies your request, we will provide information on your review rights and other information. If you agree in advance, the Fund may respond to your request by providing you a summary of the health information requested. If you request a copy of your protected health information or agree to a summary or explanation of such information, the Fund may impose a reasonable, cost-based fee to include the cost of copying (and labor), postage when you have requested the copies or summary or explanation be mailed, and the cost of preparing an explanation or summary of the protected health information. If the Fund does not maintain the protected health information that is the subject of your request for access, and the Fund knows where the requested information is maintained, the Fund will inform you where to direct the request for access. All requests should be addressed to the Privacy Officer at the Fund Office. The address is located on the last page of this Notice;

(2) Amendment. You have the right to amend your protected health information if you make the request in writing and provide a reason to support a requested amendment. The Fund must act on your request no later than 60 days after receipt of such request by either amending the information or denying your request for amendment. If the Fund amends the information as you request, it will forward the amended information to persons or entities it knows have the protected health information and that may have relied on such information to your detriment. The Fund may deny your request if it determines that the protected health information or record that is the subject of your request (i) was not created by the Fund, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment; (ii) is not part of the designated record set; (iii) would not be available for inspection or

copying under the provisions set out in paragraph (1) Inspect and Copy above; or (iv) is accurate and complete. If the Fund denies your requested amendment, in whole or in part, it will provide you with a written denial containing the basis for the denial and an explanation about your rights to disagree with the denial. All requests must be in writing and should be addressed to the Privacy Officer at the Fund Office. The address is located on the last page of this Notice;

- (3) Accounting. You have the right to receive an accounting of disclosures of protected health information made by the Fund within the previous six years prior to the date on which the accounting is requested. You do not have the right to accounting of disclosures made (i) to carry out treatment, payment and health care operations, (ii) to you, (iii) incident to a use or disclosure otherwise permitted or required by this Notice or the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164), (iv) pursuant to an authorization, (v) to persons involved in your care, (vi) for national security or intelligence purposes, (vii) to correctional institutions or law enforcement officials, (viii) as part of a limited data set in accordance, or (ix) that occurred prior to April 14, 2003. The Fund will act on your request for an accounting no later than 60 days after receipt of such a request. The Fund will provide the first accounting to you in any 12 month period without charge. The Fund may impose a reasonable, cost-based fee for each subsequent request for an accounting within the 12 month period. We will inform you in advance of the fee and provide you an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee. Your requests for an accounting must be in writing and should be addressed to the Privacy Officer at the Fund Office;
- (4) Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information when the Fund uses or discloses protected health information to carry out payment or health care operations or when the Fund discloses protected health information to your family members and friends involved in your care. The Fund is not required to agree to your request. However, if the Fund agrees to a restriction, it may not use or disclose information in violation of such restriction, unless you are in need of emergency treatment and the restricted protected health information is needed to provide the emergency treatment. Once the Fund has agreed to a restriction, it may only terminate its agreement to a restriction if:
- you agree to or request the termination in writing;
 - you orally agree to the termination and the Fund documents your agreement; or
 - the Fund informs you that it is terminating its agreement to a restriction. Such termination is only effective with respect to health information received after it has so informed you.

You also have the right to receive confidential communications of your health information upon request. The Fund must accommodate your requests to receive confidential communications, if you clearly state that the disclosure of all or part of your information could endanger you. Furthermore, you must provide information as to how payment, if any, will be handled, and you must specify an alternative address or other method of contact. You should address your requests in writing to the Privacy Officer at the Fund Office. The address is located on the last page of this Notice.

III. Other Information

- (1) Authorizations. Except for the uses and disclosures described in Sections A. and B. above, or as otherwise permitted by law, the Fund will make no uses or disclosures of your protected health information unless you have given your written authorization to the Fund permitting it to use or disclose the information. Furthermore, you may revoke the

written authorization given to the Fund at any time, provided that the revocation is also in writing. There are certain circumstances under which you may not revoke the written authorization. Those circumstances are:

- if the Fund has taken action in reliance on the authorization; or
- if the authorization was obtained as a condition of your obtaining insurance coverage, and other law provides the Fund with the right to contest a claim under the policy or the policy itself;

- (2) Complaints. If you believe your privacy rights have been violated you may file a complaint with the Privacy Officer at the Fund, or you may file a complaint with the Secretary of Health and Human Services. The address and phone number for the Privacy Officer are located below. You will not be retaliated against for filing such a complaint;
- (3) Reservation of Rights. The Fund is required to abide by the terms of the Notice currently in effect. The Fund reserves its right to change the terms of its Notice and to make the new Notice provision effective for all protected health information that it maintains prior to issuing a revised Notice. The Board of Trustees further reserves the right to modify this Notice in accordance with its practices and policies at any time.
The Fund will provide individuals with any revised Notice by mail;
- (4) How to Contact Us. If you wish to exercise any of your rights, or if you have any other questions or complaints about our privacy practices, please contact the Privacy Officer, Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund, 8814 Fargo Road, Suite 200, Richmond, Virginia 23229, (804) 282-3131.

Chapter 10 Important Information Required by ERISA

ERISA requires that certain information be furnished to each participant in an employee benefit plan. This document is your Summary Plan Description (SPD). Contributions to the Fund are made by participating employers and, under certain circumstances, by the participant. Contributions are based on negotiated contributions as set forth in the collective bargaining agreements. Benefits provided by the Fund are determined by the Board of Trustees. The Board is empowered to amend the Health and Welfare Plan at any time, and to impose any conditions, fees, or cost-sharing structure on eligibility or on the provision of benefits, as they deem advisable. All determinations by the Board of Trustees are final and binding on all parties. This Summary Plan Description is effective January 1, 2011.

- The following is important information you should know about the Fund:
The Board of Trustees is the administrator of the Fund. The Board of Trustees consists of an equal number of union and employer representatives, selected by the union and the employers who have entered into collective bargaining agreements which relate to the Fund. Inquiries may be sent to the Trustees in care of the Fund Office at 8814 Fargo Road, Suite 200, Richmond, Virginia, 23229, (804) 282-3131;
- The Board of Trustees is both the plan sponsor and the plan administrator. This means that the Board of Trustees is responsible for seeing that information about the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974;
- The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Board of Trustees by the Internal Revenue Service is 504556299;
- The Fund's agent for service of legal process is:
Michael M. McCall, Executive Director
Teamsters Joint Council No. 83 of Virginia
Health and Welfare Fund 8814 Fargo Road,
Suite 200 Richmond, Virginia, 23229
- The names and addresses of the Trustees are listed on page 2 of this document;
- All assets are held in trust by the Board of Trustees;
- The Plan Year begins on January 1 and ends on December 31 of each year.

Statement of Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

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

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor;
- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Fund

participants. 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 welfare benefit or exercising your rights under ERISA. 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 Fund and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the material and pay you **up to \$110 a day** until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. ***In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.*** If it should happen that Fund fiduciaries misuse Fund 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.

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Chapter 11 Miscellaneous

121. I need to send some documents to the Fund Office. Can they be faxed?

Yes, the Fund Office will accept faxed documents. However, the Fund reserves the right to require the submission of original documents and/or signatures if necessary.

122. Can I send these documents by email?

Yes, you can send documents such as birth certificates, marriage certificates, or divorce decrees and any pertinent forms to documents@tjc83funds.net.

123. Does the Fund have a website?

Yes. For additional information regarding your benefits, please log on to our website at www.tjc83funds.org