TEAMSTERS JOINT COUNCIL NO. 83 OF VIRGINIA

HEALTH & WELFARE FUND

ACTIVE EMPLOYEE

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 an active employee 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 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.

An Addendum, which appears after Chapter 11, describes special rules that may apply to you if you participate in a non-grandfathered plan as described in Question 189.

The questions and answers in the SPD are not intended to change in any way your rights under the Active Employee 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, Schedule of Benefits, and SPD. No employer, union, or any representative of any employer or union, is authorized to interpret the Plan Document, 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 numerous employers that are obligated to contribute to the Fund as required by collective bargaining and participation agreements. The contributions received

are invested and used to provide the benefits listed in Chapter 3 for those meeting the eligibility requirements listed in Chapter 2. Other than contributions to the Fund made by participating employers, no other funding source is used to provide benefits other than COBRA and Direct Pay payments. Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund is a self-funded, self-administered 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:	Employer Trustees:
John D. Farrish	W. Robert Davidson
James R. Smith Teamsters Local Union No. 592	William A. Nations ABF Freight System
James Wright Teamsters Local Union No. 822	James I. 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 from the Fund Office upon written request sent to the address provided in Question 2.

7. Is the Fund maintained pursuant to collective bargaining and participation agreements?
Yes, the Fund is maintained pursuant to a number of collective bargaining and participation agreements or contracts. The agreements state the contribution rate, identify the employees for whom contributions to the Fund will be made, identify the circumstances requiring contributions to be paid, such as the requirement to pay contributions in any week in which a regular employee works at least one day, and designate the schedule(s) of benefits made available to the employees on whose behalf contributions to

the Fund are made (each a “Schedule of Benefits” or “Benefit Plan”). Because the language for each contract is different, participants should review their own contract to learn more.

Chapter 2 Eligibility for You and Your Dependents
This Chapter explains how you and your dependents become covered, remain covered and lose coverage.

Participant – Active Coverage Eligibility

8. When does my coverage start? (Section 2.2.A)
As a general rule, you will become eligible for coverage on the first day of the week for which your employer contributes to the Fund on your behalf. Your first contribution also provides you coverage for the next two calendar months.

For example: Jack goes to work for a contributing employer on Wednesday, April 20. His company then pays for the week containing April 20. Upon receipt of the contribution, the Fund awards coverage starting on the first day of the week containing April 20. Because the first day of the week containing April 20 is a Saturday, Jack's coverage begins Saturday, April 16.

In general, contributions are provided by your employer as required by your collective bargaining or participation agreement. The contributions may be solely from employer funds or a combination of employer funds and deductions from your paycheck, if required by your collective bargaining agreement.

9. How does the period of insurance coverage relate to contributions? (Section 2.3)
Contributions received in any given month provide you coverage at least 2 months later as noted below:

Contributions paid for all weeks or all but one week in:	Provides coverage for:
January	March
February	April
March	May
April	June
May	July
June	August
September	July
August	October
September	November
October	December
November	January
December	February

10. When does my coverage end? (Section 2.4 & Section 2.10)
Generally speaking, coverage will end on the earliest of the following:

- the day before the day you enter active duty into the Armed or Uniformed Services of the United States;
- the last day coverage is available to all employees of an employer who leaves the Fund;
- the date of your death; or.
- the last day of the month for which coverage was earned as listed in Question 9 unless you have had at least 20 weeks of coverage paid to the Fund on your behalf over the immediately preceding 6 months. If this condition is met, you will be provided coverage for 1 additional month

For example: Joseph was laid off from work in April. His employer paid 2 weeks of contributions for the time he worked in April.

Work Period	Contributions Paid	Coverage Period	Number of Weeks Paid
November	4	January	8 (for Nov. and Dec.)
December	4	February	8 (for Jan. and Feb.)
January	4	March	6 (for Mar. and two weeks in April)
February	4	April	
March	4	May	
April	2	None	June*

* Generally, the 2 weeks of contributions in April is not enough to give Joseph coverage for June. Under the special rule, however, because the Fund received more than 20 weeks of contributions on Joseph's behalf between November and April, Joseph is eligible for coverage in June.

Certain exceptions to this rule such as the election of COBRA, Direct Pay, Free Coverage and Extension of Benefits exist and are described later in this chapter.

11. None of the explanations in Questions 8-10 seem to apply to my employer's arrangement for providing me and my family with health and welfare coverage. Could other guidelines apply to me? (Section 2.2.C)

Yes. Some collective bargaining agreements or participation agreements provide the employer with the ability to determine coverage eligibility and to provide the Fund with a monthly roster of employees who should be covered pursuant to the collective bargaining or participation agreement. If you work for a company with this type of collective bargaining agreement or participation agreement, you and your eligible dependents will be provided coverage for each month you are listed on the employer's roster, and the employer remits the required contributions on your behalf. You and your eligible dependents' coverage will end on the last day of the month for which your employer reported and paid contributions on your behalf, regardless of the month in which your termination for any reason occurred.

Simply put, once you satisfy the eligibility requirements for coverage under the Fund, you and your eligible dependents, if any, will continue to be eligible (as described above), as long as your employer lists your name on the eligibility roster submitted to the Fund and pays contributions to the Fund on your behalf.

12. Can my coverage be reinstated? (Section 2.13)

Yes. If your coverage lapses because you become ineligible for coverage for any month and then become eligible again in a later month, your coverage will be reinstated on the first day of the week for which contributions are again paid on your behalf. Coverage will also be provided during the resulting "two-month lag" as described in Question 8 and continue as described in Question 9. If you initially became eligible under the plan provision entitled "special rule where collective bargaining agreement establishes different standards for eligibility" (Section 2.2.C), your coverage will be reinstated on the first day of the month for which your employer submits an eligibility roster and contributions on your behalf in accordance with the special rule.

Spouse – Eligibility For coverage

13. When will my spouse's coverage start? (Section 2.14.A)

As a Fund participant, you may elect coverage for your lawful spouse (sometimes referred to in this SPD as a "dependent"). As a general rule, your spouse becomes eligible for coverage at the same time you do. If you get married while you are already covered by the Fund, your spouse's coverage starts on the date of your marriage.

14. How do I add my spouse to my health coverage if I get married after I become eligible for health benefits?

You must send a copy of your marriage certificate, along with a completed dependent form, to the Fund Office.

15. When does my spouse's coverage end? (Section 2.16)

Your spouse's coverage under the Fund ends on the earliest of the following:

- the date your coverage ends unless sufficient contributions are provided by your employer as required by the Uniformed Services Employment and Reemployment Act of 1994 ("USERRA");
- the date you and your spouse are no longer lawfully married (a copy of your divorce decree is required);
- the day before your spouse enters military service;
- the date your employer ceases to be a participating employer in the Fund; or
- the date of your spouse's death.

Certain exceptions to this rule, such as the election of COBRA, Direct Pay, Free Coverage and Extension of Benefits exist and are described later in this chapter.

Qualifying Child – Eligibility For Coverage

16. Who is considered a Qualifying Child? (Section 1.15.B &1.15.C)

As a Fund participant, you may elect coverage for your Qualifying Child (sometimes referred to in this SPD as a "dependent"). The Fund considers a Qualifying Child to be any child born to you or adopted by you, your stepchild, or a child for whom you have legal custody. A "stepchild" is defined as the natural child or adopted child (including a child placed for adoption) of your lawful spouse, or a child for whom your lawful spouse has legal custody. Other than in the event of incapacity as described in Question 20, coverage for a Qualifying Child ends on the last day of the month in which the Qualifying Child attains age 26. A Qualifying Child under the age of 26 may be treated as a "dependent" for purposes of Fund eligibility regardless of whether the Qualifying Child is claimed as a "dependent" for tax purposes.

17. How do I add a dependent child to my health coverage after I become eligible for health benefits?

The following must be submitted to the Fund Office in order to add dependent children to your health coverage:

To Add:	You must submit the following:
a child born to you	dependent form, child's birth certificate identifying you as the parent or legal paternity documentation

an adopted child	dependent form, child's birth certificate & adoption papers
a stepchild	dependent form, child's birth certificate & your marriage certificate
a child for which you have legal custody	dependent form, child's birth certificate and a copy of custody papers
an incapacitated child over the age of 26, as described in Question 20	documents for child described above, plus documentation from the Physician stating the child is incapacitated and proof of Social Security Disability award to be reviewed annually by the Fund Office

18. When will coverage start for my Qualifying Child? (Section 2.14.A)
As a general rule, your Qualifying Children will become eligible for coverage with the Fund on the same date your coverage starts. If you are already eligible for coverage, your Qualifying Children will be covered when they first become eligible for coverage under the Fund.

19. When will my Qualifying Child's coverage end? (Section 2.16)
As a general rule, your Qualifying Child's coverage will end on the earliest of the following:

- the date your coverage ends unless coverage is maintained through an appropriate level of contributions from your employer as required under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") or in case of your death, the last day you would have been eligible due to your employer's contributions;
- the last day your dependent meets the definition of a Qualifying Child as described in Question 16;
- the day before the date your Qualifying Child enters the military;
- the date your employer ceases to contribute to the Fund;
- the date of your Qualifying Child's death.

20. Will my Qualifying Child's coverage end on the last day of the month in which he or she attains age 26 even if he or she is physically or mentally incapacitated? (Section 1.15.C.1 and 1.15.C.2)
Not necessarily. A Qualifying Child who is physically or mentally incapacitated will remain eligible for coverage regardless of his or her age while he or she meets either of the following two sets of conditions:

- the child must have been covered by the Fund while deemed a "Qualifying Child" as described in Question 16;
- the child must be incapable of self-sustaining employment by reason of mental retardation or physical disability, as determined by the appropriate state or federal agencies or the Fund's medical consultant;
- the child must be chiefly dependent upon you for his or her support and maintenance as confirmed by a physician in writing; and
- proof of incapacity must be submitted to the Fund Office within 90 days after the date the child would otherwise have lost coverage (and as required thereafter but no more often than yearly);

OR

- the child was never eligible for benefits because he or she fails to meet the conditions of being a Qualifying Child under the age of 26, as described in Question 16;
- the incapacity occurred prior to you becoming eligible for benefits;
- the child must be incapable of sustaining employment by reason of mental retardation or physical disability, as determined by the appropriate state or federal agencies or the Fund's medical consultant;

- the child must be chiefly dependent upon you for his or her support or maintenance as confirmed by a physician in writing; and
- proof of incapacity must be submitted to the Fund Office within 90 days after the date you become eligible for benefits (and as required thereafter but no more often than yearly).

Continuation of Medical Coverage During a Period of Short Term Disability

21a. If I have a period of short-term disability, could my dependents and I still be eligible for medical coverage under the Fund? (Section 2.5)

Yes, you and your dependents may still be eligible for medical coverage if continuation of your medical coverage ("Free Coverage") is listed in your Schedule of Benefits. If your regular coverage ends because you become totally disabled to perform the duties of your job, you and your dependents may qualify for continued medical coverage under the Fund at no cost to you for the period of time set forth in your Schedule of Benefits.

Your continuation of medical benefits ends on the earliest of the following:

- the last day you are disabled (unable to perform the duties of your job);
- the day before you return to active employment;
- the date you die;
- the last day of the coverage period provided in your Schedule of Benefits;
- the last day group coverage is in effect due to your previous employer ceasing participation with the Fund;
- the day before you begin receiving benefits from Medicare/Medicaid, any union, union-management pension fund or any other retirement plan; or
- in the case of your spouse or Qualifying Child, the date in which he or she no longer qualifies as a dependent.

Medical benefits do not include life insurance benefits, accidental death and dismemberment benefits or short-term disability benefits.

21b. Can Free Coverage be renewed?

Free Coverage can only be renewed if you incur an injury or illness different from the injury or illness for which Free Coverage was originally provided.

Continuation of Life Insurance Benefits During Permanent and Total Disability

22. Will I still be eligible for life insurance benefits if my active coverage ends because I become permanently and totally disabled? (Section 2.6)

Yes, you may still be eligible for life insurance benefits if continuation of life insurance during permanent and total disability (known as "PTD") is listed in your Schedule of Benefits and you meet the requirements listed in Question 24. Please note, the continuation of life insurance during periods of permanent and total disability applies only to you, not your dependents.

23. Does my life insurance benefit amount change if I qualify for PTD? (Section 2.6.D)

Yes, the amount of your life insurance benefit will be reduced and is listed in your Schedule of Benefits under Permanent and Total Disability in the Life Insurance section.

24. How do I become eligible for continuation of life insurance benefits during permanent and total disability? (Section 2.6.A, 2.6.B., and 2.6.C)
In order to qualify for this benefit, you must lose medical coverage with the Fund before your 60th birthday because you become totally disabled to perform any work, except as allowed under the social security disability program. You must have been permanently and totally disabled for 9 consecutive months before qualifying to continue your life insurance.

25. Do I have to send any documents to the Fund Office in order to become eligible for PTD life insurance coverage? (Section 2.6.B and 2.6.G)
Yes, in order to get PTD life insurance coverage, you must submit the following documents:

- a copy of your Social Security Disability Award or a copy of your Social Security Disability application if you do not have your award;
- a certified copy of your birth certificate;
- a doctor's statement of permanent and total disability including commencement date.

The Fund will not pay life insurance benefits in cases where your death precedes the Fund Office's receipt of all required documentation.

26. How long do I have to submit the documents listed in Question 25? (Section 2.6.B)
Generally, you must submit the documents required to continue PTD life insurance within 1 year of the date the permanent and total disability commenced. However, if a Social Security Disability Award cannot be supplied in 1 year, a copy of the Social Security Disability application, with all the required documents, must be supplied within the 1 year period. Eligibility for benefits will be awarded upon receipt of the Social Security Disability Award.

27. How long am I eligible for PTD life insurance coverage? (Section 2.6.B)
PTD coverage is provided for 1 year from the date of the initial approval.

28. Can I keep PTD life insurance coverage longer than 1 year? (Section 2.6.C)
Yes. You will be required to submit the following documents to prove that you are still permanently and totally disabled once a year:

- a physician's statement verifying your continued permanent and total disability; and
- if you are younger than age 65, a statement from the Social Security Administration verifying that you are still receiving social security disability; or
- if you are age 65 or older, the forms necessary to obtain a Social Security Earnings Report.

In addition, the Fund has the right, at any time during the continuation of your PTD life insurance coverage, to require proof of your continuing permanent and total disability and to have a physician of its choice examine you.

29. If my condition will never improve, am I still required to provide the documents mentioned in the previous question? (Section 2.6.C)
No. If you can supply medical evidence that conclusively proves to the Trustees that you cannot improve in the future, you may request a permanent PTD approval. If approved, you will not be required to supply the yearly documentation as stated in Question 28.

30. When does my PTD life insurance coverage end? (Section 2.6.F)

Your PTD life insurance coverage will end on the earliest of the following dates:

- the date you cease to be permanently and totally disabled;
- the date you refuse to have any physical examination required by the Fund;
- the date you fail to give the Fund proof of continuing permanent and total disability unless the Trustees waive the requirement (see Question 28);
- the date your previous employer ceases to participate with the Fund unless your past Employer ceased to be a participating Employer prior to January 1, 1994;
- in cases where your employer who is eligible for Continuation of Life Insurance Benefits During Permanent and Total Disability ("PTD") ceased to be a participating Employer prior to January 1, 1994, your eligibility for this benefit does not terminate except under the conditions described in Section 2.6.F.1, Section 2.6.F.2 or Section 2.6.F.3.

Extension of Benefits While Totally Disabled

31. What is Extension of Benefits? (Section 2.7)

If you or your dependents become totally disabled while eligible for certain benefits, medical coverage that you and your dependents had with the Fund can be extended for a period of time after the date that these benefits would normally have terminated. There are 2 types of extension while you are totally disabled**:**

- extension of medical benefits (this does not include dental, orthodontic, vision and out-of-pocket benefits); and
- extension of life insurance benefits.

Benefits payable under an extension of benefits are subject to the same rules that applied to your benefits before you became entitled to the extension.

32. How is "total disability" defined? (Section 1.48)

You will be considered "totally disabled" during any period when, as a result of a non-work related injury or illness, you are completely unable to work at any job for wage or profit, as documented by a treating physician. Your Spouse or Qualifying Child(ren) will be considered "totally disabled" during any period when, as a result of a non-work related injury or illness, he or she is unable to do the normal activities of a person of the same age and sex as determined by the Fund's Medical Consultant.

33. When does the extension period begin? (Section 2.7.B.4)

Extension of benefits while totally disabled will begin after "Free Coverage" has ended, as described in Question 21, or when Direct Pay and COBRA coverage end, if elected.

34. How do my dependents and I qualify for extension of medical benefits? (Section 2.7.B)

Medical benefits are extended to you or your dependents when you and/or they lose coverage due to total disability. Except as provided in Questions 38 and 39, extension of medical benefits coverage does not include dental, orthodontic, vision and out-of-pocket expense benefits. The Fund, however, will only pay medical expenses that are related to the injury or illness that caused the total disability.

35. When does coverage under the extension for medical benefits end? (Section 2.7.B.2. & 2.7.D)

Coverage under extension of medical benefits ends on the earliest of the following dates:

- the day before the day that you or your dependent cease to be totally disabled or stop receiving

regular treatment by a physician for the total disability;

- for benefits other than major medical expense benefits, the date that is 3 months after your termination date;
- for major medical expense benefits, the date that is 1 year after your termination date;
- the date you or your dependent become eligible for retiree benefit coverage;
- the date coverage ends for all employees of the contributing employer you worked for immediately prior to your eligibility for extension.

36. How do I qualify for an extension of life insurance? (Section 2.7.C)

The full life insurance amount listed under your Schedule of Benefits will be extended for you during periods of total disability for a maximum of 6 months from the date your life insurance would otherwise have ended.

37. When does life insurance coverage under the extension rules end? (Section 2.7.C & 2.7.D)

Life insurance coverage will end on the earlier of:

- the date that is 6 months after the date your coverage would have otherwise ended;
- the date on which you ceased to be totally disabled;
- the date coverage ends for all employees of the contributing employer you worked for immediately prior to your eligibility for extension.

Extension of Dental Benefits, Orthodontic Benefits and Vision Care Benefits

38. When is coverage for dental, orthodontic and vision expenses extended? (Section 2.8)

Coverage for dental, orthodontic and vision expenses is extended only for expenses that are incurred for treatment that started before coverage with the Fund ended.

39. When does coverage under the extension of dental, orthodontic and vision benefit end? (Section 2.8.B & 2.8.C)

Coverage under extension of dental, orthodontic and vision benefits ends on the earliest of the following dates:

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

COBRA

40. What is "COBRA?" (Section 2.10)

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 loss of coverage due to a "qualifying event."

41. 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.

42. What kind of COBRA benefits can my dependents and/or I buy from the Fund? (Section 2.10.B)
You and/or your dependents may choose the Health Plan that covered you immediately prior to the qualifying event or you may choose any equal or other lower priced plan offered by the Fund. You may choose dental and vision (non-core) benefits in addition to medical (core) benefits, if the option is available for the Health Plan you select.

If the last Schedule of Benefits that covered you immediately prior to the qualifying event did not provide dental and vision benefits, you can buy only core coverage from the Fund.

43. Can my dependents or I buy non-medical coverage on a COBRA plan? (Section 2.10.B)
No. Neither you nor your dependents can buy non-medical coverage when purchasing COBRA benefits. You cannot purchase life insurance benefits, accidental death and dismemberment benefits, or short-term disability income benefits.

44. When does COBRA coverage end? (Section 2.10.E)
You, your spouse and Qualifying Children can continue COBRA coverage until a "Termination Event" occurs. "Termination Events" are:

- the end of the 18-month period (or, as applicable, 29-month or 36-month period) of time as explained in Question 41;
- the date on which the Fund terminates or stops providing all health care coverage;
- the date on which you, your spouse, or Qualifying Children 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 you or your spouse, or Qualifying Children qualifies for Medicare;
- the first month for which a COBRA coverage premium is not paid in a timely manner; or
- the date your coverage is reinstated due to your employer's commencement of contributions.

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

45. How is COBRA coverage purchased? (Section 2.10.F & 2.10.G)
In order to purchase COBRA coverage, you must:

- notify the Fund Office of a qualifying event within 60 days of the later of:

    - the date the qualifying event occurred; or
    - the date you and/or your dependents lose coverage due to the qualifying event;
- you or a qualified beneficiary must complete the COBRA coverage election form, which will be sent to you and/or other qualified beneficiaries within 30 days of your notification to the Fund, 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 46).

46. When are COBRA premium payments due? (Section 2.10.G)
The first COBRA coverage premium includes payment for the current month plus the amount due for each month since you lost coverage due to a qualifying event. The first premium must be paid no later than 45 days after the date you elected COBRA coverage. The Fund will issue a billing statement 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. **

47. How much is COBRA coverage and who pays for it? (Section 2.10.H.2)
If you elect COBRA for yourself and/or your dependents, you (or your dependents) must pay the monthly COBRA payment in order to retain COBRA coverage for the month. The monthly payment is equal to the full annual cost of the medical coverage offered under the applicable Benefit Plan, divided by 12.

Unless otherwise provided in a collective bargaining agreement or participation agreement, neither the Fund nor any employer is responsible for paying any portion of the cost of your or your dependent's COBRA premiums.

The amount of your COBRA coverage premium, however, will be reduced by any employer contributions received by the Fund on your behalf during any month of COBRA continuation coverage for which you make a monthly payment.

If your employer's contributions plus your COBRA coverage premium payment exceed the cost of COBRA coverage, the excess will be promptly refunded to you but only up to the amount of your payment. Under no circumstances can excess employer contributions be applied to future months of COBRA coverage or refunded to you.

48. 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

49. 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;
- eligibility for Medicare:
  - copy of Medicare card or other official documents showing effective date;
- disability, as determined by the Social Security Administration, that started within the first 60 days you were eligible for COBRA coverage:
  - Social Security Administration disability determination;
  - disability must last at least 18 months for you to be eligible for an additional 11 months of COBRA availability.

Direct Pay

50. What is Direct Pay? (Section 2.9)
Direct Pay is a program that allows you to maintain eligibility for medical, dental, vision, or life benefits from the Fund if you are unable to maintain your benefits due to:

- a leave of absence;
- layoff;
- lack of work;
- expiration of coverage as explained in Questions 21 through 30; or
- reasons qualifying you for an extension of benefits as explained in Questions 31 through 38.

You may directly pay the Fund Office to keep your eligible benefits in place. Direct Pay allows you a choice of Benefit Plans. You may keep the Health Plan by which you were last covered as an active employee, or you may choose any equal or lower cost plan, for up to 18 months.

51. Are all benefits covered by Direct Pay? (Section 2.9.B)
Direct Pay provides all benefits listed in a Schedule of Benefits except the Short Term Disability Income Benefit.

52. How do I elect Direct Pay? (Section 2.9.C)
You may call the Fund Office to request an application packet. In the packet you will find worksheets which allow you to calculate the amount you must pay the Fund for the benefit plan you choose. Once you have made these decisions, you must return the Direct Pay application along with your payment.

53. How do I calculate my Direct Pay premium? (Section 2.9.F)
Your premium is based on the following:

- the Health Plan you elect;
- the number of weeks of contributions due in the month for which you elect coverage; and
- whether or not any contributions are paid by a contributing employer.

Please refer to your application packet for more details.

54. When are my payments due? (Section 2.9.E)
Payments are due by the 10th day of the month 2 months prior to the month for which you wish to purchase Direct Pay coverage.

55. How long may I pay Direct Pay? (Section 2.9.D)
Direct Pay is available for up to 18 months. If your active coverage reinstates and you lose coverage again due to any of the events listed in Question 50, you may again elect Direct Pay for up to another 18 months.

56. Does Direct Pay replace COBRA?
No. You may elect Direct Pay for up to 18 months. If at any time during the 18 months you fail to make your Direct Pay payment in full and on time, you will be offered COBRA continuation benefits (Question 40). Also, if you pay Direct Pay for the entire 18 months available and wish to continue paying for coverage, you may do so through COBRA.

<u>Qualified Medical Child Support Order</u>
57. What is a Qualified Medical Child Support Order? (Section 2.12.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 Qualifying Child. The person designated in the QMCSO is referred to as an Alternate Recipient.

58. 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 qualifying child. If joint custody exists, EOBs will also be sent to the Participant;
- 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 qualifying child's benefits will be sent to the Alternate Recipient.

59. To be qualified, what information must be provided in the order? (Section 2.12.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.

60. 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 2.12.D)
No. The order cannot change the type or form of benefits the Fund offers.

61. What are the Fund's responsibilities upon receipt of a medical child support order? (Section 2.10.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.

62. 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

<u>Termination of Group Coverage</u>
63. If my employer stops participating in the Fund, how will my family's eligibility be affected? (Section 2.18)
To the fullest extent permitted by law, including COBRA and its rules, if your employer stops participating in the Fund, you and your dependents will lose all eligibility to receive any benefits from the Fund. This means that no benefits will be provided for you and your dependent after your employer stops participating in the Fund.

Notwithstanding any other provision of this Summary, the Trustees of the Fund have the absolute and sole right to terminate or change the benefits of any and/or all Schedules of Benefits at any time, as they deem appropriate. In addition, the Trustees reserve the right to amend or terminate the Fund 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 as determined by the Trustees, including but not limited to medical, life insurance, disability, dental, vision 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.

Chapter 3: Benefits

This Chapter explains the types of benefits offered by the Fund. Subject to your Schedule of Benefits (as explained in Question 64) and the limitations and conditions set forth in the Fund, the general types of benefits offered by the Fund are as follows:

- Accidental Death and Dismemberment Insurance
- Life Insurance
- Short Term Disability Income Benefits
- Surgical and Medical Benefits
- Mental Health and Substance Use Disorder Benefits
- Prescription Drug Benefits
- Vision, Dental and Pediatric Orthodontic Care
- Rehabilitation Benefits
- Employee Assistance Program

Important: Not all of the Fund's Schedules of Benefits provide all of the benefits discussed in this Chapter. Check your Schedule of Benefits to find out if you and your family are eligible for a particular benefit.

64. What determines my Schedule of Benefits?

The collective bargaining agreement between your participating employer and your local union or the participation agreement between the Fund and non-collectively bargained groups determines the amount of contributions made to the Fund on your behalf. Your health benefits are based on a Schedule of Benefits related to the contribution rate contained in the collective bargaining agreement or participation agreement. The Schedules of Benefits (listed by participating employer) can be found on the Fund's website at http://www.tjc83funds.org/health-welfare.asp.

Accidental Death and Dismemberment Benefit

65. What is the Accidental Death and Dismemberment Benefit (AD&D)? (Section 3.2.A)

If you have an accident while you are covered by the Fund and you suffer certain losses, the Fund or its designated life insurance carrier will pay benefits to you or your beneficiary, in addition to any life insurance you may be due.

66. Who is covered by the Accidental Death and Dismemberment Benefit? (Section 3.2.A)

Only you, the participant, are covered by the Accidental Death and Dismemberment Benefit. This benefit is not available to your spouse or Qualifying Child(ren).

67. What losses are covered and how much is payable under the Accidental Death and Dismemberment benefit? (Section 3.2.A)

The amount of benefits payable under the Accidental Death and Dismemberment Benefit is equal to the percentage listed below, multiplied by the Accidental Death and Dismemberment benefit amount listed in your Schedule of Benefits.

Percentage of Accidental Death & Dismemberment (AD&D) Amount

Loss	Listed in Schedule of Benefits
Loss of life	100% of AD&D Benefit
Loss of 1 hand, 1 foot, or sight in 1 eye	50% of AD&D Benefit
Loss of more than one of the above in a single accident	100% of AD&D Benefit

"Loss of hands or feet" is defined as severance at or above the wrist or ankle. "Loss of sight" is defined as an entire and irrevocable loss of vision.

68. What is not covered by the Accidental Death and Dismemberment Benefit? (Section 3.2.C)

No payment will be made under the Accidental Death and Dismemberment Benefit if a loss results directly or indirectly from any of the following:

- illness or infection, except pyogenic (such as Staph or strep) from an accidental cut or wound, if the illness or infection is closely related to or contributes to the cause of loss;
- your commission of, or attempt to commit, an illegal act;
- war, declared or undeclared, or any act of war;
- your participation in insurrection, rebellion, riot or civil commotion.

For Example: Bob, a Fund Participant, is killed in a car accident. Because his death was accidental, his Beneficiary will receive the following, as listed in Bob's Schedule of Benefits: Life Insurance Benefit and 100% of the Accidental Death and Dismemberment Benefit.

69. Are there any additional provisions related to the Accidental Death and Dismemberment Benefit? (Section 3.2.D)

Yes, the following additional provisions apply:

- no legal action to obtain benefits from the Fund can occur any sooner than 60 days or later than 3 years from the date your proof of loss is received by the Fund.
- the Fund has the right to require the individual suffering the loss (other than loss of life) to be examined by a physician of its choice and as often as it deems necessary.
- if a claim is made for a loss of life, the Fund reserves the right to require an autopsy.

Chiropractic Expense Benefit

70. What does the Chiropractic Expense benefit cover? (Section 3.20.A)

If the Chiropractic Expense Benefit is listed in your Schedule of Benefits, it covers charges for eligible services and supplies provided or authorized by a chiropractor. To qualify for payment, the treatment must be:

- performed by a Doctor of Chiropractics;
- medically necessary to treat musculoskeletal problems of the spine; and
- within acceptable practice guidelines.

71. Is the Chiropractic Expense Benefit subject to the deductible, any visit limits, benefit maximums, co-payments, etc.? (Section 3.20.A)

Yes, the Chiropractic Expense Benefit is subject to the following:

- annual visit limit;
- co-payment; and
- co-insurance, if x-ray or lab services are performed and billed outside of the actual doctor's office or if any services are performed at an out-of-network provider.

Comprehensive Rehabilitation Expense Benefit

72. What does the Comprehensive Rehabilitation Expense Benefit cover? (Section 3.18.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 approved by the Fund's Medical Consultant, and essential for the necessary care and treatment of the non-work related injury or illness suffered:

- 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.

73. What is not covered by the Comprehensive Rehabilitation Expense Benefit? (Section 3.18.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

74. What does the Dental Expense Benefit cover? (Section 3.11.A, 3.11.C and 3.11.D)

If the Dental Expense Benefit is listed in your Schedule of Benefits, it 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.

75. How much is provided under the Dental Expense Benefit? (Section 3.11.A)

This depends on whether the charge is incurred in or out-of-network. If in-network, the Fund recognizes the charge after applying a discount for using a provider in the Fund's dental network. If using an out-of-network provider, the Fund limits payment to amounts considered reasonable and customary, according to the fee schedule maintained for this purpose by the Fund. In addition, benefits are payable up to the yearly family maximum amount listed in your Schedule of Benefits. This maximum does not apply to pediatric

care considered essential benefits.

76. What is not covered by the Dental Expense Benefit? (Section 3.11.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."

Diagnostic X-ray and Laboratory Expense Benefit

77. What does the Diagnostic X-Ray/Lab Expense Benefit cover? (Section 3.9.A)

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

- performed/read at a facility identifying itself as a facility ; or
- performed/read at a hospital and is unrelated to an emergency room visit or inpatient stay.

78. What is not covered by the Diagnostic X-Ray/Lab Expense Benefit? (Section 3.9.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 and billed 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;
- x-rays or laboratory work by a chiropractor for the treatment of musculoskeletal conditions of the spine, as such charges are considered under the Chiropractic Benefit;
- expenses not payable in accordance with Chapter 6, "General Limitations."

79. Is the Diagnostic X-Ray/Lab Expense Benefit subject to any cost-sharing provisions? (Section 3.9.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 Blue Cross/Blue Shield);
- out-of-pocket limits, which vary depending on your Plan's schedule of benefits..

Disease Management Program

80. What is provided by the Disease Management Program? (Section 3.5.A)

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

- 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)

81. Is the Disease Management Program subject to any cost sharing provisions? (Section 3.5.A)

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

82. How do I participate in the program?

A review of medical data is performed to identify chronic conditions you or your dependents may have, as listed in Question 80. 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

83. What is covered by the Emergency Room Benefit? (Section 3.7.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.

84. What is not covered by the Emergency Room Benefit? (Section 3.7.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".

85. Is the Emergency Room Benefit subject to any cost sharing provisions?
Yes, the Emergency Room Benefit is subject to the co-payment.

Pre-Certification and Inpatient Hospital Expense Benefit

86. What does the Inpatient Hospital Expense Benefit cover? (Section 3.6.A)
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.

87. How much does the Inpatient Hospital Expense benefit pay for room and board charges? (Section 3.4 & 3.6.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 guidelines. 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 consecutive days payable per year under the Inpatient Hospital Expense Benefit.

88. What are necessary services and supplies as related to the Inpatient Hospital Expense Benefit?
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.

89. If I have to travel to a hospital for an inpatient admission, will the Fund pay for lodging expenses? (Section 3.4.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.

90. Will the Fund pay any expenses for an early admission for surgery or weekend admission? (Section 3.4.C.1 & 3.4.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.

91. What is not covered by the Inpatient Hospital Expense Benefit? (Section 3.6.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."

92. Is the Inpatient Hospital Expense Benefit subject to any cost-sharing provisions? (Section 3.6.A)
Yes. The Inpatient Hospital Expense Benefit is subject to the following:

- co-insurance (the percentage is dependent upon whether the hospital participates with Blue Cross Blue Shield PPO Network);
- annual deductible;
- out-of-pocket limits, which vary depending on your Plan's schedule of benefits.

Life Insurance Benefit

93. What Life Insurance Benefits are provided by the Fund? (Section 3.1)
The Fund or its appointed life insurance carrier will pay you Life Insurance Benefits if one or more of your eligible dependents dies, or will pay your beneficiary Life Insurance Benefits upon your death. Proper proof of death must be received by the Fund Office in order to consider any payment of life insurance benefits. An eligible dependent for Life Insurance Benefits includes a child who was delivered still born within the last trimester of pregnancy, however the Fund will not pay life insurance benefits for a pregnancy terminated as a result of an abortion, even if the abortion was lawful.

94. How much is the Life Insurance Benefit?
Refer to your Schedule of Benefits for the Life Insurance Benefit amounts.

95. How do I name a beneficiary? (Section 3.1.A.3)
When completing your enrollment form, you will be asked to designate a beneficiary.

96. Can I change my beneficiary of my life insurance benefit? (Section 3.1.A.3)
Yes. You can change the beneficiary of your life insurance at any time by filing a written request with the Fund Office. You do not need to get permission from the present beneficiary to make such a change.

97. Can I name my estate as the beneficiary of my life insurance benefit? (Section 3.1.A.3)
No.

98. What happens if I die and my beneficiary is a minor? (Section 3.1.C.2)
If your beneficiary is a minor, life insurance benefits will be paid to a guardian or other legally appointed representative of the child. If there is no guardian or representative, the Fund may make payments to the person or institution that has custody of the minor.

99. What happens if I die without naming a beneficiary or if my beneficiary dies before me? (Section 3.1.A.2)

If there is no beneficiary on file for you or if your beneficiary dies before you or within 24 hours of you, your life insurance benefit will be paid in the following order or priority:

- your spouse;
- your children;
- your mother and/or father;
- the executor or administrator of your estate.

100. Who receives the benefits for the death of my spouse and/or children? (Section 3.1.B)

You will receive the benefits available. If you also die, benefits available on behalf of your spouse and/or children will be paid in the following order of priority:

- the dependent's mother and/or father;
- the dependent's children;
- the dependent's brother or sisters;
- the dependent's executor or administrator.

101. Can I have any of my Life Insurance benefit sent to a funeral home to cover my burial cost? (Section 3.1.C.1)

Yes. The Fund requires proper assignment from you or your beneficiary and an itemized statement from the funeral home to make payment on your burial costs.

Major Medical Expense Benefit

102. What expenses are paid under the Major Medical Expense Benefit? (Section 3.14.B)

In general, the Fund pays Major Medical Expense Benefits for expenses actually incurred by you or a covered dependent for medical services and supplies which are recommended by a Physician and are essential for the necessary care and treatment of an injury or illness, subject to the applicable deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket maximums, and network status, and in the percentage, specified in your Schedule of Benefits, as determined pursuant to the Fund and subject to your Schedule of Benefits. For this purpose, an "illness" means any physical illness, mental illness, functional nervous disorder, and pregnancy.

Unless covered by other benefits provided by the Fund, the following expenses are payable under the Major Medical Expense Benefit (in general as long as provided other than by a member of your family):

- Charges made by a Hospital, not to exceed the amount shown in the applicable Schedule of Benefits;
- Charges made by a Physician, psychologist, psychiatrist, midwife, or ophthalmologist in accordance with his or her license for professional services;
- Charges made by a licensed counselor, mental health professional, or social worker for professional services;
- Charges made by a Registered Nurse or a Licensed Practical Nurse 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; 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 home, the maximum amount payable shall be determined by the Fund's preferred provider network's allowable charge;

- Charges for women's health services, contraception, pre- and post-natal care, delivery, and inpatient services associated with pregnancy;
- Charges for outpatient and inpatient mental and behavioral health services and substance use disorder services;
- Charges made for prescription drugs lawfully obtainable only upon the written prescription of a Physician by a participant or 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;
- If provided in your Schedule of Benefits, charges made for the purchase of one (1) set of hearing aids for any five (5) year period, up to the applicable fee schedule. Such hearing aids must be prescribed by a licensed ear, nose and throat physician based on the results of the following diagnostic services: complete examination, audiogram (air/bone/speech), impedance audiometry, and hearing aid evaluation;
- 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, osseous surgery not connected with dental implants, or medical procedures relating to the treatment of the lips, tongue or cheeks;
- Charges for rehabilitative services, physical therapy, speech therapy or occupational therapy;
- Charges for home health care, for hospice care, or for a nursing home or a nursing or rehabilitative 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.

103. How much is payable under the Major Medical Expense Benefit? (Section 3.14.A)
Refer to your Schedule of Benefits and Summary of Benefits and Coverage ("SBC") for applicable deductibles, discounts, coinsurance, co-payments, fee allowances, out-of-pocket maximums, and the percentage of Major Medical Expenses payable for in-network and out-of-network services.

104. What charges are not included in the Major Medical Expense benefit? (Section 3.14.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 non-medically necessary hearing aids;
- 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 or 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 consecutive 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 musculoskeletal conditions of the spine, except as provided for in Question 70;
- Charges related to the treatment of learning disabilities;
- Charges for which benefits are not payable under the Fund according to Chapter 6, "General Limitations";
- Charges for the drug Spinraza.

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.

105. Is the Major Medical Expense Benefit subject to any cost sharing provisions? (Section 3.14.A)
Yes. The Major Medical Expense Benefit is subject to the following:

- annual deductible;
- co-insurance;
- annual visit limit (physical therapy, speech therapy, occupational therapy);
- out-of-pocket limits, which vary depending on your Plan's Schedule of Benefits;
- Preventive services are subject to cost-sharing while the Fund is "grandfathered" as described in Question 189.

Newborns' and Mothers' Health Protection Act of 1996

106. Does the Fund provide benefits under the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)? (Section 3.4.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 days following a vaginal delivery and 4 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

107. What is the Out-of-Pocket Expense Benefit? (Section 3.16.A & 3.17.A)

For purposes of the Out-of-Pocket Expense Benefit, the term "out-of-pocket" is the amount you must pay, excluding your annual deductible or co-payments, as the co-insurance percentage referred to in your Schedule of Benefits. Once your "out-of-pocket" co-insurance 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.

108. What expenses are not covered by the Out-of-Pocket Expense Benefit? (Section 3.16.C & 3.17.B)

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

- Co-payment when utilizing a network doctor or the emergency room, unless you participate in a non-grandfathered plan as described in Question 189;
- Dental, vision, and orthodontic 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 unless you participate in a non-grandfathered plan as described in Question 189;
- Charges covered under Extension of Medical Benefits unless you participate in a non-grandfathered plan as described in Question 189;
- 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 or notification requirements;
- Charges applied to the annual deductible, unless you participate in a non-grandfathered plan;
- Charges that are in connection with follow-up care related to the Organ Transplant Benefit, unless you participate in a non-grandfathered plan;
- 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 of Benefits Plan 12 has satisfied the out-of-pocket maximum for co-insurance. He is admitted to an in-network hospital for a 3-day stay. If Steve had not already reached his Out-of-Pocket Benefit 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.

Employee Assistance Program

109. What is the Employee Assistance Program? (Section 3.21)

The Employee Assistance Program (or EAP) provides confidential, short term counseling for a variety of problems through Anthem. The program is available to participants whose employer does not provide an EAP, is free to use and provides assistance for eligible members in areas such as:

Mental Health	Eldercare Issues
Childcare Issues	Family Conflict
Financial Issues	Alcohol & Drug Problems
Stress Management	Legal Concerns

110. Who is eligible for assistance? (Section 3.21)

You and any other members of your household may use the EAP services if "EAP" is listed on the back of your medical identification card. If "EAP" is not listed on the back of your medical identification card, the benefit is provided by your employer.

111. How does the program work?

Call the toll free number, 800-346-5484, to speak to a counselor. Once the initial assessment is made, further short term counseling may be recommended through an EAP affiliate in your area. Any contact with the EAP is strictly confidential. Information regarding your utilization of this service is not available to your employer, the Fund Office or the union.

Organ Transplant Expense Benefit

112. What does the Organ Transplant Expense Benefit cover? (Section 3.19.A, 3.19.B & 3.19.C)

If listed in your Schedule of Benefits 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); and
- coverage will be provided for follow-up care in the hospital or the home. Immunosuppressant drugs are provided under the prescription drug program benefit.

113. Is the Organ Transplant Expense Benefit subject to any cost-sharing provisions? (Section 3.19.A & 3.19.B)

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

- deductible;
- co-insurance;
- out-of-pocket limits, which vary depending on your Plan's Schedule of Benefits.

Follow-up care, if included in your Schedule of Benefits, is subject to:

- deductible;
- co-insurance;
- out-of-pocket limits, which vary depending on your Plan's Schedule of Benefits.

114. What expenses are not covered under the Organ Transplant Expense Benefit? (Section 3.19.D)
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 unless an approved clinical trial if a participant of a non-grandfathered plan;
- Expenses for the transportation of surgeons or family members; and
- Expenses related to an organ transplant that is not performed at a transplant facility approved by the Fund's medical consultant; and
- Any limitations set forth in Chapter 6 "General Limitations".

Orthodontic Expense Benefit

115. What does the Orthodontic Expense Benefit cover? (Section 3.12.A)
If listed in your Schedule of Benefits, the Orthodontic Expense Benefit covers orthodontic treatment for your qualifying children under the age of 18 for the following conditions:

- Extreme bucco-lingual version of teeth;
- Protrusion of maxillary anterior teeth;
- Maxillary or mandibular arch that is either protrusive or retrusive relaxation; or
- Malalignment of teeth which unquestionably interferes with function or creates marked facial deformity.

Benefits up to the maximum available will be paid upon submission of appropriate claim forms without consideration of whether treatment began during a period of eligibility, but whether treatment is still being provided upon the initial date of Orthodontic Care Expense Benefit eligibility. The maximum listed in your Schedule of Benefits will not apply to orthodontics considered Essential Benefits as defined by the Affordable Care Act.

116. Are orthodontic benefits subject to a waiting period? (Section 2.14.B)
Yes, benefits are available on the first day of the calendar month following the date your coverage has been in effect 24 months unless you become eligible for coverage as a transfer from another Teamster health & welfare fund.

117. What expenses are not covered by the Orthodontic Expense Benefit? (Section 3.12.B)
The following expenses are not payable as an Orthodontic Expense Benefit:

- Service or supplies incurred after age 17, even if the qualifying child meets the definition of dependent or is in any way incapacitated;
- Charges for the replacement of lost or stolen appliances, and the repair of appliances damaged when not in the mouth;
- Charges for supplies normally used at home (for example, toothpaste, toothbrushes, waterpiks, and mouthwashes);
- Expenses incurred for a dental service that is not performed by or under the supervision of a physician or dentist;
- Expenses that are not payable according to Chapter 6, "General Limitations;" and
- Expenses incurred during the applicable waiting period.

Physician Office Visit Benefit

118. What is covered by the Physician Office Visit Benefit? (Section 3.15.B)

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 a facility identifying itself and billing as a doctor's office. In addition, the Physician Office Visit Benefit covers charges submitted by a licensed psychologist, licensed optometrist or ophthalmologist, licensed counselor, mental health professional 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.

119. What if another provider bills for lab and/or x-ray services even though they may be performed in the doctor's office?

If a provider other than your doctor bills for your x-ray or lab work, the Fund will pay the x-ray and lab bills under the Diagnostic X-ray and Laboratory Expense Benefit. (See Questions 77 and 78)

120. What is not covered by the Physician Office Visit Benefit? (Section 3.15.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".

121. Is the Physician Office Visit Benefit subject to any cost-sharing provisions? (Section 3.15.A)

Yes. The Physician Office Visit Benefit is subject to the following based on your Schedule of Benefits:

- co-payment;
- co-insurance;
- deductible;
- out-of-pocket limits, which vary depending on your Plan's schedule of benefits.

Prescription Drug Expense Benefit

122. What is the Prescription Drug Expense Benefit? (Section 3.10)

The Prescription Drug Expense Benefit provides you, your spouse and Qualifying Children benefits for drugs and other allowable supplies through participating retail pharmacies or the Optum Rx Mail Order Pharmacy or the BriovaRx specialty pharmacy.

123. What expenses are covered by the Prescription Drug Expense Benefit? (Section 3.10.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.

124. 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 Optum Rx's Mail Order Pharmacy. "Specialty" drugs include: (a) biotechnology drugs; (b) orphan drugs used to treat rare diseases; (c) typically high-cost drugs; (d) drugs administered by oral or injectable routes, including infusions in any outpatient setting; (e) drugs requiring on-going frequent patient management or monitoring; and (f) drugs that require specialized coordination,

handling and distribution services for appropriate medication administration. Some specialty drugs can be obtained at an in-network retail pharmacy. Other specialty drugs are required to be purchased from BriovaRx Mail Order Pharmacy, a part of the Optum Rx family. Please contact the Fund Office to verify the requirements for the particular drug you are prescribed.

125. Is the Prescription Drug Expense Benefit subject to any cost-sharing provisions? (Section 3.10.A)

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

- co-insurance; or
- co-payment; and
- if a participant of a non-grandfathered plan, the prescription out-of-pocket limit.

126. What expenses are not covered by the Prescription Drug Expense Benefit? (Section 3.10.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 programs, step therapy or quantity limit;
- Drugs listed on the Formulary Exclusion list; and
- Drugs and medicines not payable in accordance with Chapter 6 "General Limitations";
- Spinraza.

Procedures Requiring Pre-certification

127. 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.

Short-Term Disability Income Benefit

128. What is covered by the Short-Term Disability Income Benefit? (Section 3.3.A)

The Short-Term Disability Income Benefit pays a weekly benefit to you, if you become "disabled" while eligible for benefits.

Short-Term Disability benefits are available for up to 26 weeks per a given illness or injury. If you return to work and did not use all 26 weeks, you may use the balance if you qualify for Short-Term Disability benefits in the future and suffer a reoccurrence of the same injury or illness. See Q 135 for treatment in the case of different injuries or illnesses.

129. How is the term "disability" defined? (Section 3.3.A)

For purposes of the Short-Term Disability Income Benefit, the term "disability" means that you are completely unable to perform the duties of your job.

130. Who is covered by the Short-term Disability Income Benefit? (Section 3.3.A)

The Short-Term Disability Income Benefit provides benefits only for you as a participant and not to your dependents.

131. What does the Fund Office need to start Short-Term Disability Benefits?

To begin Short-Term Disability Benefits, a Disability Claim Form must be completed, including your statement of disability, treatment information from your Physician and a statement from your employer providing the date you last worked, and if available, the date you returned to work.

132. How much is payable under the Short-Term Disability Income Benefit? (Section 3.3.A)

The amount payable under the Short-Term Disability Income benefit can be found in your Schedule of Benefits.

133. When do Short-Term Disability Income Benefits start? (Section 3.3.B)

For Injuries

If the disability is caused by an injury, benefits will start on the first day that you receive treatment by a Physician after the date you last worked because of the injury. Please note, if the disability begins more than 90 days after the injury occurs that results in the disability, benefits will be provided under the same guidelines established for illness (see below).

> *For Example*: Jake is injured on June 24, and misses work on June 25 because of the injury. He is treated by a Physician on June 26. The Physician states that Jake has been disabled since the injury happened on June 24. When does Short-Term Disability start?
> Jake's Short-Term Disability Income benefits start on June 26; because that is the first day he was treated by a Physician after his date last worked.

For Illness

If the disability is caused by an illness, you must satisfy a waiting period before Short-Term Disability Benefits begin. The waiting period starts on the first day you receive treatment by a physician after the date you last worked because of the illness. The waiting period is 7 days (beginning with the date of the first treatment). Short-term Disability Income Benefits start on the eighth day.

> *For Example:* On July 15, Tyler left work because he was sick. Still out sick on July 18, Tyler saw his doctor. The doctor stated that Tyler's disability started on July 15. Tyler's Short-Term Disability Income Benefits start on July 25. Why?
>
> July 15 Tyler's last day worked;
> July 18 Tyler's first contact with his doctor after his last day worked;

July 18	First day of the 7-day waiting period;
July 24	Last day of the 7-day waiting period;
July 25	Short-Term Disability Benefits start.

134. When do Short-Term Disability Income Benefits end? (Section 3.3.C)

Short-Term Disability Income Benefits end on the earliest of the following dates:

- the last day that you are disabled, except when you have been released to light duty by your Physician and there is no light duty available from your employer;
- the end of the maximum payment period listed in your Schedule of Benefits;
- the day that your employer ceases to be a participating employer with the Fund;
- the date you begin receiving Social Security benefits, retirement benefits from any union, union-management pension fund or any other retirement plan;
- the date of your death.

135. What happens if I return to work but then become disabled again? (Section 3.3.D)

If the two periods of disability are caused by unrelated injuries or illnesses, they will be treated as separate periods of disability if they are separated by a return to active employment for at least 1day.

For Example: Ronnie returned to work on March 5 after being out on disability for an appendectomy. On March 7, on his way home from work, Ronnie is involved in a car accident and breaks his leg. He is taken to the hospital and treated for his injuries. Ronnie's doctor states he is disabled as of March 7, the date of the accident.

Because this period of disability is not related to his appendectomy, which caused the first period of disability, and Ronnie returned to work for at least one day, the disability beginning March 7 is treated as a separate and new period of disability. Ronnie is eligible to receive up to the maximum number of weeks of disability listed in his Schedule of Benefits provided his coverage was in effect at the start of his new disability.

136. What is not covered by the Short-Term Disability Income Benefit? (Section 3.3.E)

Short-Term Disability Income Benefits will not be paid for the following:

- a disability that is caused by an injury or illness arising out of, or in the course of, any employment for wage or profit, or for which you are entitled to benefits under Worker's Compensation or a similar law;
- any disability after you begin receiving Social Security benefits and/or your retirement benefits (this rule does not apply if you are receiving retirement benefits solely because you reached 70.5 years of age);
- a disability incurred while you are on strike;
- a disability that starts while you are on layoff, unless employer based coverage with the Fund is effective when you become disabled;
- any period of disability when you are receiving payment of any kind for working in any type of job;

- any period in which the employee receives his regular salary from his employer.

Surgical Expense Benefit

137. What is covered by the Surgical Expense Benefit? (Section 3.8.A & 3.8.B)

The Surgical Expense Benefit covers the surgeon's charge for services performed for you or a dependent, 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.

138. How are multiple procedures performed during the same surgery considered for payment? (Section 3.8.C)

- 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.

139. Is the Surgical Expense Benefit subject to any cost sharing provisions or limitations? (Section 3.8.A & 3.8.F)

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

- deductible;
- co-insurance;
- out-of-pocket limits, which vary depending on your Plan's schedule of benefits.

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

Vision Care Expense Benefit

140. What expenses are payable under the Vision Care Expense Benefit? (Section 3.13.A)

If listed in your Schedule of Benefits, the Vision Care Expense Benefit covers charges incurred by you or a dependent by a licensed optometrist or by a physician for a complete eye examination. It also covers charges for lenses, frames, or contact lenses.

141. How much is payable under the Vision Care Expense Benefit? (Section 3.13.A)

Refer to your Schedule of Benefits to find out how much is payable for out-of-network charges. Refer to the EyeMed benefit summary to determine what you must pay for in-network charges.

142. What is the Vision Care Network?

The Fund's Vision Care Network is made up of optical providers that offer you and your eligible dependents vision care at a discounted price.

A listing of EyeMed Vision Care Network providers may be requested from the Fund Office or downloaded from their website at www.eyemedvisioncare.com.

143. Are my dependents and I required to use the Vision Care Network?
No, but if you choose to use an out-of-network provider, your out-of-pocket expenses may be higher.

144. What expenses are not covered by the Vision Care Expense Benefit? (Section 3.13.B)
The following expenses are not covered by the Vision Care Expense Benefit:

- Expenses for more than 1 complete eye examination in any 1 calendar year;
- Expenses for more than 1 set of eyeglasses (frames and lenses) **OR** contact lenses in any 1 calendar year;
- Expenses for sunglasses, tinted contact lenses, tinted glasses or their fitting unless prescribed by a physician or licensed optometrist for the treatment of a visual defect, injury or disease; expense for the surgical care of an eye disease or injury;
- Expense for artificial eyes;
- Expenses for visual training, and reading rate and comprehensive studies; and
- Expenses listed in Chapter 6, "General Limitations".

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

145. 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 debilitative medical conditions. You can do this by:

- utilizing the free services of the Fund's Employee Assistance Program;
- 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.
- and filling and taking prescriptions as directed by your doctor.

146. 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.

147. 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).

148. What are the requirements for the pre-certification of my in-patient admission to a hospital? (Section 3.4.A & 3.4.E)
You or your covered dependents must contact the Fund's Designated Medical Consultant at 888-852-8382 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:

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

149. If I don't notify the Fund's Designated Medical Consultant as described, will there be a penalty? (Section 3.4.B)
Yes. Failure to contact the Fund's Designated Medical Consultant as referenced in Question 148 will result in a $500 reduction of the Fund's payment for benefits relating to the inpatient admission.

150. 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;
- Name of your employer;
- Patient's name;
- Diagnosis (reason for treatment);
- Type of surgery, if any, to be performed;
- Date of admission;
- Name and phone number of the hospital; and
- Physician's name, address, and phone number.

151. 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 inpatient hospital admission is not deemed medically necessary, you may be completely responsible for payment of all charges connected with your admission.

152. 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

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

A Preferred Provider Organization is a group of Physicians, 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.

154. Which PPO does the Fund use?

The Fund uses the Anthem PPO Network.

155. Am I required to use a PPO Physician, 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 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.

156. How do I learn which Physicians, 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 Fund 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.

157. What is not covered by the Fund? (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:
    o the amount of benefits paid by the Fund on your behalf; or
    o 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 allowed 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, chiropractor 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, chiropractor 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 or chiropractor;
- 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 in connection with artificial insemination or any other means to promote pregnancy;
- Charges that are for services not listed or otherwise described in the Schedule of Benefits or Fund 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 40 through 49 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 covered dependent which resulted from the participation in any illegal act;
- Charges 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;
- Expenses relating to pre-certification procedures defined in Question 127 unless approved by the Fund's Medical Consultant;
- Services, procedures, and prescription drugs with a date of service prior to August 25, 2015 related to gender reassignment;
- No payment will be made for any charge for service rendered by a member of your or your Dependent's family;
- Spinraza.

Chapter 7 Claim Filing and Claim Payment

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

158. 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.

159. Who files claims with the Fund?

Your doctor, dentist, hospital, chiropractor, 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.

Disability Claims

160. How do I file a disability claim?

You must file a disability claim form with the Fund for the payment of disability benefits. Disability claim forms are available at the Fund Office and can also be downloaded from our website at www.tjc83funds.org.

You must complete and sign "Section 1" of the form, your employer must complete and sign "Section 2" and your doctor must complete and sign "Section 3." Disability claim forms without all 3 sections complete will not be processed and can result in a delay in your benefits if you may be eligible for.

161. 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.

162. 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.

163. 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.

164. 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.

165. 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 in 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.

166. 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.

167. 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,
- maxillo-facial surgery,
- hysterectomy
- bariatric (weight loss) surgery

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
- is determined to be urgent by an individual acting on behalf of the Fund applying the judgment of a prudent layperson who possesses average knowledge of health and medicine.

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, Visions, 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
Life Insurance, Accidental Death and Dismemberment	90 days	90 days
Short Term Disability Benefits	45 days	Two 30 day extensions

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 or your authorized representative 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

168. 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 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 written payment arrangement is made.

If the overpayment is made to an in-network service provider such as a doctor or hospital, the Fund will refer the matter to 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

169. 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 5.3 & 5.4)

If you or your spouse is offered free group health insurance, you are required to enroll in the plan offered unless you would be forfeiting any other benefit (i.e., additional vacation).

"Coordination of benefits" indicates that you or your dependents have health coverage with more than one group health plan, including Medicare, 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.

170. 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:

- Medicare is primary as permitted by law;
- 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 Benefit Plan that covers the person as a dependent is secondary;
- for a qualifying child, the plan of the parent whose birthday (month and day) comes first during the calendar year will be primary, except as explained below;

In cases where the parents are separated or divorced:

- for qualifying children under the age of 18, the plan of the parent who is court ordered to provide health coverage, will be primary. If no such 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, and the plan of the noncustodial parent will be third. If the parents have joint custody of the child, the parent who claims the qualifying child for tax purposes will be primary;
- for qualifying children age 18 and older, the plan of the parent with whom the qualifying child resides, will be primary. If the qualifying child lives with neither parent, the plan of the parent whose birthday (month and day) comes first during the calendar year will be primary.

<u>Additional Coordination of Benefits Guidelines:</u>

- under some plans, the coordination of benefits rules for qualifying 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 qualifying 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.

  <u>For example:</u> 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.

171. Are there situations for which the Fund will not pay benefits as a secondary payer? (Section 5.2.D & Section 5.3)

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 other coverage was available free of charge that, if utilized, would have been the primary carrier for the charges under review. However, if the coverage was rejected because other benefits would be forfeited (i.e. additional vacation), this rule would not apply;
- the Fund will not pay any benefits if other coverage would have been available had your dependent filled out the proper enrollment forms or enrolled during the proper enrollment period.

172. How are secondary payments calculated?

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.

<u>Subrogation</u>

173. 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, prescription, accidental death and dismemberment, short term disability 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.

174. 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.

175. Subrogation seems to apply to non-work related injuries or illnesses. What happens if I am injured on the job?

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

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

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 3 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.

177. 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.

178. 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 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.

179. What is considered a "document, record or other information" as referenced in Question 178?
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."

180. 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 3.4.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.

If you are a participant in a non-grandfathered plan, as described in question 189, refer to the Addendum for information regarding additional review procedures that may apply.

181. 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.

182. 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.

183. Are there any special rules that would change the time frame listed in Question 182?
Yes.

<u>Urgent Care Claims</u>
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 15 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.

184. 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.

185. 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 U.S. Department of Health and Human Services' HIPAA Privacy Regulations, as simplified effective March 26, 2013("Privacy Regulations"). The following describes how the Fund Office may lawfully use or disclose your protected health information.

As part of its operations, 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. This information is referred to in this Summary and defined in the Privacy Regulations as "Protected Health Information" or "PHI". PHI is information that is identifiable to an individual.

The Fund is required by law to maintain the privacy of your Protected Health Information.

A. The Fund's use and disclosure of your Protected Health Information is limited to treatment, payment or healthcare operations, as follows:

- 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 over the age of 26 seeking approval of the drug Retin-A to ensure that the drug is not prescribed for cosmetic reasons;
- Payment. The Fund may use or disclose Protected Health Information to a person or entity for the purposes of carrying out the Fund's payment activities, such as to doctors or other healthcare providers, other insurance carriers and occasionally other third parties. For example, the Fund may receive Protected Health Information from your doctor's office about your office visit and the diagnosis in order to make payment to the doctor on your behalf. The Fund may disclose your Protected Health Information to a healthcare provider, another health plan, or health care clearinghouse for their payment activities. We may disclose your information to another health plan, for example, for the purpose of coordinating their and our benefits;
- Health Care Operations. The Fund may disclose your Protected Health Information to facilitate its health care operations, such as underwriting, contribution establishment, and other activities relating to health insurance, business planning, and business management. For example, as part of the Fund's health care operations, it may receive Protected Health Information from its care management company about an inpatient hospital stay. The Fund may disclose Protected Health Information to another health plan, health care clearinghouse or health care provider for the health care operations activities of that entity, if both the Fund and the other entity either has or had a relationship with you, the Protected Health Information pertains to the relationship, and the disclosure is for the purpose of conducting quality assessment and improvement activities or for the purpose of health care fraud and abuse detection or compliance;
- 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, 2016.

- 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. Inquires 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.

<u>Statement of Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)</u>
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.

Chapter 11 Miscellaneous

186. 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.

187. 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.

188. Does the Fund have a website?
Yes. For additional information regarding your benefits, please log on to our website at www.tjc83funds.org

189. Is the Fund considered a "grandfathered health plan"?
The Fund administers group health plans that qualify as "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act) as well as a group health plan that do not. Whether you are covered under a grandfathered health plan depends on the Plan specific to your employer. You can contact the plan administrator, as outlined below, to determine whether you are covered by a grandfathered health plan. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Information specific to participants in a non-grandfathered health plan appears in the Addendum for Participants in a Non-grandfathered health plan, which immediately follows this Question 189. You should consult your specific Plan and Schedule of Benefits to determine the coverage that applies to you.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Michael McCall, CEBS at (804) 282-3131 or toll free at 800-852-0806. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Addendum – Information for Participants in a Non-Grandfathered Plan

Information contained in this Addendum applies ***only*** to participants in a non-grandfathered plan, as described in Question 189. You must consult your Plan document and Schedule of Benefits to verify i) that your Plan is a Non-Grandfathered Plan, and ii) that your Plan includes the features described in this Addendum. You may direct questions regarding grandfathered plan status to the plan administrator, as described in Question 189.

Preventative Care and Other Benefits

If you are a participant in a non-grandfathered plan, your Plan and Schedule of Benefits may provide that certain Fund rules regarding payment for preventative care, out-of-pocket or annual benefit limits, or other provisions do not apply or apply differently. As noted in the main text of the SPD, a Plan's status as a non-grandfathered plan may affect the information noted in the following Questions:

79. Is the Diagnostic X-Ray/Lab Expense Benefit subject to any cost-sharing provisions? (Section 3.9.A)

92. Is the Inpatient Hospital Expense Benefit subject to any cost-sharing provisions? (Section 3.6.A)

105. Is the Major Medical Expense Benefit subject to any cost sharing provisions? (Section 3.14.A)

108. What expenses are not covered by the Out-of-Pocket Expense Benefit? (Section 3.16.C & 3.17.B)

113. Is the Organ Transplant Expense Benefit subject to any cost-sharing provisions? (Section 3.19.A & 3.19.B)

114. What expenses are not covered under the Organ Transplant Expense Benefit? (Section 3.19.D)

121. Is the Physician Office Visit Benefit subject to any cost-sharing provisions? (Section 3.15.A)

125. Is the Prescription Drug Expense Benefit subject to any cost-sharing provisions? (Section 3.10.A)

139. Is the Surgical Expense Benefit subject to any cost sharing provisions or limitations? (Section 3.8.A & 3.8.F)

Again, you should consult your Plan document and Schedule of Benefits as your Plan's non-grandfathered status may affect the information contained in other Questions aside from those listed above.

External Review Provisions

If you are a participant in a non-grandfathered plan, you may be able to pursue review procedures that are in addition to the appeal procedures described in Chapter 8 of the SPD.

Addendum to Question 180. Who reviews and rules on an appeal?
If you are a participant in a non-grandfathered plan, you may request external review once the appeals procedure has been exhausted. Under this procedure, the Plan will refer your appeal to an Independent Review Organization (Sections 6.2.G, 6.2.H, and 6.2.I). If you are covered by this procedure, you must file a request for external review within four months of the date you received the final adverse benefit determination.

Addendum to Question 182. When should I expect a decision on my appeal from the Board of Trustees?
If you are a participant in a non-grandfathered plan and file a request for external review, you will receive a decision from the Independent Review Organization (IRO) within 45 days of the IRO's receipt of your request for review.

Addendum to Question 184. Is the Board's decision concerning my appeal final and binding?
If you are a participant in a non-grandfathered plan, you may have the option of filing a request for an external review as described in the Addendum to Question 180.