
# USW District 10, Local 286 Welfare Trust Fund

# Summary Plan Description and Plan Document

Amended and restated January 1, 2018

# USW District 10, Local 286
# Welfare Trust Fund

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To All Employees:

We are pleased to present this booklet describing the benefits of the Health and Welfare Plan offered to members of the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers Union, Local 286. These benefits represent financial protection for you and your covered dependents. We urge you to read this material carefully and to become familiar with the rules and regulations of the USW District 10, Local 286 Welfare Trust Fund (the "Plan" or "Fund" or "Trust Fund") and the benefits that you and your dependents may be entitled to from the Plan. You should know that we, as the Board of Trustees, have overall responsibility for running the Plan, and are the "Plan Administrator," for the Plan. When you see "Plan Administrator" in this document, you should know that the term refers to us or, where appropriate, to the individuals working in the Fund Office to whom we have delegated the responsibility for administering the Plan and its benefits on a daily basis.

Certain benefits offered under the Plan are currently provided under insurance contracts entered into between the Plan and various insurance carriers. These benefits are described in this document, and in the certificates of insurance and benefits booklets issued by the insurance companies, which are incorporated into this Summary Plan Description and Plan document by reference.

This document provides general information about these benefit plans that may not be covered in the individual plan booklets, including:

- Information about who is eligible, how you enroll for coverage, and how and when you may change your benefit elections;
- Key facts about how the benefit plans are administered (you may need this information when you file certain claims); and
- A statement of your rights under the Employee Retirement Income Security Act of 1974 (ERISA), which is a federal law that concerns the funding and administration of benefit plans and your right to benefits and communications about those benefits.

Thus, this document (along with insurance agreements) constitutes the Plan document, according to which the Plan is operated. This document is also the Plan's Summary Plan Description, also as required by the law. This document provides no guarantee that you are eligible to participate in every benefit or program described. Different eligibility provisions and benefit levels apply to employees with different employers. Specific material will be provided to you that apply to employees of your Employer. Please refer to "Plan Administration and Other Important Information" for information regarding contributing employers. Each benefit program may have its own eligibility requirements, so be sure to review individual eligibility requirements set forth in this document and the booklets issued by the insurance companies and service providers carefully.

The Plan, through this document and referenced documents, is a plan document and a summary plan description and is intended to satisfy the written document requirements of section 402 of ERISA. An amendment to this document is considered an amendment to the official Plan document.

The Plan provides benefits in accordance with applicable federal laws, including the Children's Health Insurance Program Reauthorization Act of 2009, the Consolidated Omnibus Budget Reconciliation Act, ERISA, the Health Insurance Portability and Accountability Act, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, the Genetic Information Nondiscrimination Act, and the Patient Protection and Affordable Care Act.

The protection provided by this Plan is important to you and your family. Learn as much about these benefits as you can. If you have questions or would like additional information, contact the Fund Office.

Respectfully yours,

THE BOARD OF TRUSTEES

By: Carlo Simone, III - Office Manager

# Important to Remember

You pay nothing toward the cost of this Plan (although you may be required to make a contribution towards the cost of medical or other coverage). Your Employer is obligated under the terms of the collective bargaining agreement or participation agreement with District Local 10-286 (or other participating locals) to make contributions for employees in the collective bargaining unit. These contributions together with any employee contributions are paid to the Trust Fund. The Fund accumulates these monies and they become the assets of the Trust Fund and are used to pay insurance premiums and other Fund expenses. If your Employer is not paying into the Fund on your behalf, please contact your Union Office so that your rights under the Fund may be protected.

For further information or claim forms, call or write:

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410-424 North 8th Street
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Telephone: 215-829-9212

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# Contents



This document incorporates by reference one or more specific booklets or plan summaries that describe in more detail certain of the benefit specific provisions governing the USW District 10, Local 286 Welfare Trust Fund.

# Eligibility Rules

**Commencement of Eligibility**
In general, all new employees shall become eligible for benefits following a period of employment with a Contributing Employer (but no longer than 90 days), provided the required contributions are made by the Employer on their behalf. The length of your eligibility period depends on the provisions of the collective bargaining agreement or participation agreement with your Employer. In order to receive benefits under the Plan, some benefit programs require you to enroll, while for others, coverage is automatic. Your Employer will provide documentation that completely explains the eligibility provisions and benefit levels.

Generally your spouse and eligible children or other dependents become eligible for coverage at the same time you become eligible. However, this rule may vary from benefit to benefit. Please refer to the conditions and limitations to eligibility that is provided in the certificates of insurance and benefits booklets provided by the applicable insurance companies.

**Continuation of Eligibility**
Once you become eligible, coverage will remain in effect as long as your Employer continues to make the required contributions on your behalf. In the event an employer fails to make the required contributions to the Fund, the Fund reserves the right to cancel your coverage. Currently, plan rules require that eligibility will cease on the day following the day your employer is 45 days in arrears on its monthly contribution obligation, or as specified in the delinquency policy.

**Fund Enrollment Cards**
Every participant must submit a completed enrollment card before any claims will be paid. Enrollment cards may be obtained through your Employer or by calling or writing the Fund Office.

**Eligible Dependents**
Coverage of your spouse and eligible children or other dependents generally begins at the same time your coverage begins, although this may vary with some benefits; you should check the specific eligibility provisions for each benefit. Eligible dependents include your lawful spouse and children.

Your "spouse" is the person who is legally married to you while you are covered under this Plan, including an individual who is your partner under a civil-union/domestic partner or similar law. There may be important personal tax consequences that arise as a result of civil union/domestic partner coverage. Before enrolling your civil union/domestic partner and his or her eligible children, you should talk to your tax advisor about the tax implications for you.

Your “child” means a person who has not attained the age of 26, and is:

- Your natural born child or the natural born child of your spouse regardless of where or with whom the child lives;
- Your stepchild so long as you and the child’s natural parent remain married;
- Your foster child;
- A child who is: (a) legally adopted by you, or your spouse, or (b) placed with you, or your spouse, for adoption;
- Your or your spouse’s legal ward (but not your foster child) who: (a) resides with you in a regular parent-child relationship; (b) is chiefly dependent on you for support and maintenance; and (c) is unmarried;
- Your or your spouse’s unmarried grandchild for whom you have court-ordered custody;
- A child that the Plan is required to cover under the terms of a Qualified Medical Child Support Order (“QMCSO”).

It is also possible for you to cover your unmarried dependent on the plan that is incapable of self-sustaining employment by reason of mental retardation or physical handicap. For your handicapped dependent child

to remain covered after age 26, they must be legally or financially dependent primarily on you. You must submit proof of the child's inability to engage in self-sustaining employment by reason of mental retardation or physical handicap within 31 days of the child's attainment of age 26.

**Qualified medical child support orders (QMCSOs)**
A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law.

If a QMCSO requires the Plan to provide health coverage, dependent children may also include your children who do not live with you and for whom you do not provide financial support. In general, QMCSOs are orders under state law requiring a parent to provide health care support to a child - for example, in case of separation or divorce. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who do not reside with you. However, children who are no longer eligible, due to their age for example, cannot be added under a QMCSO.

You may obtain a copy of the Plan procedures governing QMCSO determinations, free of charge, by contacting the Plan Administrator.

**Documentation of dependents**
If you elect coverage for yourself and your eligible dependents, you must certify in writing that your eligible dependents meet all Plan eligibility requirements. You must also provide social security numbers for your dependents, as requested, in order to cover dependents under the Plan. The Plan maintains the right to request documentation from you at any time to ensure that your dependents meet the eligibility criteria. In the event you provide a false certification or false or misleading information, ineligible members will be terminated from coverage and you will be required to reimburse the Fund for all amounts paid on your behalf.

**Notification**
You are responsible for notifying the Plan Administrator in writing within 60 days in the event of divorce, termination of domestic partnership, or in the event your child ceases to meet the eligibility requirements for benefit coverage. For more information about your duty to notify the Plan Administrator in such an event, see the *Continuation Coverage* section of this document.

**No Dual Coverage Permitted**
If you are married to another employee covered by the Fund, you may enroll as an employee or as a dependent, but you cannot be covered as both. Dependent children may be covered under one member's coverage only.

**Effective Date**

*Health care coverage:* Coverage for you and your dependent(s) is effective on the date you first meet the eligibility requirements.

*All other coverages:* If you are absent due to illness or injury on your scheduled effective date of coverage, your coverage will become effective on the date you return to work.

**Change In Address**
Employees must immediately notify the Fund Office of any change in address.

**Open Enrollment**
As set forth under the *Benefits* section below and elsewhere, depending on the provisions of the collective bargaining agreement that applies, eligible participants may have some choice regarding the precise medical program in which they choose to enroll. Each participant is entitled to change his or her health care

program once a year at the Plan's open enrollment in November and December effective the following January 1.

**Spousal Option**
If provided in the collective bargaining agreement or participation agreement with your Employer, you can opt out of health care coverage only and receive payment for a portion of the contributions your Employer is obligated to make toward health care coverage, based on the terms of the collective bargaining agreement; provided, however, that you provide proof that you are covered by a health care plan through your spouse's health care coverage.

**Termination of Eligibility**
***Lay-offs.*** If your employment is terminated with a Contributing Employer due to a "Lay-Off," your coverage will be terminated at the end of any extended period provided under the collective bargaining agreement or participation agreement with your Employer.

***Leave under Family Medical Leave Act (FMLA).*** The federal Family and Medical Leave Act (FMLA) allows eligible employees to take leave for certain reasons, including for serious illness, service member family leave and exigency leave, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition. Under the FMLA you may be entitled to take a leave of absence with continued benefits coverage in certain situations. In order for the Fund Office to continue benefits for you and your dependents during an FMLA absence, your Employer must continue to make contributions on your behalf, unless you are receiving Disability benefits. If the Fund Office does not receive these contributions, benefits will end. If you do not return to active employment immediately following the end of your leave, your employer is no longer obligated to make contributions on your behalf. Disabled participants must apply for and secure an "Approved Leave of Absence" from their Employer in order to have their coverage continue during the periods of disability.

***Military Service*.** If you enter the military service (other than a temporary tour of duty not exceeding 30 days), your coverage will terminate on the first day of active military service. If you return to work with a Contributing Employer within the period during which you have re-employment rights under federal law, your employment will be treated as continuous, provided you meet any notice requirements.

If you take a military leave, whether for active duty or for training, you are entitled to elect to extend your health coverage for up to 24 months (or the day you fail to return to work after the end of the leave if sooner) as long as you give the Plan advance notice of the leave (with certain exceptions) and make such payments as are required and permitted under federal law. This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave, cannot exceed five years (with certain exceptions). If the entire length of the leave is 30 days or less, you will not be required to pay any more than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

COBRA continuation coverage will run concurrently with military leave continuation coverage, under USERRA, subject to the limitation of COBRA. (See the *Continuation Coverage* section of this document for more information on COBRA). This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period.

***Termination of Employment/Disability.*** Unless you are disabled, your insurance coverage will be terminated on the last day of the month in which your employment terminates (either through quitting or discharge for cause). A disabled Employee will remain a participant during a period of continued disability that commenced while this Employee was eligible under this Plan. This Employee shall only be terminated at the end of the period provided under the collective bargaining agreement or participation agreement with his Employer.

**Reinstatement**
An Employee whose coverage has been terminated shall be reinstated on the first day of the month immediately following his return to active employment with a participating Employer.

**Plan Termination**
In the event your Employer ceases to be a Contributing Employer in the Plan, your benefits will cease on the last day of the month in which the Employer's last contribution is received.

# Benefits

The following benefits are generally available under this Plan: medical/prescription drug, dental, vision, member assistance program, life insurance/accidental death and dismemberment, and weekly disability coverage.

As a part of this document, you will receive an individual benefit statement providing a Schedule of Benefits provided to you through the Fund by insurance carrier(s) in accordance with the provisions of the collective bargaining agreement or participation agreement with your Employer. Not all the benefits described herein apply to all participants. Each participant must consult their own Schedule of Benefits for details on the benefits that apply to him or her.

Whenever this document refers to a collective bargaining agreement or participation agreement, they shall include any participation agreement that your Employer has entered into with the Fund. The following pages contain a brief description of the various benefit options offered under the Plan. With respect to the specific benefit options offered under the Plan, you can find a more complete description of the level of benefits provided by consulting the benefit booklet issued by the applicable service provider or in the applicable certificates of insurance issued by the insurance companies. You may obtain copies of the booklets and/or certificates applicable to all benefits. If you need a copy, please contact the Plan Administrator.

The amount of the premium payment required of you for benefit eligibility, if any, will be set out in the collective bargaining agreement that covers your employment. As part of the collective bargaining agreement, you may be able to make any required contributions on a pre-tax basis through a cafeteria plan; if so, you will be subject to the provisions of that cafeteria plan.

**No guarantee of tax consequences**

Neither the Plan Administrator nor the Trustees make any commitment or guarantee that any amounts paid to or for the benefit of a participant under the Plan will be excludable from the participant's gross income for federal, state, or local income tax purposes.

# Medical/Prescription Drug

Various health care programs, including HMO and PPO options, are available **depending upon your collective bargaining agreement or participation agreement and geographic location**. You may elect to participate in any one of the programs offered under the provisions of your collective bargaining agreement or participation agreement. Some options may require you to pay part of the cost.

The medical benefits available under the health benefits program are provided through an insurance contract with the insurance providers (as listed in the *Plan Administration and Other Important Information* section). These benefits (including information about the amount payable, required deductibles, co-payments, maximums, limitations, coordination of benefits and exclusions) are summarized in the applicable benefit booklet/ certificates of insurance issued by the insurance companies. These booklets and certificates are also available from the Plan Administrator, and the applicable materials may vary depending upon the collective bargaining agreement that covers your employment. You should make sure that you receive the materials related to your employment.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the medical plan. You may automatically access the online provider directory at your medical plan website or by calling your medical plan (see the *Plan Administration and Other Important Information* section of this document for addresses and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

A description of the claims procedure for each health care program available to you is provided in the booklets included as part of this document. All eligible claims for health care benefits under the plan are processed by your medical, vision or dental plan under a group insurance contract. Each insurance carrier has developed a certificate/booklet that describes the coverage under the plan. The certificate(s)/booklet(s) also describes the rules determining eligibility to participate in the carrier's plan and eligibility to receive benefits from that plan.

### Cost of Coverage

Your employer may pay the full cost of your health care coverage, or you may be required to share in the cost as determined by the provisions of your collective bargaining agreement or participation agreement with your employer.

If you are required to pay a portion of the cost of coverage and through collective bargaining your employer adopts a section 125 plan under the Internal Revenue Code (IRC), your contributions may be made on a pre-tax basis. The contribution amounts are set through collective bargaining and will be furnished to employees when they are hired and during the annual enrollment process.

When you pay pre-tax, your Employer and you do not pay Social Security taxes on your health care contributions, so the earnings reported for Social Security benefit purposes are less than your actual earnings. Therefore, depending on your income level, your Social Security benefit at retirement may be *slightly* reduced.

### Identification Cards

Every Participant who has submitted a completed enrollment card and who meets the Eligibility Requirements will be issued an Identification Card indicating that he has been insured by the health plan of their choice.

### Irrevocability of elections

The federal government rules govern when you can change certain benefit coverage elections outside of annual open enrollment. These rules apply to before-tax coverage elections, if any, you make for your medical, vision, and dental benefits, as further set forth in your employer's cafeteria plan, if such a plan has been negotiated. Except as described in this Plan and the component documents, a participant's election under a cafeteria plan may be irrevocable for the duration of the period of coverage to which it relates. In

other words, unless an exception applies, the participant may not change any elections made under a qualified cafeteria plan for the duration of the period of coverage regarding: (a) participation in certain benefits under this Plan; (b) salary reduction amounts; or (c) election of particular benefit package options.

However, you may be able to make changes in the event of a significant life event, referred to in this document as a "change in status". Any change you make must be consistent with the change in status. Changes in status include the following:

- birth or legal adoption of a child,
- death of a spouse/partner or child,
- entitlement to Medicare or Medicaid,
- marriage, divorce, legal separation or annulment,
- termination of, or a significant change in, your spouse or child's employment status or work site that results in a gain or loss of eligibility for health coverage,
- significant change in the cost of coverage under a health plan,
- significant change in your or your spouse's health coverage attributable to your spouse's employment,
- state domestic relations order pertaining to medical coverage of a dependent, or
- your child no longer meets the plan's eligibility requirements due to age or student status.

***If you do not change your coverage within 31 days of the change in status, you must wait until the next annual enrollment period. Contact the Fund Office to make a change.***

**Changing your coverage – all other participants**

If your collective bargaining agreement or participation agreement allows you to change coverage at any time during the course of employment, you may do so consistent with the provisions of that agreement.

**If you waive coverage**

If you waived coverage because you had other coverage-and you returned a signed statement attesting to that fact-you may enroll for coverage in this Plan if you lose your other coverage due to a change in status. You must enroll within 31 days of the date your other coverage ends. If you do not change your coverage within 31 days after the change in status, you must wait until the next annual enrollment period.

Under the Health Insurance Portability and Accountability Act (HIPAA), if you do not complete an enrollment form indicating that you are waiving coverage under a Fund-sponsored medical plan, and do not provide proof of other coverage as required, the Fund has the right to deny enrollment at a later time if other coverage is lost due to losing eligibility, changes in employer contributions, or the end of COBRA coverage.

**Special enrollment events under HIPAA**

Under the Health Insurance Portability and Accountability Act (HIPAA), you have special enrollment rights under certain circumstances.

***Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program).*** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if your Employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the Employer stops contributing toward the other coverage). When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order

to trigger a special enrollment for loss of other coverage. However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the Employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

***Loss of eligibility for Medicaid or a State Children's Health Insurance Program.*** If you or your dependents (including your spouse) are eligible, but not enrolled, for coverage under the Plan while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this Pan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

***New dependent by marriage, birth, adoption, or placement for adoption.*** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

***Eligibility for Medicaid or a State Children's Health Insurance Program.*** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

### Special rights for mothers and newborn children

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

### Special rule for Newborn or Newly Adopted Children

Benefits are payable for 31 days from the moment of birth or the date the employee assumes a legal obligation for support in anticipation of adoption. If you do not submit an enrollment form within 31 days, no payment will be made for expenses incurred after the 31st day, and you will have to wait until the next open enrollment period to add the child to your coverage.

### Women's Health and Cancer Rights Act

The health benefits program will provide certain benefits related to benefits received in connection with a mastectomy. The health benefits program shall include reconstructive surgery following a mastectomy.

If you or your dependent(s) (including your spouse) are receiving medical benefits under the health benefits program in connection with a mastectomy and you or your dependent(s) (including your spouse) elect breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Reconstructive benefits are subject to annual health benefits program deductibles and coinsurance provisions like other medical and surgical benefits covered under the health benefits program.

For additional information regarding the medical benefits provided under the health benefits program, please contact the Plan Administrator.

### Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 prohibits the Employer and Plan Administrator from using employees' and family members' genetic information in deciding eligibility and contributions for group health plan benefits. In addition, the Employer and Plan Administrator cannot use genetic information for underwriting purposes.

# Member Assistance Program

The Member Assistance Program (MAP) provides confidential assessment and referral services at no cost to eligible employees, their covered spouses and dependents. The benefits are provided under a contract with a service provider described in the *Plan Administration and Other Important Information* section. Any contact you have with the Member Assistance Program is strictly confidential and in accordance with all Federal, State and Local regulations. Benefits offered under the Program (including information about who is eligible to receive benefits, limitations and exclusions are summarized in the benefit information issued by the insurance provider and available from the Plan Administrator. For additional information regarding the Member Assistance Program, please contact the Plan Administrator. The program is a professional and confidential advocacy service designed to help you and your eligible dependents resolve personal living problems before they affect your well-being, your work, or family life. It is a benefit that can help solve problems before they get out of control.

Free help is available seven days a week by calling Total Care Network, Inc. (TCN) at 1-800-298-2299 from Pennsylvania, New Jersey, and Delaware or in Philadelphia by calling 215-425-8140. A TCN Member Assistance Specialist can be reached Monday through Friday from 9:00A. to 5:00 PM for assessment and treatment referral and 24 hours a day for emergency situations. In the event of alcohol or drug abuse, depression, stress/anxiety, martial/family problems or job-related problems, a MAP specialist will conduct an in-depth telephonic assessment and recommend a plan of action. The MAP will discuss the resources available to you. Any necessary referrals will be made to licensed professionals within your existing insurance network.

**Mental Health/Substance Abuse Benefits**

You must contact Total Care Network at 1-800-298-2299 before using your insurance coverage for mental health and substance abuse benefits. If you do not first contact Total Care Network, you may:

- Jeopardize your eligibility for welfare fund benefits.
- Forfeit your weekly disability benefits in the event your treatment requires you to miss work.

All conversations with Total Care Network are totally confidential. No information concerning the nature of your problems will be released to your employer without your express written consent.

While the services of Total Care Network are free, any subsequent treatment with an insurance provider or facility will be in accordance with your contract of insurance through the Fund. You will be responsible for any existing deductibles or co-payments.

# Dental

The dental benefits available are provided through an insurance contract with the insurance providers listed in the *Plan Administration and Other Important Information* section below. These benefits (including information about the amount payable, required deductibles, co-payments, maximums, limitations, and exclusions) are summarized in the applicable certificates of insurance issued by the insurance companies. These certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the dental plan. You may automatically access the online provider directory at your dental plan website or by calling your dental plan (see the *Plan Administration and Other Important Information* section of this document for addresses and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

For additional information regarding the dental benefits provided under the plan, please contact the Plan Administrator.

# Vision

The vision benefits provided are provided through contracts with an insurance contract with the insurance providers listed in the *Plan Administration and Other Important Information* section below. These benefits (including information about the amount payable, required deductibles, co-payments, maximums, limitations, and exclusions) are summarized in the applicable certificates of insurance issued by the insurance companies. These certificates are also available from the Plan Administrator.

You may select a network provider, if applicable, from the directory of providers upon your eligibility to participate in the vision plan. You may automatically access the online provider directory at your vision plan website or by calling your vision plan (see the *Plan Administration and Other Important Information* section of this Document for addresses and phone numbers). A directory of network providers in your area will also be provided automatically by the Plan Administrator upon request, and at no cost to you.

For additional information regarding the vision benefits provided under the plan, please contact the Plan Administrator.

# Life Insurance

The life insurance benefits program provides eligible employees with life insurance benefit protection and accidental death and dismemberment (AD&D) benefits in accordance with the pertinent collective bargaining agreement. The benefits are provided through insurance contracts with the insurance provider(s) described in the *Plan Administration and Other Important Information* section below.

These benefits (including information about who is eligible to receive benefits, the amount payable, maximums, limitations, and exclusions) are summarized in the applicable descriptions provided by the insurance provider(s). The descriptions are also available from the Plan Administrator.

**Taxes on imputed income**

In some cases, an additional amount of taxable pay, known as imputed income, may be added to your W-2 earnings. Imputed income is the amount the Internal Revenue Service (IRS) requires to be added to your taxable pay for the "value" of the Plan-provided life insurance in excess of $50,000. The value of your insurance is not the face amount of your life insurance coverage over $50,000. Instead, the IRS assigns a dollar amount (premium) of taxable income for each $1,000 of life insurance over $50,000. The IRS determines this premium according to a formula using IRS Table I Rates. This excess cost is considered "imputed income" by the IRS and is subject to federal income taxes and Social Security and Medicare taxes.

For additional information regarding the life insurance benefits offered under the life insurance benefits program, please contact the Plan Administrator.

Note: Many states have regulations that require certain individuals who lose coverage under the group life policy to covert to an individual life policy. The life insurance carrier should be able to provide the specific requirements for the conversion for the State in which the policy is written.

# Weekly Disability Benefit

The weekly disability benefit program provides an eligible employee with certain salary continuation benefits in the event that illness or injury prevents an eligible employee from working for a period of time.

The Fund provides eligible New Jersey employees with weekly disability benefit protection in accordance with the New Jersey Temporary Disability State Plan as further described below. Weekly disability benefits are also provided to all other eligible employees through insurance contracts with the provider(s) described in the *Plan Administration and Other Important Information* section.

Claim forms for Weekly Disability Benefits are available from the Fund Office. After you have submitted a properly completed claim form to the Fund Office, benefit payments will be made directly to you or your surviving designated beneficiary. For more information regarding the benefits offered under the program, please contact the Plan Administrator.

## 1. Weekly Disability Benefits (Except for New Jersey Employees)

Weekly disability benefits will be payable to you if, while eligible, you become disabled and unable to work in your current job because of a non-occupational accident or sickness. Injuries or sickness sustained on the job or which are compensable under Workers' Compensation are not covered.

Benefits will begin:

- as of the first day of disability due to an accident, or
- as of the 8th day of disability due to sickness.

Benefits will continue for any one period of disability up to a maximum number of weeks as per the collective bargaining agreement.

You do not have to be confined to your home but must be under the care of a physician to collect these benefits. No disability is considered as having begun prior to the first visit of or to a doctor.

Successive disability periods separated by less than two weeks of continuous active employment shall be considered as one continuous period of disability unless they arise from different and unrelated causes. For some members, depending on the collective bargaining agreement, two or more disabilities will be deemed the same period of disability if they are from a different cause and not separated by one full day of active work.

**Notice of Claim**

You are required to immediately notify the Fund Office upon becoming disabled. Notice of a claim in the case of disability may be given either by writing or calling the Fund Office, informing it of the fact that you are disabled and unable to work and supplying the office with other basic information, including your name, the name of your Employer, the date you became disabled, the last day you worked and the nature and cause of your disability. Failure to report an accident or illness to the Fund Office within seven days following the last day of employment will result in a loss of benefits unless you are able to establish that you were unable to report as required.

Disability payments will normally be paid for the period certified on the claim form up until the time of the last examination by the doctor. In order to receive additional payments for continuing periods of disability, the employee must submit Continuance of Disability claim forms.

**Weekly Benefit Amount**

The weekly benefit amount is determined in accordance with the collective bargaining agreement.

**Proof of Loss**
Proof of Loss shall consist of a properly completed claim form, certified by your attending physician. This proof of loss must be filed with the Fund Office within 90 days from the date of the doctor's certification of the loss.

**Claim Forms**
The Fund Office, upon receipt of a Notice of Claim, will furnish the form that is necessary in order to file proof of loss. The Trustees shall have been deemed to have supplied such forms upon mailing the claim forms to the last known mailing address of the eligible participant as recorded in the Fund Office records.

**Filing Claims**
To qualify for Weekly Disability benefits, you must submit a completed claim form. The Employee's attending physician must certify on this form that the Employee was totally disabled and show the dates of all examinations and treatments. Further, the Employee's Employer must complete the appropriate section of the form, indicating the last day worked by the claimant. "Totally disabled" means unable to perform the material duties of your job and you are not doing any work for payment and you are under the regular care of physician.

**Medical Examination**
The Trustees reserve the right to have any claimant for weekly disability benefits referred to a physician of their choice for examination or re-examination. Failure without good excuse to report to the Fund's physician within 48 hours after notice to do so may result in suspension of disability payments.

**Unemployment and Workers' Compensation**
Persons receiving unemployment, Workers' Compensation or retirement (except if 65 but still working) benefits from an Industry Pension Fund that covers employees in the paper or box industries are ineligible for disability benefits under this Plan.

**If You Die While Receiving Weekly Disability Benefits**
If you die after your disability claim has been approved but before you receive the full disability benefit, your surviving designated beneficiary may be eligible to receive the remainder of your disability benefit. Contact the Fund Office for more information.

**Assignment of Weekly Disability Benefits**
No assignment of Weekly Disability Benefits will be valid.

**Third Party Payments**
In the event that you are entitled to any third party recovery, the Plan will pay disability benefits until the dispute is resolved, but you are required to reimburse the Plan for benefits paid in the event that you receive a recovery from a third party, and you must appropriately acknowledge your obligation to reimburse the Fund for benefits paid before you receive those benefits. See the *Recovery Provisions* section of this document for more information.

## 2. Weekly Disability Benefits (Participants Employed in the State of New Jersey)

All participants who are employed in the State of New Jersey are covered for Weekly Disability Benefits under either Unemployment and Disability Insurance of New Jersey or a Private Plan through your Employer. Accordingly, no Weekly Disability Benefits will be paid by the Welfare Fund to members working in the State of New Jersey. The Employer is responsible for giving notice to all Employees as to the type of plan under which such Employees are covered. If you are an employed worker covered by a Private Plan through your Employer and you become disabled or ill, you should advise your Employer promptly and request the necessary forms to claim benefits under the private plan.

If you are an employed worker covered by the State Plan and you become disabled or ill, you should obtain Form DS-1 (Proof and Claim for Disability Benefits) and complete the claim portion of the form. Have your doctor make the necessary statement and certification, and have your Employer complete his section of the form. DS-1 Forms may be obtained from your doctor, your Employer, or Local Unemployment Insurance Claims Office.

The competed DS-1 Form should be mailed to the Disability Insurance Service, Trenton, New Jersey 08625.

# Covered and Non-covered Services

See the applicable certificates of insurance and benefits booklets provided by your applicable insurance company for a specific listing of covered and non-covered services and benefits under the various programs described herein. These documents have been included for your reference.

# Claims and Appeal Process

The Plan maintains a claims and appeals procedure for filing claims and requesting review of denied claims. This procedure, as set forth below, describes how you should present your claims, and if a claim is denied in full or in part, how you should appeal the denial and what information you should provide. Please refer to these procedures when submitting claims or presenting your appeal.

The Plan may provide two types of benefits: self-funded (or "self-insured") benefits or insured (or "fully-insured") benefits. Insured benefits are benefits that are provided to Participants through contracts with insurance providers, whereas self-funded benefits are provided by the Plan itself and not through an insurance provider. For insured benefits, you must file claims for benefits directly with the corresponding insurance company, which maintains its own claims and appeals policy. For self-funded benefit plans and for general eligibility determinations of any benefits under the Plan, you must follow the claims and appeal process described below.

Please note that as of January 1, 2018, the Plan does not offer any benefits that are self-funded. Therefore, as of January 1, 2018, the claims administration process as set forth below only applies to determinations of general eligibility for benefits and benefit denials based on general ineligibility for benefits. However, should any benefits under the Plan become self-funded in the future, these procedures will also apply to claims and appeals submitted regarding such self-funded benefits.

The Board of Trustees has delegated to the insurance providers the authority to determine claims and hear appeals concerning insured benefits, except where the denial of particular claim is based on general ineligibility, in which case this Process applies and the Board of Trustees retains authority to adjudicate claims and appeals. Accordingly, the Board of Trustees has retained exclusive and final authority and has complete discretion to decide any and all questions relating to general eligibility for self-funded or insured benefits under the Plan.

As part of the claims administration process, the insurance companies (or the Board of Trustees, in the case of a self-insured plan) will:

- Pay claims for benefits due under the plans;
- Provide written explanations of the reasons for denied claims;
- Handle claimant requests for reviews of denied claims; and
- Make the final decision on denied claims.

**Definitions**
For purposes of dealing with Claims under the Plan the following words or phrases shall have the following meanings:

A. *Adverse Benefit Determination* is any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, rescission of coverage, or failure to provide or make payment, including those based on a determination of an Employee' s, Dependent's or Beneficiary's general eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

B. *Authorized Representative* is a person or organization who demonstrates to the satisfaction of the Claims Administrator, in its sole and absolute discretion, that he, she or it has been authorized to act on behalf of an Employee, Dependent or Beneficiary with respect to a Claim, or appeal of an Adverse Benefit Determination regarding a Claim. In the case of a Claim involving Urgent Care, a

health care professional having knowledge of the Claimant's medical condition shall be permitted to act as Claimant's Authorized Representative.

C. *Board of Trustees* is the Board of Trustees of the USW District 10, Local 286 Welfare Trust Fund or any duly appointed Appeals Committee thereof.

D. *Claim*. A Claim is a written or electronic request for a Plan benefit, including, without limitation, a written or electronic request for pre-certification for a hospital admission, made by Claimant in accordance with the Plan's procedure for filing benefit claims.

E. *Claimant* is an Employee, Dependent, Beneficiary or Authorized Representative of such individuals who submit a Claim.

F. *Claims Administrator* is the Plan Administrator or is the person or entity designated by the Plan Administrator and charged with making benefit determinations.

G. *Disability Claim* is a Claim for which the Plan conditions the availability, payment or commencement of that benefit upon a showing of disability.

H. *Post-Service Claim* is a Claim for a benefit under the Plan other than an Urgent or Pre-Service Claim.

I. *Pre-Service Claim* is a Claim for a benefit under the Plan for which the Plan conditions the receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

J. *Receipt of Claim*. A Claim is considered received by the Plan when the Claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether the filed claim contains all the information necessary to make a benefit determination. A verbal request for coverage will be considered received on the day of the conversation only if a Claim is received by the Plan within 48 hours of the time of the conversation.

K. *Urgent Claim* is a Claim for medical care or treatment that, if the time periods for making non-urgent care determinations are applied, could seriously jeopardize the life or health of an Employee or Dependent or the ability of the Employee or Dependent to regain maximum function. A Claim will also be considered an Urgent Claim if, in the opinion of a physician with knowledge of the Employee's or Dependent's condition, failure to obtain the care or treatment which is the basis of the Claim would subject the Employee or Dependent to severe pain that cannot be adequately managed without such care or treatment.

**Urgent Claims**

A Claimant or his Authorized Representative may submit an Urgent Claim to the Claims Administrator at any time twenty-four hours a day, seven days a week and fifty-two weeks a year.

As soon as possible, taking into account the medical exigencies, but in no event later than 72 hours after Receipt of an Urgent Claim by the Plan, the Claims Administrator will notify the Claimant of the Plan's benefit determination with respect to the claim. If the Claimant fails to provide sufficient information for the Plan to make a determination with respect to the Claim, the Claims Administrator will notify the Claimant within 24 hours of the Receipt of the Claim what additional information is required to complete the Claim. The Claimant will have at least 48 hours (taking into account the circumstances) to provide the additional information, and the Claims Administrator will issue a decision on the Claim as soon as possible, but in no event later than 48 hours after the earlier of:

(1) the Plan's receipt of the additional information, or
(2) the end of the period within which the Claimant was required to provide the additional information.

Notification to the Claimant of the Adverse Benefit Determination will be made by written or electronic media or, when appropriate, orally (*e.g.*, by telephone), followed by written or electronic confirmation within three days.

**Concurrent Care Decisions**
If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

A. Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claims Administrator shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

B. If a Claimant requests to extend a course of treatment (beyond the period of time or number of treatments initially approved by the Claims Administrator) that involves an Urgent Claim, such Claim shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify the Claimant of the Plan's benefit determination, within 24 hours after Receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Any appeal of an Adverse Benefit Determination with respect to a request to extend a course of treatment shall be governed by the appeal procedures described below, as appropriate to the type of Claim involved (i.e., Urgent, Pre-Service or Post-Service).

**Pre-Service Claims**
A Claimant or his Authorized Representative may submit a Pre-Service Claim to the Claims Administrator during regular business hours.

Within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 calendar days after Receipt of a Pre-Service Claim by the Plan, the Claims Administrator will notify the Claimant of the Plan' s benefit determination with respect to the Claim, whether adverse or not. If the Claims Administrator determines that an extension of the 15-day period is necessary due to matters beyond the Plan's control, the 15-day period will be extended for an additional 15 days, and the Claimant will be notified (within the initial 15-day period) of the circumstances necessitating the extension and the date by which the Plan expects to make a decision on the Claim. If the extension is necessary due to the Claimant's failure to provide sufficient information for the Plan to make a determination with respect to the Claim, the Claims Administrator will notify the Claimant (within the initial 15-day period) what additional information is needed to complete the Claim, and the Claimant will have at least 45 days to provide the additional information. The 15-day period within which the Plan will issue its decision will be tolled from the date on which notice of the extension is sent to the Claimant until the earlier of:

(i) the date the Claimant responds to the request for additional information or
(ii) the end of the period within which the Claimant was required to provide the additional information.

**Post-Service Claims**
A Claimant or his Authorized Representative may submit a Post-Service Claim to the Fund Office during regular business hours. Within a reasonable period of time, but not later than 30 calendar days after Receipt of a Post-Service Claim by the Plan, the Claims Administrator will notify the Claimant of the Plan's benefit determination with respect to the Claim. The Claims Administrator need only notify the Claimant of an adverse benefit determination. If the Claims Administrator determines that an extension of the 30-day period is necessary due to matters beyond the Plan's control, the 30-day period will be extended for an additional 15 days, and the Claimant will be notified (within the initial 30-day period) of the circumstances necessitating the extension and the date by which the Plan expects to make a decision on the Claim. If the extension is necessary due to the Claimant's failure to provide sufficient information for the Plan to make a determination with respect to the Claim, the Claims Administrator will notify the Claimant (within the initial 30-day period) what additional information is needed to complete the Claim. The Claimant will have at least 45 days to provide the additional information. The 15-day period within which the Plan will issue its decision will be tolled from the date on which notice of the extension is sent to the Claimant until the earlier of: (i) the date

the Claimant responds to the request for additional information or (ii) the end of the period within which the Claimant was required to provide the additional information.

**Disability Benefit**
You will be notified of any adverse decision by the Plan with regard to disability benefits within a reasonable period of time, but in no case later than 45 days after receipt of the claim. An extension of up to 30 days is allowable for matters beyond control of the Plan. You will be notified of any extension including the reason why the extension is necessary and the date by which the Plan expects to make a decision, prior to the expiration of the initial 45-day period.

If within the first 30-day extension the Plan determines that a decision cannot be made within the extended period due to matters beyond the control of the Plan, an additional extension of up to 30 days is permissible. You will receive notice prior to the expiration of the first 30-day extension of the reason for the additional extension and the date as of which the plan expects to make a decision. This notice will also explain the standards used by the Plan in determining whether a participant is entitled to a disability benefit, the unresolved issues preventing a decision on your claim, and any additional information needed to resolve those issues. If the additional extension is due to the need for more information, you will have 45 days in which to provide the additional information.

**Failure to Follow Claims Procedures**

A. A Claimant who fails to follow the Plan's procedures for filing an Urgent or Pre-Service Claim will be notified of the failure and the proper steps that should be followed in filing the Claim. For Urgent Claims, such notice will be issued within 24 hours of the initial contact with the Plan. For Pre-Service Claims, such notice will be issued within 5 days of the initial contact.

This notification may be oral, unless the Claimant (or his Authorized Representative) requests written notice.

B. The above rules apply only if the failure by the Claimant is:

   (i) A communication by a Claimant or his Authorized Representative that is received by a person customarily responsible for handling benefit matters under the Plan; and
   (ii) A communication that names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

**Notice of Claims Decisions**
Following Receipt of a Claim, and in accordance with the appropriate claims procedure, the Claims Administrator shall issue a written or electronic explanation of benefits form or other notice describing the Plan's decision concerning the Claim. In particular, you will be given notice advising you of any Adverse Benefit Determination. This notice will come from the insurance carrier when the benefits are provided by that carrier. In the event that a benefit is self-funded, or where the claim has been denied on the basis of general ineligibility, the notice will come from the Fund Office.

In the event of an Adverse Benefit Determination, then the notice will include, at a minimum, the following information, provided in a manner that is calculated to be understood by the Claimant:

A. The specific reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan’s standard, if any, that was used in denying the claim;

B. Reference to the specific Plan provisions on which the determination is based;

C. Information sufficient to identify the claim involved (including date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, which the Plan must provide as soon as practicable. The Plan should not

consider a request for the diagnosis code or treatment code to be a request for internal appeal or external review.

D. When appropriate, a description of any additional information or material necessary for the proper processing of the Claim, and the reason it is needed.

E. A copy of the Plan's appeal procedures and time periods that the Claimant needs to follow in order to appeal the Claim, including, when appropriate, a description of the Plan's expedited review process applicable to Urgent Claims, a statement about the Claimant's right to bring suit pursuant to section 502(a) of ERISA, and a description of available internal appeals and external review processes.

F. When appropriate, a copy of any internal rule, guideline, protocol or similar criterion that was relied upon in making the Adverse Benefit Determination. Alternatively, the notice may indicate that such rule, guideline, protocol or criterion was relied upon in making the Adverse Benefit Determination and that a copy is available at no cost at the Claimant's request.

G. For a Claim involving a determination of medical necessity, experimental treatment or similar exclusions, the notice will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances. Alternatively, the notice may indicate that such explanation is available at no cost at the Claimant's request.

H. The Plan must disclose the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman to assist with internal claims and appeals and external review processes.

**Procedures For Appeals**
You have the right to appeal from any Adverse Benefit Determination. How you appeal, where you appeal and the time frames for filing an appeal and receiving a response are the subject of this portion of this document, called Procedures for Appeals.

***Where Do I File My Appeal***
Each appeal is decided by either the Board of Trustees or an insurance carrier or other provider to whom the Board of Trustees has delegated authority to decide appeals. This includes the insurance carriers that provide insured benefits. Who makes the decision on your appeal will depend upon the nature of the benefits you are seeking. Contact the Fund Office to determine where to file your appeal. If your appeal concerns general eligibility (or a self-funded benefit) the Board of Trustees will decide your appeal. Otherwise, the relevant insurance carrier will decide your appeal.

***Who May File An Appeal***
Either you or your authorized representative may file an appeal. If an authorized representative files an appeal he/she shall, along with the appeal, submit documentation establishing that the participant authorized the representative to act on the participant's behalf. Generally, a copy of the authorization will be sufficient; the original document may also be requested.

***When You Must File Your Appeal***
You must file your appeal within 180 days after you have received notification of an adverse benefit determination

***What Must You Submit For Your Appeal To Be Considered***
You may submit written comments, documents, records or other information that you believe is important and that relates to your claim for benefits.

***Your Right To Information***
You are entitled to certain information free of charge. You may ask the Fund Office, insurance carrier for any document, record or information that was submitted, considered or generated during the course of considering your claim for benefits. You may request to know which of those documents were relied upon

by the person making the decision about your benefit claim. You may also ask for any statements of policy or guidance concerning any denied treatment option or benefit relating to the claimant's diagnosis, whether or not such policy or guidance was relied upon in your case. You are not entitled to information about another participant's claims or benefit information. You may also ask for copies of these procedures.

***Procedures Following The Appeal***

A. Each person or entity making a determination on an appeal shall take into account all of the comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

B. Each person or entity shall make the determination on appeal without affording deference to the initial adverse benefit determination. The determination will be made by someone other that the person making the initial benefit determination or a subordinate of that person.

C. Where an appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the person or entity deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be a person who was already consulted in connection with the claim, nor will it be a person who is a subordinate of a person who was already consulted in connection with the claim on appeal.

***Notice Of Decision***

Following the submission of your appeal you will be notified of the decision on the appeal. Notice of final adverse benefit determination must include:

A. The specific reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, a discussion of the decision, as well as a description of the Plan's standard, if any, that was used in denying the claim;

B. Reference to the specific Plan provisions on which the determination is based;

C. Information sufficient to identify the claim involved (including date of service, the health care provider, the claim amount, if applicable);

D. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning associated with any final internal Adverse Benefit Determination;

E. A statement that Claimant may receive documents, records, or other information relevant to the claim upon request and free of charge;

F. A statement describing any voluntary appeals procedures;

G. A statement about the Claimant's right to bring suit pursuant to section 502(a) of ERISA;

H. When appropriate, a copy of any internal rule, guideline, protocol or similar criterion that was relied upon in making the Adverse Benefit Determination. Alternatively, the notice may indicate that such rule, guideline, protocol or criterion was relied upon in making the Adverse Benefit Determination and that a copy is available at no cost at the Claimant's request:

I. For a Claim involving a determination of medical necessity, experimental treatment or similar exclusions, the notice will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances. Alternatively, the notice may indicate that such explanation is available at no cost at the Claimant's request.

***Timing of Notification of Benefit Determination on Review***
If the Board of Trustees decides your appeal, you will be notified of the decision within five (5) days following the date that the Board of Trustees next meets, unless your appeal was only filed within thirty (30) days of that meeting, in which case your appeal may be carried over to the next quarterly meeting of the Trustees. If special circumstances require an extension of time for a determination to be made in your appeal, you will be notified in writing of those circumstances and a decision may be delayed to a date not later than the third meeting of the Board of Trustees following the date of your appeal.

If an insurance carrier or other entity or person decides your appeal, you will be notified as set forth in the appropriate insurance carrier booklet for that entity, usually within sixty (60) days following the date of your appeal unless the benefits provider has a two-step appeals procedure. In case of appeals involving pre-approval for benefits, there will be an expedited review process.

**Urgent Care Appeals**
Each provider of health benefits, including the relevant insurers, has its own expedited Urgent Care Appeals Procedure, which is attached as an appropriate exhibit in that carrier's benefit booklet. Generally, each procedure requires that you ask for an expedited appeal of the benefit denial, and you may make this request orally or in writing. You should also be able to transmit any information you wish the health care provider to review either by telephone, facsimile or through some other expeditious method. You should be notified of a decision on your Urgent Care Appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after it is submitted.

**Pre-Service Claims Appeals**
You should be notified of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, generally 30 days.

**Post-Service Claims Appeals**
You should be notified of the Plan's benefit determination on review within a reasonable period of time, generally 60 days. Regarding insurer benefits, where one appeal is provided notification shall be provided within 60 days. Where there are two levels of appeal, notification shall be provided within 30 days with respect to any one of the two appeals.

**Disability Claims Appeals**
You should be notified of the Plan's benefit determination on review within 45 days.

***Exhaustion of Appeals and Right to Sue***
If you have received an Adverse Benefit Determination, you are required to complete the appeals procedures set forth in this procedure before you may bring a lawsuit claiming benefits from this Health and Welfare Fund or one of the insurance carriers. If, after exhaustion of the appeals process, you believe that you are still entitled to a benefit you may have the right to bring a lawsuit to claim those benefits.

***Standards of Review***

A. In each appeal the individual or entity deciding the appeal (sometimes called a Fiduciary) will examine plan documents relating to the claim for benefits to ensure that the decision is based on governing plan documents and to ensure that the plan provisions are being applied consistently with respect to similarly situated participants.

B. The Board of Trustees or its designee has the right to interpret the plan of benefits, the agreement and declaration of trust and have the authority to make reasonable determinations of disputed facts with respect to claims for benefits. All interpretations and factual determinations by the Board of Trustees shall be final and binding on the participant and on all persons claiming by or through the participants, and benefits will be paid only where the Board of Trustees or its designee determines in its discretion to provide them. Where the Board of Trustees has delegated the authority to hear and determine appeals it shall have authority to interpret the plan of benefits which is the subject matter of its contract with the fund and to make factual determinations relating to the claim for benefits, and such interpretations shall be final and binding on the participant and on all persons

claiming by or though the participant; provided, however, that the Trustees reserve the right to make an independent determination with respect to the designee's compliance with its contract with the Fund.

C. The general rules under ERISA are described in this section. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply. The Plan intends to comply with the many changes that are required by new standards for internal claims and appeals and external reviews as required by the Patient Protection and Affordable Care Act.

# Coordination of Benefits

The descriptive booklet(s) provided by the third party administrator or insurance carrier may include coordination of benefit provisions applicable to the health plan benefits offered under this Plan. See the component documents for more information. To the extent that these provisions are not described in the applicable certificates or descriptive booklets, they are described in this section.

This Plan has been designed to help meet the costs of medical services and treatments. Since it is not intended that the Plan provide benefits greater than the actual medical and dental expenses incurred, the amount of benefits payable under this Plan is coordinated with benefits payable under any other "plan."

When you receive services that are also covered under another plan, a determination is made as to which plan is "primary" and which plan is "secondary." The primary plan considers the services without regard to the secondary plan. The secondary plan will then consider the balances on covered services according to the limitations of its programs.

If this Plan is determined to be the secondary plan, payment for covered services will not exceed the difference between the primary plan's payment and the charge.

However, the Plan's health care program will not pay more than it would have, had there been no other coverage.

The primary plan will be determined in the following order:

1. If the other plan does not include a provision to coordinate benefits, it will be the primary plan.

2. If the other plan does include a provision to coordinate benefits then:

    a. The plan covering the patient as the employee/subscriber is the primary plan.

    b. Except for situations where the parents of a child are separated or divorced, the plan covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the plan which covered the parent longer will be primary.

    c. In those situations where the parents are separated or divorced, the primary plan is determined as follows:

        (i) the plan covering the parent with custody of the child is primary
        (ii) if the parent with custody of the child has remarried, the step-parent's plan will pay for covered services before the plan of the parent without custody.
        (iii) a court decree may determine the primary plan.

    d. When a determination cannot be made with the above rules, the plan that has covered the patient for the longer period of time is the primary plan.

Coordination of benefits provisions apply to the health plans only and, to the extent that these provisions are not described in the applicable certificates or descriptive booklets, are described in this section. To the extent that the descriptive booklet(s) provided by the third party administrator or insurance carrier includes coordination of benefit provisions, the provisions of the descriptive booklet(s) will govern.

In the event that a legal conflict exists between two plans as to which is the primary plan and which is the secondary plan, the plan that has covered the patient for the longer time will be considered the primary plan. When a plan does not have a coordination of benefits provision, the rules in this provision are not applicable and such plan's coverage is automatically considered the primary plan.

Even if the Plan is your primary plan or secondary plan, in states with no-fault automobile insurance, the automobile insurance carrier is the primary insurance for injuries resulting from an automobile accident. In no fault states, all medical expenses related to an automobile accident should be submitted to the automobile insurance carrier first. The Plan will pay covered expenses not payable under the no-fault automobile insurance according to the coordination of benefit rules discussed above. Then, you can submit claims under another plan, such as your spouse's employer's plan, for any expenses not paid by the Plan. Depending on the coordination of benefit provisions of the other plan, you may or may not receive additional benefits.

### *Coordination with Medicare*

When you or your eligible dependents are entitled to Medicare and are covered under the Plan, the Plan continues to be the primary plan as long as you are an active employee. The Plan is primary plan for the following situations:

- Eligible active employees age 65 and over and who are entitled to Medicare benefits;
- Dependent spouses age 65 and over who participate in the Plan on the basis of current employment status of the employee and who are entitled to Medicare benefits;
- Social Security disabled participants who are covered by the Plan on the basis of your active employment status with Employer and who are entitled to Medicare benefits; and
- For the first 30 months of Medicare entitlement, certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD).

# Recovery Provisions

The descriptive booklet(s) provided by the third party administrator or insurance carrier may include subrogation, acts of third party, and right of recovery provisions applicable to the health plan benefits offered under this Plan. See the component documents for more information. To the extent that these provisions are not described in the applicable certificates or descriptive booklets, they are described in this section.

**Repayment of Benefits (Subrogation)**

The Fund has the right to seek and/or collect repayment of benefits as follows:

1. To the extent that benefits are provided or paid under this Plan to you or your eligible dependent, the Fund shall be subrogated and succeed to any rights of recovery you or your eligible dependent incurred against any person or organization.

2. You or your eligible dependent shall pay the Fund in full all amounts recovered by suit, settlement, or otherwise from any third party or insurer to the extent of the benefits provided and paid from the Fund, regardless of the characterization of the third party recovery such as, damages, pain and suffering, expenses, etc.

3. You or your eligible dependent are required to take such actions, furnish such information and assistance, and execute such papers as the Fund may require to facilitate enforcement of its rights, and shall take no action prejudicing the rights and interests of the Fund.

4. Whenever you or your eligible dependent file a claim or lawsuit against any other party for damages which relate in any manner to a claim filed or intended to be filed with this Fund, you agree to notify the Fund Office, in writing, within five (5) days after such filing.

5. The Trustees shall have the right to prescribe the form of subrogation/repayment agreement which you or your eligible dependent must sign. If any payments are received by you or your eligible dependent by reason of the filing and/or settlement of such other claim or lawsuit, you or your eligible dependent agree that this Fund shall be reimbursed out of and from such received payments to the extent of the payments made by this Fund to such claimant by reason of the said claim.

**Errors in Benefit Payments**

The Trustees specifically retain the right to recover all monies paid in error to, or on behalf of any person, from such person. Upon the discovery of a payment “made in error,” the Trustees shall notify the recipient or beneficiary of such payment, indicating the circumstances and amount of such payment together with a request for repayment. Upon failure to repay the amount due within a reasonable time after such notification, the Trustees may take such legal action as they deem necessary or in the case of a participant of the Fund, the amount of the payment made in error may be deducted from any future payments which such participant or his dependents or beneficiary may become entitled to under this Plan.

**Fraud**

Any person attempting to submit false, misleading or incomplete information, or who in any way attempts to defraud the Fund, may become ineligible for benefits, amounts wrongly paid may be collected through deductions from future benefits, and the Trustees may take other steps in such matter as the Trustees deem advisable. Notwithstanding the foregoing, the Fund will not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Fund must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

# Continuation Coverage

There are several types of continuation coverage that may apply to particular component benefit programs. For more information, see the included carrier materials for the particular component benefit programs. Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services. Note also that state law may provide continuation and/or conversion coverage.

A Federal law - the Consolidated Omnibus Budget Reconciliation Act - (commonly known as "COBRA") requires employers who sponsor health care plans to offer a temporary coverage extension to employees and their eligible dependents in certain situations. This section provides a detailed description of COBRA coverage. The descriptive booklet(s) provided by the third party administrator or insurance carrier also include a complete explanation of your COBRA rights and responsibilities. If you have any questions about your COBRA rights, please read your Initial COBRA Notice, a copy of which has been attached as Appendix B to this document.

Note that you may have options other than COBRA available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. For more information about the Marketplace, visit www.HealthCare.gov. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

The chart below shows the Qualifying Events that may entitle you (or your dependent) to your current group health plan, dental and vision coverages through COBRA. The chart also shows the length of time coverage may continue. The rights to continued coverage apply separately to you, your spouse, and/or dependent children.

| Qualifying Event | Who May Continue | How Long |
|---|---|---|
| Your employment stops for any reason other than gross misconduct or you have a reduction in hours | You | 18 months<br>(Up to 29 months if you or a qualified beneficiary is disabled at the time employment stops or within 60 days of beginning Continuation Coverage)*<br>If you are on duty in the uniformed services for more than 31 days, your spouse and dependents may continue coverage for up to 18 months. |
| | Dependent(s) enrolled when your coverage ends | Up to 36 months if you are enrolled in Medicare** |
| Divorce/legal separation and you stop coverage for your spouse or children | Ex-spouse/legally separated spouse and/or dependent children enrolled when your coverage ends | 36 months |
| Dependent child no longer eligible | Dependent child if enrolled when your coverage ends | 36 months |
| You enroll in Medicare and drop coverage in the Fund-sponsored Plan | Dependent spouse/children if enrolled when your coverage ends | 36 months |
| You die | Dependent spouse/children if enrolled at time of your death | 36 months (the Employer pays the cost for the first 6 months) |

* If the disabled individual (under the Social Security definition) entitled to the extension has non-disabled family members who are entitled to Continuation of Coverage, the non-disabled family members may continue coverage for up to 29 months as well.

** If you enroll for Medicare before you terminate employment or before you lose full-time status, your dependents may continue coverage up to the later of 36 months from the date you enroll for Medicare, or 18 months from the date of your termination or reduction in hours. For example, if you enroll for Medicare on January 1, and terminate employment a month later on February 1, your spouse and children may continue coverage for up to 36 months, counting from January 1.

**Employer Delinquency**

Where a discontinuation in coverage results from employer delinquency, the Plan will permit a continuation of coverage upon payment by the affected participant, first of continuation coverage premiums for all months of employer delinquency, and then for continuation coverage thereafter, up to eighteen (18) months for continuation coverage.

**The Cost of Continued Coverage**

Any person who elects to continue coverage under the plan must pay the full cost (your share and the Employer's share). In addition to the full cost, the Employer may charge an additional 2% for administrative expenses. There is a grace period of at least 30 days for the payment of the regularly scheduled premium. The first premium payment is due within 45 days of the date of the COBRA election. A disabled person (and covered family members) who extends coverage for more than 18 months may be required to pay 150% of the premium for months 19 through 29. However, if only the non-disabled family members elect to continue coverage under COBRA, then the cost will be 102% (full cost plus 2% for administrative expenses).

Payments must be made no later than the first day of coverage in each month. COBRA coverage will end if payment is not received within 30 days of the due date.

**Applying For Continuation of Coverage**

In most cases, you will be notified if you're eligible to continue coverage. However, you or your dependents *must* notify the Plan Administrator in the event of divorce, legal separation or when a dependent child is no longer eligible for coverage. You will then receive notice of eligibility for continuation of health care coverage under the Plan.

You will have 60 days from the time coverage stops or the date the notice is sent, whichever is later, to apply for Continuation of Coverage. You and each eligible dependent have the right to make an individual election for Continuation of Coverage.

***If you or your dependents do not file your application for continued coverage during the period outlined above, you will lose the opportunity to continue your coverage.***

**Disability Extension**

If you or a qualified dependent is totally disabled under the Social Security definition at the time of a reduction in hours or termination of employment, or within 60 days of beginning COBRA coverage, the disabled person and family members who are also eligible for COBRA coverage may extend the continuation coverage period up to 29 months.

To extend coverage beyond the 18-month period, you must provide a letter of determination to your local Human Resources representative before the end of the 18-month period to show that you are entitled to Social Security disability benefits. You must provide the disability determination to the Fund Office within 60 days of its receipt and before the end of the 18-month period.

If Social Security determination of disability stops, you must notify the Plan Administrator within 31 days of the final Social Security determination. COBRA coverage will stop on the first of the month following 31 days after the determination that you or a dependent is no longer disabled.

### Adding Dependents or Changing Elections

If you are a former employee who has elected to continue coverage, you may add a new spouse, domestic partner, your newborn or adopted children to your continuation coverage, provided you do so within 60 days of the marriage, birth, adoption or placement for adoption and pay the required premium. You also may change your medical, dental, and vision elections, and enroll or drop eligible dependents, during any enrollment period offered to active employees.

### When Continued Coverage Ends

The continued coverage will end for any person:

- when the premium for the individual's continuation coverage is not received on time (payment must be received by the first day of the month for which the premium applies);

- when an individual already covered by COBRA coverage becomes covered under another health care plan as an employee or dependent-unless the other plan contains a pre-existing condition exclusion or limitation. Continued coverage will not terminate until the individual is no longer affected by a pre-existing condition exclusion or limitation under the other group health plan; an individual can be dropped from COBRA coverage if he or she becomes covered under a new health care plan and the new plan gives credit for prior coverage that serves to eliminate the pre-existing condition exclusion period;

- on the date after electing COBRA coverage on which an individual becomes enrolled for Medicare benefits; when, in the case of an individual whose coverage is being continued because of the special extended coverage period for disabled individuals, it is determined that the individual is no longer disabled under the Social Security laws;

- on the day after the date that a member who is on duty in the uniformed services fails to apply for, or return to, active employment with the employer; or

- when the Fund no longer provides group health coverage to any employees.

If, during the 18-month or 29-month period, a second event occurs that would require continued coverage, coverage may be extended - but not beyond a total period of 36 months. No one may continue COBRA coverage under a Fund-sponsored health care plan for more than 36 months for any reason.

# Converting Group Medical Coverage After Termination

Contact your insured group medical carrier for information on converting to an individual policy. Many PPOs, HMOs, and other insured plans will permit you to continue membership or equivalent coverage on an individual policy. Conversion rights may also be available to your spouse and/or dependents when their coverage may not otherwise qualify for health insurance under normal circumstances. Due to this fact, however, the cost of the coverage is usually high and the conversion plans, prescribed by the state insurance regulations, will not offer the same comprehensive coverage as the Plan. For that reason, you should also contact other insurance companies so you can be sure you are getting the best coverage for your money.

For more information about conversion rights, contact the Plan Administrator.

***Individual coverage after termination***

You may be able to obtain coverage under an individual insurance policy issued by an insurance company.

The opportunity to buy an individual insurance policy is the same whether the individual is laid off, is fired or quits his or her job. For information on individual insurance policies you should contact your State Insurance Commissioner's Office.

For information on individual plan options that might be available through the Health Insurance Marketplace, visit www.HealthCare.gov

# Funding

All contributions to the Plan are made by the Contributing Employers in accordance with their collective bargaining agreements or participation agreements with the Union. The collective bargaining agreements or participation agreements require contributions to the Plan at fixed rates. Employees may be required to make a contribution towards the cost of medical or other coverage. These contributions together with any Contributing Employer contributions are paid to the Trust Fund.

The Fund Office will provide you, upon written request, with information as to whether a particular employer is contributing to this Plan on behalf of employees working under the collective bargaining agreement or participation agreement.

Benefits are provided from the Fund's assets, which are accumulated under the provisions of the collective bargaining agreement or participation agreement and the trust agreement, and held in a trust fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. Assets of the Fund are managed under authority of the Board of Trustees.

# ERISA

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

***Receive information about your plan and benefits***

You can review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plans, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plans with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.

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

Receive a summary of the plans' annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

***Continue group medical plan coverage***

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the medical plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary and the other documents governing the plans on the rules governing your COBRA continuation coverage rights.

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

***Prudent actions by plan fiduciaries***

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

***Enforce your rights***

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plans and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 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 plans' 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 fiduciaries misuse the plans' assets, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### *Assistance with your questions*

If you have any questions about your plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

# Plan Administration and Other Important Information

The Trustees shall have the sole and absolute discretion to determine eligibility for benefits under the Plan and to construe and interpret the plan of benefits, and the Agreement of Trust, including, but not limited to, doubtful or disputed terms, and to make factual determinations with respect thereto. Any construction, interpretation or application of the Plan by the Trustees shall be final, conclusive and binding on all Participants and on any person claiming benefits by, through or on behalf of any Participant.

Being a member of any Local 10-286 benefit plan does not grant any current or future employment rights. Plan membership is not an inducement or condition of employment. A right to benefits is determined solely under each Plan and underlying benefit's provisions.

The Trustees are responsible for the general administration of the Plan. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's or any other person's rights or obligations, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all parties.

The Trustees may designate other organizations or persons to carry out specific fiduciary or non-fiduciary responsibilities of the Trustees in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,
- The responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and
- The responsibility to act as a "Claims Administrator", as defined below in the section labeled "Plan Information" and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

***Power and authority of the insurance company***

Certain benefits under these Plans are fully insured. Benefits may be provided under a group insurance contract entered into between the Trustees and an insurance company. With respect to fully insured benefits, claims for benefits should be sent to the insurance company. The insurance company is responsible for paying claims, not the Trustees.

The insurance company is responsible for:

- Determining eligibility for and the amount of any benefits payable under the applicable benefit coverage.
- Prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to the applicable benefit coverage.

The insurance company also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the applicable benefit coverage.

The Plan Administrator hereby delegates to each insurance company the discretionary authority to construe and interpret the terms and provisions of the insurance benefits they are contracted to provide as listed herein.

***Questions***

If you have any general questions regarding the Plan, or any benefit program offered under the plan, please contact the Plan Administrator.

| **Plan Information** | |
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| Plan Sponsor | Board of Trustees of the USW District 10, Local 286 Welfare Trust Fund, 410-24 North 8th Street, Philadelphia, PA 19123 |
| Tax Identification Number for the Board | 23-1661924 |
| Plan Administrator | Joint Board of Trustees, consisting of five representatives from the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers Union and five employer representatives as follows:<br><br>**Union Trustees**<br><br>Ms. Edina DeCarlo<br>USW Local 10-286<br>410-424 N. 8th Street<br>Philadelphia, PA 19123<br><br>Mr. Michael A. Connell<br>USW Local 10-286<br>410-424 N. 8th Street<br>Philadelphia, PA 19123<br><br>Mr. Jimmie T. Nolan<br>USW Local 10-286<br>410-424 N. 8th Street<br>Philadelphia, PA 19123<br><br>Mr. Carlo Simone, III<br>USW Local10-286<br>410-424 N. 8th Street<br>Philadelphia, PA 19123<br><br>Mr. Mario Tatom<br>USW Local 10-286<br>410-424 N. 8th Street<br>Philadelphia, PA 19123<br><br>**Employer Trustees**<br><br>Mr. Bill Bregman<br>Delta Paper<br>8295 National Highway<br>Pennsauken, NJ 08110<br><br>Mr. Michael Ferman<br>Newman & Co.<br>6101 Tacony St.<br>Philadelphia, PA 19135 |

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| | Mr. Ken Gordon<br>Catalent Pharma Solutions<br>3001 Red Lion Road<br>Philadelphia, PA 19114<br><br>Mr. Robin Schaffer<br>Case Wilder Paper Company<br>500 Mamaroneck Avenue<br>Harrison, NY 10528<br><br>Jim Zambon<br>Weber Display & Packaging<br>3500 Richmond Street<br>Philadelphia, PA 19134<br><br>The Trustees are charged with the responsibility of carrying out the provisions of the Plan. In general, the Trustees' responsibilities include, but are not limited to:<br>➢ developing and amending the Plan, and<br>➢ providing for the payment of benefits in accordance with the provisions of the Plan.<br>In accordance with the Trust Agreement, the Trustees may delegate authority to a subcommittee of Trustees or to another fiduciary, person or entity to perform specific functions with respect to administration of the Fund.<br><br>In the discharge of its duties, the Board of Trustees is aided and advised by Legal Counsel, a Benefits Consultant and an Accountant (as set forth at the beginning of this document), as well as administrative personnel who are responsible for all Plan and Fund records and communications. |
| Fund Office | The day-to-day business of the Plan is handled by the Fund Office:<br><br>Carlo Simone, III<br>USW Local 10-286<br>410-424 North 8th Street<br>Philadelphia, PA 19123<br>Telephone: 215-829-9212 |
| COBRA Administrator | Carlo Simone, III<br>Office Manager<br>USW Local 10-286<br>410-424 North 8th Street<br>Philadelphia, PA 19123 |
| Claims Administrators | See charts below |
| Agent for Service of Legal Process | The Board of Trustees has been designated as the agent for the service of legal process. Service of legal process may be made upon each Plan Trustee or the Fund Office. |
| Plan Year | January 1 to December 31 |
| Contributing Employers | The Plan is supported by contributions made by employers. A complete list of employers and employee organizations sponsoring the Plan may be obtained upon written request to |

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| | the Plan Administrator and is available for examination by participants and beneficiaries. |
| **Plan Types, Names and Numbers** | |
| ➢ Medical / Prescription Drug<br>➢ Dental<br>➢ Vision<br>➢ Life Insurance<br>➢ Accidental Death and Dismemberment (AD&D)<br>➢ Weekly Disability Benefit<br>➢ Member Assistance Program | USW District 10, Local 286 Welfare Trust Fund<br><br>Plan Number 501 |
| **Claims Administrators** | |
| **Self-Funded Plans:**<br>*The following benefits are self-insured through the Fund. The Trustees have engaged the services of the following third-party administrators who are responsible for processing claims for these self-funded benefits. The ERISA fiduciary responsibility under the Plan to make a final decision on denied claims for self-funded benefits may be retained by the Trustees or delegated to the Claims Administrator. Any such delegation of this ERISA fiduciary responsibility to the Claims Administrator will be set forth in the associated documents which describe the benefit program:* | |
| None | |
| **Insured Plans:**<br>*The following benefits are insured through contracts with insurance companies who also administer claims for these benefits and are solely responsible for providing benefits. The ERISA fiduciary responsibility under the Plan to make a final decision on denied claims for fully insured benefits is delegated to the insurance companies:* | |
| Medical / Prescription Drug<br>Vision | Independence Blue Cross<br>1901 Market Street<br>Philadelphia, PA 19103-1480<br>www.ibx.com<br>800-275-2583 |
| Dental DMO | Delta Dental<br>1 Delta Drive<br>Mechanicsburg, PA 17055<br>www.deltadentalins.com<br>717-697-5251 |
| Weekly Disability Benefit | Reliance Standard Life Insurance Company<br>2001 Market Street, Suite 1500<br>Philadelphia, PA 19103<br>www.reliancestandard.com<br>800- 351-7500 |
| Basic Life<br>Basic Accidental Death & Dismemberment (AD&D) | Reliance Standard Life Insurance Company<br>2001 Market Street, Suite 1500<br>Philadelphia, PA 19103<br>www.reliancestandard.com<br>800- 351-7500 |

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| Member Assistance Program | Total Care Network<br>Penn Treaty Park Place<br>1341 North Delaware Ave., Suite 403<br>Philadelphia, PA 19125-4300<br>800-298-2299 / 215-425-8140 |

***SPD/Plan Document***

This Document constitutes the Plan document for the USW District 10, Local 286 Welfare Trust Fund and is an amendment and restatement of the Plan effective as of January 1, 2018. The Trustees maintain the Plan for the exclusive benefit of eligible employees and their eligible spouses and dependents. The Plan provides benefits through the component benefit programs described herein. Each of these component programs is described in a contract, certificate or booklet issued by an insurance company, a plan summary, or another governing document prepared by the Plan or vendor for the benefits listed herein. A copy of each applicable component document is attached to this Plan. This Document should be read in combination with the certificates of insurance and benefit booklets, which are incorporated by reference into this Document. The Plan, through this Document and referenced documents, is a plan document and a summary plan description and is intended to satisfy the written document requirements of section 402 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") Separate Cafeteria Plan documents intended to satisfy the written document requirements of section 125 of the Internal Revenue Code maintained by certain of the Participating Employers are incorporated by reference in this Plan, and are intended to satisfy the written document requirements of the Internal Revenue Code with respect to those benefits.

***Plan amendment and termination***

Although it is the present intention of the continue the benefits contained in this Plan, the Trustees reserve the right, whether in an individual case or more generally, to alter, reduce or eliminate any benefits, policy or practice, in whole or in part, without notice, subject to the applicable collective bargaining agreement(s), Trust agreement and applicable law.

The Trustees reserve the right to amend or terminate the Plan in accordance with the provisions in the Trust Agreement. No benefits provided by this Plan shall be considered vested benefits. Amendments to this Plan may be adopted by a majority vote of the Trustees as set forth more particularly in the Trust Agreement.

***Assignment of benefits***

Except as may otherwise be required by applicable law, or as otherwise specifically provided in the Plan or by certificates of insurance and benefit booklets, you will not be entitled to assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any amount payable to you, your spouse or any dependents at any time under the Plan. Any attempt to assign, sell, transfer, pledge, charge, encumber or allow the attachment or alienation of any such amount, whether presently or thereafter payable will be void. If you, your spouse or dependent attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or any part thereof, then the Plan Administrator, if it so elects, may direct that such amount be withheld and that the same or any part thereof be paid or applied to or for the benefit of you, your spouse or your dependents, or any of them in such manner and proportion as the Plan Administrator may deem proper.

Notwithstanding the foregoing provisions of this *Assignment of Benefits* section, you may request and authorize the Plan Administrator or the appropriate insurance company or service provider to pay benefits directly to the hospital, physician, dentist or other person furnishing services or supplies covered under the applicable benefit program and any such payment, if made, shall constitute a complete discharge of the liability of the plan therefore. Benefits also may be assigned to an alternate recipient pursuant to a QMCSO.

### *Medicaid eligibility and assignment of rights*

The Plan will not take into account whether an individual is eligible for, or is currently receiving medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a participant or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid Plan pursuant to §1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law which provides that the State has acquired the rights with respect to such individual to payment for such items and services under the Plan.

### *Important legal notice*

The Plan Administrator shall be responsible for the general administration of the Plan. The Plan Administrator and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, will have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including component benefit programs), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including component benefit programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator will be final and binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

### *Waiver of terms*

No term, condition or provision of the Plan shall be deemed waived, and the provisions of the Plan will be enforced, unless the Trustees or you specifically waive in writing the condition or provision. The written waiver will not be deemed a continuing waiver unless stated specifically in the waiver, and each waiver will operate only as to the specific term or condition waived.

### *Excess payments*

If the Plan has made an erroneous or excess payment to or on behalf of you, your spouse or dependents, the Plan Administrator shall be entitled to take action to correct the error, including recovering the excess from you, your spouse or dependents. To the extent permitted by applicable law, the recovery of the overpayment may be made by offsetting the amount of any other benefit or amount payable to or on behalf of you, your spouse or dependents by the amount of the overpayment.

### *Limitation of rights*

This document will not be held or construed to give any person any legal or equitable right against the Trustees, the Plan Administrator, or any other person connected with the Contributing Employers or the Plan, except as expressly provided in this document or as provided by applicable law; or to give any person any legal or equitable right to any assets of the Plan.

### *Severability*

If any provision of this document is held invalid or unenforceable, its invalidity or unenforceability will not affect any other provision of this document. The document shall be construed and enforced as if such provision had not been included in this document.

### *Tax consequences*

The Trustees do not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in the Plan. You should consult with professional tax advisors to determine the tax consequences of participation.

### *Applicable law*

This document shall be construed in accordance with the laws of the Commonwealth of Pennsylvania, except to the extent such laws are pre-empted by the law of any other state or by federal law.

### *Paperless communications*

Notwithstanding anything contained in this document to the contrary, the Trustees may from time to time establish uniform procedures whereby with respect to any or all instances in this document where a writing is required, including but not limited to any required written notice, election, consent, authorization, instruction, direction, designation, request or claim communication may be made by any other means designated by the Trustees, including paperless communication, and such alternative communication shall be deemed to constitute a writing to the extent permitted by applicable law, provided that such alternative communication is carried out in accordance with such procedures in effect at such time.

# HIPAA Privacy and Security

This section describes the manner in which the Plan will protect certain health information used or maintained by the Plan.

The Joint Board of Trustees (the "Board") sponsors and maintains certain group health plans that are subject to the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") regulations as are described more fully in this Document. Under the privacy and security rules of HIPAA, and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), and as HIPPA and the HIPPA regulations were amended by the American Recovery and Reinvestment Act of 2009 ("ARRA"), a group health plan must: (i) restrict the use and disclosure of protected health information ("PHI"), (ii) ensure the confidentiality, integrity, and availability of all electronic protected health information ("e-PHI") the plan creates, receives, maintains, or transmits, (iii) protect against any reasonably anticipated threats or hazards to the security and integrity of such information, (iv) protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA privacy rules set forth in 45 CFR Part 164, Subpart E, and (v) ensure compliance with the HIPAA security rules set forth in 45 CFR Part 164, Subpart C by its workforce.

1. **Uses and Disclosures of PHI.** The Board and each Participating Employer (the “Company”) may disclose a Plan participant’s PHI to the Company (or to the Company’s agent) for the Plan administration functions described under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations.

2. **Restriction on Plan Disclosure to the Company.** Neither the Plan nor any of its Business Associates, health insurance issuers, or HMOs, will disclose PHI to the Company except upon the Plan’s receipt of the Company certification that the Plan has been amended to incorporate the agreements of the Company under paragraph 3, except as otherwise permitted or required by law.

3. **Privacy Agreements of the Company.** As a condition for obtaining PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

    a. Not use or further disclose such PHI other than as permitted by paragraph 1 of this section, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

    b. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Company with respect to such information;

    c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company, and not use or disclose PHI that is genetic information for underwriting purposes;

    d. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Company becomes aware;

    e. Make the PHI of a particular participant available for purposes of the participant’s requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

    f. Make the PHI of a particular participant available for purposes of required accounting of disclosures by the Company pursuant to the participant’s request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

    g. Make the Company’s internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

h. If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

i. Ensure that there is adequate separation between the Plan and the Company by implementing the terms of subparagraphs (1) through (3), below:

   1. Employees with Access to PHI: The following employees or other individuals under the control of the Company are the only individuals that may access PHI received from the Plan: Fund Manager and others involved in Plan Administration functions.

   2. Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Company for the Plan.

   3. Mechanism for Resolving Noncompliance. If the Company or any other person(s) responsible for monitoring compliance determines that any person described in (1), above, has violated any of the restrictions of this section, then such individual shall be disciplined in accordance with the policies of the Company established for purposes of privacy compliance, up to and including dismissal from employment. The Company shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

j. Notify a participant or participants of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:

   1. the names of the individuals whose PHI was involved in the Breach;
   2. the circumstances surrounding the Breach;
   3. the date of the Breach and the date of its discovery;
   4. the information Breached;
   5. any steps the impacted individuals should take to protect themselves;
   6. the steps the Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and
   7. a contact person who can provide additional information about the Breach.

The Company will cooperate with you in the investigation of, and response to, the Breaches it reports to you. For this purpose, the term "Breach" means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

4. **Security Agreements of the Company.** As a condition for obtaining e-PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

   b. Ensure that the adequate separation between the Plan and the Company as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

   c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

   d. Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, "Security Incident" shall mean successful unauthorized access to, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

e. Upon request from the Plan, the Company agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Company.

5. **PHI not Subject to this Section**. Notwithstanding the foregoing, the terms of this section shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504 (f)(l)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations; provided however that paragraph 4 above shall apply if and only if e-PHI beyond enrollment, disenrollment, summary health information, and authorized disclosures is obtained by the Company, and the Company adopts the literal interpretation of 45 CFR 164.314(b)(1), which would apply paragraph 4 unless the only e-PHI obtained is enrollment, disenrollment, summary health information, or authorized disclosures.

6. **Definitions**. All capitalized terms within this section not otherwise defined by the provisions of this section shall have the meaning given them in the respective Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA.

# Appendix A
# Summary Plan Description Attachments

This Appendix is considered a part of the Plan and may be amended by the Trustees at any time for any reason without consent of any person except as otherwise provided by applicable law. Formal amendment of the Plan is not necessary to amend this Appendix. It may be amended by adding a new Appendix with the current date and current listing of incorporated documents.

The following benefits are further described in summaries and booklets which will be provided to participants as attachments to this document upon request. The terms, conditions and limitations of the benefits are set forth in the Plan and the underlying incorporated documents referenced herein. Certain documents are incorporated by reference in this Appendix, including any written document pursuant to which the applicable benefit is provided under the Plan (e.g., written plans, vendor contracts, insurance policies, coverage certificates, summary plan descriptions, or other materials describing benefits provided thereunder).

As of January 1, 2018, the following Plan benefits are further described in summaries and booklets attached to this document:

- Medical/Prescription Drug
- Member Assistance Program
- Vision
- Dental
- Life Insurance
- Accidental Death & Dismemberment (AD&D)
- Weekly Disability Benefit

# Appendix B
# HIPAA Privacy Notice

## UNITED STEELWORKERS DISTRICT 10, LOCAL 286 WELFARE TRUST FUND

## HIPAA NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

THIS NOTICE APPLIES TO THE FOLLOWING HEALTH CARE COVERAGE PROGRAMS MADE AVAILABLE TO MEMBER EMPLOYERS OF THE UNITED STEELWORKERS DISTRICT 10, LOCAL 286 WELFARE FUND, REFERRED TO IN THIS NOTICE AS THE "PLAN." IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE PLAN'S PRIVACY OFFICER.

Protected Health Information (PHI) is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment for health care services provided to you, or your physical or mental health or condition (including genetic information), in the past, present or future. This Notice of Privacy Practices describes how we may use and disclose your PHI. It also describes your rights to access and control your PHI.

As a provider of group health plan services we are required by Federal law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices.

The Plan will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by HIPAA, and more fully set forth in the Privacy and Security Policies developed by the Plan and amended periodically.

We are required to abide by the terms of this Notice of Privacy Practices, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that we are maintaining at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals covered under the Plan at that time.

### PERMITTED USES AND DISCLOSURES

#### Treatment, Payment and Health Care Operations

Federal Law allows a group health plan to use and disclose PHI, for the purposes of treatment, payment and health care operations, without your consent or authorization. Examples of the uses and disclosures that we, as a group health plan, may make under each section are listed below:

***Treatment.*** Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. As a group health plan we do not provide treatment; however, we may disclose your PHI, for example, the name of your treating dentist, to a treating orthodontist, so that the orthodontist may ask for your dental x-rays from your treating dentist.

***Payment.*** Payment refers to the activities of a group health plan in collecting premiums and paying claims under the Plan for health care services you receive. Examples of uses and disclosures under this section include the sending of PHI to an external medical review company to determine the medical necessity or experimental status of a treatment; sharing PHI with other insurers to determine coordination of benefits or settle subrogation clain1s; providing PHI to the Plan's utilization review ("UR") for precertification or case management services; providing PHI in the billing, collection and payment of premiums and fees to plan

vendors such as PPO Networks, UR Companies, Prescription Drug Card Companies and reinsurance carriers; and sending PHI to a reinsurance carrier to obtain reimbursement of claims paid under the Plan.

***Health Care Operations.*** Health Care Operations refers to the basic business functions necessary to operate a group health plan. Examples of uses and disclosures under this section include conducting quality assessment studies to evaluate the Plans performance or the performance of a particular network or vendor; the use of PHI in determining the cost impact of benefit design changes; the disclosure of PHI to underwriters for the purpose of calculating premium rates and providing reinsurance quotes to the Plan; the disclosure of PHI to stop-loss or reinsurance carriers to obtain claim reimbursements to the Plan; disclosure of PHI to plan consultants who provide legal, actuarial and auditing services to the Plan; and use of PHI in general data analysis used in the long term management and planning for the Plan. Notably, the Plan may not use or disclose genetic information for underwriting purposes

***Other Uses and Disclosures Allowed Without Authorization***
Federal law also allows a group health plan to use and disclose PHI, without your consent or authorization, in the following ways:

- To you, as the covered individual.
- To a personal representative designated by you to receive PHI or a personal representative designated by law such as the parent or legal guardian of child, or the surviving family members or representative of the estate of a deceased individual.
- To the Secretary of the federal Department of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine our compliance with the HIPAA Privacy Rules.
- To a Business Associate as part of a contracted agreement to perform services for the group health plan.
- To a health oversight agency, such as the Department of Labor (DOL), the Internal Revenue Service (IRS) and the Insurance Commissioner's Office, to respond to inquiries or investigations of the Plan, requests to audit the Plan, or to obtain necessary licenses.
- To public health officials to prevent public health risks, including (a) to prevent or control disease, injury or disability; (b) to report births and deaths; (c) to report child abuse or neglect; (d) to report reactions to medications or problems with products; (e) to notify people of recalls of products they may be using; (f) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (g) to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence.
- To military authorities, as required, if you are a member or veteran of the armed forces.
- To authorized federal officials for intelligence, counterintelligence and national security activities authorized by law, or to conduct special investigations and provide protection to the President of the United States.
- In response to a court order, subpoena, discovery request or other lawful judicial or administrative proceeding.
- As required for law enforcement purposes. For example to notify authorities of a criminal act
- As required to comply with Workers' Compensation or other similar programs established by law.
- To the Plan Sponsor, as necessary to carry out administrative functions of the Plan such as evaluating renewal quotes for reinsurance of the Plan, funding check registers, reviewing claim appeals, approving subrogation settlements and evaluating the performance of the Plan.
- In providing you with information about treatment alternatives and health services that may be of interest to you as a result of a specific condition that the Plan is case managing.

## OTHER USES AND DISCLOSURES

Other uses and disclosures of your PHI that are not described above will only be made upon receiving your written authorization. In particular, you should know that the Plan must obtain your written authorization to use or disclose your PHI for most types of marketing initiatives, or to sell your PHI. To the extent that the PHI maintained by the Plan contains psychotherapy notes, the Plan may not use or disclose such information without first obtaining your written authorization. You may revoke an authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in good faith with the authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the benefits provided to you through the Plan.

## YOUR RIGHTS IN RELATION TO PROTECTED HEALTH INFORMATION

### Right to Request Restrictions on Uses and Disclosures

You have the right to request that the Plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the Plan restrict the use or disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Contact listed in this Notice and must state the specific restriction requested and to whom that restriction would apply.

If you paid out-of-pocket for a specific item or service, you have the right to request that PHI relating to such item or service not be disclosed to another health plan for purposes of payment or health care operations, and the Plan must honor such a request. However, the Plan is not required to agree to other restrictions that you request. If the Plan does agree to a requested restriction, the Plan may not violate that restriction except as necessary to allow the provision of emergency medical care to you.

While the Plan does not currently intend to use or disclose your PHI to contact you for fundraising purposes, you should know that if that intent changes, the Plan will amend this Notice accordingly, and you will be afforded the opportunity to opt out of receiving such fundraising communications.

### Right to Receive Confidential Communications

You have the right to request that communications involving PHI be provided to you at an alternative location or by an alternative means of communication. The Plan is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Contact listed in this Notice.

### Right to Access to Your Protected Health Information

You have the right to inspect and copy your PHI that is contained in a designated record set for as long as the Plan maintains the Pill. A designated record set contains claim information, premium and billing records and any other records the Plan has created in making claim and coverage decisions relating to you. Federal law does prohibit you from having access to the following records: psychotherapy notes; information complied in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. Requests for access to your Pill should be directed to the Privacy Contact listed in this Notice. You may request that the Plan provide you with access to your PHI in electronic format, and the Plan will accommodate such request, if electronic formats are available (the Plan does not presently store or use electronic PHI).

### Right to Amend Protected Health Information

You have the right to request that PHI in a designated record set be amended for as long as the Plan maintains the PHI. The Plan may deny your request for amendment if it determines that the PHI was not created by the Plan, is not part of designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and the Plan has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Contact listed in this Notice.

**Right to Receive an Accounting of Disclosures**
You have the right to receive an accounting of all disclosures of your PHI that the Plan has made, if any, for reasons other than disclosures for treatment, payment and health care operations, as described above, and disclosures made to you or your personal representative. Your right to an accounting of disclosures applies only to PHI created or maintained by the Plan for a period of six years prior to the date of your request. Requests for an accounting of disclosures of your Pill should be directed to the Privacy Contact listed in this Notice.

While the Plan does not currently utilize an electronic health record, it may do so in the future. If your PHl is maintained in an electronic health record, and if the Plan has made disclosure of your PHI through the electronic health record for treatment, payment and/or health care operations purposes, you have a right to request an accounting of such disclosures that were made during the previous three years.

**Right to Receive a Paper Copy of this Notice**
You have the right to receive a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. Requests for a paper copy of this Notice should be directed to the Privacy Contact listed in this Notice.

**Right to Receive Notice of a Breach.** The Plan is required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of "Unsecured PHI" as soon as possible, but in no event later than 60 days following the discovery of the breach. "Unsecured PHI" is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. In the event that such a breach occurs, the Plan will notify the Secretary of the Department of Health and Human Services, and if such breach affects 500 or more individuals, the Plan will also notify local media outlets.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of Health and Human Services. Complaints should be filed in writing with the Privacy Contact listed in this Notice. The Plan will not retaliate against you for filing a complaint.

**PRIVACY CONTACT**

You may contact the Privacy Office for the Fund as follows: Edina DeCarlo or Sam Kenish at the Fund office at 215-829-9212.

# Appendix C
# COBRA Initial Notice

## USW DISTRICT 10, LOCAL 286
## WELFARE TRUST FUND CONTINUATION OF
## COVERAGE UNDER COBRA

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 coverage would otherwise end because of a life event known as 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 for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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 Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, and if Plan provides retiree health coverage:

commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

**You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Carlo Simone, Ill - Office Manager
USW - Local 10-286
410-424 North 8th Street
Philadelphia, PA 19123
215-829-9212

**How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 6oth day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide notice to:

Carlo Simone, Ill - Office Manager
USW - Local 10-286
410-424 North 8th Street
Philadelphia, PA 19123
215-829-9212

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of 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**
Carlo Simone, Ill - Office Manager
USW - Local 10-286
410-424 North 8th Street
Philadelphia, PA 19123
215-829-9212