EXCAVATING AND BUILDING MATERIAL DRIVERS UNION LOCAL 436

WELFARE FUND

SUMMARY PLAN DESCRIPTION

Updated as of January 1, 2015

The following shall be added at the end of the Section of the Plan titled, "How To File Claims And Appeals" on page 45 of the attached summary plan description.

Special Rules Relating Disability Claims And Appeals.

Disability claim denial notices will contain the following additional information:

- An explanation as to why the Plan disagreed with the views of: (i) health care or vocational professionals who evaluated the Claimant or advised the Plan; or (ii) a disability determination of the Social Security Administration.

- If a denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist or were not used.

- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

- If the denial is a final internal denial, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

- Denial notices will be provided in a culturally and linguistically appropriate manner.

Disability Claims – Other Considerations.

- A retroactive cancellation of disability coverage will be treated as a claim denial unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

- Disability claims and appeals will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

The Plan will take the following additional steps before denying a disability claim on appeal:

- The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination in connection with the claim. The Claimant will then be given a reasonable opportunity to respond prior to the decision on appeal.
- Before the Plan will deny an appeal based on a new or additional rationale, the Plan will provide the Claimant, free of charge, with the rationale. The Claimant will then be given a reasonable opportunity to respond prior to the decision on appeal.

Excavating and Building Material Drivers Union Local Welfare Fund
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Introduction

About This Booklet

The Board of Trustees of the Welfare Fund of Teamsters Local Union No. 436 ("Welfare Fund" or "Plan") is pleased to provide you with this updated Summary Plan Description ("SPD")/Plan Document, which contains current health and welfare information for active employees, retired employees, and eligible dependents. The benefits described in this booklet are effective as of January 1, 2015.

Your health coverage is provided through an insured arrangement between the Plan and HealthSpan, Inc. ("HealthSpan"). In other words, the Plan pays an insurance premium on your behalf to HealthSpan who in turn provides you with health care coverage. In order for you to understand the terms and conditions of your coverage, HealthSpan provides you with a separate Evidence of Coverage booklet ("EOC") and/or a Certificate of Insurance booklet ("COI") describing your health care coverage. The EOC and/or the COI are incorporated herein by reference, and a copy of one or both is included with this SPD as appropriate. Should you need another copy of your EOC or COI, or both, please contact HealthSpan. Some retiree coverage for Medicare eligible retirees and dependents is through United American. If applicable, a copy of the United American Certificate of Insurance is included with this SPD. If you receive coverage through United American, please contact United American if you need another copy of your Certificate of Insurance. Please read these materials carefully and keep them in a safe place.

In this booklet, we've tried to organize information in an easy-to-understand format. Some of the sections in the booklet include:

- **Summary Of Benefits—**An at-a-glance summary of Plan benefits.
- **Important Contact Information—**This tells you who to contact when you have a question about your benefits.
- **Life Events—**Details how your benefits are affected by different events that can occur in your life.
- **Benefit Information—**Explanations about the Plan's medical, prescription drug, vision, weekly accident and sickness, life insurance, and AD&D benefits.
- **How To File A Claim—**Gives you a step-by-step process for filing claims, including what you need to do if a claim is denied.
- **Definitions—**Defines important terms used throughout this booklet.

This Summary Plan Description (SPD) serves as the Plan's legal Plan Document. The Plan's medical benefits are further explained in the HealthSpan and United American benefit booklets. If there is a discrepancy between this booklet and those other documents, those other documents will govern.

Only the full Board of Trustees is authorized to interpret the benefits described in this booklet. No employer or union nor any representative of any employer or union, in such capacity, is authorized to interpret the Plan nor can any such person act as agent of the Trustees. The Trustees reserve the right to amend, modify, or discontinue all or part of this Plan, whenever, in their judgment, conditions so warrant. This booklet replaces and supersedes any prior Welfare Fund communication materials or Summary Plan Descriptions/Plan Documents.

Benefits Provided By The Fund

The Fund offers the following benefits:

- Comprehensive medical benefits;
- Prescription drug coverage;
- Vision benefits;
- Weekly accident and sickness benefits;
- Life insurance benefits; and
- Accidental death and dismemberment (AD&D) benefits.

The benefits you are eligible for depend on whether you are:

- Active or retired;
- A participant who has opted out of medical and prescription benefits through the Fund's "opt out" provision;
- In the HealthSpan HMO or Point of Service plan;
- Under or over age 65;
- Eligible for Medicare; and
- Covered for benefits under the Pension Fund.

Pages 4 - 15 provide a summary of the Plan's different benefit plans and pages 18 – 26 describe eligibility for benefits.

The Plan offers HealthSpan's HMO ("HMO Plan") and Point of Service ("POS Plan") plans for active participants and non-Medicare eligible retirees under age 65, and non-Medicare eligible dependents. The plan you are eligible for depends on the choices you make when you become a participant in the Welfare Fund or when you make your selection during the Welfare Fund's annual open enrollment period. You will receive information from the Fund Office about your choices at initial enrollment and annually thereafter.

Please take some time to review this booklet. If you're married, share this booklet with your spouse. We recommend that you keep this booklet with your important papers so you can refer to it when needed. If you have questions about the benefits described in this booklet, contact the Fund Office at 216-328-0436 or 877-396-3436.

Sincerely,

The Board of Trustees

Summary of Benefits: HMO Plan

For active employees, non-Medicare eligible retirees under age 65, and non-Medicare eligible dependents

COMPREHENSIVE MEDICAL BENEFITS	***MEMBER PAYS***
Embedded[4] Deductible (Calendar Year Single/Family) Coinsurance Out of Pocket Maximum (Calendar Year Single/Family) Includes Deductible	$2,000/$4,000 None $2,000/$4,000
OUTPATIENT CARE Office Visits-Primary Care Practitioner Office Visits-Specialist	 $30 per visit $30 per visit
PREVENTIVE SERVICES Preventive Screenings[5]	 No Charge
DIAGNOSTIC SERVICES •Laboratory and Radiology Services	 No Charge[1]
HOSPITAL INPATIENT CARE Inpatient Services	 No Charge[1]
URGENT CARE SERVICES Urgent Care Visits[6]	 $35 per visit
EMERGENCY SERVICES (Fee waived if admitted) Emergency Services[2]	 $75 per visit
MENTAL HEALTH SERVICES Outpatient Services	 $30 per visit
PRESCRIPTION DRUGS •Covered Formulary Drugs and Accessories up to a 31 day supply at HealthSpan and affiliated network facilities •Formulary Generic •Formulary Brand •Specialty Drugs[7] •Up to 62 day supply of maintenance drugs by mail order from the HealthSpan Mail Order Pharmacy	 $10 copay[3] $25 copay[3] $25 copay[3]
DURABLE MEDICAL EQUIPMENT, EXTERNAL PROSTHETICS AND ORTHOTICS Coverage available for Medicare approved durable medical equipment	 No Charge

Summary of Benefits: HMO Plan (continued)

ADDITIONAL BENEFITS	***BENEFIT DESCRIPTION***
VISION BENEFIT $250 per family every two rolling years (versus calendar years)	
DOT PHYSICAL EXAMINATION BENEFIT One Examination every twenty-two (22) months *if not paid by your employer* or One Examination every eleven (11) months if medically required *if not paid by your employer*	Examination must be done at Fund's ***exclusive*** provider
WEEKLY ACCIDENT AND SICKNESS BENEFIT Non-Occupational accident or sickness Occupational accident or sickness Maternity Maternity	 $150 per week for up to 26 weeks $40 per week for up to 6 weeks $150 per week for 26 weeks **OR** $300.00 per week for 13 weeks
LIFE INSURANCE BENEFT Active Participant Active Participant over age of 65 but under age of 70 Active Participants over the age of 70 Retiree (Death benefit, not life insurance benefit; for "Welfare Only" retirees retired prior to January 1, 2014) Spouse of active employee Dependent child of active employee	 $10,000 $6,500 $5,000 $5,000 $1,500 $500
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT Accidental death Loss of both hands, both feet, sight of both eyes, or the loss of any two of these Loss of one hand, one foot, or sight of one eye Amounts are reduced for Participants over the age of 65 as described, above	 $10,000 $10,000 $5,000

[1]When a plan deductible is indicated, services are subject to deductible.
[2]Services received at non-plan Emergency facilities that do not meet the definition of Emergency Services may not be eligible for coverage.
[3]Amount is not subject to, nor does it contribute toward the satisfaction of the Out-of-Pocket Maximum. Effective January 1, 2014, upon renewal, contracts for employers with 51 or more employees will automatically accumulate deductibles and covered Essential Health Benefits to the Out-of-Pocket Maximum. HealthSpan will apply transitional relief to delay the accumulation of prescription drugs, pediatric dental, pediatric vision and chiropractic services.
[4]Plan Deductibles are Embedded. The Individual Deductible counts toward the Family Deductible. Each family member is responsible for meeting the specified Individual Deductible amount, enabling that family member to receive benefits before meeting the Family Deductible. Once the Family Deductible is met, coverage begins for all covered family members.
[5]Preventive screenings as required by federal law.
[6]Additional charges will apply when diagnostic or specialty imaging services are provided during an Urgent Care Visit.
[7]Specialty drugs are very high cost medications approved by the Food and Drug Administration (FDA).

This summary of benefits contains highlights only.
This is not a contract. Specific benefits, exclusions and limitations are contained in the Group Agreement we have with the Plan and the Evidence of Coverage you will receive when you become a member. For specific questions about coverage, existing Members may call our Customer Relations Department at (216) 621-7100 or toll-free at 1-800-686-7100. New Members may call a HealthSpan Representative at (216) 479-5770 or toll-free at 1-800-400-1907. Our TTY line is (216) 635-4444 for the hearing impaired.

Summary Of Benefits: Point of Service Plan

For active employees, non-Medicare eligible retirees under age 65, and non-Medicare eligible dependents

COMPREHENSIVE MEDICAL BENEFITS	Tier 1: HealthSpan/ Affiliated Providers ***MEMBER PAYS***	Tier 2† : Health*Smart* Preferred Care Providers ***MEMBER PAYS***	Tier 3† :Out of Network Providers ***MEMBER PAYS***
Embedded[6] Deductible (Calendar Year Single/Family) •Tier 1 and Tier 2 Cross Accumulate	$2,000/$4,000[3]	$3,000/$6,000[3]	$4,000/$8,000[3]
Coinsurance	20%	30%	50%
Out of Pocket Maximum (Calendar Year Single/Family) •Tier 1 and 2 Cross Accumulate	$2,500/$5,000 Includes Deductible	$4,000/$8,000 Includes Deductible	$5,000/$10,000
Lifetime Maximum	None	None	None
OUTPATIENT CARE			
Office Visits-Primary Care Physician	$30 copay	$40 copay[3]	50% after deductible
Office Visits-Specialist	$30 copay	$50 copay[3]	50% after deductible
Office Visits-Vision Exams available through affiliated providers	$30 copay[3]	Covered under Tier 1	Covered at Tier 1
Allergy treatment	$5 copay	30% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	30% after deductible	50% after deductible
Occupational Therapy	20% after deductible[3] 20 visits per calendar year	30% after deductible Limited to 20 visits per calendar year[1]	50% after deductible Limited to 20 visits per calendar year[1]
Physical Therapy	20% after deductible[3] Limited to 20 visits per calendar year	30% after deductible Limited to 20 visits per calendar year[1]	50% after deductible Limited to 20 visits per calendar year[1]
Speech Therapy	20% after deductible[3] Limited to 20 visits per calendar year	30% after deductible Limited to 20 visits per calendar year[1]	50% after deductible Limited to 20 visits per calendar year[1]

Summary Of Benefits: Point of Service Plan (continued)

COMPREHENSIVE MEDICAL BENEFITS	Tier 1: HealthSpan/ Affiliated Providers ***MEMBER PAYS***	Tier 2[†]: Health*Smart* Preferred Care Providers ***MEMBER PAYS***	Tier 3[†]:Out of Network Providers ***MEMBER PAYS***
PREVENTIVE SERVICES			
Preventive Adult Physical primary care exam •Limited to a combined maximum benefit of one Routine visit per calendar year for Tier 2 and 3.	No Charge	No Charge	50% after deductible
Preventive Well Child Care primary care exam as defined by Patient Protection and Affordable Care Act (PPACA)	No Charge	No Charge	50% after deductible
Preventive Mammogram and cervical cancer screening as defined by PPACA	No Charge	No Charge	50% after deductible
Preventive Lab and X-ray screenings as defined by PPACA	No Charge	No Charge	50% after deductible
Preventive Immunizations as defined by PPACA	No Charge	No Charge	50% after deductible
LABORATORY AND RADIOLOGICAL SERVICES			
Laboratory and diagnostic testing, X-rays	20% after deductible	30% after deductible	50% after deductible
HOSPITAL INPATIENT CARE			
Inpatient Services	20% after deductible	30% after deductible	50% after deductible
URGENT CARE SERVICES			
Urgent Care Visits	$35 copay	$75 copay[3]	50% after deductible
Laboratory and diagnostic testing, x-rays	20% after deductible	30% after deductible	50% after deductible
EMERGENCY SERVICES (Fee waived if admitted)			
Emergency use of any Emergency Room[2]	$100 copay	Emergencies treated at providers in this Tier are covered at the Tier 1 benefit level	Emergencies treated at providers in this Tier are covered at the Tier 1 benefit level
Non-emergent use of Emergency Services	See Tiers 2 and 3	30% after deductible	50% after deductible
AMBULANCE SERVICES			
•Only when required by medical condition and transportation in any other vehicle would endanger your health	20% after deductible	30% after deductible	50% after deductible

Summary Of Benefits: Point of Service Plan (continued)

COMPREHENSIVE MEDICAL BENEFITS	Tier 1: HealthSpan/ Affiliated Provider ***MEMBER PAYS***	Tier 2† : Health*Smart* Preferred Care Providers ***MEMBER PAYS***	Tier 3† :Out of Network Providers ***MEMBER PAYS***
BIOLOGICALLY BASED MENTAL ILLNESSES			
Inpatient Services (does not include residential services)	20% after deductible	30% after deductible	50% after deductible
Outpatient Services	$30 copay	$50 copay	50% after deductible
MENTAL HEALTH			
Inpatient Services (does not include residential services)	20% after deductible	30% after deductible	50% after deductible
Outpatient Services	$30 copay[3]	$40 copay	50% after deductible
CHEMICAL DEPENDENCY & ALCOHOL RELATED SERVICES			
Inpatient Services (does not include residential services)	20% after deductible	30% after deductible	50% after deductible
Outpatient Services	$30 copay[3]	$50 copay3	50% after deductible
TRANSPLANTS			
Inpatient-including follow-up care	20% after deductible	Covered only through Tier 1 providers	Covered only through Tier 1 providers
Outpatient –including follow up care	$30 copay		
ALTERNATE CARE			
Home Health Services	20% after deductible	30% after deductible	50%[3] after deductible
Hospice Home Care/Respite Care	No Charge	30% after deductible	50%[3] after deductible
Skilled Nursing Facility	20% after deductible[3] 100 days maximum	30% after deductible Limited to 7 days per calendar year[1]	50% after deductible Limited to 7 days per calendar year[1]
DURABLE MEDICAL EQUIPMENT, EXTERNAL PROSTHETICS AND ORTHOTICS	No Charge	30% after deductible	50% after deductible
CHIROPRACTIC SERVICES			
Chiropractic Services	Not Covered	30% after deductible Limited to 20 visits per calendar year[1]	50% after deductible Limited to 20 visits per calendar year[1]

Summary Of Benefits: Point of Service Plan (continued)

COMPREHENSIVE MEDICAL BENEFITS	Tier 1: HealthSpan/ Affiliated Providers	Tier 2† : Health*Smart* Preferred Care Providers	Tier 3† :Out of Network Providers
PRESCRIPTION DRUGS			
All Generics\Formulary Brand\Non-Formulary Brand[10] •up to a 31-day supply	HealthSpan Facilities[8] $10\$25\$40[3]	MedImpact Pharmacies $25\$40\$55[3]	**Out of Network** Covered at Tier 1 or 2 locations only
Specialty Drugs[7]	$75[3]	$100[3]	Covered at Tier 1 or 2 locations only
•90-day supply All Generics\Brand Formulary\ Brand Non-formulary	$20\$50\$80[3]	Covered at Tier 1 Mail Order only	Covered at Tier 1 Mail Order only
•90-day supply of Specialty Drugs Mail Order	$150[3]	Covered at Tier 1 Mail Order only	Covered at Tier 1 Mail Order only

ADDITIONAL BENEFITS	***BENEFIT DESCRIPTION***
VISION BENEFIT $250 per family every two rolling years (versus calendar years)	
DOT PHYSICAL EXAMINATION BENEFIT One Examination every twenty-two (22) months *if not paid by your employer* or One Examination every eleven (11) months if medically required *if not paid by your employer*	Examination must be done at Fund's ***exclusive*** provider
WEEKLY ACCIDENT AND SICKNESS BENEFIT	
Non-occupational accident or sickness	$150 per week for up to 26 weeks
Occupational accident or sickness	$40 per week for up to 6 weeks
Maternity	$150 per week for 26 weeks **OR** $300.00 per week for 13 weeks
LIFE INSURANCE BENEFT	
Active Participant	$10,000
Active Participant over age of 65 but under age of 70	$6,500
Active Participants over the age of 70	$5,000
Retiree (Death benefit, not life insurance benefit; for "Welfare Only" retirees retired prior to January 1, 2014)	$5,000
Spouse of active employee	$1,500
Dependent child of active employee	$500
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT	
Accidental death	$10,000
Loss of both hands, both feet, sight of both eyes, or the loss of any two of these	$10,000
Loss of one hand, one foot, or sight of one eye	$5,000
Amounts are reduced for Participants over the age of 65 as described, above	

† Payments are based upon the Maximum Allowable Charge (MAC) as defined in the *Certificate of Coverage* for covered services. Maximum Allowable Charge is the lesser of the Negotiated Rate, the Usual, Customary and Reasonable Charge or the Actual Billed Charge. The Member is responsible for any charges that exceed MAC for out-of-network services.

[1] Combined Tier Two and Tier Three maximum benefit.

[2] Services for emergencies are covered at any emergency room at the Tier 1 benefit level. Emergency medical services that do not meet Tier 1 definition are eligible for coverage at the appropriate Tier 2 or Tier 3 deductible and coinsurance level benefits provided through HealthSpan.

[3] Amount is not subject to, nor does it contribute toward satisfaction of the Out-of-pocket Maximum for specified tier. Effective January 1, 2014, upon renewal, contracts for employers with 51 or more employees will automatically accumulate Tier 1 and Tier 2 deductibles and covered Essential Health Benefits to the Out-of-Pocket Maximum. HealthSpan will apply transitional relief to delay the accumulation of prescription drugs, pediatric dental, pediatric vision and chiropractic services.

[4] Limited to only one specialized hospital admit per year either chemical dependency or alcohol treatment

[5] Limited to $550 Chemical Dependency Services and $550 Alcohol Related Services per calendar year for both Inpatient and Outpatient Services for both Tier 2 and Tier 3, unless otherwise stated.

[6] Plan Deductibles are Embedded. The Individual Deductible counts toward the Family Deductible. Each family member is responsible for meeting the specified Individual Deductible amount, enabling that family member to receive benefits before meeting the Family Deductible. Once the Family Deductible is met, coverage begins for all covered family members.

[7] Specialty drugs are very high cost medications approved by the Food and Drug Administration (FDA).

[8] Effective January 1, 2011, the Tier 1 pharmacy network includes all HealthSpan medical office pharmacies in our service area plus eight select non-HealthSpan pharmacies. Ask your HealthSpan representative for a list of Tier 1 pharmacies.

[9] Group contracts starting on or after 7/1/2010 provide additional Dependent coverage up to age 28, when certain criteria are met. Contact your employer for more details.

[10] If the member or physician requests a brand drug and a generic equivalent exists, the member pays the brand copay PLUS the difference between the cost of the brand drug and the generic drug.

GENERAL EXCLUSIONS

This summary of benefits contains highlights only. This is not a contract. Specific benefits, exclusions, and limitations are contained in the Group Agreement we have with your employer and the Evidence of Coverage (EOC) and Certificate of Insurance (COI) you will receive when you become a member. For specific questions about coverage, existing Members may call our Customer Relations Department at (216) 621-7100 or toll-free at 1-800-686-7100. New Members may call a HealthSpan Representative at (216) 479-5770 or toll-free at 1-800-400-1907. Our TTY line is (216) 635-4444 for the hearing impaired.

Plan Deductibles do not contribute to the satisfaction of the Tier 1, Tier 2, or Tier 3 Out-of-Pocket Maximums, unless otherwise stated. Copayments and per visit deductibles are not subject to, nor do they contribute toward satisfaction of the Tier 2 or Tier 3 Plan Deductibles. Copayments are not subject to, nor do they contribute to the satisfaction of the Tier 2 and Tier 3 Out-of-Pocket Maximums. Plan Deductibles do not cross accumulate across Tiers 1, 2, or 3, unless otherwise stated.

For additional HealthSpan Services, visit our website, HealthSpan.org. Through HealthSpan.org, members can access comprehensive, physician-reviewed information on a variety of health topics, search for specific topics in our health and drug encyclopedias, complete a total health assessment, and more. Members who receive care at HealthSpan medical centers can also use our website to check most lab test results, schedule non-urgent primary care appointments, refill prescriptions, order ID cards, and e-mail questions to their HealthSpan practitioner or a member services representative. In addition, members can call our 24-Hour Care Line to receive advice and assistance.

Basic Coverage Information: Any person may cancel coverage within 72 hours after having signed the agreement or offer to enroll in the plan. Cancellation occurs when written notice of cancellation is given to HealthSpan or its agents or representatives. The notice of cancellation shall be considered given when the prospective subscriber mails a letter to HealthSpan.

General Limitations and Exclusions within Tier 1 including but not limited to: Services that are not medically necessary; services and supplies not provided, arranged, or authorized by a HealthSpan or affiliated physician; services that are the financial responsibility of an employer or services a government agency is required by law to provide; services provided under any Workers' Compensation or employer's liability law; certain physical examinations, cardiac rehabilitation exercise program; custodial or intermediate care; long term rehabilitative services including physical, speech, and occupational therapy; services other than artificial insemination for conception by artificial means, including but not limited to, in vitro fertilization, ovum transplants, gamete intrafallopian transfer, zygote intrafallopian transfer; conception by artificial means; services related to the procurement and storage of donor semen; services related to sexual reassignment; services to reverse voluntary, surgically induced infertility; experimental or investigational services; non-human and artificial organs and their implantation; specialized behavioral modification programs for chronic conditions; alternative medical services including acupuncture, naturopathy, and massage therapy; hypnotherapy and hypnotic anesthesia; cosmetic surgery or services.

Group Exclusions and Limitations within Tier 2 and Tier 3: Hearing and vision exams, treatment for involuntary infertility, emergency services as defined by Tier 1, transplants and transplant related services, unless otherwise stated, durable medical equipment, prosthetic devices and orthotic appliances. Certain services may be subject to precertification. HealthSpan will make no payment for treatment, confinement or supplies to the extent such treatment services or supplies were provided arranged, paid for or payable by HealthSpan.

Added Choice® is underwritten by HealthSpan. This benefit chart is a summary only. Details on benefit coverage are contained in the Evidence of Coverage (EOC) and Certificate of Insurance (COI) you will receive when you become a member. The EOC and COI are the binding documents between Health Plan and its Members. In the case of a conflict between this benefit chart and the EOC or COI, the EOC and COI will prevail. Precertification is required for some services provided by Preferred Provider Organization and Out-of-Network providers. Details are contained in the COI. For specific questions about coverage, existing members should call our Customer Relations Department at (216) 621-1950 or toll-free at 1-888-744-6334. New members should call a HealthSpan representative at (216) 479-5770 or toll-free 1-800-400-1907. Our TTY line is (216) 635-4444 for the hearing impaired.

Health Plan Drug Formulary: HealthSpan uses a formulary. The medications included in the Formulary are chosen by a group of physicians, pharmacists, and nurses known as the Pharmacy and Therapeutics Committee. This Committee meets regularly to evaluate and choose those medications that are effective, safe, and useful in caring for our members. Please note that some health benefit plans provide coverage of non-formulary drugs at a higher non-formulary copayment.

Not all health benefit plans include coverage for prescription drugs. Some drugs may be excluded from coverage. Some plans have limitations on the dollar amount of coverage. Some medications may have quantity restrictions limiting the amount of the drug you can receive per prescription or copayment. Coverage of certain formulary medications may also be subject to restrictions established by the Pharmacy and Therapeutics Committee.

For more information regarding our prescription drug benefit procedures or your benefit, please call our Customer Relations Department at (216) 621-7100 or 1-800-686-7100 or visit HealthSpan.org to view the Member Drug Formulary.

Summary Of Benefits: HealthSpan Medicare Plus

For Medicare-eligible retirees and Medicare-eligible dependents under age 65

COMPREHENSIVE MEDICAL BENEFIT	***MEMBER PAYS***
Out-of-Pocket Maximum[1] (Calendar Year, Single/Family)	$2,500/$6,000
OUTPATIENT CARE	
Office Visits-Primary Care Practitioner	$5 per visit
Office Visits-Specialist	$5 per visit
PREVENTIVE SERVICES	
Mammography, Pap Smear	No Charge
Prostate cancer screening	No Charge
Colorectal cancer screening	No Charge
Cardiovascular screening blood tests	No Charge
Diabetes screening tests	No Charge
Bone Mass Measurement	No Charge
DIAGNOSTIC SERVICES	
•Laboratory and Radiology Services	No Charge
HOSPITAL INPATIENT CARE	
Inpatient Services	$250 per benefit period
URGENT CARE SERVICES	
Urgent Care Visits	$35 per visit
EMERGENCY SERVICES - (Fee waived if admitted)	
Worldwide emergency coverage	$65 per visit
MENTAL HEALTH SERVICES	
Outpatient Services	$5 per visit
DURABLE MEDICAL EQUIPMENT (DME), EXTERNAL PROSTHETICS AND ORTHORTICS Durable Medical Equipment •Medicare-approved durable medical equipment, external prosthetics, and orthotics, including glucose monitors, test strips, and lancets	No Charge
PRESCRIPTION DRUGS Prescription Drugs • Covered Formulary Drugs and Accessories up to a 31 day supply at HealthSpan and affiliated network facilities. • Up to 62 day supply of maintenance drugs by mail order form the HealthSpan Mail Order Pharmacy. *Medical services provided or arranged by your HealthSpan Physician.*	No Charge
ADDITIONAL BENEFITS	
VISION BENEFIT $250 per family every two rolling years (if eligible)	

Summary of Benefits: United American Plan

For Medicare eligible retirees and Medicare eligible dependents age 65 or older and Medicare eligible disabled participants under age 65

Medicare Part A			
SERVICES	***MEDICARE PAYS***	***PLAN PAYS***	***YOU PAY***
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A Deductible)	$0
-61st through 90th day	All but $315 a day	$315 a day	$0
-91st day and after:			
While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
-Beyond the Additional 365 days	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
SKILLED NURSING FACILITY*			
Days 1 – 20 per benefit period:*	100%	$0	$0
Days 21 – 100:	All but $157.50 per day	$157.50 per day	$0
Days 101 and beyond:	$0	$0	All costs
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	

Summary of Benefits: United American Plan (continued)

Medicare Part B			
SERVICES	***MEDICARE PAYS***	***PLAN PAYS***	***YOU PAY***
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	100% 75% of the amount not paid by Medicare until you reach your of pocket maximum of $1,000, then 100%	$0 25% of the amount not paid by Medicare until you reach your of pocket maximum of $1,000, then $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
Medicare Parts A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $147 of Medicare Approved Amounts*	0%	100%	$0
Remainder of Medicare Approved Amounts	80%	75% of the amount not paid by Medicare until you reach your of pocket maximum of $1,000, then 100%	25% of the amount not paid by Medicare until you reach your of pocket maximum of $1,000, then $0

Summary of Benefits: United American Plan (continued)

Other Benefits Not Covered by Medicare			
SERVICES	***MEDICARE PAYS***	***PLAN PAYS***	***YOU PAY***
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

* *Once you have been billed $147 of Medicare-Approved amounts for covered services (which are noted with an asterisk), Medicare Part B Deductible will have been met for the calendar year

NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

Important Contact Information

If You Need Information About …	Contact …
Eligibility for benefits, enrollment, life insurance disability and vision claims	Local 436 Welfare Fund 6051 Carey Drive Valley View, OH 44125-4259 Telephone: 216-328-0436 Facsimile: 216-328-0652 Toll Free: 877-396-3436
Comprehensive medical benefits and Prescription drug benefits	For information about providers or medical claims through HealthSpan (HMO Plan, POS Plan, and Medicare Plus Plan): **HealthSpan** 1001 Lakeside Ave, Suite 1200 Cleveland, OH 44114 Claims Department PO Box 5316 Cleveland OH 44101-0316 Customer Relations: 1-216-621-7100 1-800-686-7100 www.healthspannetwork.com _____ For information about benefits provided through United American: **United American** P.O. Box 8080 McKinney, Texas Claims Department: United American uses Automated Claims. For more information please call the Customer Relations number below. Customer Relations: 1-800-730-4648 www.unitedamerican.com

If You Need Information About …	Contact …
Online resources for health information The Fund cannot endorse or guarantee the information on these sites.	www.webmd.com (general wellness) www.mayoclinic.com (consumer-oriented information about illnesses and drugs) www.medlineplus.gov (comprehensive data on any health condition, operated by the U.S. National Library of Medicine) www.kidshealth.org (health information for parents, children, and teenagers) www.alzheimers.org (Alzheimer's Disease Education & Referral Center) www.aad.org (American Academy of Dermatology) www.aapcc.org (American Association of Poison Control Centers) www.ada.org (American Dental Association) www.lungusa.org (American Lung Association) www.nida.nih.gov (National Institute of Drug Abuse) www.nimh.nih.gov (National Institute of Mental Health) www.ninds.nih.gov (National Institute of Neurological Disorders and Stroke) www.nia.nih.gov (National Institute on Aging) www.healthcare.gov(Health Exchange marketplace information and PPACA information) www.fmcsa.dot.gov/regulations/medical (Federal Motor Carrier Safety Administration medical requirements)

Eligibility

Active Employees

Initial Eligibility

Your eligibility for benefits as an active member is based on the amount of contributions the Fund office receives from your employer. The collective bargaining agreement between your employer and Teamsters Local Union No. 436 controls the amount and conditions under which the employer pays those contributions. Your employer is obligated to pay contributions to the Fund office the month after you earn them. For example, if you work in May, the employer reports that work and pays those contributions in June.

There may be different eligibility requirements for new employers accepted into the Plan. These participants would be notified of the requirements, which are based on the terms of the employer's agreement with the Fund.

After your employer submits its first contributions to the Welfare Fund on your behalf the Fund will mail you the necessary enrollment forms. You will need to complete these forms and provide the necessary documentation such as birth or marriage certificates, before Plan benefits are paid on your behalf.

Month-To-Month Eligibility

If you have one hundred sixty hours or four weeks of contributions made on your behalf for work in one month, you become eligible for coverage two months later. For all eligibility purposes forty hours of contributions equals one week of contributions.

Example

Jim begins working for a contributing employer in January 2014. In February his employer reports to the Fund office that he worked 170 hours in January. Because he has worked at least four weeks and his employer made at least four weeks of contributions on his behalf for January 2014. Therefore, he becomes eligible for coverage March 1 and remains eligible for the entire month of March 2014.

Quarterly Eligibility

As a new participant you can also become eligible for coverage for a full quarter, an eligibility quarter, if you have the required contributions made on your behalf in the corresponding work quarter(s) as shown in the chart that follows.

If you have 9 or more weeks of employer contributions in the following quarter:	OR	If you have 13 or more weeks of employer contributions in the following work quarters (to consecutive work quarters): THEN	You are eligible for coverage in the following coverage quarter:
August, September, October		May, June, July, August, September, October	January, February, March
November, December, January		August, September, October, November, December, January	April, May, June
February, March, April		November, December, January, February, March, April	July, August, September
May, June, July		February, March, April, May, June, July	October, November, December

Example 1

Mary begins working for a contributing employer in May 2014. Her employer makes the following contributions to the Fund on her behalf and she is eligible as follows:

Month	Weeks of Contributions	Eligible? / If so, When?
May	3.5	No
June	3.5	No
July	4.0	Yes, Mary is eligible in both September and October through December because of month to month eligibility, July contributions make her eligible September, and having more than 9 weeks of contributions in the work quarter of May to July.

Example 2

Todd begins working for a contributing employer in May 2014. His employer makes the following contributions to the Fund on his behalf and he is eligible as follows:

Month	Weeks of Contributions	Eligible? If so, When?
May	3.0	No
June	2.0	No
July	3.0	No
August	1.0	No
September	2.0	No
October	2.0	Yes, Todd is eligible January – March 2015 because of 13 weeks of contributions in the two previous consecutive work quarters.

Once you become eligible for a full coverage quarter your continuing eligibility will come under rules for continuing eligibility.

Continuing Eligibility

Once you become eligible for a full quarter of benefits under the Plan, your eligibility continues provided you:

- Have the applicable number of weeks of employer contributions made on your behalf;
- Have the weeks necessary in your Eligibility Reserve to extend coverage; or
- You are eligible to and make the necessary self-payments.

The Fund office will mail you an eligibility letter near the beginning of March, June, September and December to let you know if you are eligible for the upcoming eligibility quarter. This letter will show you the weeks your employer(s) reported on your behalf, your Eligibility Reserve amount and whether you are eligible or not for that upcoming quarter.

Continuing Eligibility through Employer Contributions

Once you become eligible for a full quarter, you continue to remain eligible if you have the necessary employer contributions as shown in the chart below.

Nine or more weeks of employer contributions in these work quarters:	Will make you eligible in the following eligibility coverage quarters:
August, September & October	January, February & March
November, December & January	April, May & June
February, March & April	July, August & September
May, June & July	October, November & December

Continuing Eligibility Using Eligibility Reserve

You can use “Eligibility Reserve” to help you stay eligible for benefits if you do not work for 9 weeks in a work quarter. Once you have been eligible for a full quarter, that is after you have

established initial quarterly eligibility, any weeks in excess of 9 in any one work quarter will accumulate in your Eligibility Reserve. You may accumulate up to 36 weeks of reserve, four full quarters of coverage. These weeks can be carried over indefinitely as long as you remain a participant in the Welfare Fund. The Fund will automatically apply your available reserve to maintain your eligibility and you must use the weeks in your reserve to continue coverage before making self-payments.

You will lose your Eligibility Reserve after one year from your last employer contributions if

- Your employer contributions end; and
- You do not agree to the terms of using Eligibility Reserve as explained, below; and
- You either do not make the self-payments as described below or you have exhausted your ability to self-pay.

Continuing Eligibility through Self-Payments

If your employer contributions and Eligibility Reserve do not equal or exceed nine weeks, you may be able to maintain eligibility by making "self-payments" to the Fund to make up the difference between the total of your contributions and reserve and the 9 weeks needed to maintain eligibility. You will receive a letter shortly after you receive your quarterly eligibility letter informing you of the amount you owe and the conditions for making payment. The amount of the payment will vary based on the number of weeks you are short and the plan, HMO or POS, in which you are enrolled. The amounts you need to pay for the HMO or POS plan will be set annually by the Board of Trustees.

You do not have to make the self-payments. If you do not make the required self payments you receive no credit for the employer contributions that were reported to you and your Eligibility Reserve is not changed. The "unused" contributions will not be returned to you or your employer. If you receive no further employer contributions you cannot re-establish eligibility. If you do not self-pay, but have contributions made on your behalf, you can re-establish eligibility by making self-payment at that time.

Duration of Self – Payment

If no employer contributions are received on your behalf and your Eligibility Reserve is depleted, you may make self-payments to continue coverage for up to four consecutive eligibility quarters. After those four quarters are complete your eligibility for Fund benefits will cease and you must re-establish eligibility as a new member.

Conditions on Using Eligibility Reserve or Making Self – Payments

If you maintain eligibility through the use of the Eligibility Reserve or self-payment alone, or through a combination of the two, and without any employer contributions, you will be ineligible for Welfare Fund benefits if you go to work for any employer that performs the type of work done by an employer contributing to the Welfare Fund.

Dependents

Dependents become eligible for coverage on the same date your coverage begins so long as you provide the needed documentation required by the Welfare Fund. If you acquire a dependent while eligible for coverage, your dependent becomes eligible for benefits as of the date you acquire the dependent so long as you provide the needed documentation required by the Welfare Fund.

"Foster child" — A child

- Legally placed in your home by a court or authorized placement agency; or
- Placed in your household on a temporary custody order by a court of law during which period the child is a member of your household and resides in your home per the custody order.

Eligible dependents include:

- Your lawful spouse provided that you and your spouse are not legally separated. ***However***,
  - if your spouse has employer sponsored medical and prescription coverage available to her or him through employment; and
  - that coverage is comparable to that offered by the Welfare Fund; and
  - the cost is less than $100 per month—

  then your spouse will not be a dependent for purposes of the Welfare Fund's medical, prescription, vision and life insurance benefits. If your spouse loses coverage or the coverage becomes too expensive or not comparable, then he or she can be reinstated as a dependent upon the Fund receiving notice of that change. The Fund will ask you to update your records every year.
- Your children through age 26 provided they are: natural children, legally adopted children, stepchildren, or foster children.
- Your adult children who are between the ages of 26 and 28; provided that all of the following conditions are satisfied:
  - the adult children are unmarried;
  - the adult children are residents of Ohio, or are Ohio residents enrolled in an accredited public or private institution of higher learning outside the State of Ohio;
  - the adult children are not eligible to participate in any other employer sponsored health benefit plan; and
  - the adult children are not eligible for Medicaid or Medicare.

  You may have to pay an additional premium to provide benefits for your children between the ages of 26 and 28.
- Children for whom coverage must be provided because of a Qualified Medical Support Order (QMCSO).

When Coverage Ends

Your eligibility for coverage under the Plan will end when:

- Your employer no longer makes the required weeks of contributions on your behalf (and you do not continue coverage using your Reserve Eligibility or by making self-payments);
- You do not have enough accumulated weeks in your Reserve Eligibility (and you do not make the self-payments);
- You do not make timely self-payments;
- You do not make the required self-payment for COBRA Continuation Coverage by the due date;
- You are eligible for and do not elect COBRA Continuation Coverage; or
- The Plan ends.

For Your Dependents

Your eligible dependent's coverage will end on the earliest of these dates:

- The date your eligibility under the Plan ends;
- The date your dependent no longer meets the definition of an eligible dependent;
- The day before entering into full-time, active duty with the Armed Forces of the United States (except for temporary active duty of two weeks or less or as otherwise required by USERRA); or
- The date the Plan ends.

Opt Out Option

Normally, you and your eligible dependents automatically become eligible and maintain eligibility once your employer has made the contributions required by the collective bargaining agreement between your employer and Teamsters Local 436 and you meet the eligibility requirements in this SPD. You do not have to choose to be covered nor can you refuse coverage. However, in certain circumstances you may be able to refuse coverage for you and your family and receive a financial incentive to do so.

How do you qualify to be able to opt-out of Local 436 Welfare Fund coverage?

First, your employer has to have agreed to and established the Master Cafeteria Plan for Participating Employers in the Excavating, Building Material and Construction Drivers Union Local 436 Welfare Fund or have a cafeteria or section 125 plan of its own.

Second, you, and all eligible dependents have to be covered by another plan that provides medical benefits:

- if you are married, the coverage has to be provided by your spouse's employer, or
- if you are not married and are covered by Veterans Administration coverage because of your service in the US Armed Forces.

If these two conditions are met, you and all dependents will not be eligible for the Welfare Fund's medical and prescription benefits for the entire year of your election. You and your dependents will still be eligible for the Welfare Fund's life insurance, short term disability, vision benefits and DOT required physicals. Your wage rate will be increased by the amount of any wage diversion made by your employer to the Welfare Fund contribution rate. Additionally another fifty cents ($0.50) will be added to your wage rate. The amount of diversion will vary based on your collective bargaining agreement. Each employer's diversion is different. Call the Fund Office for specific questions.

When can you opt out?

You will have the opportunity to opt out when you are first employed by a contributing employer that participates in a cafeteria plan. Not all employers do. After that you will have the opportunity to opt out during the Welfare Fund's annual open enrollment period. Your decision will not carry forward from one year to another. You must renew your election each year and provide any required documentation each year.

What happens if you lose that other coverage?

You can change your decision to opt out if your spouse loses employment, loses the applicable coverage or it is changed, you divorce, or another child comes into your family whether by adoption or birth.

Retired Members

Members who retiree from Local 436 service can choose to continue Welfare Fund benefits through retiree coverage. You can become eligible for retiree benefits under the Plan if you voluntarily and permanently stop working for an employer provided that:

The Plan coordinates coverage with Medicare for retired members and their spouses who are entitled to Medicare. Therefore, if you are retired, you and your spouse should apply for Medicare Parts A *and* B before reaching age 65.

- You have at least 15 years of continuous service with an employer before your retirement;
- You have been a member of the bargaining unit represented by the union, had been employed by the Fund or been employed by the union for not less than 15 continuous years before your retirement; and
- Contributions have been made on your behalf to the Welfare Fund for at least 8 out of 10 years immediately before your retirement.

If you do not elect retiree coverage at the time of your retirement you cannot choose to elect retiree coverage at a later date regardless of the change in your circumstances.

If you continue coverage under the Plan as a retiree, you may continue medical, prescription drug, and vision benefits. Additionally, if you are not a participant in the Local 436 Pension Fund you are entitled to a $5,000 death benefit from the Welfare Fund so long as you have retired prior to January 1, 2014.

The first self-payment for retiree benefits is due in the Fund Office **on the first of the month** for which you want to continue coverage. However, you can use any current work quarter employer contributions made on your behalf in lieu of self-payments.

Example

Tom's employer reports 9 or more weeks on his behalf for the May to July 2014 work quarter making him eligible for benefits from October through December. He decides to retire November 1, 2014. His first self-payment will be due January 1, 2015.

The Trustees establish and adjust the required self-payment from time to time based on the cost to provide benefits.

Your coverage will continue on a month-to-month basis, provided you make the required self-payments. Self-payments must be received in the Fund Office by the first day of the month for which you want to continue coverage. You have a grace period to the end of the month to submit your self-payments.

Example:

Steve is retired and pays for retiree coverage by making self-payments. To continue coverage for the month of September, the Fund Office must receive his self-payment by September 1st. If the Fund Office does not receive his payment by the end of September his coverage will end as of August 31st.

When Coverage Ends For Retired Employees

You or your dependents will lose eligibility for retiree benefit coverage if any one of the following events occurs:

- You become eligible for active employee benefits because you return to work with a contributing employer;
- The Plan ends;
- A self-payment is not made on a timely basis; or
- The Plan discontinues retiree benefits.

If you do not make timely self-payments for retiree coverage, your coverage will end.

The Trustees reserve the right to expand, reduce or cancel coverage for retired and active members, change eligibility requirements, change the amount of self-payments needed to participate in this plan and otherwise exercise their prudent discretion at any time without legal right or recourse by any person.

Reinstatement Of Eligibility

For Active Employees

If your eligibility ends and you have not had an employer contribution within one year of the last received employer contribution on your behalf, you must again establish by meeting the Initial Eligibility requirements found on pages 18 – 20.

For Retired Employees

Once your eligibility for coverage as a retiree ends, you cannot reinstate it. However, you may again be covered under the Plan if you return to work and establish eligibility for active coverage by meeting the Initial Eligibility requirements found on pages 18 – 20.

Changes In Eligibility Rules

The Trustees reserve the right, at their discretion, to change, modify, or discontinue all or part of the eligibility rules or the benefits provided under the Plan at any time. The Trustees have the authority to establish contribution rates and self-payment rules and they reserve the right to change them at any time in their sole and unrestricted discretion.

Life Events

Your benefits are designed to meet your needs at different stages of your life. This section describes how your Plan benefits are affected when different lifestyle changes occur.

Buying A New Home Or Moving

When you buy a new home or move, it's important to contact the Fund Office to update your address. This will help assure you receive important benefit information in a timely manner. Call the Fund office for a new enrollment form to change your address.

Getting Married

When you get married, your spouse is eligible for medical (including prescription drug), vision, and life insurance benefits. If you provide the required information, including an updated enrollment form, a marriage certificate and other Fund forms regarding your spouse's medical insurance coverage, if any, within thirty (30), days of your marriage, your spouse will be covered as of the date of the marriage. If you provide the necessary information after thirty (30), days, your spouse's coverage will be effective the first day of the next month following the Fund's receipt of that information.

When you marry, you may also want to update your beneficiary information for your life insurance and AD&D benefits.

If your spouse is covered under another medical plan (*e.g.*, employer sponsored, or Medicare), you must report such other coverage to the Fund Office. The amount of benefits payable under this Plan will be coordinated with your spouse's other coverage; benefits for your spouse under this Plan will typically be paid after any benefits are payable from your spouse's employer's plan.

If that other coverage is provided through employment, please refer to the rules on page 22 to determine if that coverage excludes your spouse from Welfare Fund coverage.

Surviving spouses of retirees who remarry are *not* eligible to cover their new spouse under the Plan. However, they may continue their coverage under the Plan provided they make the required self-payment.

Adding A Child

Your natural born child is eligible for coverage on their date of birth. If you adopt a child or have a child placed with you for adoption, coverage will become effective on the date of adoption or placement. You may cover stepchildren, under the Plan as of your date of marriage. In addition, you may cover foster children for whom you have been appointed the legal guardian. Regardless of the type of dependent you are covering, he or she must meet the Plan's definition of an eligible dependent described on page 22. To assure that your dependent is covered, you must notify the Fund Office to enroll your dependent for coverage. Your dependent becomes eligible for benefits as of the date you acquire the dependent, *so long as you provide the needed documentation to the Welfare Fund within thirty (30) days of the birth or adoption.*

When you add a child, provide the Fund Office with:

- The birth date, effective date of adoption or placement for adoption, or the date of your marriage (for stepchildren).
- A copy of the birth certificate, adoption papers, court order, or marriage certificate (for stepchildren).
- A copy of your child's other medical insurance information, if he or she is covered under another plan.
- An updated enrollment form.

Getting Legally Separated Or Divorced

If you and your spouse legally separate or divorce, your spouse will no longer be eligible for coverage as a dependent under the Plan. However, your spouse may elect to continue coverage under COBRA Continuation Coverage for up to 36 months. You or your spouse **must** notify the Fund Office within 60 days of the divorce or legal separation date for your spouse to receive COBRA Continuation Coverage. At this time, you may also want to review your beneficiary designation for your life insurance and AD&D benefits, if eligible.

This Plan recognizes Qualified Domestic Relations Orders (QDROs) and Qualified Medical Child Support Orders (QMCSOs) and provides benefits for eligible dependents, as determined by the order(s). QMCSOs, a court order, decree, or administrative order relating to child support, must:

- Contain specific information as stipulated by the Fund Office;
- Be submitted to the Plan Administrator, who will determine whether the order is qualified as a QMCSO under federal law.

A copy of the procedures that the Plan follows to make this determination is available at the Fund Office, free of charge.

Child Losing Eligibility

Your child is no longer eligible for coverage when he or she reaches age 26 (or 28 if certain requirements are met). You must notify the Fund Office within 60 days of when your child is no longer eligible for coverage. Your child may elect to continue coverage under COBRA for up to 36 months.

If your child is no longer eligible for coverage under the Plan, he or she can elect to continue coverage under COBRA Continuation Coverage. Within 60 days of losing eligibility for coverage, he or she must:

- Contact the Fund Office; and
- Enroll for COBRA Continuation Coverage if he or she plans to continue coverage under the Plan.

When You Are Out Of Work Due To Disability (For Active Employees)

If you are out of work due to a work-related or non-work related accident or sickness that results in your total disability, you may receive weekly accident and sickness benefits until you recover or receive the maximum number of weeks of benefits for one period of disability, whichever occurs first. If you become disabled due to an injury that is covered by the AD&D benefit, you may also be eligible for an AD&D benefit.

During your disability, you will periodically be asked to complete a form providing evidence of your continued disability. Your employer and your physician will need to complete parts of the form.

The maximum amount of benefits payable under this benefit is $150 per week for 26 weeks. It is *not* payable for:

- time you are laid off or on strike, unless hospitalized;
- if you are disabled for an illness, for the first eight days of illness, unless hospitalized;
- if it is work related;
- for time you are not eligible for benefits;
- back sprains, strains and whiplash; or
- alcoholism, alcohol or drug abuse or nervous disorders.

This benefit is not payable for sprains and strains.

If you are out of work due to a disability:

- Notify your employer and the Fund Office.
- Provide the Fund Office with proof of your disability.
- Apply for weekly accident and sickness benefits.

If you are out of work due to a work-related disability, you should also:

- Contact your local workers' compensation office and apply for workers' compensation benefits.

If you are out of work due to a work-related disability, you may be eligible for workers' compensation benefits. Contact your local or state workers' compensation office. You may be eligible for a disability benefit from the Welfare Fund in the amount of $40 per week for a maximum of 6 weeks.

In The Event Of Your Death

If you are eligible for coverage on the date of your death, your beneficiary may receive a life insurance benefit (if you are not receiving benefits from the Pension Fund) and an AD&D benefit (for active employees only, if your death is caused by an accident). Your beneficiary should apply for benefits as soon as possible, but within at least one year of your death.

See pages 5, 9, and 38 - 40 for more information about these benefits.

Continuation Of Coverage For Dependents Of Active Employees

Please refer to information on COBRA continuation coverage below.

Continuation Of Coverage For Dependents Of Retired Employees

Dependents of Retired Employees can maintain eligibility for retiree benefits by continuing self-payment. Coverage will continue unless self-payments are stopped, or a dependent no longer meets the requirements of an eligible dependent.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), is a federal law that requires plans to offer a temporary extension of plan benefits to employees and eligible dependents ("qualified beneficiaries") who would otherwise lose coverage under a plan. Qualified beneficiaries include you and each dependent that was covered under the Plan on the day before a qualifying event occurs and who would lose coverage as a result of a "Qualifying Event" (see below). Children born, adopted, or placed for adoption, and foster children have the same COBRA rights as a spouse or dependent who was covered by the Plan before the event that triggered COBRA Continuation Coverage.

Under certain circumstances, you can continue coverage by making self-payments to the Plan for COBRA Continuation Coverage. You will *not* be eligible to continue coverage for weekly accident and sickness, life insurance, or AD&D benefits. By making self-payments, you may continue medical (including prescription drug coverage), and vision benefits. You may also have other health coverage options available to you, such as those available on the Health Insurance Marketplace. For more information on this and COBRA continuation coverage, please see pages 57 and following.

The COBRA Continuation Coverage will be identical to the medical and prescription coverage you had under the Plan (life insurance, weekly sickness and accident benefit, and DOT physical exam benefit are excluded). If you have a newborn child, adopt a child, or have a child placed with you for adoption or foster care while COBRA Continuation Coverage is in effect, you may add the child to your coverage. You must notify the Fund Office, in writing, of the birth or placement to have this child added to your coverage.

Like all qualified beneficiaries with COBRA Continuation Coverage, their continued coverage depends on timely and uninterrupted payments on their behalf.

Qualifying Events

If you or your eligible dependents lose coverage as a result of a qualifying event, you are entitled to elect COBRA Continuation Coverage. Qualifying events include your:

- Reduction in hours or termination of employment;
- Death;
- Legal separation or divorce;
- Entitlement to Medicare; and
- Dependent no longer meeting the definition of a dependent under the Plan.

When the Fund Office has been notified that one of these events has occurred, you and your eligible dependents will be notified of the right to elect COBRA Continuation Coverage. Upon notification, the Fund Office will send you a COBRA application and *Notice of Health Continuation Procedures*.

Notifying The Fund Office

You or your dependent must inform the Fund Office of a legal separation, divorce, or a child losing dependent status under the Plan within 60 days of the qualifying event. If you do not notify the Fund Office within 60 days of such an event, you and/or your dependents will lose your right to elect COBRA Continuation Coverage.

Your employer will notify the Fund Office of your termination of employment, reduction in hours, entitlement to Medicare, or death. To help ensure that you do not suffer a gap in coverage, we encourage you or your family to notify the Fund Office of **any** qualifying events as soon as they occur. ***If you do not notify the Fund Office within 60 days of a qualifying event, you and your eligible dependents will lose your right to elect COBRA Continuation Coverage.***

When the Fund Office is notified that one of these events has occurred, you and your eligible dependents will be notified of your right to elect COBRA Continuation Coverage. Once you receive a COBRA notice, you have 60 days to respond if you want to elect COBRA Continuation Coverage. Your eligible dependents have the option to elect coverage independently from you.

Period Of Coverage

Coverage continues for a maximum of:

- 18 months if your coverage ends due to your termination of employment or your reduction in hours.
- 29 months if you or one of your eligible dependents is disabled when your coverage ends or if you become disabled within 60 days of the date your coverage ends due to termination of your employment or reduction in hours. To continue coverage for up to 29 months, you must notify the Fund Office of your determination of disability by the Social Security Administration within 60 days of the determination.
- 36 months if your spouse or other dependent's coverage ends because of your:
  - Death;
  - Legal separation or divorce;
  - Entitlement to Medicare; or
  - Eligible dependent child no longer qualifying for dependent coverage under the Plan.

It's important to notify the Fund Office within 60 days of a qualifying event. If you do not do this, you and your dependents will lose your right to elect COBRA Continuation Coverage.

Loss Of Continued Coverage

COBRA Continuation Coverage for each person will end if:

- You do not make the self-payment for COBRA Continuation Coverage on time;
- You become covered under another group health plan;
- You become entitled to Medicare; or
- The Fund no longer maintains any group health plans.

Paying For COBRA Continuation Coverage

The Fund Office will notify you of the cost of your COBRA Continuation Coverage when it notifies you of your right to coverage. The cost for COBRA Continuation Coverage will be determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this coverage.

Your first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your and/or your eligible dependents' coverage under the Plan ended. The Fund Office will notify you of the first payment due date, which is no later than 45 days after your election. Subsequent payments are due the first of the month and are considered timely if made

within 30 days after the first day of the month. If a payment is late, coverage will be terminated if the payment is not received by the last day of that month.

Serving In The Uniformed Services (For Active Employees)

The Fund provides benefits to you and your eligible dependents during your military service in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Please contact the Fund Office before you enter military service to receive details about how and to what extent your coverage and that of your eligible dependents can be maintained.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Inactive duty training;
- Full-time National Guard duty; and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

If you elect to continue coverage and you are in the uniformed services for less than 31 days, you will be treated as if you had not entered the uniformed services, for purposes of your coverage. If your service continues for more than 31 days, you may elect to continue coverage under the Plan under the same rules that apply to active members not in the military, see pages 20 – 22. Your coverage will continue until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- 18 consecutive months after your coverage would have otherwise ended.

However, your coverage will end at midnight on the earliest of the day:

- Your coverage would otherwise end as described above;
- Your former employer no longer provides any health plan coverage to any employee;
- Your self-payment is due and unpaid; or
- You again become covered under the Plan.

Your coverage ends on the first day of the month following the date you enter uniformed services and elect not to continue coverage. Your eligible dependents may continue coverage under the Plan by electing and making self-payments for COBRA Continuation Coverage.

You need to notify the Fund Office in writing when you enter the military and when you return to work with a contributing employer. For more information about continuing coverage under USERRA, contact the Fund Office.

Reemployment
Following your discharge from service, you may be eligible to apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in health care coverage provided by your employer.

Reinstating Your Coverage

Following discharge from military service, you may apply for reemployment with your former employer in accordance with USERRA. Reemployment includes the right to elect reinstatement in the existing health coverage provided by your employer. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service.

When you are discharged or released from military service that was:

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for a contributing employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for a contributing employer; or
- More than 180 days, you have up to 90 days after discharge to return to work for a contributing employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred during your military service, you have until the end of the period that is necessary for you to recover to return to or make yourself available for work for a contributing employer. The Fund will maintain your prior eligibility status until the end of the leave, provided your employer properly grants the leave under the federal law and makes the required notification and payment to the Fund.

Family And Medical Leave (For Active Employees)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption, or placement with you for adoption of a child;
- The care of a seriously ill spouse, parent, or child; or
- Your own serious illness.

During your leave, you will maintain all the coverage offered under the Plan. You will remain eligible until the end of the leave, provided your contributing employer properly grants the leave and makes the required notification and payment to the Fund. See your employer to learn about your rights and obligations under FMLA. Not all employers are subject to FMLA.

If you and your employer have a dispute regarding your eligibility and coverage under the FMLA, the Fund will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

If you have been granted FMLA leave, your employer must notify the Fund Office at least 14 days before the leave begins, except in an emergency, and then no later than seven days after the leave begins. You may wish to notify the Fund Office when you are granted FMLA leave, but you are not required to do so. Your employer will be asked to complete some forms to verify your eligibility for benefits while you are on leave. To be eligible for coverage during FMLA leave, your employer must pay the cost of coverage in an amount determined by the Fund for each week you are on FMLA leave.

When You Retire

When you retire, coverage for you and your eligible dependents will be continued provided you meet the eligibility requirements described on page 25 - 26.

If you and your eligible dependents are non-Medicare eligible and under age 65, your coverage will continue under the HMO Plan or the POS Plan. You will be eligible for the same medical, prescription and vision coverage you were eligible for as an active employee, except that you will no longer be eligible for the DOT physical exam benefit, weekly accident and sickness benefit, life and AD&D benefits, and dependent life insurance benefits, if applicable.

If you or your eligible dependents are Medicare-eligible whether because of age or disability you are eligible for benefits under the Medicare Plus Plan or the United American Medicare Supplement Plan. These benefits include medical, prescription drug, vision and death benefits (provided you are “Welfare Only” retiree retired prior to January 1, 2014.

If you are an active employee and lose eligibility for active coverage due to retirement and do not meet the eligibility requirements for retiree coverage, you may be eligible for COBRA Continuation Coverage.

Comprehensive Medical Benefits

The Plan offers comprehensive health care coverage to help you and your dependents stay healthy, and provide financial protection against catastrophic health care expenses.

Preferred Provider Organization (PPO)

A PPO is a network of health care providers who have agreed to charge negotiated rates. Since PPO providers have agreed to these negotiated rates, you help control health care costs for yourself and the Plan when you use PPO providers.

The Plan offers these different medical plans:

- **HMO Plan and POS Plan.** For active employees, non-Medicare eligible retirees and non-Medicare eligible dependents, the Plan offers two plans of benefits: HMO Plan and POS Plan. The HMO Plan is summarized on beginning on page 4, and the POS Plan is summarized beginning on page 6. The contributions that your employer makes on your behalf and your initial or annual election determine whether you are eligible for the HMO Plan or the POS Plan. You will receive a letter quarterly that will state which plan you are eligible for. For more detailed information regarding the benefits provided under the HMO Plan or the POS Plan, please refer to the HealthSpan EOC and/ or the COI provided with this SPD.
- **HealthSpan Medicare Plus Plan.** For Medicare-eligible retirees and dependents the Plan offers the Medicare Plus Plan, which is summarized beginning on page 12. If you are eligible for the Medicare Plus Plan, a HealthSpan EOC has been provided with this SPD. Please refer to the HealthSpan EOC for more detailed information regarding the benefits provided under the Medicare Plus Plan.
- **United American Plan.** For Medicare-eligible retirees and dependents the Plan offers the United American Plan, which is summarized beginning on page 13. These benefits are also available to Medicare-eligible, disabled participants under age 65. These participants have a choice between the Medicare Plus Plan and the United American Plan. If you are eligible for the United American Plan, a United American Certificate of Insurance has been provided with this SPD. For more detailed information regarding the benefits provided under the United American Plan, please refer to the United American Certificate of Insurance.

At any time, you may contact the Fund Office at 216-328-0436 or 877-396-3436 to confirm which plan you are eligible for or to request more information on the benefits provided under each plan.

Vision Benefits

Vision care can play an important role in your overall health. The Plan provides a vision benefit to you and your eligible dependents in the amount of $250 per family every two rolling years (two years from the date services initially received). To submit a claim or receive reimbursement of services contact the Fund office at 216-328-0436 or 877-396-3436 for additional information and to request a claim form.

Covered Expenses

The Plan covers these vision expenses during the benefit periods specified:

- Routine vision analysis and tonometry test.
- Single vision, bifocal, trifocal and lenticular lenses. Standard lens options include: photochromatic, scratch resistant, fashion or gradient tints, progressive or no-line multifocals, anti-reflective, polycarbonate, and prescription sunglasses.
- Frames.
- Contact lenses and examination.

Expenses Not Covered

In addition to exclusions and limitations explained in other sections of this booklet, the Plan does not cover these expenses under the Plan's vision benefits:

1. Medical or surgical treatment of the eyes.
2. Drugs or medications.
3. Non-prescription lenses.
4. Examination or materials not listed as a covered service.
5. Services or materials provided by federal, state, or local government or workers' compensation.
6. Low vision aids.
7. Sales or other tax.

Who is eligible for this benefit?

All eligible active members and their eligible dependents.

All eligible retired members and dependents that self-pay for retiree coverage are also eligible for this benefit, so long as they have had continuous retiree coverage with the Welfare Fund since their date of retirement. In other words, if you decided not to join the Plan's retiree coverage at the time for your retirement but instead elected to become covered during one of the Plan's "open enrollment" periods for retirees, you will not be eligible for this benefit. If you have a question regarding eligibility, call the Fund office.

Dot Physical Examination Benefit

The Federal Motor Carrier Safety Administration requires that a driver subject to its laws undergo a Department of Transportation (DOT) physical examination conducted a licensed "medical examiner" listed on the Federal Motor Carrier Safety Administration (FMCSA) National Registry in order to assure that the driver is physically qualified to drive a commercial motor vehicle (CMV), and to obtain a commercial driver's license (CDL).

If your job requires you to have a CDL, the Welfare Fund will provide and pay for a DOT examination every twenty-two (22) months to fulfill this requirement. This time limit allows you enough time to schedule and undergo the examination for the CDL that is valid for two years.

At times a driver's medical condition requires that a CDL be renewed every year. If that is the case and the medical examiner so limits your CDL, you will be eligible for this benefit every eleven (11), months.

The Welfare Fund contracts with CCF Center for Corporate Health at Company Health Care, 5595 Transportation Blvd #200, Garfield Heights Ohio 44125, 216-587-5431, to provide this examination. Call them directly for an appointment.

This benefit does not cover any pre-employment physical, return to work physical or any form of drug testing outside of the DOT physical.

Who is eligible for this benefit?

In order to be receive this benefit,

- You must be eligible for *active* Welfare Fund benefits (members only);
- You must undergo the examination at Company Health Care; and
- Your employer's collective bargaining agreement with Local Union 436 or your employer's employment practices do not require your employer to pay for this examination.

In The Event Of Disability Or Death

Weekly accident and sickness, life insurance, and accidental death and dismemberment (AD&D) benefits help provide financial protection to you and/or your family in the event you become injured, totally disabled, or die. This section describes these benefits.

Weekly Accident And Sickness Benefit (For Active Employees)

You may be eligible for weekly accident and sickness benefits if you become totally disabled. To receive weekly accident and sickness benefits, you must:

- Be an eligible, active employee;
- Have been eligible for benefits for two-consecutive coverage quarters;
- Be totally disabled, which means you cannot work at your regular occupation as a result of an injury, sickness, or disease;
- Be under the regular care of a physician (other than a chiropractor) during the period for which you are claiming benefits.

You or your estate should apply for weekly accident and sickness, life insurance, and/or AD&D benefits **as soon as possible** but within at least a year of accident, sickness, or death.

You will be required to submit a physician's (other than a chiropractor's) certification of your total disability. During your disability you will periodically be asked to complete a form to determine your continued eligibility for disability benefits. You, your employer and your physician may be required to complete this form.

Benefit Amount

The amount and duration of weekly accident and sickness benefits is shown in the **Summary Of Benefits** beginning on page 4. Payment will be made at the daily rate of one-seventh (1/7) of the weekly benefit during partial weeks of continuing disability. Successive periods of disability separated by less than three months of active work on a full-time basis will be considered as one period of disability unless the subsequent period of total disability:

- Is due to a different cause; and
- Begins after you return to full-time work in your regular occupation for at least one full day.

If you can't work because of an injury or sickness:

- Call your employer and the Fund Office.
- See a physician as soon as possible.
- File a claim with the Fund Office for weekly accident and sickness benefits.

Weekly accident and sickness benefits are subject to Social Security, federal income, and unemployment taxes and may be included in your gross income for tax purposes. If you have questions about including your benefits in your gross income or about exclusions in the law, you should consult your tax advisor or legal counsel.

Exclusions

In addition to exclusions and limitations explained in other sections of this booklet, weekly accident and sickness benefits are not payable for any total disability:

1. Due to back sprains, back strains, or whiplash.

2. During periods of layoff or strike, unless you are hospital confined.

3. Due to injury, sickness, or disease that is job related for which you are receiving wages under workers' compensation or similar laws.

4. Due to an accident sustained or contracted in consequence of being intoxicated or under the influence of alcohol or any drug or medicine, unless such drug or medicine has been prescribed by a physician.

Life Insurance Benefit

The Plan provides a life insurance benefit in the event of the death of:

- An eligible, active employee;
- A retiree who is a Welfare Only retiree who retired prior to January 1, 2014 (death benefit); and
- An eligible dependent of an active employee.

Benefit Amount

The amount of the benefit is shown in the **Summary Of Benefits** beginning on page 4, see the Summary Of Benefits under which you are covered). For the life insurance benefit to be payable, written notice of your or your dependent's death must be provided to the Fund Office as soon as possible after death, but no more than one year after death.

In the event of your eligible dependent's death and provided you qualify for dependent life insurance benefits, benefits will be paid to you. In the event of your death, benefits will be paid to the beneficiary you have on file at the Fund Office. For information on naming a beneficiary see page 40.

Conversion Of Your Life Insurance Benefit

If you lose coverage under the Plan or the Plan terminates life insurance benefits, you may apply to convert your life insurance benefit to an individual policy. If you want to convert your life insurance policy, you need to contact the Fund Office for information about converting your policy and the appropriate forms, and make a written application within 31 days of the date your life insurance coverage under the Plan ends.

Accidental Death And Dismemberment (AD&D) Benefit (For Active Employees)

The AD&D benefit is payable for the loss of life, limbs, or sight as shown in the **Summary Of Benefits** beginning on page 4. Benefits are payable for losses as a result of an accidental injury on or off the job.

These benefits are paid in addition to any other benefits payable under the Plan, including the Plan's life insurance benefit. Loss must occur within 90 days from the day of the accident. Only one principle amount will apply toward a single accident. Benefits are paid directly to you for an injury or to your beneficiary in the event of your death.

Definition Of Loss

Loss of:

- Sight means the irrecoverable loss of sight; and
- Hand or foot means severance at or above the wrist or ankle joint.

Limitations And Exclusions

In addition to exclusions and limitations explained in other sections of this booklet, AD&D benefits will not be paid for:

1. Self-inflicted injuries.
2. Injuries incurred during or as a result of war or insurrection, whether declared or undeclared.
3. Injuries incurred during or as a direct result of the commission of a felony or an assault.
4. Injuries resulting from bacterial infection or any illness or disease of any kind.
5. Hernia.
6. Injuries resulting from surgical treatment.
7. Injuries excluded from coverage on the certificate of the group insurance coverage.

Naming A Beneficiary

A beneficiary is the person(s) you designate to receive your life insurance and AD&D benefits. You may change your beneficiary at any time. Contact the Fund Office for a beneficiary designation form.

You may designate anyone you wish as your beneficiary for life insurance and AD&D benefits (if you are eligible for these benefits). To change or designate a beneficiary(ies), you need to complete the Fund's enrollment form and file it with the Fund Office. You can change your beneficiary at any time, without the consent of your previous beneficiary. Your beneficiary designation becomes effective once the Fund Office receives and accepts your completed beneficiary form.

It is very important that you designate a beneficiary. If you do not designate a beneficiary, your life insurance and AD&D benefit (if applicable) will be paid to your estate after the Fund Office receives a court order or designating the executor of your estate or an order naming the person to whom the benefit will be paid.

If a provision in this Summary Plan Description conflicts with the insurance company's certificate of coverage, the certificate of coverage will control.

How To File Claims And Appeals

How To File Claims

If you or an eligible dependent has coverage under more than one health care plan, benefits are coordinated (see page 47).

The Plan has established and maintains reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations. These procedures are designed to contain administrative processes and safeguards to ensure and to verify that benefit claim determinations are made in accordance with governing Plan documents and that the Plan provisions have been applied consistently with respect to similarly situated Claimants.

Claim for Benefits

The manner in which you file your claim for benefits will depend on the nature of your claim and the entity involved with the processing of such claim.

Benefits Administered by HealthSpan (HMO, POS, and Medicare Plus Plans)

Please refer to the HealthSpan EOC and/or COI for complete details on the procedures necessary to file your claim as well as how to appeal a denial of your claim.

Benefits administered by United American (Medicare Retiree Plan)

Please refer to the United American Certificate of Insurance for complete details on the procedures necessary to file your claim as well as how to appeal a denial of your claim.

Benefits Administered by the Plan (Weekly Accident and Sickness Benefit, Life Insurance, Accidental Death & Dismemberment Benefit, Vision Benefit and DOT Physical Benefit)

Claims should be submitted to the Fund Office as soon as possible; do not delay in filing any claims. Claims shall be untimely if not filed within one (1) calendar year from the date of injury, illness or death, as applicable. Please contact the Fund Office at 216-328-0436 or 877-396-3436 to obtain the correct claim form.

- *If the claim you are submitting is the result of an accident,* be sure to complete the information requested about the accident.
- *If you are applying for Weekly Accident and Sickness benefits,* be sure the physician has completed his/her portion of the claim form. Otherwise, payment of the benefit could be delayed. Only completed clam form is acceptable.

Send the completed claim form and any supporting documentation for all claims, except medical claims, to:

Teamsters Local Union 436
Welfare Fund
6051 Carey Drive
Valley View, OH 44125-4259
Telephone: 216-328-0436
Toll free: 877-396-3436

The Fund will not accept claims or appeals filed by facsimile or electronic mail.

Your claim will be reviewed and you will be notified of a decision on your claim as described below. If your claim is denied, in whole or in part, you may appeal a claim decision as described below.

Please Note: During disability, you will periodically be asked to complete a form to determine your continued eligibility for disability benefits. You and your physician must complete this form.

Discretionary Authority Of Plan Administrator

> **Days**
>
> For the purpose of the claim and appeal processes, "days" refers to calendar days, not business days.

The Plan Administrator, which includes the Board of Trustees and other individuals to whom responsibility for the administration of the Fund has been delegated, has discretion and authority to interpret the terms of the this booklet, the Plan's legal Plan Document, and Agreement and Declaration of Trust and to interpret any facts relevant to a determination, and to determine eligibility and entitlement to Plan benefits. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Authorized Representative

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim without you having to complete a special authorization form. The Plan may accept a treating physician as an authorized representative for non-urgent care claims.

Timing Of Claim Decisions And Benefit Payment

When you submit a claim for benefits to the Fund Office, the Fund Office will determine if you are eligible for benefits and calculate the amount of benefits payable, if any.

Vision Care Claims

Generally, all vision care benefits will be paid as soon as possible after acceptable proof is received. If a claim is approved, payment will be made and the payment will be considered notice that the claim was approved. An initial determination will be made within 30 calendar days from receipt of your vision care claim. If additional time is necessary, up to 15 additional calendar days, due to matters beyond the control of the Plan, you will be informed of the extension within the initial deadline. The written notice will state the special circumstances and the date the Plan expects to make a decision. In addition, if additional information is needed to process your claim, you will be notified within 15 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, the Plan will make a determination within 15 days.

Weekly Accident And Sickness Benefit Claims

Generally, you will receive written notice of a decision on your initial claim within 45 days of receipt of your claim. If additional time is required to make a determination on your claim (for reasons beyond the control of the Plan), you will be notified within this time. The written notice will state the special circumstances and the date the Plan expects to make a decision. The Plan may extend this

45-day period up to an additional 60 days maximum. However, if a determination is not made within the first 75 days, you will be notified that an additional 30 days is necessary.

In some instances, the Plan may require additional information to process and make a determination on your claim. If such information is required, the Plan will notify you within 45 days of receiving your request. You then have up to 45 days in which to submit the additional information. If you do not provide the information within this time, then your claim may be denied.

Life Insurance And AD&D Benefit Claims

Generally you will receive written notice on a decision on your claim within 90 days after the Plan receives your claim. If circumstances require an extension of time for processing your claim, you will be notified in writing that an extension is necessary. The notice will state the special circumstances and the date the Plan expects to make a decision. The extension will not be for more than 90 days from the end of the initial 90-day period.

If A Claim Is Denied

If your claim is denied (in whole or in part), the Plan will:

- Provide you with certain information about your claim; and
- Notify you of its denial of your claim within certain timeframes.

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling the Fund Office at 216-328-0436 or 877-396-3436. If a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

Information Requirements

When the Plan notifies you of its initial denial on your claim, it will provide:

- The specific reason or reasons for the decision;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed; and
- A copy of the Plan's review procedures and time periods to appeal your claim, plus a statement that you may bring a lawsuit under ERISA following the review of your claim.

In addition, for ***vision care*** and ***weekly accident and sickness benefit*** claims the notice will include:

- A copy of any internal rule, guideline, protocol, or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or a statement that is available to you at no cost upon request, if your claim is denied due to medical necessity, experimental treatment, or similar exclusion or limit.

Appealing A Denied Claim

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you file a lawsuit under ERISA, the federal law governing employee benefits.

As mentioned previously, appeals relative to the insured benefits provided through HealthSpan and United American need to be appealed in accordance with their respective certificate requirements.

(i) ***Eligibility Claims***

In most cases, disagreements about eligibility can be handled informally by calling the Fund Office. If the eligibility issues cannot be resolved, you will be asked to file an appeal that will be considered by the Claims Review Board ("CRB"), consisting of a panel of Trustees. The CRB's decision will be returned within a week, in most cases. If you receive an adverse benefit determination based upon your eligibility from the CRB, then the review shall be by the full Board of Trustees in accordance with the provisions set forth in subsection (iii) below.

(ii) ***Benefits administered by the Plan (Weekly Accident and Sickness, Life Insurance, Accidental Death & Dismemberment, DOT Physical Exams and Vision Claims)***

With respect to those claims adjudicated by the Fund, you are required to appeal any adverse benefit determination directly to the CRB in accordance with these procedures.

These procedures also apply to appeals of vision benefit determinations and Eligibility determinations.

In general, you should send your written request for an appeal to the Plan Administrator at the Fund Office as soon as possible. If your claim is denied or if you are otherwise dissatisfied with a determination under the Plan, you must file your **written appeal** within:

- 180 days from the date of a decision for ***eligibility, vision care*** or ***weekly accident and sickness benefit*** claims; or
- 60 days from the date of a decision for ***life insurance*** or ***AD&D benefit*** claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- Submit additional materials, including comments, statements, or documents; and
- Request to review all relevant information (free of charge).

In addition, if your claim is for ***vision care*** or ***weekly accident and sickness benefits*** and is denied based on:

- An internal rule, guideline, protocol or other similar criteria, you have the right to request a free copy of such information; and
- A medical necessity, experimental treatment, or similar exclusion or limit, you have the right to request a free copy of an explanation of the scientific or clinical judgment for the determination.

Appeal Decisions

If you file your appeal on time and follow any applicable required procedures, a new, full and independent review of your claim will be made and the decision will not be deferred to the initial

benefit decision. The CRB will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, of the decision on any appeal within five calendar days.

Appeal Timeframes

The Plan's determination on your appeal will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

- ***Eligibility, Vision Care Claims, Weekly Accident And Sickness, Life Insurance, and AD&D Benefit and DOT Physical Exam:*** The determination will be made at the CRB's next regularly scheduled quarterly meeting following receipt of your appeal. However, if the appeal is received within 30 days of that meeting, the determination may be made at the second meeting following receipt of your appeal. If special circumstances require a further extension, a decision will be made at the third meeting following receipt of your appeal. If an extension is necessary, the Fund will notify you of the reason for the delay and when the decision will be made.

Medical Judgments

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional whom:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and
- Was not consulted (or is not subordinate to the person who was consulted) in connection with the denial of your claim.

You have the right to be advised of the identity, upon request, of any medical experts consulted in making a determination of your appeal.

Information Requirements

When the Plan notifies you of its determination on your appeal, it will provide:

- The specific reason or reasons for the decision, including reference to the Plan provisions on which the decision was based;
- A statement notifying you that you have the right to request a free copy of all documents, records and relevant information;
- Information relating to any additional voluntary appeal procedures offered by the Plan; and
- A statement that you may bring a civil action suit under ERISA.

In addition, for ***vision care, weekly accident and sickness benefit*** appeals, the notice will include:

- A copy of any internal rule, guideline, protocol, or similar criteria that was relied on, or a statement that a copy is available to you at no cost upon request; and
- A copy of the scientific or clinical judgment, or statement that is available to you at no cost upon request, if your appeal is denied due to medical necessity, experimental treatment, or similar exclusion or limit.

Payment to Legal Representative

In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant, any such payment under the Plan may be made to such representative and such payment will discharge any liability under the Plan.

Proof of Incurred Charge

Unless stated to the contrary in the applicable insured program, proof of an incurred charge under the Plan must be provided in writing and furnished to the Plan Administrator within one (1) year after the incurred charge and must cover the occurrence, character, and extent of the expense.

Right to Examine

The Plan Administrator shall have the right and opportunity to, at its own expense, have a Physician examine the individual whose injury or disease is the basis of a claim when and as often as it may reasonably require.

Failure to File a Request

If a Claimant fails to file a request for review in accordance with the procedures outlined herein, such claimant shall have no rights of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

Coordination Of Benefits

When members of a family are covered under more than one hospital, medical, or surgical expense policy, health care services plan, or self-insurance plan, there may be instances of duplication of coverage: two plans paying benefits for the same health care expenses. This Plan takes into account benefits coverage you and your dependents have under other plans to ensure that benefits payable are not more than the actual expenses incurred. The Plan's coordination of benefits (COB) provision coordinates the medical, prescription drug, and vision benefits payable by this Plan with similar benefits payable under other plans.

If you and/or your dependents are covered by this Plan and by another plan(s) that provides medical, prescription drug, and/or vision benefits, benefits will be coordinated between the plans. This Plan will never pay more on any claim than it would have if it did not coordinate benefits with another plan.

The plan that pays benefits first is called the "primary plan," and the plan that pays benefits second, is called the "secondary plan." Special rules are used to determine which plan is primary and secondary, as explained below. When benefits are coordinated, you receive payments from the primary *and* secondary plan.

Which Plan Pays First

These rules determine which plan pays first:

1. A plan that does not coordinate benefits will always pay first.

2. A plan that covers a person as an employee, subscriber, or member other than as a dependent will pay before a plan that covers a person as a dependent.

3. For claims of dependent children whose parents are married, the plan that covers the parent whose birthday (month and day) falls first in the calendar year will pay first. If the parents have the same birthday, the plan covering the parent for the longer period of time will pay first. However, if your spouse's plan has some other COB rule (for example, a "gender rule" which says that the father's health plan is always primary), the Plan will follow the rules of that plan.

4. For claims of dependent children of separated or divorced parents, these rules determine which plan pays first:

   If there is a court decree that establishes financial responsibility for health care expenses, the plan covering the dependent children of the parent who has the responsibility will be primary.

   If there is no court decree, the order of benefits will be:

   - The plan of the parent with custody;
   - The plan of the step-parent with custody; and then
   - The plan of the parent without custody.

5. A plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, pays before a plan that covers the person as a laid off or retired employee, or as that employee's dependent. This provision only applies if the other plan has a COB provision.

If none of the above rules determines order of payment, the plan that has covered the person for the longest continuous time pays benefits first. In addition, before this Plan is liable for payment, you must have exhausted all benefits available under the other plan and you must have followed the rules, advice, and instructions, and executed any and all applications and procedures as required, to secure all available coverage from the other plan.

If this Plan provides benefits it was not obligated to pay, the Plan has a right to recover those payments.

Coordination With Medicare

Persons age 65 and older or disabled are eligible to enroll for benefits under Title XVIII of the Social Security Act of 1965 (Medicare). Part A of Medicare, which covers hospital expenses, generally does not require a premium payment. Part B covers other types of medical expenses and requires you to pay a monthly premium. To be covered under Parts A and B, you need to apply.

If you and/or your spouse are age 65 or older and retired or otherwise eligible for Medicare where Medicare is your primary coverage, coverage under the Plan will be coordinated with Medicare Parts A and B. The coverage will be coordinated whether or not you have applied for the coverage from the Social Security Administration. It is important that you apply for Medicare as soon as you are eligible because the benefits provided by the Plan will be reduced according to payments Medicare would make.

If you are still eligible for benefits as an active employee and are performing work for which contributions are paid to the Fund, your benefits will also be coordinated with Medicare. However, if Medicare is not your primary coverage, the Plan will pay first, and Medicare will pay any additional amounts where Medicare coverage is applicable (if you are enrolled in Medicare).

When coordinating with Medicare, this Plan and Medicare together will not cover more than 100% of covered expenses for an accident or illness.

Order Of Benefit Payment

This Plan has *primary* responsibility for expenses incurred by you and/or your dependent spouse when:

- You are an active employee and age 65 or older;
- You are an active employee and your spouse is age 65 or older and/or disabled; or
- You are disabled, but maintain your current employment status with your employer.

The Plan has *secondary* responsibility for you and your dependent spouse if you are:

- Not actively employed by an employer that pays all or part of the required contributions for eligibility; and
- Eligible for Medicare Part A because of age.

The Plan will have secondary responsibility (even if the eligible person is also eligible for Medicare Part A because of age) for expenses incurred by an eligible person who is eligible for primary Medicare benefits because of end-stage renal disease, (after the first 30 months of Medicare eligibility).

The Plan will have primary responsibility for the claims of an eligible person who is eligible for secondary Medicare benefits solely because of end-stage renal disease.

Subrogation

Subrogation

If the Plan pays benefits on your behalf as a result of an injury caused by another party, the Plan has the right to seek payment or repayment of those benefits from the party that caused the injury.

The Plan reserves the right of subrogation. This means that, to the extent the Plan provides or pays benefits or expenses for covered services, we assume your legal rights to recover the value of those benefits or expenses from any person, entity, organization, or insurer, including your own insurer and any under insured or uninsured coverage, that may be legally obligated to pay you for the value of those benefits or expenses. The amount of the Plan's subrogation rights will equal the total amount paid by the Plan for the benefits or expenses for covered services. The Plan's right of subrogation will have priority over yours or anyone else's subrogation for the total amount the Plan paid for covered services and is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. This provision is intended to, and does reject, supersede the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of subrogation.

The Plan also reserves the right of reimbursement. This means that, to the extent the Plan provides or pays benefits or expenses for covered services, you must repay the Plan any amounts recovered by suit, claim, settlement, or otherwise, from any third party or insurer and any under insured or uninsured coverage, as well as from any other person, entity, organization, or insurer, including your own insurer, from which you receive payments (even if such payments are not designated as payments of medical expenses). The amount of the Plan's reimbursement rights will equal the total amount paid by the Plan for the benefits or expenses for covered services. The Plan's right of reimbursement will have priority over yours or anyone else's right until the Plan recovers the total amount the Plan paid for covered services. The Plan's right of reimbursement for the total amount the Plan paid for covered services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. This provision is intended to, and does reject, supersede the "make whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of reimbursement.

Constructive Trust

A Participant or his attorney who receives any recovery (whether by judgment, settlement, compromise or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision or otherwise make restitution to the Plan. A Participant or his attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because the Participant or his attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

Recoupment

If the plan should provide any form of benefit under the Plan to you and/or your Dependent(s) and, for whatever reason, such benefit was not required under the terms of the Plan or otherwise mistakenly paid, the Plan shall have the right to offset future benefits to the extent of the overpayment. This provision does not limit the Plan's right to recover such amount by any other lawful means.

Rescission of Benefits

In accordance with the PPACA, the Fund will only "rescind," or cancel, or discontinue coverage retroactively in cases where a Participant or the Participant's eligible Dependent (or a person seeking coverage on behalf of such individual) has performed an act, practice, or omission that constitutes fraud, or in cases where such an individual makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Fund. If the Fund seeks to rescind benefits on such grounds, it will provide the individual with thirty (30) calendar days advance written notice prior to rescission, along with information about appeal rights. Please note that a retroactive termination of coverage due to a Participant's failure to timely pay premiums is not a rescission.

Your duties include:

- You must provide the Plan or its designee any information requested by the Plan or its designee within five days of the request.
- You must notify the Plan or its designee promptly of how, when, and where an accident or incident resulting in personal injury to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan or its designee in the investigation, settlement, and protection of the Plan's rights.
- You must send the Plan or its designee copies of any police report, notices, or other papers received in connection with the accident or incident resulting in personal injury to you.
- You must not settle or compromise any claims unless the Plan or its designee is notified in writing at least 30 days before such settlement or compromise and the Plan or its designee agrees to it in writing.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) - NOTICE OF PRIVACY PRACTICES

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

THE FOLLOWING SPECIFIC INFORMATION CONSTITUTES YOUR NOTICE OF PRIVACY PRACTICES. THIS SECTION DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Group Health Plans ("Plans" or "Plan") provided by the Fund to its participants, its participants' dependents and, as applicable, retired participants. This Notice describes how the Fund's Plans, collectively we, us, our, Plan or Plans, may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our Plans with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all participants then covered by the Plans. Copies of our current Notice may be obtained by contacting the Fund Office, 6051 Carey Drive, Valley View Ohio 44125-4259, 216-328-0436 or 877-396-3436.

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the following employee benefits that we provide to participants, participant dependents and, as applicable, retired participants: health coverage, dental coverage, vision coverage and prescription drug coverage.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

The following activities, involving uses or disclosures of PHI require your authorization:

- Disclosures that constitute a sale of Protected Health Information;
- Uses and disclosures of Protected Health Information for marketing purposes; and
- Any disclosure of your psychotherapy notes.

Other uses and disclosures not described in this Notice of Privacy Practices may require your authorization.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health, Vision, Dental, and Prescription Drug Plan Operations – We may use and disclose your PHI as necessary for our health, vision, dental and prescription drug operations. Examples of Plan operations include activities relating to the creation, renewal, or replacement of the Plans, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Plan. The Plans are prohibited from using or disclosing PHI that is genetic information of an individual for underwriting purposes.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of the Plans. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth, death, and for public health investigations.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions, such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefits.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for the enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of PHI, as described above, we will restrict our uses or disclosure of your PHI in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

- ***Access to Your PHI –*** You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for claims records). Submit records requests to the Fund office at the address below. We may charge you a fee for copying and postage.
- ***Amendments to Your PHI*** – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Submit amendment requests to the address below.
- ***Accounting for Disclosures of Your PHI –*** You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those pursuant to valid legal process or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative and submitted to the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.
- ***Restrictions on Use and Disclosure of Your PHI –*** You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment and disclosures made to persons involved in your care. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction

you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

- ***Request for Confidential Communications –*** You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.
- ***Right to a Paper Copy of This Notice -*** You have the right to a paper copy of this Notice at any time.

QUESTIONS OR COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint. The Plans are required by law to notify affected individuals following a breach of unsecured PHI.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact the Fund Office by writing to:
Teamsters Local Union 436
Welfare Fund
6051 Carey Drive
Valley View, OH 44125-4259
Telephone: 216-328-0436
Toll free: 877-396-3436

THE NEWBORNS' AND MOTHERS HEALTH PROTECTION ACT OF 1996 (The Newborns' Act)

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For more information on precertification, contact your plan administrator.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the "Women's Health and Cancer Rights Act of 1998 (WHCRA)". For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, 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;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical, surgical and prosthetic benefits provided under this Plan.

Please refer to the "Schedule of Benefits" in the front of this Benefit Booklet for Deductibles and Coinsurance applicable to these benefits.

If you would like more information on WHCRA benefits, call the Fund Office at 216-328-0436 or 877-396-3436.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA)

GINA amends the Employee Retirement Income Security Act of 1974 (ERISA) to expand nondiscrimination protections under group health plans.

Effective for group health plans for plan years beginning after May 21, 2009, GINA prohibits group health plans from:

- adjusting premiums or contribution amounts for a group on the basis of Genetic Information;
- requesting or requiring an individual or family member of an individual to undergo a genetic test; or
- requesting or requiring, or purchasing genetic information (1) for underwriting purposes; or (2) with respect to any individual prior to such individual's enrollment in connection with such enrollment.

However, a plan is permitted to use the minimum necessary amount of genetic testing results to make a determination about claim payment.

GINA authorizes the Secretary of Labor to impose a penalty against any sponsor of a group health plan for any failure to meet requirements of this Act. GINA also allows a waiver or limitation on such penalty if the failure was not discovered after exercising reasonable diligence or was due to reasonable cause and not willful neglect, and to the extent that the Secretary determines payment of penalty would be excessive relative to failure involved.

Genetic Information: means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. It shall also include, with respect to any individual, any request for or receipt of genetic services or participation in clinical research which includes genetic services by such individual or any family member of such individual. It shall not include information about the sex or age of any individual.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

To the extent the applicable medical plan provides mental health and substance abuse benefits, it will not place financial requirements, such as co-pays and deductibles, and treatment limitations, such as visit limits, on mental health or substance use disorder benefits that are more restrictive than the predominant requirements or limitations applied to substantially all medical and/or surgical benefits. Such coverage shall be subject to any applicable deductibles and coinsurance, as well as any limits on the number of covered hospital days and/or outpatient visits.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)
INFORMATION ON COBRA CONTINUATION COVERAGE

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

You may have other options 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.

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

Teamsters Local 436 Welfare Fund
6051 Carey Drive
Valley View Ohio 44125-4259

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information:
Teamsters Local Union 436
Welfare Fund
6051 Carey Drive
Valley View, OH 44125-4259
Telephone: 216-328-0436
Toll free: 877-396-3436

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	

ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	**MONTANA** – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability

SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Plan Information

Name Of Plan

The name of the Plan is Excavating and Building Material Drivers Union Local 436 Welfare Fund.

Board Of Trustees

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of employer and union representatives. If you wish to contact the Board of Trustees, you may send correspondence to the Fund Office or to the address shown below. The Trustees of the Plan, as of April 1, 2015, are:

Union

Gary M. Tiboni, Chairman
Teamster Local Union No. 436
6051 Carey Drive
Valley View, Ohio 44125

Jack Fortesque
Teamster Local Union No. 436
6051 Carey Drive
Valley View, Ohio 44125

Nicholas M. Magistrelli
Teamster Local Union No. 436
6051 Carey Drive
Valley View, Ohio 44125

Jack Fortesque
Teamster Local Union No. 436
6051 Carey Drive
Valley View, Ohio 44125

Dennis M. Kashi, Sr.
Teamster Local Union No. 436
6051 Carey Drive
Valley View, Ohio 44125

Rosario Sara
Teamster Local Union No. 436
6051 Carey Drive
Valley View, Ohio 44125

Employer

Brock P. Walls
Westview Concrete Corp.
PO Box 38159
Olmsted Falls, Ohio 44138

Jeffrey E. Nock
Terrace Construction
3965 Pearl Road
Cleveland, Ohio 44109-3103

John E. Sarrouh
Rockport Ready Mix
3092 Rockefeller Avenue
Cleveland, Ohio 44115

John W. Ziss, Jr.
Kurtz Bros., Inc.
6415 Granger Road
Independence, Ohio 44131

Plan Sponsor And Administrator

The Board of Trustees is both the Plan Sponsor and Plan Administrator. Vision, and weekly accident and sickness benefits are self-insured. All medical, prescription drug, life insurance benefits, and AD&D benefits are insured through outside insurance companies.

Identification Numbers

The number assigned to the Plan is 501. The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 34-0821253.

Agent For Service Of Legal Process

The Board of Trustees is the Plan's agent for service of legal process. If legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees or upon any of the Trustees individually at:

Excavating and Building Material Drivers Union Local 436 Welfare Fund
6051 Carey Drive
Valley View, Ohio 44125-4259

Source Of Contributions

The benefits described in this booklet are provided through employer contributions. Contributions to the Plan are made by employers in accordance with their collective bargaining agreements. All agreements must be approved and accepted by the Trustees.

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

An employee whose eligibility is to terminate will be allowed under certain circumstances to continue coverage for a limited period of time by making direct contributions to the Plan.

Type Of Plan

This is a group health and welfare plan. This Plan is maintained to provide medical benefits in the event of sickness or accident. Prescription drug, vision, weekly accident and sickness, life insurance, and accidental death and dismemberment benefits are also provided if you meet the applicable eligibility requirements. The Plan benefits are shown in the **Summary Of Benefits** beginning on page 4.

Trust Fund

All assets of the Plan are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Fund's assets are presently invested by the Board of Trustees in savings accounts and securities.

Eligibility

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described fully in this booklet.

Claim Procedures

The procedures to follow for filing a claim for benefits are explained starting on page 41 of this booklet. If all or any part of your claim is denied, you have the right to request that the Board of Trustees review the matter and that the matter be submitted to a hearing.

Plan Year

The records of the Plan are kept separately for each Plan year. The Plan year begins on January 1 and ends on December 31.

Plan Amendment And Termination

While the Trustees intend to maintain the Plan indefinitely, they have the authority, in their sole discretion and without prior notice to participants, employees, contributing employers, the union, and others affected, acting in accordance with the provisions of the Trust Agreement regarding Trustee acts, to amend or terminate the Plan in whole or in part at any time by execution of an instrument in writing should conditions so warrant. If the Plan is modified or terminated, you will be notified in writing or as required by law.

The Trust may be terminated as a result of the expiration of all collective bargaining agreements requiring payment of contributions to the Fund, or for any other reason deemed necessary by the Trustees.

In the event of a termination, any and all assets remaining after the payment of all obligations and expenses will be used, in accordance with a plan for dissolution adopted by the Trustees, to continue the benefits provided by the existing Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any participating employer, association, or labor organization.

Statement Of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights.

Receive Information About Your Plan And Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description/Plan Document. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description/Plan Document and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:

You lose coverage under the Plan;

You become entitled to elect COBRA Continuation Coverage; or

Your COBRA Continuation Coverage ends.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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. However, you must exhaust all Plan appeal procedures before beginning any legal action.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Summary Plan Description/Plan Document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

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

For more information about your rights and responsibilities under ERISA:

- Call 866-444-3272; or
- Visit www.dol.gov/ebsa.

Definitions

Administrator — Any person duly designated by the Trustees pursuant to the Trust Agreement to perform any and all necessary and proper duties incident to the administration of the Fund, including in scope, but not limited to, the hiring of personnel, professional or otherwise, to achieve the objectives of the Fund.

Collective bargaining agreement — The successive collective bargaining agreements in force and effect between employers and the union, plus any amendments thereto, that provide for, among other things, contributions to be made to the Fund.

Contributions — The money paid, or required to be paid, by employers to the Fund pursuant to collective bargaining agreements or other written agreements described in the Trust Agreement.

Covered person — The participant, retiree, and any and all eligible dependents.

Covered services — Those services or supplies described in this booklet that will be considered for payment.

Eligible dependents — See page 22 and following.

Employer — The various employers of participants for whom the union is the collective bargaining representative, who have satisfied the requirements for participation as established by the Trustees, and who agree to be bound by the terms and conditions of the Trust Agreement.

The term “employer” also includes the union and the Fund for their respective participants, provided that the union and the Fund:

- Become contractually obligated to make contributions on behalf of their participants;
- Sign a copy of the Trust Agreement or, in some other manner acceptable to the Trustees, consent in writing to be bound by the terms and provisions of the Trust Agreement; and
- Have been accepted for participation in the Fund by the Trustees in their absolute discretion.

The term “employer” will not include a self-employed person, sole proprietor, or partner unless the self-employed person, sole proprietor, or partner makes contributions for at least one other participant.

Fund — The trust fund established under the Trust Agreement.

Participant — All employees who are:

- Employed by employers; and
- Eligible for benefits under the terms and provisions of the Plan.

However, in no event will the term “participant” include any self-employed person, sole proprietor, or partner, with the exceptions of the:

- So-called “owner-operator” that contracts with an employer making contributions on his/her behalf; and
- Self-employed person, sole proprietor, or partner that makes contributions for at least one other participant.

Plan or **Plan Document** — This document that sets forth the methods and procedures for the payment of benefits from the Fund (directly or indirectly) by the Trustees on behalf of covered persons and beneficiaries in accordance with the eligibility requirements and covered services described herein.

Retired or **Retiree** — Any participant who has voluntarily and permanently ceased employment for an employer provided that:

- He/she has at least 15 years of continuous service in the employ of an employer before his/her retirement (periods of absence from work due to strike, layoff, and/or illness excepted);
- He/she had been a member of the bargaining unit represented by the union or had been employed by the Fund for not less than 15 continuous years before his/her retirement (absence due to sickness and/or layoff excepted); and
- Contributions have been made on his/her behalf into the Fund for not less than eight continuous years immediately before his/her retirement (whichever is later).

In making the foregoing computation, any period of illness, layoff, or strike will be considered to be part of the 15 years of employment required and such 15 years will be continuous employment up to and including the time of his/her retirement.

Trust Agreement — The amended and restated Agreement and Declaration of Trust establishing the Welfare Fund of Teamsters Union Local No. 436 and this Summary Plan Description/Plan Document.

Trustees — The employer trustees and the union (participant) trustees, collectively, as selected in accordance with the terms and conditions of the Trust Agreement.

Union — Teamsters Local Union No. 436.