SUMMARY PLAN DESCRIPTION

BENEFIT PROGRAM

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WESTERN PENNSYLVANIA TEAMSTERS
AND
EMPLOYERS WELFARE FUND

November 2019

TABLE OF CONTENTS

BENEFIT PROGRAM

GENERAL PROVISIONS

WESTERN PENNSYLVANIA TEAMSTERS
AND
EMPLOYERS WELFARE FUND

Effective
January 1, 2017

WESTERN PENNSYLVANIA TEAMSTERS AND EMPLOYERS WELFARE FUND

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IMPORTANT INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each participant (or eligible participant) in an Employee Benefit Plan. This is your SUMMARY PLAN DESCRIPTION. Contributions to this Plan are made by the Participating Employers. Contributions are based on negotiated contribution rates as set forth in the Collective Bargaining Agreement.

PLAN IDENTIFICATION NUMBER
E.I.N. 25-1000614 P.N. 501

This Plan is provided through the Trustees of the Western Pennsylvania Teamsters and Employers Welfare Fund, whose address is:

50 Abele Road, Suite 1005
Bridgeville, PA 15017

Agent for Service of Legal Process (legal process may also be served upon a Trustee or the Trustees):

Mr. Vincent Szeligo, Attorney
50 Abele Rd., Ste. 1005
Bridgeville, PA 15017

The Administrator for this Plan (as defined by Section 3 (16) of ERISA):

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50 Abele Rd., Ste. 1005
Bridgeville, PA 15017

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The Plan Year of the Welfare Fund starts on January 1 and ends on December 31, and consists of an entire Calendar Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies. The Welfare Fund offers Benefit Programs for medical, hospitalization, dental, vision, life/accidental death and dismemberment, and loss of time coverages at levels which vary for the participant, a spouse and dependents (if applicable).

Relevant provisions of the Collective Bargaining Agreement, the names of the parties and its expiration date may be reviewed at the Administrative Office:

Western Pennsylvania Teamsters and Employers Welfare Fund
50 Abele Road, Suite 1005
Bridgeville, PA 15017

The Collective Bargaining Agreements are between any Teamster Local Union affiliated with Joint Council of Teamsters No. 40, or any other union approved by the Trustees, and the various Employers that have entered into labor contracts with such Unions. The Benefit Programs are Group Health Plans.

The Plan provides benefits in accordance with applicable federal laws including the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Employee Retirement Income Security Act (ERISA), the Health Insurance Portability and Accountability Act (HIPAA), Michelle's Law, the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), and the Genetic Information Nondiscrimination Act (GINA) and the Mental Health Parity Act (MHPA) (including the Paul Wellstone and Pete Domenici Mental Health and Substance Abuse Equity Act (Wellstone Act)).

Changes required to this plan under Patient Protection and Affordable Care Act of 2010 and the Health Care Reconciliation Act of 2010 (collectively, the "Affordable Care Act") were implemented as of January 1, 2011 based upon a good faith interpretation of the Affordable Care Act and applicable federal regulations. The plan is legally classified as a "non-grandfathered, self-insured multiemployer welfare plan".

PLAN INTERPRETATION

The Trustees have the power to construe, and full discretionary authority to interpret, the provisions of this Plan, including, but not limited to, full and final determinations as to all issues concerning group coverage and eligibility for benefits. To the extend the terms of this Plan conflict with a Summary of Benefits and Coverage, or other document, the terms of this document take precedence.

ELIGIBILITY PROVISIONS

FOR YOU

THE FUND PROVIDES BENEFITS FOR:

Active employees of Contributing Employers on the seniority list and other groups for whom the Contributing Employer has agreed to make contributions.

INITIAL ELIGIBILITY

New employees hired by a Contributing Employer will be eligible for benefits (Eligible Employee) on the first day of the second calendar month coinciding with or following thirty (30) days of continuous employment by a Contributing Employer, unless the applicable collective bargaining agreement provides otherwise.

If an employee is not actively at work on the date he/she would otherwise have become an Eligible Employee, he/she shall become an Eligible Employee on the date he/she returns to active full-time work.

CONTINUING ELIGIBILITY

Work Requirements

(a) Be an Active Employee of a Contributing Employer, and

(b) Satisfy any applicable work (compensable service) requirements specified in your collective bargaining agreement for the specified calendar month (the "Work Month").

(c) Based on (a) and (b) above, you will then be eligible for benefits during the second month (the benefit month) as shown below:

WORK MONTH	MONTH EMPLOYER CONTRIBUTION DUE	BENEFIT MONTH
January	February	March
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August
July	August	September
August	September	October
September	October	November
October	November	December
November	December	January
December	January	February

(d) If you are eligible for coverage, your Employer is absolutely required to pay contributions and you are not permitted waive coverage unless specifically permitted in your Collective Bargaining Agreement and under Fund procedures.

Reinstatement Rights

If your coverage was terminated due to layoff, disability, or leave of absence, and you return to work with a Contributing Employer, after the applicable hours per your collective bargaining agreement are performed in the calendar month (the Work Month), you will be eligible for benefits during the second month as indicated on the above chart.

FOR YOUR DEPENDENTS

Initial and Continuing Eligibility

Any coverage for an employee's dependent(s), if applicable under the Benefit Program agreed to by the Contributing Employer, shall become effective on the date the employee is covered if the employee has eligible dependents enrolled in compliance with Fund enrollment procedures or when a court of competent jurisdiction issues a Qualified Medical Child Support Order; otherwise, on the date eligible dependents are acquired.

	Coverage Effective Date
1. Member	Second month after completion of a work month (i.e., work month-January, contribution due in February, benefit month-March)
2. Spouse and children on effective date of coverage	Same as member
3. Spouse added after effective date of coverage	Same as member. Spouse will receive coverage after initial application month and contribution (i.e., marriage month-January, contribution month-February, benefit month-March)
4. New child to existing single member*	Same as member. Child will receive coverage after initial application month and contribution month

*Note that single members who will be adding a dependent by marriage, birth or adoption should make appropriate arrangements with their employer prior to contribution date to ensure new dependent has coverage on appropriate date. Without prepayment of contributions, coverage will not be provided to the dependent on the same basis as a member.

CHANGES IN STATUS

If you experience one of the events listed below, you must notify the Fund of the change within 31 days of the event. The event must be on account of and correspond with one of the following changes that affects eligibility under the plan.

Your Marital Status Changes – Marriage, divorce, death of spouse or legal separation.

Your Designation of Beneficiary – If you have designated a beneficiary on a form provided by the Fund, you may cancel a prior designation and name a new beneficiary. A divorce will not automatically result in a change unless you designate a new beneficiary in writing.

Your Number of Dependents Changes – The birth, death, adoption or placement for adoption of a child.

Termination/Commencement of Employment – The beginning or the end of employment of the employee, spouse or dependent.

Change in Work Hours – Change in work schedule of employee, spouse or dependent including a reduction or increase in hours, full-time/part-time switch.

Your Dependent Begins or Ceases to Meet Eligibility – Your dependent satisfies (or ceases to satisfy) dependent eligibility requirements.

You Have a Qualified Medical Child Support Order (QMCSO) – A Plan election to enroll or disenroll a child pursuant to a change in legal custody that effects a child's eligibility for coverage under the Plan or the plan of the child's other parent (including a qualified medical child support order).

HIPAA Special Enrollment Situations – Events such as the loss of other coverage that qualify as special enrollment events under Health Insurance Portability and Accountability Act (HIPAA) or an event that involves loss of Medicaid or State Child Health Insurance Program (CHIP) coverage or eligibility for state premium assistance.

Change in residence or worksite – Change in residence or worksite of employee, spouse or dependent, resulting in eligibility or loss of eligibility.

Medicare/Medicaid Entitlement – You, your spouse or dependent becomes entitled - or loses entitlement - to Medicare or Medicaid.

COBRA Eligibility – You, your spouse or dependent become eligible for COBRA.

Starting or Stopping an FMLA Leave

Adult Dependent Medical Coverage Made Available Effective January 1, 2011 - Eligible employees with children attaining age 19, or losing student status, electing or declining medical coverage during an initial or annual open enrollment period for child(ren) until attainment of age 26 (age 25 for dental, vision and life insurance upon submission of Student Verification).

Enrollment of Ineligible Third Parties - The Welfare Fund reserves the right to terminate your coverage if the Trustees, in their sole discretion, determine that you knowingly provided false information, directly or indirectly, with the intent to cause the Welfare Fund to provide coverage, benefits, or payments that you or a third party is not entitled to receive. Any act, practice, or omission by an individual that constitutes fraud

or an intentional misrepresentation of material fact to the Welfare Fund is strictly prohibited. The Welfare Fund aggressively pursues action (including legal action when appropriate) to recover losses caused by fraudulently obtained benefits. Failure to provide timely notice to the Welfare Fund of a change in status, including, but not limited to, a change in status resulting from divorce is an intentional misrepresentation of material fact.

TERMINATION OF BENEFITS

FOR YOU

An employee's benefits shall automatically terminate at the earliest of the following dates:

1. The date your Employer became delinquent in remitting contributions to the Fund on your behalf for one (1) month or more.

2. The date an employee enters full-time military, naval, or air service unless otherwise provided by law.

3. The date the Fund is terminated.

4. The last day of the Benefit Month for which the last contribution was made.

FOR YOUR DEPENDENTS

Dependent benefits shall automatically terminate at the earliest of the following dates:

1. The date the employee's benefits terminate or the employee becomes a participant of another plan.

2. The date the spouse ceases to be legally married to the employee.

3. The last day of the month in which a child ceases to be enrolled as a dependent as described herein.

    a. Unless otherwise provided below, coverage of a child as a dependent terminates on the last day of the month in which the child attains age 19 (unless he or she is mentally or physically disabled and primarily depends on you for support);

    b. Medical coverage is made available to child(ren) between age 19 and until attaining age 26, provided the participant enrolls the child(ren) in accord with the Fund’s Adult Dependent Enrollment procedure, or during the annual adult dependent open enrollment period, or in connection with the Student Verification (needed for dental, vision, and life insurance – see item (c).

    c. Dental, Vision and Life Insurance coverage is extended beyond age 19 for full-time students until the day he or she attains age 25 graduates or terminates his or her educational program, subject to completion of a Student Verification Form.

4. The date the dependent enters full-time military, naval or air service.

5. The last day of the Benefit Month for which the last contribution was made.

6. Notwithstanding items 1 and 5 above, for dependents eligible for the benefits under the Survivor Benefit clause, twelve (12) months from the date of the employee's death.

CONTINUATION OF COVERAGE – "COBRA"

You may be able to purchase continued group health benefits coverage under this plan pursuant to federal rights provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. The Fund will allow employees and their dependents to continue their health coverage at group rates under certain circumstances when coverage under the plans would otherwise end due to qualifying events.

There may be more economical alternatives for coverage options which do not involve this Welfare Fund. For example, under the Affordable Care Act, effective January 1, 2014, you can buy coverage through the Health Insurance Marketplace. However, if waiving COBRA and taking ACA Exchange coverage, note that COBRA coverage is counted towards eligibility for any retiree subsidy which may be part of your plan package. Other factors to consider are outlined at the ACA Health Insurance Marketplace at **www.HealthCare.gov** or by calling or by calling 800-318-2596. In the Marketplace, you could be eligible for a government subsidy to lower your monthly premiums. Being eligible for COBRA does not limit your eligibility for subsidized coverage through the Marketplace. Additionally, under HIPAA you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272 For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov

If your coverage is terminated, you will receive a COBRA Notice and Election form, together with information concerning options for continuation of coverage. The forms will provide you with an up-to-date statement of your rights in effect at that time.

COBRA Benefits

This coverage is called COBRA continuation coverage. Qualified beneficiaries are eligible for COBRA continuation coverage if your group health benefits coverage would otherwise be lost due to certain qualifying events, which are described in the chart below.

Qualified beneficiaries include you and your eligible dependents that were covered under a group health plan at the time of an initial qualifying event that would otherwise result in termination of coverage. Your qualified beneficiaries can also include your

children born to or placed with you for adoption during the time you're covered by COBRA. They have the same rights as your other qualified dependents.

COBRA – Qualifying Events at a Glance

COBRA coverage continues for you and your covered dependents for 18, 29 or 36 months from the date they would otherwise lose coverage if you became eligible for COBRA because of:

- Reduction in hours (below the minimum to be eligible for health care coverage);
- Termination of employment for any reason except gross misconduct;
- Your death;
- Your divorce or legal separation from your spouse;
- Your child's loss of status as a dependent child; or
- Your entitlement to Medicare.

QMCSO: A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Company during the covered employee's period of employment with the Company is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Your duties

Under the law, the employee or a family member has the responsibility to provide notice of a divorce, legal separation or a child losing dependent status under the Fund-sponsored group health plan. The notice must include the following information:

- The name of the employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiar(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event;
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if it is requested. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail or hand-deliver this notice to the Welfare Fund Office. This notice must be provided within 60 days from the date of the divorce, legal separation or child losing dependent status (or if later the date coverage would normally be lost because of the event). If the employee or a family member fails to provide this notice to the Welfare Fund Office during this 60-day notice period, any family member who loses coverage will not be offered the option to elect continuation coverage.

When the Welfare Fund Office is notified that one of these events has happened, the Welfare Fund Office in turn will notify you that you have the right to elect continuation coverage. If you or your family member fails to notify the Welfare Fund Office and any

claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation, or a child losing dependent status, then the employee and family members will be required to reimburse the Welfare Fund for any claims mistakenly paid.

Fund's duties

Qualified beneficiaries will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage. The employee's:

- death,
- termination (for reasons other than gross misconduct),
- reduction in hours of employment, or
- Medicare entitlement.

Electing COBRA

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described earlier, or, if later, 60 days after the Welfare Fund Office provides you with notice of your right to elect continuation coverage. An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage. To elect COBRA coverage you must complete the election form that is part of the Welfare Fund's COBRA election notice. You must mail or hand deliver this completed notice to the Welfare Fund Office. Your election must be postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you choose continuation coverage, the Fund is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the health plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. "Similarly situated" refers to a current employee or dependent who has not had a qualifying event.

If you do not choose continuation coverage within the 60-day election period, your group health coverage will end as of the end of the month in which the qualifying event occurs. If you return your election form waiving your rights to COBRA and change your mind within the 60-day period, you may revoke your waiver and still elect COBRA coverage as long as it is within the 60-day window. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Newly Eligible Child: If a former employee elects COBRA coverage and then has a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Fund's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to

COBRA coverage by providing the Welfare Fund Office with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and a copy of the birth certificate or adoption decree.

If you fail to notify Welfare Fund Office within the 30 days, you will not be offered the option to elect COBRA coverage for the newly acquired child. Other newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

Separate Elections: Each qualified beneficiary has an independent election right for COBRA coverage. For example, if the benefit plan under which coverage was provided immediately prior to the qualifying event allows for a choice among types of coverage, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect different coverage than the employee elects. A covered employee or spouse can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child.

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 36 months. Additional qualifying events, which are an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Fund, may occur while COBRA continuation coverage is in effect due to an employee's termination of employment or reduction in hours ("Second Qualifying Events"). Second Qualifying Events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits within 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee who lose coverage as a result of the qualifying event can last up to a maximum of 36 months after the date of Medicare entitlement.

COBRA coverage can end before any of the above maximum periods for several reasons. See the Early Termination of COBRA section below for more information.

Extended COBRA Periods.

An extension of the maximum period of coverage will be available to the spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs within 18 months (or, in case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction in hours. Second qualifying events include an employee's death, divorce, or a child losing dependent status (if such qualifying event would have resulted in a loss of coverage under the Fund for an active employee or dependent).

This extension is only available if you or a representative acting on your behalf notify the Welfare Fund Office in writing of a disability or a second qualifying event in order to extend the period of continuation coverage. This notice must be provided within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Fund as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Fund as an active participant). The notice must include the following information:

- The name(s) and addresses of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event;
- The signature, name and contact information of the individual sending the notice.

Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage. Extended coverage may apply under the following circumstances:

Disability

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled. If a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and you notify the Welfare Fund Office in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an 11-month extension for up to a total of 29 months of coverage may be available.

A qualified beneficiary must be determined, under the Social Security Act, to have been disabled during the first 60 days of coverage and the determination must have been made any time before the end of the 18-month period (subject to the notification requirements). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

A Notice of Disability Form is available from the Welfare Fund Office upon request. The Welfare Fund may charge 150% of the applicable premium for this coverage. To continue coverage for the additional 11 months, you or a representative acting on your

behalf must notify the Welfare Fund Office in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Fund as a result of the covered employee's termination of employment or reduction of hours.

On this form you are also required to show evidence that your notice to the Welfare Fund Office was post marked within 18 months after the covered employee's termination of employment or reduction of hours.

The notice must be provided in writing and must include the following information:

- The name(s) and addresses of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and addresses of the disabled qualified beneficiary;
- The date that the qualified beneficiary become disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail or hand deliver this notice to the Welfare Fund Office.

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If, during the extended continued coverage period, the Social Security Administration determines that the qualified beneficiary is no longer be disabled, the individual must notify the Welfare Fund Office of this redetermination within 30 days of the date that determination is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second

qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Welfare Fund. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Welfare Fund if the first qualifying event had not occurred. This extension due to a second qualifying event is available only if you notify the Welfare Fund Office in writing of the second qualifying event within 60 days after the date of the second qualifying event. **You must notify the Welfare Fund Office within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.**

Notification of Eligibility for COBRA

If you, or one of your dependents, experience a Qualifying Event, you or your Employer must notify the Welfare Fund Office. If a qualified beneficiary may be eligible for COBRA, the Fund will send you an enrollment notice form which explains the COBRA rights you, and/or your dependents, may independently elect, together with payment information for continuation of benefits.

If Social Security determines that you or your dependent is no longer disabled, you must notify the Welfare Fund Office within 30 days. You must notify the Welfare Fund Office when you or your dependent first becomes eligible for Medicare.

In order to be eligible for COBRA rights in the event of a divorce or a child who loses eligibility, you or your dependent must notify the Welfare Fund Office within 60 days of one of these events. Notice of COBRA continuation rights will be sent within 14 days of receiving your notice.

Cost of COBRA Continuation Coverage

If you elect COBRA coverage, you will be required to pay the full cost of coverage for you and your dependents. In addition, there is a 2% administration fee — making your payment a total of 102% of the cost of coverage.

If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the cost of covering an employee and any eligible dependents, if applicable. This cost increase begins with the 19th month of COBRA coverage, provided that the disabled individual is one of the individuals who elected the disability extension. The cost of group health coverage periodically changes. If you elect COBRA coverage, you will be notified by the Welfare Fund Office of any cost changes.

COBRA coverage is not effective until you elect it and make the required payment. You have an initial grace period (45 days from the date of your initial election) to make your first premium payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Fund. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Fund would have

otherwise terminated up through the end of the month before the month in which you make your first payments. You are responsible for making sure that the amount of your first payment is correct. You may contact the Welfare Fund Office to confirm the correct amount of your first payment.

Thereafter, the Welfare Fund will issue invoices for monthly payments, which are due on the 15th day of the month proceeding the coverage month. A grace period of 30 days after the first day of the coverage month is granted to make each payment (payments must be postmarked on or before the end of the 30-day grace period). If you pay part but not all the premium, and the amount you paid is not significantly less than the full amount due, you will have 30 days from the end of the initial 30-day grace period to pay the outstanding amount due.

All COBRA premiums must be paid by check or money order, but you will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the Welfare Fund Office at the address listed below. If mailed, your payment is considered to have been made on the date that it is postmarked.

If you do not make timely payments, your COBRA coverage will be terminated as of the last day of the month for which you made timely payment.

When COBRA Ends

The COBRA "clock" starts on the later of the date your regular coverage would otherwise end or the date of the qualifying event. COBRA coverage will terminate before the maximum allowable period for any of the following reasons:

- You or your dependents first become covered, after electing COBRA continuation coverage, under another group health plan that does not contain any exclusions or limitations for pre-existing conditions that apply to you or your dependents;

- You or your dependents first become entitled, after electing COBRA continuation coverage, to Medicare (COBRA coverage ends only for the person who is entitled to Medicare);

- You do not pay your premiums within 30 days of the due date (or 45 days in the case of the first payment);

- Coverage is no longer provided for any employee; or

- Social Security determines that you or your dependent is no longer disabled. In this instance, you are responsible for notifying the Welfare Fund Office within 30 days after the date Social Security determines you or your dependent is no longer disabled.

Except as provided under the Fund's COBRA opt down rules, your initial COBRA continuation coverage generally must be identical to the coverage you had immediately

before the qualifying event. However, any modification that affects active employees will also affect you. In addition, qualified beneficiaries have the same enrollment and election change rights as active employees.

For additional information on COBRA continuation coverage, rights and obligations, please contact the Fund Office.

COBRA AND THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

A FMLA leave does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of nonpayment of premium during a FMLA leave, you may be eligible for COBRA on the last day of the FMLA leave, if you decide not to return to active employment, depending on whichever situation occurs the earliest:

- When you definitively inform the Fund that you are not returning at the end of the leave; or

- The end of the leave, assuming you do not return to work.

For purposes of a FMLA leave, you will be eligible for COBRA, as described above, only if:

- You or your dependent is covered by the Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave);

- You or your dependents lose coverage under the Plan before the end of what would be the maximum COBRA period; and

- You do not return to employment at the end of the FMLA leave.

MILITARY LEAVE

If you take a military leave, whether for active duty or for training, you are entitled to extend your medical coverage for up to 36 months, as long as you give the Fund advance notice of the leave (with certain exceptions). Your total leave, when added to any prior periods of military leave from the Fund cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more for coverage than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

If you take a military leave, but your coverage under the Fund is terminated (for instance, because you do not elect the extended coverage), you will be treated as if you had not taken a military leave upon reemployment when determining whether an exclusion or waiting period applies.

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

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

All other coverages will continue/terminate during your military leave.

CERTIFICATES OF CREDITABLE COVERAGE

A Certificate of Creditable Coverage (sometimes called a HIPAA Certificate of Coverage) may be needed to prove that you and your dependents were covered for a specific period with this Fund or some other health plan.

- If requested, the Fund will provide a certificate of creditable coverage, free of charge.

If your collective bargaining agreements permits you to decline coverage for yourself or your dependents based on your having other current health coverage, the Welfare Fund will require that you provide a certificate of creditable coverage to prove that you have other health coverage in force. The Welfare Fund will only exclude coverage upon receipt of a Certificate of Coverage proving that health coverage is in effect from some other health plan, as explained in detail in the Fund's Opt-Out, Opt-Down, Opt-In rules.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Omnibus Budget Reconciliation Act of 1993 (OBRA), will affect the benefits provided under the Welfare Plan as follows:

- The Welfare Fund is required to recognize Qualified Medical Child Support Orders (QMCSOs). A child who is the subject of a QMCSO is defined to be an "alternate recipient" and is treated as a beneficiary under the Fund.

  To qualify as a QMCSO, a Medical Support Order must:

- Create or recognize the existence of an alternate recipient's right to receive benefits from which the participant or beneficiary is eligible under a group health plan or to assign those rights;

- Clearly specify the name and last known mailing address of the participant and the name and mailing address of each alternate recipient covered by the order;

- Specify a reasonable description of the type of coverage to be provided by the plan to each alternate recipient or the manner in which the type of coverage is to be determined;

- Specify each plan that the order applies to and the period to which such order applies; and

- Not require a plan to provide any type or form of benefit not otherwise provided under the plan.

OBRA provides that group health plans such as the Welfare Fund cannot consider Medicaid eligibility in enrolling an alternate recipient in the Fund. The Fund must also comply with an alternate recipient's assignment of rights under Medicaid.

- OBRA also requires all group health plans, including the Welfare Fund, to provide that, from the time a child is placed in a participant's home for adoption, the child is to be treated in the same manner as the natural children of the participant even though the adoption has not become final. Of course, it will be necessary for participants to notify their employers and the Welfare Fund that a child has been placed in the participant's home for adoption so that the Welfare Fund can enter the child on the Fund's records as an eligible dependent.

TERMINATION, AMENDMENT OR MODIFICATION OF THIS FUND

The Trustees retain the right to terminate, amend or modify this Fund or any part thereof.

MISCELLANEOUS PROVISIONS

Assignment

No Covered Person shall have the right, except as hereinafter provided, to assign, alienate, anticipate or commute any payments hereunder; and, except as prescribed by law, no payments shall be subject to the debts, contracts or engagements of any payee nor to any judicial process to levy upon or attach the same for the payment thereof. Any covered individual, however, may authorize the Fund to pay benefits against expenses due to medical care and treatment directly to the persons or institutions on whose charges the claim is based. The Fund shall be discharged from all liability to the extent of any payment made in accordance with any such authorization.

Compliance with Claim Rules

In order to obtain benefits, it is necessary that all claimants comply with the applicable claim rules set forth or established by the Trustees. The Trustees shall exercise every right provided under the terms of this Booklet and determine rules to prevent any claimant from receiving benefits for which he/she is not entitled.

Claim Forms

The Fund will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within thirty (30) days after the giving of notice, the claimant shall be deemed to have complied with the requirements of the Booklet as to proof of loss upon submitting, within the time fixed in the Booklet for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Timely Payment of Claim

Subject to written proof of loss and compliance with all claim rules, all indemnities for loss for which the Plan provides payment will be paid as they accrue.

Status of Spouse

For the purpose of coverage, the status of spouse shall be determined under the laws of the Commonwealth of Pennsylvania, except as may be required under applicable federal law. Copies of a valid marriage certificate, divorce degree, or proof of a Pennsylvania common law marriage created prior to January 1, 2005 will be required to establish current or former status of a spouse.

Covered Individual Indebtedness to Fund

The Fund shall have the right to deduct from, or offset against, the payment of any benefits for which an employee participant, his/her dependents or designated beneficiary shall be entitled, any sum to which the said covered individual is indebted to the Fund for any purpose whatsoever.

Physician Examination and Autopsy

The Fund at its own expense shall have the right and opportunity to examine the participant or dependent whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and to perform an autopsy in case of death, where it is not forbidden by law.

Legal Proceedings

With respect to claims for benefits, this Plan provides a two level mandatory claims review process which must be exhausted before claimant is entitled to bring suit under 29 U.S.C. § 502(a). This Plan adopts the Pennsylvania Wage Payment and Collection Law's statute of limitation for commencement of a lawsuit challenging a determination of benefits, regardless of whether suit is filed in federal or state court. No legal proceedings for benefits shall be commenced after three (3) years from the expiration of the date on which Claimant receives written notice that an appeal of claim has been denied.

Applicable Law

The Benefit Program is governed by ERISA, a federal law, which generally preempts the application of state laws. To the extent state laws may apply, the provisions of this Booklet are to be interpreted in accordance with the laws of the Commonwealth of Pennsylvania except as may be required by ERISA or any other controlling federal law or regulations hereunder.

GENERAL INFORMATION

RIGHTS AND PROTECTIONS UNDER ERISA

As a participant in the Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act (ERISA):

Receive Information about Your Plan and Benefits

Examine, without charge, at the Fund Office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500) filed by the plan with the DOL Employee Benefits Security Administration.

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

Receive a Summary of the Plan's Annual Financial Report

The Fund is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Benefits Plan Coverage

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

Waiver of Coverage – Opt-Out/ Opt-Down/ Opt-In Procedures

Under the Affordable Care Act, all U.S. citizens are legally required to maintain health insurance. The Welfare Fund requires that a participating employer must cover all individuals working in a classification for which it has agreed to provide coverage under the Welfare Fund and is not permitted to allow an employee to waive coverage for themselves or their dependents and is not relieved of the primary obligation to pay the entire contribution rate for the plan (although an employee may agree to reimburse the employer for some portion of the contribution).

In certain limited circumstances where permitted by a collective bargaining agreement, an eligible participant may decline coverage for themselves and or their dependents provided an Opt-Out or Opt-Down form is submitted to the Welfare Fund together with proof that the individual who is entitled to coverage is actually covered under another health plan (sometimes called a “Certificate of Coverage”). Proof of other coverage is required on an annual basis. The terms and conditions for declining coverage is set

forth in the Welfare Fund's Policy Governing Participation, as may be amended from time to time.

In special qualifying circumstances, an eligible employee who has properly waived coverage based on the existence of other coverage may enroll for coverage with the Welfare Fund by submitting a timely Opt-In form together with proof of coverage containing information showing that such other coverage was terminated in the past 60 days.

Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for you, ERISA imposes duties upon the people who are responsible for operating 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 the Fund, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you must exhaust the Fund's claims review and appeal procedure before your right to file suit in a state or federal court arises. However, since the Fund provides several levels of review, some of which are voluntary, please note that you are not required to pursue a voluntary review procedure as a precondition to the exercise of your legal right to sue. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a 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 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 the Welfare Fund or the specific Plan in which you are enrolled, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Office, you should contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory or 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

SPECIAL RIGHTS FOR MOTHERS AND NEWBORN CHILDREN

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

HIPAA PRIVACY AND SECURITY RIGHTS

The Trustees of the Welfare Fund, employees of the Welfare Fund Office, and all Business Associates providing services to the Fund respect your right to the privacy of your personal health information. The Fund only uses Protected Health Information ("PHI") in connection with day-to-day operational activities. It does not give or sell your information to parties who are not engaged in operational activities. Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), and as

HIPAA and the HIPAA regulations were amended by the American Recovery and Reinvestment Act of 2009 ("ARRA"), the Fund has instituted measures required to safeguard your protected health information, whether contained in paper files or stored and transmitted electronically.

The Welfare Fund will adhere to all of the privacy and security standards and rules issued by the relevant federal agencies as may be communicated to you from time to time. This includes the Fund's monitoring and remediation for possible security breaches. The Fund will notify a participant or participants of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach"). The Fund will cooperate with you in the investigation of, and response to, the Breaches it reports to you. A statement of the Fund's privacy procedures and your rights is available from the Fund Office or from the Welfare Fund's web site: www.wpawelfarefund.com.

CLAIMS AND APPEAL PROCESS

The Trustees of the Welfare Fund contract with private providers, in order to afford employers and unions the quality and price options desired for medical and hospitalization benefits, dental vision and life/accidental death and dismemberment benefits. The claims processing and appeal procedures for these benefits are administered by the contractual service providers (Claims Administrators) on behalf of the Fund. The actions of Claims Administrators are subject to ultimate supervision by the Trustees. All other benefits and determinations, (for instance, loss of time and retiree subsidy benefits) are administered directly by the Welfare Fund Office and the appeals are heard by the Trustees.

For benefit packages which include dental and or vision benefits, an Appendix describing those benefits and claim procedures appears in the latter portion of this booklet.

In response to federal regulations, the Trustees have taken steps to ensure that all of the Claims Administrators having contractual duties regarding the processing of benefits and claims do so in a manner which is consistent with the laws and regulations governing the claims and appeal process, as those laws and regulations are updated. Since different contractual providers, or in some cases the Fund Office itself, administers claims for specific benefits, the Fund's claims and appeal procedure uses generic terms to refer to any representatives administering benefit claims for a special Plan offered by the Fund as the "Claims Administrator". Each Claims Administrator will use their own claim forms and notices in performing their roles under the claims and appeal process and will communicate with you directly to coordinate your claim review and any internal or external appeal procedure which may be applicable. Although the language in provider documents may differ from that used in the Fund's claims and appeal procedure set forth below, their handling of claims and appeals is governed by the procedures of this Fund and by federal regulations. In all cases, the Trustees of the Fund retain the right to ultimately supervise and determine claims. If you have questions regarding how to file a claim or appeal the denial of a claim, you should refer to the specific review and dispute instructions provided by the entity responsible for administration of the specific benefit.

Claims for benefits shall be submitted electronically or in writing, within the time limits specified and in a method or form authorized by the Fund or the Claims Administrator. Specific forms setting forth the precise information needed for the various types of benefits are available from the Fund Office, or from your health care provider. The Claims Administrator has a specific amount of time to evaluate and respond to claims for benefits, beginning on the date when a complete and proper claim is received. Different timetables apply to the prompt processing of four categories of health claims, with more prompt handling required for those of a more urgent nature. The four categories are described below:

- **Urgent Care Claims** – Claims for which the application of non-urgent care timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot be adequately managed otherwise. Where a physician who has knowledge of your medical condition and who is aware of the above definition affirms that a claim is "an urgent care claim", the claim shall conclusively be treated as such;

- **Pre-Service Claims** – Claims which must be decided before a patient will be afforded access to health care (e.g., preauthorization requests);

- **Post-Service Claims** – Claims involving the payment or reimbursement of costs for health care which has already been provided;

- **Concurrent Care Claims** – Claims for which a there has been a previously approved course of treatment over a period of time or for a specific number of treatments, and the Claims Administrator later reduces or terminates coverage for those treatments.

After a complete and proper claim is received an initial determination and any subsequent appeals are handled subject to very specific time limits which are different for the different types of claim. The time limits are discussed below and are also displayed in table format.

INITIAL BENEFIT DETERMINATION

Urgent Care Claims

The Claim Administrator will notify you of their determination as soon as reasonably possible, taking into account medical exigencies but, not later than 24 hours after receipt of the claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under your Plan. In the case of such a failure, the Claim Administrator will provide you with a Notice of Improper Claim or a Notice of Incomplete Claim as soon as possible, but not later than 24 hours after receipt of the claim. Notification of the improper or incomplete filing may be made orally, unless you request written notification. The notice will identify the specific information necessary to complete the claim and you will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Administrator will notify you of its

benefit determination as soon as possible, but no later than 48 hours after the earlier of the receipt of the specified information or the end of the period afforded you to provide the specified additional information.

Pre-Service Claims

You will be notified of the Claim Administrator's determination on a pre-service claim not later than 15 days after receipt of the claim. This period may be extended by 15 days, provided the Claim Administrator determines that an extension is necessary due to matters beyond the control of the Claim Administrator and notifies you within the initial period of the circumstances requiring the extension and the date by which the Claim Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the necessary information, the notice of extension will specifically describe the required information.

If the claim is improperly filed, the Claim Administrator will provide you with a Notice of Improper Claim as soon as possible, but not later than five (5) days after receipt of the claim. If the claim is incomplete, the Claim Administrator will provide you with a Notice of Incomplete Claim as soon as possible, but not later than fifteen (15) days after receipt of the claim, identifying the specific information necessary to complete the claim. Notification of the improper or incomplete filing may be oral unless you request written notification. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-Service Claims

You will be notified of the Claim Administrator's determination on a post-service claim not later than thirty (30) days after receipt of the claim. This period may be extended by 15 days, provided the Claim Administrator determines that an extension is necessary due to matters beyond the control of the Claim Administrator and notifies you within the initial period of the circumstances requiring the extension and the date by which the Claim Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You will be afforded at least 45 days from receipt of the notice within which to provide the necessary information.

Concurrent Care Claims

If ongoing treatment (e.g., kidney dialysis) has been previously approved for a period of time (or a number of treatments) and the Claims Administrator determines that coverage will be reduce or terminated before the end of that period, the Claims Administrator will provide notice of this change sufficiently in advance to allow you to file an appeal and receive a Determination on Review. If you submit a claim seeking to extend ongoing urgent health care, the Claims Administrator must notify you whether the claim has been approved or denied within 24 hours after receiving it.

Notice of Claim Determination

The Claim Administrator will notify you of all determinations in writing and in manner calculated to be understood by you. Such notice shall contain:

- the specific reason for the determination;

- reference to the specific provisions of the Plan on which the determination is based;

- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

- if any internal rules, guidelines, medical protocols or similar criteria were used as a basis for the determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;

- a description of any remaining mandatory appeal levels, the voluntary appeal level, and the time limits applicable to the type of claim involved, together with a description of your right to bring a civil action under ERISA if you disagree with the determination;

- for determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;

- for adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

The notice will also include a statement to the following effect: “Your Plan may have other voluntary alternative dispute resolution options.

APPEAL OF AN ADVERSE BENEFIT DETERMINATION

This section generally describes the internal appeal process handled by the Fund’s medical Claims Administrators, as well as the external review process coordinated by the Fund’s Claims Administrators with you and an Independent Review Organization (“IRO”). Claims for non-medical benefits and voluntary appeals to the Welfare Fund’s Board of Trustees are described at the end of this section.

If you submit a claim which is denied by the Claims Administrator, you will receive a notice entitled “Adverse Benefit Determination.” The notice will explain the basis for the Claims Administrator’s initial determination, but if you still disagree, you are entitled to request a full and fair review of the determination. An “Adverse Benefit Determination” is defined as a denial, reduction or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. This can include a retroactive termination of coverage, in circumstance where rescissions are permitted under law. This can also include a denial to participate in the Plan. For health coverage, an Adverse Benefit

Determination also means a claim which is denied because the treatment is experimental or investigational or not medically necessary. Appeals are not automatic; you (or an appointed representative) can appeal by requesting a claim review in accordance with the time frames described in the Notice of Adverse Benefit Determination. You (or an appointed representative) can appeal and request a claim review in accordance with the timeframes described below. The request must be made in writing, except for urgent care claims which you may file orally or in writing, and should be filed with the Claim Administrator. (Since many claims are administered by contractual providers on behalf of the Fund, for the specific questions on how you should submit your appeal, you should refer to the information you receive with the Adverse Benefit Determination.)

If your internal appeal of a medical claim involves an urgent care claim, such that the timeframe for completing an appeal would seriously jeopardize your life or health, you may initiate an external review at the same time as your internal appeal.

If you file an internal appeal for medical benefits, you will continue to be covered, pending the outcome of the internal appeal. This means that any ongoing course of treatment cannot be terminated or reduced without providing advance notice and the opportunity for review.

For medical claims filed after July 1, 2011, if the Plan fails to meet the requirements of the internal claims and appeals process for your claim, you are deemed to have exhausted the internal process, and you may begin an external review request immediately.

The Claims Administrator's review on appeal must be made within the following timeframes:

- for urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours;

- for pre-service claims, within a reasonable period of time given the medical situation, but no later than 30 days after receipt of the appeal (or 15 days following each appeal if there are two mandatory appeals);

- for post-service claims, within a reasonable period of time, but not later than sixty (60) days after receipt of the appeal (or 30 days following each appeal if there are two mandatory appeals).

In certain cases, a limited extension of time may be applied, but in such case, a notice of the extension will be provided to you before the end of the initial decision-making period. If the specific type of benefit at issue is of a type for which the Trustees are responsible for determining an appeal of an Adverse Benefit Determination, their determination will be made at the regular Meeting following receipt of your appeal, provided the Trustees have at least 30 days to evaluate the appeal.

The review of an internal appeal of an Adverse Benefit Determination will be conducted by the Claim Administrator who is neither the individual who made the Initial Benefit Determination on your claim, nor the subordinate of such individual (including any

physicians involved in making a decision based on a medical judgment). Where the Adverse Benefit Determination was based in whole or in part on a medical judgment, including determinations of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Claims Administrator will consult with an appropriate health care professional having training and experience in the field of medicine involved and whose identity will be disclosed on request. No deference will be afforded to the initial determination. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

The Claims Administrator will ensure that all claims and internal appeals for medical benefits are handled impartially. The persons involved in making the decision does not receive compensation, promotion, continued employment or other similar items based upon the likelihood he or she will support a denial of benefits.

You will have the opportunity to submit or present additional evidence, written or oral statements, documents, records, and other material in support of the claim and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable DOL regulations.

The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

In connection with your internal appeal of a medical claim, you will be able to review your file and present information as part of the review. Before making a benefit determination on review, the Claims Administrator will provide you with any new or additional evidence considered or generated by the Fund, as well as any new or additional rationale to be used in reaching the decision. You'll be given this information in advance of the date on which the notice of final appeal decision is made to give you a reasonable opportunity to respond.

The decision of the Claims Administrator upon review of an appeal of an adverse benefit determination is considered a final decision. A notification of this decision will include an explanation of the specific reasons for the action taken and a statement regarding your right to request an external review, your right to request a voluntary review before the Board of Trustees of the Welfare Fund and your right to pursue legal action.

External Review Process

If your appeal is denied, the 2010 federal health care reform laws and regulations provide that you may request an external review of your claim in addition to or in lieu of other types of further review. External review is not automatic and only available if requested in writing within four months after being notified of a denied claim The external review is conducted by an Independent Review Organization (IRO) selected under a procedure utilized by the Claims Administrator and which complies with

applicable federal and state laws. The Claims Administrator will notify you of the specific procedures currently in effect for requesting an external review, including any procedures for an expedited external review which may apply.

TIME LIMITS FOR HEALTH CLAIMS

	Urgent Claims	Pre-Service Claims	Post-Service Claims
INITIAL BENEFIT DETERMINATION			
Plan Notice of Improper Claim	**24 hours** after receiving improper claim[1].	**5 days** after receiving improper claim[1].	Not Applicable
Plan Notice of Incomplete Claim	**24 hours** after receiving incomplete claim.	**15 days** after receiving incomplete claim.	**30 days** after receiving incomplete claim.
Claimant Deadline to Complete Urgent Claim	**48 hours** after receiving notice[2].	Not Applicable	Not Applicable
Plan Notice of Initial Benefit Determination on your Claim	**24 hours[3],[4] after receiving a complete claim.** **48 hours[3], [4] after receiving completed claim or after the 48-hour claimant deadline, whichever is earlier.**	15 days[4] after receiving a complete claim, - or - 30 days[4] after receiving the claim if the Plan needs more information from you and if Plan provides you an extension notice during initial 15-day period.	30 days after receiving a complete claim, - or - 45 days after receiving the claim if Plan needs more information from you and if Plan provides an extension notice during the initial 30-day period.
Claimant Deadline to Complete Non-Urgent Claim	Not Applicable	**45 days** after receiving extension notice.	**45 days** after receiving extension notice.
INTERNAL APPEAL OF ADVERSE BENEFIT DETERMINATION			
Claimant Deadline to File Appeal	**180 days**[5] after receipt of Adverse Benefit Determination.	**180 days** after receipt of Adverse Benefit Determination.	**180 days** after receipt of Adverse Benefit Determination.
Plan Notice of Benefit Determination on Review of your Appeal	**72 hours** after receiving appeal.	**30 days** after receiving the appeal, but if the contract provider has two levels of appeal, each level must be decided **15 days** after receiving each appeal[6,7].	**60 days** after receiving the appeal, but if the contract provider has two levels of appeal, each level must be decided **30 days** after receiving each appeal[6,7].
EXTERNAL APPEAL OF ADVERSE BENEFIT DETERMINATION			
Deadline to Request External Appeal	See Footnote 8.	**Four Months**[8].	**Four Months**[8].
Claimant Deadline to Request Voluntary Appeal by Trustees	Not Applicable	**45 days** after Determination on Review of Internal/External Appeal	**45 days** after Determination on Review of Internal/External Appeal
Notice of Trustees' Determination on Review	Not Applicable	Approximately **45 days** after receiving notice of appeal decision. [7]	Approximately **45 days** after receiving notice of appeal decision. [7]

[1]Plan may provide you with a Notice of Improper Claim orally unless you request written notification. An improper claim is one which fails to follow the Plan's claims and appeal procedure.

[2]You can provide information by telephone, fax, or similar method.

[3]Plan may provide notice orally if written or electronic notice is provided within 3 days after oral notification.
[4]Plan notice requirement applies to claim approvals as well as claim denials.
[5]Plan must allow you to provide information on appeal by telephone, fax, or similar method.
[6]Both levels of appeal must be completed within deadline that applies if there were only one level of appeal.
[7]Reviews made by the Trustees are conducted at their regular Meeting immediately following receipt of your appeal, except if your request is made less than thirty (30) days before the Trustees' next regular Meeting, they may postpone acting on your appeal until their next regular Meeting. You will be notified of the Trustees' determination as soon as possible, but in no event more than 5 business days after the meeting.
[8]Other timeframes for procedural steps of the external review option will be furnished by the Claims Administrator during the course of an appeal.

You should be aware that if your dispute involves a benefit which is provided under an insurance policy, Pennsylvania law may provide you with additional remedies for the review of an Adverse Benefit Determination. In such cases, you should be aware that the pursuit of such remedies is at your option and exhaustion of this remedy is not a prerequisite to your taking the dispute to court.

Claims for Non-Medical Benefits

Claims for short term disability (loss of time) benefits will be initially determined by the Claims Administrator within 45 days of receipt of your filing of a complete claim; however, a 30-day extension is provided if the Claims Administrator provides a notice with an explanation of the reason for the delay. A second 30-day extension is permitted if circumstances so warrant. If the Claims Administrator requires additional information, you will be afforded 45 days to provide the specified information. You will receive a written notification of the Claim Administrator's determination. If you disagree, an appeal of the Adverse Benefit Determination must be submitted in writing within 180 days of receipt of the determination. The Fund, or its designated representative, will make a benefit Determination on Review within 45 days of receipt of your appeal, subject to an available 45-day extension.

Claims for life insurance benefits will be initially determined by the Claims Administrator within 90 days of receipt of your filing of a complete claim; however, a 90-day extension is provided if the Claims Administrator provides a notice with an explanation of the reason for the delay. You will receive a written notification of the Claim Administrator's determination. If you disagree, an appeal of the Adverse Benefit Determination must be submitted in writing within 60 days of receipt of the determination. The Fund, or its designed representative, will make a benefit Determination on Review within 60 days of receipt of your appeal, subject to an available 60-day extension.

Voluntary Appeals

Since some forms of benefit are provided pursuant to contracts between the Fund and outside providers, where claims processing responsibilities have been delegated to those providers, the Initial Benefit Determination and, if necessary, appeals of an Adverse Benefit Determination, will be conducted in accord with the procedures established by those companies, subject to the procedures of this Welfare Fund and

the supervision of the Trustees. After you have exhausted the claims and appeal procedures established by the applicable provider, if your claim remains disputed, you may elect to submit the dispute to the Trustees, but are not required to do so. The Trustees will assign the voluntary appeal to a Trustee Sub-Committee comprised of one Employer Trustee and one Union Trustee. This stage of the appeal procedure is not mandatory and its exhaustion is not a precondition to your right to bring a civil action in court under Section 502(a) of ERISA. With regard to the Voluntary Appeal procedure:

- The Fund agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

- A Voluntary Appeal to the Trustees is only available after both the Initial Benefit Determination and Determination on Review of your appeal become final;

- The Fund will provide to you, upon request, sufficient information relating to the Voluntary Appeal procedure to enable you to make an informed judgment about whether to submit your benefit dispute to a Voluntary Appeal, including a statement that your decision will have no effect on your rights to any other benefits under the Plan and information about the applicable rules, your right to representation, and the identity of the Trustees Sub-Committee which will consider your Voluntary Appeal; and

- There are no fees or costs imposed for a Voluntary Appeal.

COORDINATION OF BENEFITS

Coordination of benefits is applicable only to persons who are insured through another group health care plan in addition to the Fund's Programs. Its purpose is to conserve funds allocated for health care by preventing duplicate payments.

When you receive services which are coverable under the Fund's Program and another group health care plan, a determination will be made as to which plan is "primary" and which is "secondary". If this Fund's Plan is the primary plan, benefit payments will be made to the full extent of the liability under the Plan. If this Plan is the secondary plan, benefits paid or payable by the primary plan will be taken into account in determining benefit payments under this Plan.

Determination as to whether the Fund's Plan or the other group health care plan is primary or secondary will be made as follows:

1. If the other group health care plan does not include a Coordination of Benefits provision, it will be the primary plan.

2. If the other group health care plan includes a Coordination of Benefits provision, the primary plan will be determined in the following order:

   a. The Plan covering the patient other than as a dependent will be considered the primary plan.

b. Where both plans cover the patient as a dependent child, the plan of the parent whose birthday falls earlier in the calendar year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be the primary plan. If the parents are separated or divorced, the following will apply:

   1) The plan which covers the child as a dependent of the parent with custody will be the primary plan;

   2) If the parent with custody has remarried, the plan which covers the child as a dependent of the parent/stepparent with custody will be primary and the plan covering the child as a dependent of the parent without custody will be secondary;

   3) Where there is a court decree which establishes financial responsibility for the health care expenses of the dependent child, the plan which covers the child as a dependent of the parent with such financial responsibility will be the primary plan.

c. Where the determination cannot be made in accordance with (a) or (b) above, the plan which has covered the patient for the longer period of time will be the primary plan; provided that:

   1) The benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person; and

   2) If the other plan does not have a provision regarding laid-off or retired employees, and, as a result, the benefits of each plan are determined after the other, then the provisions of (c)(1) above shall not apply.

3. Services provided under any governmental program for which any periodic payment of premium is made by you or for you or your dependent shall always be the primary plan, except where prohibited by law. When you become eligible for Medicare by having attained 65 years of age or because of disability or because you have been medically determined to have end stage renal disease, you should enroll promptly for Part A (Hospital Insurance).

   If it is determined that the Fund's Plan is the secondary Plan, the Fund has the right to recover any expenses already paid in excess of its liability as the secondary plan. You may be required to furnish information and to take such other action as is necessary to assure the rights of the Fund.

Coordination with Medicare

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

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

If you or a covered family member first becomes covered by Medicare as of a date after a COBRA election is made, your COBRA coverage will end.

Facility of payment

When benefit payments that would have been made under a Fund plan have been made under another plan, the Fund has the right to pay the other plan the amount that satisfies the intent of the provision. Any payment made will be considered payment of benefits under the Fund and, to the extent of such payments, the Fund's obligation to pay benefits will be satisfied.

Right of recovery

The Fund has the right to recover any payment made in excess of the maximum amount payable under this provision. The Fund may recover from one or more of the following entities in an effort to make the Fund whole:

- Any persons it paid or for whom payment was made;
- Any insurer, and any other organization; or
- Any entity that was thereby enriched.

Release of information

Certain facts are needed to apply the rules of this provision. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may get the needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. At the time a claim for benefits is made, the Claims Administrator will determine the information necessary to operate this provision.

SUBROGATION

The Fund self-insures benefits it offers. As such, whenever it makes any payment related to any illness, injury or disability for or on behalf of a participant or beneficiary, such as a spouse, child or a dependent (hereinafter a "Covered Individual"), payment is provided based on the condition that the Fund will be immediately reimbursed and vested with subrogation rights to all present and future rights of recovery relating thereto which that person, or that person's parents, children, wards, heirs, guardians,

estate, executors, attorneys, agents and other representatives, may have. Said subrogation rights are in held by the Fund in consideration for the receipt of benefits.

The Fund therefore has the right to recover all of the benefits it has paid or will pay on behalf of the Covered Individual including, but not limited to, medical benefits, dental and loss of time payments.

Any sums recovered by the Covered Individual or their representative, either by judgment, settlement or any other means, and regardless of whether such sums are by agreement or court decree allocated between distinct civil causes of action of a Covered Individual or a related co-claimant arising out of the same or related event or occurrence, and whether such sums are designated as reimbursement for medical expenses incurred or anticipated, past or future wage losses, pain and suffering, loss of support, loss of consortium, or as any other form of damages, shall be applied first to reimburse the Fund in full and therefore shall be deducted first from any recovery by or on behalf of a Covered Individual or a related co-claimant. The Fund has the right to recover the dollar amount of the benefits it has paid from any payment received by a Covered Individual or their representative no matter how the payment is allocated among co-claimants and no matter how the payment is characterized. A constructive trust applies to any payment received by a Covered Individual or their representative.

In order to secure the rights of the Fund under this section, and because of the Fund's advancement of benefits, the Covered Person hereby [1] acknowledges that the Fund shall have a first priority lien against the proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and [2] assigns to the Fund any benefits the Covered Person may have under any cause of action, automobile policy or other coverage, to the extent of the Fund's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Fund or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Fund under this section, the Covered Person acknowledges that any proceeds of settlement or judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Fund under these provisions. The Covered Person agrees that the proceeds subject to the Fund's lien are plan assets and that the Covered Person will hold such assets as a trustee for the Fund's benefit and shall remit to the Fund, or its representative, such assets upon request. If represented by counsel, the Covered Person agrees to direct such counsel to hold the proceeds subject to the Fund's lien in trust and to remit such funds to the Fund, or its representative, upon request. Should the Covered Person violate any portion of this section, the Fund shall have a right to offset future benefits otherwise payable under this plan to the extent of the value of the benefits advanced under this section to the extent not recovered by the Fund.

The Fund shall have the right of first reimbursement out of any recovery the Covered Individual is/was able to obtain even if the Covered Individual is/was not made whole. The Fund will not be responsible for the Covered Individual's attorney's fees or other costs unless the Fund has agreed in writing to pay such fees or costs.
Covered Individuals are obligated notify the Fund promptly in writing if a suit is filed or a claim submitted by the Covered Individual or on the Covered Individual's behalf related

to the accident or event which gives rise to the Covered Individual's right to recover damages or benefits. The Covered Individual also shall notify the Fund promptly if the Covered Individual receives any award as a result of litigation or if the Covered Individual receives payment from any source whatsoever for claims arising from or related to the injury. The Covered Individual shall cooperate with the Fund and its representatives to protect the Fund's subrogation rights and its efforts to obtain reimbursement for benefits paid. The Covered Individual shall execute and deliver instruments and papers, as requested by the Fund or take action requested by the Fund and shall do nothing to prejudice the Fund's right of subrogation. In particular, the Covered Individual is obligated to sign such assignments and acknowledgments as are requested by the Fund as a failure or refusal to do so may necessitate the Fund's initiation of an federal injunction action or other civil action.

Covered Individuals shall not release or discharge any such claim or demand, effect any settlement, nor dismiss any legal action against any person, insurance company, firm, corporation, or any other party without the Fund's consent. The Covered Person shall not take any action that prejudices the Fund's rights of reimbursement and consents to the right of the Fund, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Fund's rights under this section, and/or to set off from any future benefits otherwise payable under the Fund the value of benefits advanced under this section to the extent not recovered by the Fund.

A Covered Individual grants to the Fund the right to initiate or intervene in an action in the name of the Fund or the Covered Individual to enforce its right of subrogation. In the event a Covered Individual disputes any aspect of the Fund's subrogation rights, such dispute must be initially presented to the Trustees of the Fund for determination under the provisions of this Plan, and if the dispute is not resolved, must be litigated under the equitable provisions of ERISA. A Covered Individual, by his/her receipt of benefits consents to the waiver of the right to a jury trial in connection with any litigation concerning the existence of, or collection pursuant to, the Fund's subrogation rights.

The Fund's subrogation rights extend to all loss recovery rights of the Covered Individual. The loss recovery rights of the covered individual include, without limitation, all rights based upon any policy, contract, plan, benefit of membership, or other document creating responsibility for any insurance, indemnity or reimbursement , including but not limited to every form of no-fault liability insurance, personal injury protection insurance, financial responsibility insurance, uninsured and/or underinsured motorist insurance and any casualty liability insurance or medical payments coverage. Additional examples of other coverages against which the Fund's subrogation rights apply include homeowners or premises insurance, school insurance, workers' compensation insurance, automobile club rights, athletic team insurance and any other specific risk insurance or coverage; and/or any medical reimbursement rights.

INSURANCE OR OTHER ENTITIES SERVICING CLAIMS

The Fund is self-insured/self-funded for all medical and dental benefits notwithstanding the fact that outside entities, such as a Claims Administrator, provides claims processing services. Terms, conditions and definitions used in claim administration are

set forth in detail in the Claim Administrator's Benefit Booklet. These terms and conditions are available from the Fund Office upon request or can be viewed on Internet links available on the Welfare Fund's website: www.wpawelfarefund.com.

General exclusions, limitations and conditions for payment of claims

A Covered Individual shall not be entitled to any payment on a claim for benefits unless the benefits are provided for in the Claim Administration Benefit Booklet. The Claim Administrators have the responsibility of establishing the allowed amount of payment for services provided and will have absolute discretion to determine such allowed amounts by what it considers to be the usual, customary and reasonable charges for a particular service. Exclusions, limitations and conditions for payment of claims are described in detail in the Benefit Booklets available from the claims administrator or fund office.

Other benefits, such as, vision, life insurance, accidental death and dismemberment may be provided under contracts or group insurance arranged by the Welfare Fund on your behalf.

The Fund self-administers and self-funds the Loss of Time and Retiree Subsidy benefit program if included in your coverage.

GENERAL DEFINITIONS

(Wherever Used In This Booklet, the Following Terms Shall Have the Meanings Described Below)

Accredited General Hospital or Hospital - Is a hospital which is operated primarily as a general hospital rendering inpatient therapy for the several classifications of medical and surgical cases and which is approved by the Joint Commission on Accreditation of Hospitals and Insurance Carrier.

Adverse Benefit Determination – A denial, reduction or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. This can also include a denial to participate in the Plan. For health coverage, it also means a claim which is denied because the treatment is experimental or investigational or not medically necessary.

Affordable Care Act – The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act enacted in March, 2010 (collectively called the "ACA") was effective for this Plan as of January 1, 2011. The Plan is classified under the ACA as a non-grandfathered, self-funded group health plan.

Allowed Amount – In-Network Providers have contractually agreed that subject to any deductible, co-insurance and co-pay, they will accept the allowed amount established by the Claims Administrator as full payment for a covered service. You are responsible for any deductible, co-insurance and co-pay. If you use an Out-of-Network Provider your plan will generally have higher deductibles, co-insurance and co-pays. In addition, since Out-of-Network Providers have not contractually agreed to the Claims Administrator's allowed amount, you will owe the difference between the Out-of-Network Provider's charges and the allowed amount, as well as any deductible, co-insurance and co-pay.

Alternate Recipient - Any child of a participant who is recognized under a Qualified Medical Child Support Order as having a right to enrollment under this health plan with respect to such participant.

Benefit Period – The benefit period is the calendar year starting on January 1. Medical cost-sharing for coinsurance, copayments, deductibles and out-of-pocket limits which are determined on an annual basis run from January 1 to December 31.

Benefit Program - The term "Benefit Program" consists of all the various types of benefits available as summarized in this document or described in further detail in such documents maintained by any of the Fund's Claims Administrators or insurers. For instance, the medical Claims Administrator updates and maintains a "BENEFIT BOOKLET" setting forth the definitions of covered medical services and exclusions, the claim review process, the prescription drug program and formulary, network providers, and the wellness program. The "Schedule of Benefits" or "Benefits Grids" highlight key features of the Benefit Program, such as the types of benefits and the allowed amount which the Fund will recognize for a covered service. The package of benefits which your employer and union have selected is also referred to as your "Plan".

Claims Administrator – The Fund may enter into a contract with one or more organizations who are delegated administrative responsibility to issue coverage cards, define the terms and conditions by which services will be covered, limited or excluded, issue newsletters, process, review claims and claim appeals for specific categories of benefit coverages in your Benefit Program or Plan. This booklet generically refers to the specific organization responsible for administrating the applicable benefit coverage on behalf of the Welfare Fund as the Claims Administrator.

Claim Determination Period - Means a period of Hospitalization during all or part of which period any person covered under this Plan is also covered under at least one other Plan and incurs charges for one or more Allowable Benefits that are covered under this Plan and also under at least one other Plan.

Clinic - A medical institution in which patients under the supervision of legally qualified physicians are examined and evaluated on an outpatient basis.

Concurrent Care Claim – A Claim where the Plan has previously approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments.

Contributing Employer - An Employer who has entered into an agreement under which such Employer contributes to the Fund.

Covered Benefits - Those necessary, reasonable and appropriate services as determined by the Claims Administrator in such allowable amounts as the Claims Administrator determines to be the usual, customary and reasonable charges for such covered services. For medical benefits, a detailed identification of covered services, conditions and limitations is set forth in the Claims Administrator's Benefit Booklet**.**

Covered Dental Expenses - The term "Covered Dental Expenses" means the expenses actually incurred for charges made by a Dentist for the performance of a dental service when such service is essential for the necessary care of the teeth, but the amount shall in no event exceed the Maximum Allowance specified for such procedure in the Schedule of Dental Allowances.

Covered Individual - The term "Covered Individual" as used herein shall mean an Eligible Employee and/or a dependent or member of the family of an Eligible Employee who is or may become entitled to participate in the benefits provided for in the Plan.

Dental Expenses Incurred - An expense will be considered to be incurred on the date the dental service is begun if the employee or dependent is covered under the Benefit Program on such date. In order for such dental service to be a Covered Dental Expense, it must be completed while the employee or dependent is covered under the Benefit Program.

Dental Service - Any service, under the direction of a Dentist or Physician which is listed in the Schedule of Dental Allowances.

Dentist - A licensed dentist who is legally qualified to perform the particular procedure rendered by him/her.

Dependent – For medical benefits, the term "Dependent" shall mean an Eligible Employee's legally married spouse (as recognized under the laws of the Commonwealth of Pennsylvania as interpreted by state and federal courts) and each enrolled child(ren) to age 26 or as described below. The term "Dependent" shall not apply to any individual who is in full-time military, naval or air service.

In addition to any natural born child(ren) of the Eligible Employee, the word "child(ren)" includes any legally adopted child, or stepchild, or foster child.

The term dependent will also include: (1) any alternate recipient who is the subject of a Qualified Medical Child Support Order, and (2) any child who has been placed in the participant's home for adoption from the date the child is placed.

If a child is, on the date such child's coverage would otherwise terminate, incapable of self-sustaining employment by reason of mental retardation or physical handicap and such child is chiefly dependent upon the employee for support and maintenance, benefits will continue for such child so long as the employee continues to be an Eligible Employee and such incapacity continues, provided, proof of such incapacity is submitted to the Administrative Office prior to the date such dependent's coverage would have otherwise terminated.

If a child has attained age 19, and coverage has not been extended with a Student Verification Form, you have the opportunity to enroll (or not to enroll) your adult child. An adult dependent child will only be covered you affirmatively agree to enroll that adult child. The Fund's enrollment procedure requires that the participant submit a completed Adult Dependent Enrollment Form during the applicable enrollment period. An annual open enrollment period is provided to enroll or dis-enroll an adult dependent child.

For dental, vision, life insurance benefits, the term "Dependent" shall mean an Eligible Employee's wife or husband and each unmarried child(ren) to age 19, or unmarried child(ren) to age 25 who are full-time students in an institution of higher learning or qualified trade school and for whom a federal income tax exemption is claimed by the Eligible Employee. The term "Dependent" shall not apply to any individual who is in full-time military, naval or air service.

Effective January 1, 2010, a qualified student-dependent does not lose student-dependent status before the earlier of the date that is one year after the first day of a medically necessary leave of absence, or the date such coverage would otherwise terminate under the terms of the plan if: a treating physician of the dependent child provides a written certification that the child is suffering from a serious illness or injury and that the leave of absence from a post-secondary educational institution is medically necessary.

The term dependent will also include: (1) any alternate recipient who is the subject of a Qualified Medical Child Support Order, and (2) any child who has been placed in the participant's home for adoption from the date the child is placed.

Determination on Review – A notice provided by the Claims Administrator indicating the reason for the claim determination, specific provisions on which the determination is based, remaining appeal levels, experimental treatment or other similar exclusions (if applicable) and a description of the expedited review process (if applicable).

Eligible Employee - An employee actively at work with a Contributing Employer, as described in the eligibility provisions.

Enrollment Procedure – At the time an eligible employee is first entitled to coverage, the Fund will require that information relevant to its provision of benefits is truthfully and accurately stated on an enrollment card, or enrollment forms, as may then be in use by the Fund. Enrollment for coverage of an employee's eligible dependent(s) must be reported at that time, or at the time there is a change of status, as described herein. Enrollment procedure shall also be consistent with the requirements of the Fund's rules on Opt-Out/ Opt-Down/ Opt-In, if permitted under the relevant collective bargaining agreement.

Fund - Western Pennsylvania Teamsters and Employers Welfare Fund.

Fund Doctor - A licensed physician, surgeon or dentist selected by the Trustees to verify medical and dental findings and provide medical and dental information when required at no cost to the claimants.

Home Care - Is care that is centrally administered through a Home Care Agency which provides home care services to Subscribers who are eligible to participate there under.

Home Care Agency - Is an organization with permanent facilities and with medical services, including nursing services and other professional and technical services, to provide treatment for patients who have a variety of medical conditions, in their place of residence.

1. **A Contracting Home Care Agency** - Is one which has an agreement with Insurance Carrier to provide to Subscribers the allowed home care services of this Agreement.

2. **A Non-Contracting Home Care Agency -** Is one which meets all the requirements of a Home Care Agency as defined above, except for an agreement with Insurance Carrier.

Inpatient - An Eligible Employee or Dependent who, while confined in the hospital, is assigned to a bed for at least twenty-four (24) hours in any department of the hospital other than its outpatient department and for which a charge for room and board is made by the hospital.

Insured or Prepaid - The term "Insured or Prepaid" refers to those Benefits a Third Party is paid premiums from the Fund (such as, an insurance company), and the Third Party is solely responsible for the payment of all claims described in your Schedule of Benefits for which you are eligible.

Legally Married – Legal vows exchanged between a participant and the participant's spouse, which at the time they are spoken are recognized by Pennsylvania law as creating a marriage. For instance, although at one time Pennsylvania law recognized common law marriage vows could create a legal marriage, at this time common law vows can no longer create a legal marriage recognized under Pennsylvania law. Official marriage certificates issued for marriages entered into in Pennsylvania, or other states and foreign jurisdictions will be recognized by the Fund as evidence of a legal marriage. A legal marriage can only be terminated through a valid degree of divorce. A divorced spouse is not entitled to remain covered under your coverage. A divorced spouse may be entitled to purchase COBRA coverage for a period of time.

Limitations and Exclusions – The Plan only pays benefits for defined covered services. The terms and conditions which define those services which are covered or not covered, and limitations and exclusions on allowable charges are set forth in detail in the Claims Administrator's BENEFIT BOOKLET.

Period of Hospitalization - Is the duration of an inpatient confinement or the combined duration of successive confinements if discharge there from and subsequently admission of an inpatient to any Hospital occurs within a ninety (90) day period.

Physical Examination - An examination conducted by a legally qualified licensed physician to determine the physical condition of a person.

Physician, Surgeon, or Dentist - A licensed physician or surgeon who is legally qualified to practice medicine and to perform surgery.

Plan - The general and miscellaneous provisions maintained in Plan Booklets (also called "Summary Plan Descriptions"), together with terms and conditions of medical and ancillary programs referred to in a Plan Booklet, are collectively considered to be your PLAN.

Post-Service Claim – A Claim involving the payment or reimbursement of costs for medical care which has already been provided.

Pre-Service Claim – A Claim which must be decided before a patient will be afforded access to health care (e.g., preauthorization requests).

Qualified Medical Child Support Order - A medical support order which creates or recognizes an alternate recipient's right to receive benefits for which a participant or beneficiary is eligible under the plan and which does not require the plan to provide any type of benefit not otherwise provided under the plan.

Regular and Customary – The Claims Administrator established the allowed amount payable for covered services upon consideration the usual, customary and reasonable charges for a covered service or supply essential to the care of the individual. The allowed amount will generally, but not necessarily be the regular and customary amounts of average charges made for these services or supplies in the locality where the services or supplies are received, with due consideration for the nature and severity of the

conditions being treated. The Claims Administrator has complete discretion to set allowed amounts on criteria it deems reasonable and appropriate. You are not permitted to assign your right to dispute the Claims Administrator's determination of an allowed amount.

Rescission – Generally, a retroactive cancellation of coverage after claims have been submitted is a rescission. In most cases, a rescission will not be imposed; however, retroactive cancellation may be applied upon 30 days advance notice if the participant has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact. A prospective cancellation of coverage is not a rescission. A retroactive elimination of coverage back to the date of termination of employment, or other eligibility termination dates, due to delay in administrative record-keeping is not governed by the rule against rescissions.

Self-Insured - The term "Self-Insured" or "Self-Funded" refers to those benefits which are ultimately paid out of Fund assets. For such benefits, the Fund does not purchase insurance to cover the benefit costs and therefore is solely responsible for payment of all claims described in the attached Schedule of Benefits.

Skilled Nursing Facility - Is an institution with permanent facilities that include inpatient beds; and with medical services, including continuous nursing services, to provide treatment for patients who require inpatient care but do not currently require continuous hospital services and who have a variety of medical conditions.

1. **Contracting Skilled Nursing Facility** - Is an institution with which the Insurance Company has a contract for the rendering of service benefits to its Subscribers under this Agreement.

2. **Non-Contracting Skilled Nursing Facility -** Is a Skilled Nursing Facility other than a Contracting Skilled Nursing Facility.

Spouse - Is an Eligible Employee's legally married spouse (as recognized under the laws of the Commonwealth of Pennsylvania as interpreted by state and federal courts).

Summary of Benefits and Coverage (SBC) – The Affordable Care Act requires that health plans distribute this standardize table of information using terms defined in a Uniform Glossary of Health Coverage and Medical Terms. As a summary, the SBC is not the actual Plan. The terms of the actual Plan override any conflicting or ambiguous terms in the SBC.

Trustees - The term "Trustees" shall mean Employer Trustees and Union Trustees collectively and shall include their successors when appointed as Trustees.

Urgent Care Claim – A Claim for which the application of non-urgent care timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician, would subject the patient to severe pain that cannot be adequately managed otherwise.

Voluntary Appeal – A process established whereby a participant may submit a disputed determination to the Trustees for further review. This is not mandatory and can only be pursued once all other claims and appeals procedures established by the applicable Claims Administrator are exhausted.

Wellness Benefit/Requirement – The Fund may reduce the applicable annual deductible if you comply with the requirements of the Wellness program.

ABOUT YOUR BOOKLET

This Booklet and your attached Schedule of Benefits summarizes package of the benefits provided by the Welfare Fund which is applicable under the selections choose by your employer and bargaining representative.

The Benefit Program which protects you, and possibly your spouse and dependents, is the Benefit Program which corresponds to the contribution rate your Employer has agreed to make to the Fund, as shown in the contribution records on file in the Administrative Office.

This Booklet replaces any other policies, booklets, certificates or amendment riders previously issued to you.

WESTERN PENNSYLVANIA TEAMSTERS AND EMPLOYERS WELFARE FUND

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www.wpawelfarefund.com contactus@wpawelfarefund.com

CHANGE FORM

LAST NAME	FIRST NAME	M.I.	S.S.N.

ADDRESS: _____

_____

PHONE: _____

SPOUSE	DATE OF BIRTH	S.S.N.

DEPENDENT	DATE OF BIRTH	S.S.N.	SEX

CHECK THE APPROPRIATE ACTION CODES:

_____ CHANGE OF ADDRESS

_____ ADD SPOUSE (ATTACH A COPY OF MARRIAGE CERTIFICATE)

_____ REMOVE SPOUSE (ATTACH A COPY OF DIVORCE DECREE)

_____ ADD DEPENDENT (ATTACH A COPY OF BIRTH CERTIFICATE AND SOCIAL SECURITY CARD)

_____ REMOVE DEPENDENT - STATE REASON

_____ NAME CHANGE (ATTACH MARRIAGE CERTIFICATE OR LEGAL NAME CHANGE DOCUMENT)

_____ OTHER - EXPLAIN:

MEDICAL BENEFIT SUMMARY
FOR

9AC

WESTERN PENNSYLVANIA TEAMSTERS AND EMPLOYERS WELFARE FUND

May 2019

Summary of PPOBlue

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Western PA Teamsters' and Employers' Welfare Fund – 9AC

Benefit	Network	Out-of-Network (7)
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family ** If you do not complete an annual physical exam and appropriate biometric testing you will be charged an additional $200 individual deductible and a $400 family deductible	 None None	 $250 $500
Plan Pays – payment based on the plan allowance	100%	60% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period. The deductible is excluded from the Out-of-Pocket) (6) Individual Family	 None None	 $1,000 $2,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $20 copayment	60% after deductible
Primary Care Provider Office Visits	100% after $20 copayment	60% after deductible
Specialist Office Visits	100% after $30 copayment	60% after deductible
Virtual Visit Originating Site Fee	100%	60% after deductible
Urgent Care Center Visits	100% after $30 copayment	60% after deductible
Telemedicine Service	100% after $10 copayment	
Preventive Care(2)		
Routine Adult Physical exams	 100%	 Not Covered
Adult immunizations	100%	60% after deductible
Colorectal cancer screening	100%	60% after deductible
Routine gynecological exams, including a Pap Test	100%	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	60% after deductible
Diagnostic services and procedures	100%	60% after deductible
Routine Pediatric Physical exams	 100%	 Not Covered
Pediatric immunizations	100%	60% (deductible does not apply)
Diagnostic services and procedures	100%	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	100%	60% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copayment (waived if admitted)	
Ambulance	100%	
Therapy and Rehabilitation Services		
Physical Medicine	100% after $20 copayment	60% after deductible
Respiratory Therapy	100%	60% after deductible
Speech & Occupational Therapy	100% after $20 copayment	60% after deductible
Spinal Manipulations	100% after $20 copayment	60% after deductible Limit: 25 visits/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	60% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	100%	60% after deductible
Outpatient	100% after $20 copayment	60% after deductible
Other Services		
Allergy Extracts and Injections	100%	60% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	60% after deductible

Benefit	Network	Out-of-Network (7)
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	60% after deductible
Home Health Care	100%	60% after deductible Limit: 50 days/benefit period
Hospice	100%	60% after deductible
Infertility Counseling, Testing and Treatment(3)	100%	60% after deductible
Private Duty Nursing	100%	60% after deductible Limit: $5000 /benefit period
Skilled Nursing Facility Care	100%	60% after deductible Limit: 50 days/benefit period
Transplant Services	100%	60% after deductible
Precertification Requirements(4)	Yes	
Prescription Drugs		
Prescription Drug Program(5) Mandatory Generic *Defined by the National Plus Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs (30-day Supply)** generic copayment $10 formulary brand copayment $25 non-formulary brand copayment $50 **Maintenance Drugs through Mail Order (90-day Supply)** generic copayment $20 formulary brand copayment $50 non-formulary brand copayment $100	

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

(3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

(4) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

(5) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

(6) Effective with plan years beginning on or after January 1,2014 the Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, and any qualified medical expenses. The Total Maximum Out of Pocket cannot be more than $7,900 for individual and $15,800 for two or more persons

(7) For out of network services, you may be responsible for paying any difference between the provider's actual charge and the Community Blue allowable charge. Out of pocket limits do not apply to these types of member payments.

This grid is for Group Numbers

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