# Teamsters Local 922 Employers Health Trust

## Summary Plan Description

**October 2012**

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## INTRODUCTION

The Teamsters Local 922 - Employers Health Trust (hereafter called the "Plan") is a self-funded group health plan organized and qualified under, and governed by, the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 et seq., and is designed to assist you and your family with the payment of medical expenses.

This booklet is a Summary Plan Description. Using non-technical language, it describes your benefits under the Plan and will answer most of your questions. It contains a Schedule of Benefits, descriptions of the benefits listed in the Schedule, a list of the limitations of the Plan, definitions, instructions for filing claims and procedures on what to do if you have any problems with a claim.

The benefits and provisions of the Plan have been described as carefully as possible. A Table of Contents has been included to help you find the answers to your questions quickly. No one, including the Fund Office, can orally modify any Plan benefits or limitations. In order to fully understand your benefits and to avoid confusion, you and your family should read this booklet carefully and completely.

The Plan includes Medical (including prescriptions) insurance, Dental insurance, Vision insurance, Life insurance and Long-Term Care insurance. An Employee Assistance Plan (EAP) is also included. Upon enrollment, you should have received separate documentation on each Plan. Please refer to these documents for a complete description of the benefits provided. For questions regarding any of the benefits, please contact:

| | | |
|---|---|---|
| • Medical Insurance | CIGNA Healthcare | (800) 244-6224 |
| • Dental Insurance | CIGNA Healthcare | (800) 244-6224 |
| • Vision Insurance | Davis Vision | (800) 999-5431 CODE: TLO |
| • Life Insurance | Guardian | (888) 278-4542 |
| • Long-Term Care | UNUM | (800) 227-4165 PLAN: G-354821 |
| • EAP | C. A. Mayo Associates | (301) 699-0344 |

If you have any questions regarding eligibility or if you have not received any documents regarding your benefits, contact the Fund Office. The Fund Office handles the day-to-day business of the Plan and will be glad to answer your questions. Their telephone number is **(888) 490-8800**.

## Notice Regarding Status of Plan as a Grandfathered Health Plan

The Teamsters Local 922 Employers Health Trust believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Teamsters Local 922 Employers Health Trust may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Administrator at the telephone numbers listed below. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions, please contact the Fund Office at (410) 872-9500 or toll free at (888) 490-8800. Membership Services Representatives are available to assist you Monday through Friday from 8:30 AM until 5 PM.

**Note Regarding HIPAA Privacy:**

**The Fund Office complies with the privacy requirements outlined in the Health Insurance Portability and Accountability Act, otherwise known as HIPAA. The HIPAA Privacy Regulations are designed to provide protection against the unauthorized use and disclosure of a patient's health information.**

**If you call with a question about a member's claim, the Fund Office is required to confirm that the caller can identify several key pieces of information about the claimant. In addition to the member's name, the caller will be required to provide three (3) of the following forms of identity:**

- Membership number
- Member date of birth
- Member address
- Member phone number
- Member zip code

Under certain circumstances, a completed Personal Representative or Authorization form will be required for an adult member. Adult members include the employee, spouse, and dependent child age 18 and over.

## GENERAL INFORMATION

**Teamsters Local 922 - Employers Health Trust**
**Information Required By:**
**Employee Retirement Income Security Act of 1974:**
**(Title 29, United States Code, 1001 et seq.)**

The Teamsters Local 922 - Employers Health Trust is administered by a Joint Board of Trustees consisting of two union representatives and two employer representatives. The Fund was established as a result of collective bargaining between your union and contributing employers. The Joint Board of Trustees of the Teamsters Local 922 - Employers Health Trust is:

**UNION TRUSTEES:**

Ferline Buie, Chairman
Teamsters Local 922
2120 Bladensburg Rd, NE
Washington, D.C. 20018

Rudolph Gardner
Teamsters Local 922
2120 Bladensburg Rd, NE
Washington, D.C. 20018

**EMPLOYER TRUSTEES:**

Stephanie Audette, Secretary
W.M.A.T.A
600 Fifth Street, NW
Washington, DC 20001

Billye Pounds
Giant Food
8580 Old Dorsey Run Rd.
Jessup, MD 20794

The Trustees have authority to contract and manage the operation and administration of the Health Trust's Plan.

### Type of Plan

This welfare plan provides life insurance, hospitalization, surgical, medical disability, dental, vision care, pharmaceutical care and major medical benefits to eligible Participants and their qualified dependents.

### Plan Identification Numbers

- Employer Identification Number: **52-1158-708**
- IRS Plan Number: **575**
- Life Insurance and Accidental Death and Dismemberment Policy Number: **24870-3**

### Health Plan Administrator

This Plan is administered by a Third Party Contract Administrator, Carday Associates, Inc. 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046, (410) 872-9500. You should contact the Fund Office if you have any questions about the plan or your benefits.

## CHAPTER I

## ELIGIBILITY RULES

### Who Is Eligible?

**Employee** -- All active employees within the jurisdiction of a participating Local and employed by participating Employers who are subject to an Agreement and Declaration of Trust will be eligible for benefits.

**Retirees** -- All Active Employees, age 52 or older, with at least 15 years of service, who retire from a participating employer, are eligible for the benefits described in this Plan. Benefits will be continued for the Retirees and his/her spouse until the Retiree is eligible for Medicare. At that time, coverage under this Plan will terminate for both the Retiree and spouse.

**Disabled Retirees (WMATA)** -- All Active Employees, with at least 10 years of service, who retire from WMATA, are eligible for the benefits described in this Plan. Benefits will be continued for the Retiree and his/her spouse until the Retiree is eligible for Medicare. At that time, the coverage under this Plan will terminate for both the Retiree and spouse.

**Dependents** - Eligible dependents are your:

a. Spouse – A husband or wife under a legal marriage (who is neither divorced nor legally separated). Common-law and domestic partners are excluded;
b. Dependent children under age 26;
c. A child who, upon reaching age 26 and who is physically or mentally incapable of self support will continue to be considered a child for as long as the incapacity continues provided proof of such incapacity is provided to the Fund Office and that the child became incapacitated prior to age 21.

A Spouse or child in the armed forces of any country is not eligible for coverage.

The term "**dependent children**" means any of a Participant's:

a. Natural children;
b. Legally adopted children or children placed in the Employee's home pending final adoption;
c. Stepchildren who depend on you for support;
d. Children who are under the legal guardianship of the employee;
e. Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order ("QMCSO").

### Eligibility While Disabled

As a Participant, whenever you are unable to work due to sickness or injury and you are receiving Disability Income benefits from the Plan, you will be able to maintain your health coverage at no cost to you.

If, however, you are receiving Worker's Compensation, you will be eligible to maintain health coverage for a period of up to 39 weeks, provided that a contribution is made on your behalf. The contribution must be made by your employer or by you. While on Worker's Compensation, you will not receive sick credit hours.

## ENROLLMENT

### HOW DO I ENROLL?

**Employee** - To become covered by the Plan, you must complete an enrollment application. During your new employee orientation, you will be given an application to complete. You should return the completed form to the Personnel/Human Resources Department within 30 days from your eligibility date.

When you enroll, you may select Individual, Employee plus one, or Family coverage. Family coverage would cover the Employee and two or more Dependents.

***Retiree*** *- You must complete an enrollment application within 30 days of your termination date as an Active Employee.*

**Special Enrollment Period:** If you are declining enrollment for your Dependents (including your Spouse) because of other health insurance coverage, you may in the future be able to enroll your Dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

A Dependent who is eligible but not enrolled is allowed to enroll in the Plan at a date later than the initial enrollment period, if:

a) The Employee states in writing that the other coverage is the reason for declining initial enrollment;

b) The other coverage that the Dependent had was COBRA coverage and the COBRA coverage was exhausted;

c) The coverage is other health plan coverage and it is terminated due to loss of eligibility:

- as a result of legal separation, divorce, death, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), termination of employment, or reduction in the number of hours of employment or termination of employer contributions to the coverage and not due to failure to pay or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the plan);

d) The other coverage the Dependent had was offered through an HMO, or other arrangement (in the group or individual market) that does not provide benefits to individuals who no longer reside, live, or work in a service area and no other benefit package is available to the individual;

e) The individual incurs a claim that would meet or exceed a lifetime limit on all benefits;

f) A plan no longer offers any benefits to a class of similarly situated individuals.

NOTE: When a loss of eligibility occurs, the Employee must request enrollment in writing within 30 days of exhaustion, termination of coverage or (in the case of the lifetime limit) of the date he/she incurs a claim that meets or exceeds the lifetime limit.

g) In addition, if you have a new Dependent as a result of marriage, birth, adoption, or Placement for Adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or Placement for Adoption. Coverage will be effective:

- In the case of a marriage, on a date specified by the Plan Administrator that is not later than the first day of the first month beginning after the date the Employee submits an election form electing coverage for the Employee and/or Dependent(s) under the Plan;
- In the case of a Dependent's birth, the date of such birth;
- In the case of a Dependent's adoption or Placement for Adoption, the date of such adoption, or Placement for Adoption.

h) A child who becomes an alternate beneficiary because of a recognized Qualified Medical Child Support Order is eligible to be added to the Plan provided that you request enrollment within 30 days.

**New Dependents** – A newborn, an adopted child, a child placed for adoption and a previously ineligible dependent who meets the eligibility requirements are eligible to be added to the Plan.

Coverage for the new Dependent becomes effective on the date of eligibility provided that you request enrollment within 30 days.

If your current enrollment election already provides coverage for the Dependent without a change, coverage is in effect from the date of eligibility upon receipt of a new enrollment application.

**Open Enrollment -** Within each 12 month period during this program, an open enrollment period shall be authorized to allow eligible employees to change their participation elections or to obtain new participation for the employee and/or eligible dependents. The open enrollment period shall be each October 1st through November 15th with an effective date of the following January 1st.

***Changing Coverage*** *- You may change your election during the Plan Year if you experience any of the following Life Events:*

- *There is a change in employment status, including termination or commencement of employment of the employee, spouse, or dependent.*
- *The employee or spouse has a significant change in health coverage attributable to the spouse's employment.*
- *There is a reduction or increase in hours of employment by the employee, spouse, or dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence.*
- *There is a change in legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.*
- *There is a change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent.*
- *Your dependent satisfies or ceases to satisfy the requirements for unmarried dependents, due to attainment of age, student status, or any similar circumstances as provided in the accident or health plan under which the employee receives coverage.*

- *There is a change in the place of residence or work of the employee, spouse, or dependent.*

- *There is a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in ERISA) that requires accident or health coverage for an employee's child. The employee can change his election to provide coverage for the child if the order requires coverage under the employee's plan; or, the employee can make an election change to cancel coverage for the child if the order requires the former spouse to provide coverage.*

- *Eligibility for Medicare or Medicaid (other than pediatric vaccines).*

***The consistency rule requires that the change in status results in the employee, spouse, or dependent gaining or losing eligibility for accident or health coverage under health plan of the spouse's or dependent's employer; and that the election change corresponds with that gain or loss of coverage.***

**Uniformed Service under USERRA –** A Participant who is absent from employment with the Employer on account of being in "uniformed service" as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period in which he is in "uniformed service." The manner in which such payments are made shall be determined by the Plan Administrator in a manner similar to that of COBRA.

## EFFECTIVE DATE OF COVERAGE

### WHEN DOES MY COVERAGE BECOME EFFECTIVE?

#### Initial and On-going Eligibility

**Employee** -- When you are newly hired by a participating employer, in a job classification represented by the Union, and have contributions made on your behalf by your respective employer, you are eligible to participate in the Fund. Once contributions begin eligibility is determined as follows:

| Contributions Commenced | Eligibility Month |
|---|---|
| January | February |
| February | March |
| March | April |
| April | May |
| May | June |
| June | July |
| July | August |
| August | September |
| September | October |
| October | November |
| November | December |
| December | January |

#### Co-Payment Required for Eligibility

If your collective bargaining agreement requires that you "co-pay" a portion of the contribution, you will not be eligible for any month in which you fail to make such a co-payment. Employees covered by such collective bargaining agreements may be permitted to "opt-out" of such co-payments, or coverage, if the “opt-out” provision is part of your collective bargaining agreement and if you meet the “opt-out” requirements.

The trustees reserve the right to suspend and reactivate the co-payment deductions at any time.

#### “Opt-Out” Requirements

Under the terms of some collective bargaining agreements covered employees have the right to elect not to be covered under the Teamster Local 922-Employers Health Fund, in certain proscribed circumstances. If the collective bargaining agreement permits, otherwise eligible participants in this Fund may elect to “Opt-Out” of coverage.

Under the rules of the Fund, to “Opt-Out” of coverage, you must have similar coverage elsewhere and provide proof of such coverage. If you “opt-out” of coverage, no benefits will be paid for you or for any of your dependents who would have otherwise been eligible.

Plan participants must “Opt-Out” of coverage prior to first becoming eligible or during any Open Enrollment Period. If a participant “Opts-Out” of coverage during any Open Enrollment Period, the “Opt-Out” is effective the following January 1st. An “Opt-Out” form must be completed and submitted to the Fund Office with proof of other coverage.

# TERMINATION

## WHEN DOES MY COVERAGE TERMINATE?

**Employee** - Employee coverage shall automatically terminate immediately upon the earliest of the following dates, unless the covered Employee elects Continuation of Coverage (COBRA):

a. The last day of the month following the month that employment terminates;
b. Except in the case of certain leaves of absence, the last day of the month in which the employee ceases to be eligible;
c. The date this Plan is terminated (if Continuation of Coverage not available);
d. The date the employee receives the maximum lifetime benefits provided by the Plan;
e. With respect to any coverage requiring Participant contributions, and with respect to which Participant contributions are discontinued, the period for which the employee fails to make any required contribution;
f. Except to the extent required by law, when the covered employee enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding 1 month in any calendar year.

**Retiree** - Retiree coverage shall automatically terminate immediately upon the earliest of the following dates, unless the covered Retiree elects Continuation of Coverage:

a. The date on which the Retiree is eligible for Medicare;
b. The date this Plan is terminated (if Continuation of Coverage not available);
c. With respect to any coverage requiring Participant contributions, the period for which the Retiree fails to make any required contribution.

**Dependent** - Dependent coverage shall automatically terminate immediately upon the earliest of the
following dates, unless the Employee or covered Dependent elects Continuation of Coverage:

a. The last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan;
b. The last day of the month in which the Employee's coverage under the Plan is terminated;
c. With respect to any coverage requiring Participant contributions, and with respect to which Participant contributions are discontinued, the period for which the Employee fails to make any required contribution;
d. The date the Plan is terminated (Continuation of Coverage not available);
e. Except to the extent required by law, when such Dependent enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding 1 month in any calendar year.

**Certificate of Creditable Coverage –** Each terminating participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For employees with dependent coverage, the certificate provided may include information on all covered dependents. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Human Resources office.

## CONTINUATION OF COVERAGE

A covered person may continue coverage for a period of 18, 29 or 36 months, at his/her own expense, pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" as follows:

1. **Termination of Employment:** A covered employee, spouse and dependent child (qualified beneficiary) may elect to continue coverage under this Plan for up to 18 months, if their eligibility ends due to one of the following qualifying events:

   a. The covered employee is terminated (for reasons other than Gross Misconduct*);
   b. The covered employee's number of hours of employment is reduced.

   *Gross Misconduct is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the employee's behavior in performance of his or her work, provided such violation has harmed the Employer or other employees or has been repeated by the employee despite warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

   **Disability Extension:** A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and non-disabled family members who are entitled to COBRA continuation coverage, if he is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security Disability Income benefits.

   The Qualified Beneficiary must send the COBRA Administrator a copy of the Social Security office's disability determination letter within 60 days after the latest of (and in no event later than the end of the 18$^{th}$ month of COBRA coverage):

   a. The date of the Social Security Administration's disability determination
   b. The date on which the qualifying event occurs
   c. The date on which the qualified beneficiary loses coverage; or
   d. The date on which the qualified beneficiary is informed of the obligation to provide the disability notice.

   If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Administrator must receive a copy of the Social Security office's letter within 30 days after it determines that he is no longer disabled. Please send the required documentation to the COBRA Administrator at the address shown at the end of this Section.

2. **Loss of Dependent Eligibility:** A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his or her eligibility ends due to any of the following qualifying events:

   a. The covered employee dies
   b. The covered employee is divorced or legally separated
   c. The covered employee becomes eligible for and elects Medicare benefits
   d. A Dependent child ceases to be a Dependent (as defined by the Plan).

The Employee or covered Dependent must notify the Plan Sponsor as follows:

**Notice Obligations**

A covered employee, spouse or dependent is responsible for notifying the Fund Office of the employee's divorce or legal separation, or of the employee's child losing dependent status. The qualified beneficiary must notify the Plan Sponsor within 60 days of the date of the event or the date on which coverage would terminate, whichever is later. Written notification must be provided to:

Membership Services
Teamsters Local 922 – Employers Health Trust
Carday Associates, Inc.
7130 Columbia Gateway Drive,
Suite A,
Columbia, MD 21046
(410) 872-9500
(888) 490-8800

The qualified beneficiary may be required to complete a "COBRA Qualifying Event Notification Form" and attach official documentation that substantiates the event. If you do not have access to a form, please provide the Fund Office with the following information in writing and attach a copy of official documentation: employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in COBRA coverage being forfeited.

**Multiple Event Extension:** If a covered Dependent elects the 18 month continuation following an event shown in Part 1 and later becomes entitled to a 36 month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18-month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage effective date, the Dependent must notify the Fund Officer in writing**,** within 60 days of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) COBRA contact and address can be found at the end of this section.

**Election** - A covered Employee can elect COBRA coverage for himself or herself and/or his or her covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for his or her Dependents, such coverage may be elected by the Dependents. No Spouse or child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before any of the above qualifying events except for the following: A Qualified Beneficiary includes a child born to or placed for adoption with a covered Employee during the period of COBRA coverage. An election on behalf of a minor child can be made by the child's parent or legal guardian.

To continue coverage, the Employee or Dependent, hereinafter called a continuee, affected by the qualifying event must make written election by the 60th day following: (a) the last day of coverage; or (b) the date he is sent notice of the right to continue coverage; whichever is later.

Within 45 days of the election date, the continuee must pay the required monthly premium for the COBRA coverage period prior to the election. The 18 or 36-month continuation period will begin on the earliest of the above qualifying events.

**Monthly Premium** - The due date for the monthly premium is the first day of each coverage month and COBRA allows 30 days from the due date to send the premium to the COBRA Administrator. The monthly premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated active employee. However, when a disabled continuee extends coverage beyond 18 months, the monthly premium will increase to 150% of that total average monthly premium. The monthly premium is subject to change at the beginning of each Plan Year.

**Payment of Claims** - No claim will be payable under this COBRA provision, until the Fund Office receives the applicable monthly premium for the continuee's coverage.

**Termination** - Coverage under the COBRA provision will terminate on the earliest of the following:

a. The date on which the Employer ceases to provide a group health plan to employees;
b. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by creditable coverage);
c. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
d. The date the continuee fails to make timely payment of the monthly premium under the Plan;
e. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
f. The end of the applicable 18, 29 or 36 month period. In no case will coverage continue beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the COBRA coverage period;
g. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated active employees.

**COBRA Administrator –** If you have any questions about the law or your obligations, you may contact the Fund Office.

## CHAPTER II

## MEDICAL BENEFITS
## (CIGNA HEALTHCARE)

Medical benefits under this Plan are provided by CIGNA Healthcare (CIGNA). Please refer to your CIGNA Summary Plan Description for benefit information. You can reach CIGNA by calling (800) 244-6224 or on the internet at www.cigna.com**.** Each year, as required by the Patient Protection and Affordable Care Act, a summary of the benefits provided, called the Summary of Benefits and Coverage (SBC) will be distributed to you by mail with the Open Enrollment materials.

## CHAPTER III

## VISION CARE BENEFITS
## (DAVIS VISION)

The purpose of the Vision Care Plan is to provide all eligible employees and their eligible dependents with a complete vision care program, to maintain visual efficiency, to prevent the development of conditions that might result in serious loss of sight and to maintain each employee's ability to see safely on and off the job.

The following coverage is provided when preformed by a practitioner who participates with the Vision Care program. A list of participating vision care providers is available to you through the Fund Office.

**Eye Examination -** Including dilation as professionally indicated, is covered with no co-payment, once every 12 months, by a network provider.

**Lenses**- One pair, in any prescription, once every 12 months including:

- Single vision, bifocal or trifocal lenses.
- Lentricular or cataract lenses.
- Glass Grey #3 prescription lenses.
- Fashion, sun or gradient tinted plastic prescription lenses.
- Oversize lenses.
- Polycarbonate (impact-resistant) lenses for dependent children and monocular patients.

**Frame -** Once every 12 months, with no co-payment when chosen from the Fashion or Designer levels of the designated vision care plan frame collection, (many with retail values up to $175). Or, a $100 allowance applied toward the cost of a frame chosen from the provider's own selection of frames.

**Collection Contact Lenses (in lieu of eyeglasses) -** Any contact lenses from the Collection will be covered in full after a $25 copayment per the number indicated below.

- 4 boxes of disposable contact lenses
- 2 boxes of planned replacement contact lenses

The contact lens evaluation and fitting are also included when Collection contact lenses are prescribed.

A $100 allowance will be applied toward other contact lenses offered by the service provider, fitting fees and follow-up care. The service provider will determine your co-payment or credit allowance based on the type of contact lenses required.

**OPTIONAL ITEMS-** The following items are considered optional and if chosen are available to you at the point-of-service, subject to the specified co-payment for each option.

**Lens Coatings/Treatments**

- UV (ultraviolet protection) .....$12
- SuperShield (scratch-resistant coating) ..... $20
- Glare Resistant Treatment .....$35

**Lens Types**

- Blended invisible bifocals .....$20
- Photogrey Extra (sun-sensitive) ..... $20
- Polycarbonate (impact resistant)..... $30
- Transitions (sun-sensitive) ..... $65
- High Index (thinner/lighter) ..... $55
- Polaroid .....$75
- Standard Progressives*.....$50
- Premium Progressives*.....$90

Progressive lenses can be worn by most people. Conventional bifocals will be supplied for anyone who is unable to adapt to progressive lenses, however, the fixed fees noted above will not be refunded.

**EYEGLASS WARRANTY**

A one year unconditional breakage warranty is provided for all eyeglasses completely supplied by the vision care program and purchased at a participating facility.

**OUT OF NETWORK BENEFITS**

Out of network ***reimbursement*** for covered vision services obtained outside of the network of participating providers are available, once every 12 months as follows:

**Eye Examination:** ..... up to **$30**

**Spectacle Lenses (pair):**

Single Vision ..... up to **$25**
Bifocal ..... up to **$35**
Trifocal ..... up to $**45**
Lentricular ..... up to **$60**

**Frame:** ..... up to **$30**

**Contact Lenses (in lieu of eyeglasses):** ... up to **$75**

**EXCLUSIONS -** In addition to the General Exclusions and Limitations and other provisions of the Plan, vision benefits are not included for the following:

- Medical treatment of eye disease or injury.
- Vision therapy.
- Special Lenses or coatings (other than those previously described).

- Replacement of lost or stolen eyewear.
- Non-prescription lenses.
- Services not performed by a licensed practitioner.
- Contact lenses and eyeglasses in the same 12 month period.
- Services or materials for which the patient may be compensated under Workers' Compensation Law or services for which the patient without cost obtains the needed care from any federal governmental organization, county, municipality, or special service district.
- Second pair of glasses instead of bifocals.
- Laser Vision Correction (except that the vision care service provider may offer special discounts to members when performed by one of their participating providers).

## CHAPTER IV

## DENTAL PLAN
## (GROUP DENTAL SERVICES)

Dental benefits under this Plan are provided by CIGNA Healthcare (CIGNA). Please refer to your CIGNA Summary Plan Description for benefit information. You can reach CIGNA by calling (800) 244-6224 or on the internet at www.cigna.com.

## CHAPTER V

## EMPLOYEE ASSISTANCE PROGRAM
## SUBSTANCE ABUSE

The Plan offers confidential alcohol and drug abuse services to all eligible Participants who enroll in the Employee Assistance Program ("EAP"). All Participants with a drug and alcohol related illness must first contact the EAP. No health and welfare benefits will be available without first contacting the EAP. Only Active participants are covered for these benefits not their dependents and not those individuals receiving continuation of coverage under COBRA.

If you, as a Participant, contact the EAP counselor or are referred by your shop steward, supervisor, Employer or a Union official, you are eligible to receive both in-patient and outpatient treatment, on a fully confidential basis, paid for by the Plan, as long as your treatment is received through the EAP program. If counseling through the EAP is recommended in conjunction with a court order, coverage is not available through the Health Fund.

The employee assistance counselor's office is located at:

**C. A. Mayo & Associates, Inc.**
**3403 Perry Street**
**Mount Rainier, Maryland 20712**
**(301) 699-0344**

## CHAPTER VI

## LIFE INSURANCE

Eligible active participants are entitled to a death benefit payable to your designated beneficiary when the appropriate documentation is furnished to show that you have died while this insurance is in force. The death benefit is the amount shown below, for your class of coverage in effect on the date of your death. This is a Summary of the coverage. For a detailed description of the coverage, it's limitations and exclusions, please refer to the Life Insurance plan description available through the Fund Office.

**Class I**

| | | **The Benefit is:** |
|---|---|---|
| Life (for death by illness or accident) | | $25,000 |
| Accidental Death and Dismemberment (AD&D): | Multiple Dismemberment | $25,000 |
| | Single Dismemberment | $12,500 |

**Class II**

| | | **The Benefit is:** |
|---|---|---|
| Life (for death by illness or accident) | | $10,000 |
| Accidental Death and Dismemberment (AD&D): | Multiple Dismemberment | $10,000 |
| | Single Dismemberment | $ 5,000 |

**Covered Losses for AD&D (Both Classes):**

Covered loss means: (a) loss of life; or (b) single dismemberment; or (c) multiple dismemberment. The loss must be the direct result of an accident which occurs while you are insured, independent of all other causes. And, it must occur within 90 days of the date of accident.

Single dismemberment means: (a) the irreversible loss of one hand by severance at or above the wrist; or (b) the irreversible loss of one foot by severance at or above the ankle or (c) the total and permanent loss of sight in one eye. Multiple dismemberment means any two or more single irreversible losses due to the same accident.

**Exclusions: The carrier will not pay AD&D benefits for any loss caused directly or indirectly:**

- By intentional self-injury, suicide or attempted suicide;
- By disease of any kind, and any treatment of such disease;
- By infection except septic infection of and through a visible wound accidentally sustained independent of all physical causes;
- By your taking part in a riot or other civil disorder, or in the commission or attempted commission of a felony;
- By travel on any type of aircraft if you are an instructor or crew member, or have nay duties at all on that aircraft;
- By declared or undeclared war or act of war or armed aggression;
- While you are a member of any armed force;

- While you are the driver in an automobile accident, if you are legally intoxicated at such time; or

- By your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

**Conversion Rights**

Your group life insurance ends if your employment ends, or if you stop being a member of an eligible class of employees. If either happens, you can convert all or part of your group life insurance to an individual life insurance policy. Please refer to the Life Insurance Plan Description section entitled “Converting Your Group Term Life Insurance” for full details on how to do so.

**Retiree Death Benefit**

Eligible Retirees whose employer pays Health & Welfare contributions on their behalf, to age 65, are entitled to a $10,000 death benefit that remains in effect for the life of the participant.

Retirees who self-pay their Health & Welfare premium can retain the $10,000 death benefit upon their election and assume payment of the monthly premium at the same group rate paid by the Fund in addition to the current rate of contribution for health coverage.

## CHAPTER VII

## LONG TERM CARE

The Health Trust provides base coverage for both active employees and retirees as follows. All benefits are subject to a 90-day waiting period from the occurrence date, and are subject to all limitations and exclusions of the Long Term Care Insurance carrier, as described in the **Certificate of Coverage**, a separate booklet available through the Fund Office.

### Monthly Benefit Maximum (Active Employees Only)

Long Term Care Facility Monthly Benefit is $1,500.
Long Term Care Assisted Living Facility Monthly Benefit is $900.
Professional Home Care Monthly Benefit is $750.
Long Term Care Facility Monthly Benefit Duration is 3 years.
Lifetime Long Term Care Facility Maximum Benefit is $54,000.

### Monthly Benefit Maximum (Retirees)

Long Term Care Facility Monthly Benefit is $1,000.
Long Term Care Assisted Living Facility Monthly Benefit is $600.
Professional Home Care Monthly Benefit is $500.
Long Term Care Facility Monthly Benefit Duration is 3 years.
Lifetime Long Term Care Facility Maximum Benefit is $36,000.

There are additional optional benefits such as increased maximum benefits, Inflation Protection and coverage for other eligible family members, for which the employee can self-pay. If you are interested in purchasing additional Long Term Care coverage, please refer to the complete Certificate of Coverage or contact the Fund Office.

## CHAPTER VIII

## DISABILITY INCOME BENEFITS

Disability Income Benefits are payable on a weekly basis up to the maximum amounts of $6850 for Class I Benefits and $2080 for Class II Benefits, for loss of earnings due to a non-occupational accident or sickness, which prevents you from performing any and every duty pertaining to your employment**.**

Benefits begin on the first day of accident disability, and on the eighth day of sickness disability, and continue for the duration of any one continuous period of disability up to the maximum of 39 weeks for Class I Benefits and 26 weeks for Class II Benefits. No benefits are payable, however, for periods when you are receiving sick leave benefits from your employer.

Should your absence due to a non-occupational accident or illness continue beyond the period during which you are entitled to such benefits from your employer, your Disability Income benefits will begin on the first day your paid sick leave ends.

Disability does not require that you be house confined. However, you must be under the direct care of a physician. Supplemental Disability forms for extended coverage must be filled out and submitted to the Fund Office in order to maintain eligibility.

### Successive Periods of Disability

For this coverage, a continuous period of disability includes all periods of disability due to the same or related cause or causes, separated by less than 90 days of continuous full-time, active work. If you return to continuous full-time active work for a period of at least 90 days, any subsequent disability will be considered a new disability regardless of its cause or causes.

## CHAPTER IX

## GENERAL INFORMATION

### DEFINITIONS

**Active Employee** - An employee who performs the regular duties of his/her job as defined by the collective bargaining agreement covering such employee.

**Calendar Year** - The 12-month period from January 1 through December 31 of each year.

**Certificate of Coverage** –A written document that reflects certain details about an individual's creditable health coverage. It is intended to establish an individual's prior creditable coverage for purposes of reducing the extent to which a plan offering health coverage can apply a pre-existing exclusion. You should have received a certificate of creditable coverage from your prior plan. You may request a certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that certificate to the Employer in order for your creditable coverage to reduce your Pre-Existing Condition Waiting Period under this Plan.

**Creditable Coverage -** Coverage under almost any other type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps Plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable coverage is measured in days. Each day of creditable coverage reduces by one day any Pre-Existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any creditable coverage, and you will be subject to the full Pre-Existing Condition Waiting Period.

**Effective Date** - The date on which coverage for an eligible Employee or an eligible Dependent begins.

**Electronic Protected Health Information (EPHI)** – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

**Employer** – Any signatory to a collective bargaining agreement requiring contributions to the Fund.

**Enrollment Date -** The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period. The date of hire will usually be the enrollment date. However, the enrollment date for a late enrollee is the first day of coverage.

**Exhaustion of COBRA Continuation Coverage -** An individual's COBRA coverage ends for any reason other than either the failure of the individual to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

**Family and Medical Leave Act of 1993 (FMLA)** - This applies to employers with 50 or more employees for at least 20 workweeks in the current or preceding calendar year. The following are some definitions identified by the FMLA:

Eligible Employee - An individual who has been employed by Teamsters Local - 922 Employers Health Trust Company for at least 12 months, has performed at least 1250 hours of service during the previous 12 month period, and has worked at a location where at least 50 employees are employed by the Employer within 75 miles.

Family Member - The (a) employee's biological, step, or foster parent or (b) a natural, adopted, foster, or step child, or a legal ward under 18 years of age, or 18 years and older and incapable of self-care because of a mental or physical disability or (c) spouse.

Serious Health Condition - An illness, injury, impairment, or physical or mental condition that involves; (a) inpatient care in a hospital, hospice or residential medical care facility, or (b) continuing treatment by a health provider.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

**Fiduciary** - The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of this Plan. The named fiduciary for this Plan is the Employer.

**Fund Office** - The Fund Office is Carday Associates, Inc, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046.

**Medicare** - The programs established by Title XVIII of Public Law 89-97 (79 Statutes 291), as amended, entitled Health Insurance for the Aged Act.

**Participant** - Any eligible employee or eligible Dependent who has elected coverage in this Plan and has fulfilled all requirements to continue participation.

**Placement for Adoption -** The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

**Plan/This Plan** - The plan of benefits as contained in the Summary Plan Description and Plan Document, and any agreements, schedules and amendments endorsed by the Plan Sponsor.

**Plan Administrator** - The person/organization responsible for the day-to-day functions and management of this Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. If an Administrator is not appointed in the instrument which governs the Plan, then the Administrator is the Plan Sponsor. The Plan Administrator is the Board of Trustee of Teamsters Local - 922 Employers Health Trust Company.

**Plan Sponsor** - Section 3(16) (B) of ERISA defines the Plan Sponsor as Teamsters Local - 922 Employers Health Trust.

**Protected Health Information (PHI)** - Individually identifiable health information which is maintained or transmitted by a health plan.

**Qualified Beneficiary -** Individuals who are entitled to COBRA continuation coverage. An individual who has been covered by the group health plan on the day before the event that caused a loss of coverage, and a child born to, or placed for adoption with, the covered employee during the period of COBRA coverage are Qualified Beneficiaries.

**Qualified Medical Child Support Order (QMCSO)** - A Medical Child Support Order as defined in section 609(a)(2)(B) of ERISA if the Medical Child Support Order:

a. Creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which the Participant or beneficiary is eligible under a group health plan;
b. Specifies the name and last known mailing address of the Participant and of each alternate recipient covered by the order;
c. Specifies a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient (or how it is determined);
d. Specifies each plan to which the order applies and the period to which such order applies;
e. Does not require a plan to provide any type or form of benefit not otherwise provided under the Plan.

Upon receipt of a Medical Child Support Order, the Plan Administrator or Claims Administrator shall follow these procedures:

a. The Plan Administrator shall promptly notify in writing the Participant, each alternative recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and these QMCSO procedures for determining whether such order is a QMCSO.
b. The Plan Administrator shall permit the alternate recipient to designate a representative to receive copies of notices sent to the alternate recipient regarding the Medical Child Support Order.
c. The Claims Administrator shall within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the parties indicated in subsection (a) above of such determination.
d. The Plan Administrator shall ensure the alternate recipient is treated by the Plan as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the alternate recipient a copy of the Summary Plan Description and any subsequent Plan amendments.

**Security Incidents** – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

**Significant Break in Coverage -** A break in coverage of 63 days or more. Waiting Periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the plan when evaluating whether to impose a pre-existing condition limitation period.

**Waiting Period -** A waiting period is the period that must pass before an employee or Dependent is eligible to enroll under a group health plan. The waiting period does not count as prior creditable coverage or as days in a break in coverage.

**CONDITIONS OF COVERAGE** - The benefits described are available only when Covered Services are received after a Participant's effective date.

All Covered Services must be medically necessary, prescribed by a Physician or other professional provider, and rendered by a Physician (see Definitions).

Payment will be made for Covered Services according to the benefits in effect on the date the services are received.

A Participant has the right to select the provider of his choice. Teamsters Local - 922 Employers Health Trust Company has no responsibility for a provider's failure or refusal to render services to a Participant. Furthermore, Teamsters Local - 922 Employers Health Trust Company is not liable for anything the provider may or may not do.

**COORDINATION OF BENEFITS** - This Plan contains a non-profit provision coordinating it with other similar plans under which an individual may be covered so that the total benefits available during the calendar year will not exceed the benefits of this Plan that would have been provided in the absence of Coordination of Benefits.

If, in coordinating the benefits of this Plan with those of another plan, the rules set forth in the following Order of Benefit Determination paragraph would require this Plan to be the primary payor and the other plan, according to its rules, is the secondary payor, then the benefits of that other plan will be ignored for the purpose of determining the benefits of this Plan.

If, in coordinating the benefits of this Plan with those of another plan, the rules set forth in the following Order of Benefit Determination paragraph would require this Plan to be the secondary payor, and the other plan the primary payor, then benefits will be paid by this Plan to the extent of the difference between the dollar amount the primary plan will pay and the dollar amount of allowable expenses.

An "allowable expense" is a health care service or expense including deductibles, coinsurance or co-payments that is covered in full or in part by any of the plans involved.

"Plans" means these types of medical benefits:

a. Group insurance and group subscribed contracts;
b. Uninsured arrangements of group or group-type coverage;
c. Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;
d. Group-type contracts (obtained and maintained only because of membership in a particular organization or group);
e. Group, group-type or individual automobile "no fault" and traditional automobile "fault" type policies;
f. Medicare or other government benefits;
g. Group or group-type hospital indemnity benefits in excess of $200 per day;
h. Medical care portions of group long-term care contracts (such as skilled nursing care).

Order of Benefit Determination: When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses.

A plan without a coordination provision similar to this Plan is always the primary plan. If all plans have such a provision:

a. The plan covering the patient directly, rather than as an employee's dependent, is primary.
b. If a child is covered under both parent's plans, the plan of the parent whose birthday (day and month only, without regard to the year of birth) comes earlier in the year is primary; however when the parents are separated or divorced, their plans pay in this order:

    1) If court decree has established financial responsibility for the child's health care

expenses, the plan of the parent with this responsibility;
2) The plan of the parent with custody of the child;
3) The plan of the stepparent married to the parent with custody of the child;
4) The plan of the parent not having custody of the child.

c. Active/Inactive Employee: The plan covering a person as an employee who is neither laid off nor retired (or as that person's dependent) pays benefits first. The plan covering that person as a laid off or retired employee (or as that person's dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
d. If none of the above rules determine the order of benefits, the plan covering the patient longest is primary. The plan covering that person for the shorter time pays second.
e. If none of the previously discussed rules apply, then the plans are to share the allowable expenses equally.

This Plan will always be primary for an expense incurred by a disabled Participant age 65 or under, other than a retired employee, for which Medicare benefits are available. This does not apply to charges incurred for End Stage Renal Disease.

With respect to a Participant's automobile insurance coverage, no fault and otherwise, where permitted by law, that coverage shall be primary to the coverage afforded by this Plan.

The Plan covering the individual as an Employee, retiree, or as a Dependent of an Employee will be primary, and the plan providing continuation coverage (COBRA) will be secondary. There are different rules for Medicare and COBRA. See that section below.

When the above rules reduce the total amount of benefits otherwise payable under this Plan, each benefit charge that would be payable shall be reduced proportionately.

**EFFECT OF MEDICARE**

**Active Employees and Spouses Age 65 and Over** - When an Employee in Active Service who is age 65 or over and when the covered dependent spouse of any such Employee who is age 65 or over becomes eligible for Medicare, the individual must choose either of the following options:

a. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
b. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

**Medicare Program/Premium Reimbursements**

If you are an active participant eligible for Medicare, the Fund will coordinate your benefits with Medicare just as it would with any other secondary plan. (See page 26, Coordination of Benefits).

When you reach age 65 or if you are permanently and totally disabled for two (2) years, you are automatically eligible to participate in the Federal Medicare Basic Hospital Insurance Plan A. Plan A provides comprehensive hospital benefits at no cost to you. The Federal Medicare program also offers Plan B, a Voluntary Supplementary Medical Insurance Program. However, to obtain such comprehensive surgical-medical benefits, you must elect to participate in the Medicare Part B

medical program and pay the monthly participation charge set by the federal government for such benefit coverage.

If you continue in active employment after attaining age 65, the Fund will reimburse you the monthly premium payment for Part B Medicare benefits. In order to be reimbursed, you must first file a request with the Fund Office and then substantiate that the payments are being made.

**Disability Due to End Stage Renal Disease (ESRD)** - If a Participant becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of disability, in addition to the 3 month waiting period or a maximum of 33 months, when applicable. After the initial 30 or 33 months, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare - **Medicare is the primary payor for individuals entitled to Medicare due to disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the "current employment status" of the individual or a family member then Medicare is the secondary payor.**

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

## COBRA and MEDICARE

**Medicare due to ESRD at the time of COBRA election –** Medicare is the secondary payor for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payor.

**Medicare due to Age at the time of COBRA election –** Medicare is the primary payor and the COBRA plan the secondary payor. However, if the coverage under the group health plan is by virtue of the "current employment status" of the individual or a spouse of any age then Medicare is the secondary payor.

**Medicare due to Disability at the time of COBRA election** - Medicare is the primary payor for individuals entitled to Medicare due to disability and under age 65 that have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the "current employment status" of the individual or a family member then Medicare is the secondary payor.

## SUBROGATION/REIMBURSEMENT

1. The Plan may elect, but is not required, to advance payment of medical or dental benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of a covered person where other insurance (such as auto or homeowners) is available. As a condition of providing benefits in such situations, the Plan and its agents shall have the right to recoup all benefits paid, either:

    a. By subrogation directly from the responsible party (whether an unrelated third party or another covered person) or its insurer, without regard to whether the covered person is pursuing a claim against that responsible party, or
    b. By reimbursement from the covered person, when the covered person has recovered compensation for such injury from any source described below.

    The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or other deductions, without regard to whether the covered person is fully compensated by his/her net recovery from all the sources described in subsection 2, and without regard to allocation or designation of the recovery. ***The Plan explicitly has the right of first recovery, even where a participant or beneficiary is not made whole.*** If the covered person's net recovery is less than the benefits paid, then the Plan is entitled to be paid all of the net recovery achieved. All funds received by or for any covered person, up to and including the amount of claims paid, are subject to the Plan's equitable lien thereon and are deemed to be held in constructive trust for the benefit of the Plan until such funds are delivered to the Plan or its attorneys. The Plan does not pay for, nor is responsible for the participant's attorney's fees.

2. The Plan's rights of subrogation and/or reimbursement shall have priority against and shall constitute a first lien against any and all payments, settlements, judgments or awards made by or received from the responsible party, its insurer, or any other source on behalf of that by:

    a. any insurance company under an uninsured, underinsured or medical payment provision on behalf of the covered person and
    b. any other source (such as crime victim restitution funds and Workers' Compensation) whose payment is designed or intended to compensate or reimburse the covered person for the injury or damages sustained.

3. It is the covered person's obligation to:

    a. cooperate with the Plan or its agents in defining, verifying and protecting its rights of subrogation and reimbursement
    b. provide the Plan with pertinent information regarding the injury or sickness, including various forms of documentation, accident reports, settlement reports and any other requested additional information.
    c. do nothing to prejudice the Plan's rights of subrogation and reimbursement
    d. promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received and
    e. to not settle, without the prior consent of the Plan, any claim that the covered person may have against any legally responsible party or insurance carrier.

Failure to comply with any of these requirements may result in the withholding of payment by the Plan of further medical, dental or disability benefits and/or shall render the covered person responsible for the attorneys' fees and costs incurred by the Plan in protecting its rights.

4. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

   These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan or its administrator and signed by the Covered person.

**RIGHTS OF RECOVERY** - Whenever payments have been made by the Claims Administrator with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Claims Administrator shall have the right to recover such excess payments. If a covered Employee is paid a benefit greater than that allowed by the Plan, the covered Employee will be requested to refund the overpayment. If the refund is not received from the covered Employee, the amount of overpayment will be deducted from future benefits. Similarly, if payment is made on the behalf of a covered Employee to a hospital, Physician, or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

**NO VERBAL MODIFICATIONS** - The Participant shall not rely on any oral statement from an Employee of the Fund Office including, but not limited to, a customer service representative to:

a. Modify or otherwise affect the benefits, General Limitations and Exclusions, or other provisions of this Plan;
b. Increase, reduce, waive or void any coverages or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan. Any written or oral verification received from the Fund Office is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a Participant.

**PLAN MODIFICATION AND AMENDMENT** - Amendment/modification of the Plan shall be in writing and signed by an officer of the Plan Sponsor pursuant to authorization by the Plan Sponsor's Board of Directors. The Plan Sponsor may modify or amend the Plan from time to time at its sole discretion. The amendments or modifications which affect the Plan Participants will be communicated to them. The foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may have been made by the Plan Sponsor with the bargaining representatives of any Employees. Participants will be notified of material reductions in services or benefits within 60 days of adoption of the change.

**PLAN TERMINATION** - The Plan Sponsor may terminate the Plan which shall be accomplished in writing and signed by an officer of the Plan Sponsor pursuant to authorization of the Plan Sponsor's Board of Directors. Upon termination, the rights of Participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Participants. In the event of Plan termination, all claims incurred by a Participant must be received by the Claims Administrator within 90 days after the date of termination.

**WORKERS' COMPENSATION** - If a participant is injured while at his/her place of employment or requires medical care as a result of employment, the participant should obtain care for such injuries through the arrangements provided by his/her Employer under Workers' Compensation laws. This Plan does not provide benefits for expenses which can be reimbursed under Workers' Compensation laws. However, benefits will be provided for expenses not covered by Workers' Compensation.

**NO GUARANTEE OF EMPLOYMENT** - Neither the Plan nor any provisions contained in the Plan shall be construed to be a contract between the Employer and the Employee, or consideration for, or an inducement of, the employment of any Employee by the Employer. Nothing contained in the Plan shall grant any Employee the right to be retained in the service of the Employer nor shall it limit in any way the right of the Employer to discharge or to terminate the service of any Employee at any time, without regard to the effect such discharge or termination may have on any rights under the Plan to the extent consistent with ERISA.

**CONFORMITY WITH THE LAW** – This Plan of benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws. If any provision of this plan is contrary to any applicable law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirements.

**INTERPRETATION OF THE PLAN** – The Plan Administrator has the sole and absolute discretion to construe and interpret the provisions and terms of the plan, to resolve any disputes which may arise under the plan and otherwise determine the operation and administration of the plan. In making such interpretations and determinations, the Plan Administrator shall take into account the interpretation of the provisions and terms of the plan by the plan's reinsurance carrier and any other relevant information.

Any and all such decisions and determinations made by the Plan shall be final and binding upon all parties.

**GENDER AND NUMBER** - The masculine gender shall be deemed to include the feminine and the singular shall include the plural unless otherwise clearly required by the context.

**CLAIM APPEAL PROCEDURE** – Claims for benefits under the Plan must be filed in the manner and within the time limits stated under "Proof of Loss" above. If a Participant or a Participant's spouse, dependent or beneficiary (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may request review of the claims with the Claims Administrator. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an adverse benefit determination. The Claims Administrator shall review the claim itself or appoint an individual or an entity to review the claim.

## I. INITIAL BENEFIT DETERMINATION

Health Benefit Claims – Urgent Care Claims

If the Claimant's claim is for urgent care health benefits, the Claims Administrator shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator shall notify the Claimant as soon as possible, but not later than 24 hours after receipt

of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant.

**The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.**

A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

Health Benefit Claims – Concurrent Care Claims

If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an adverse initial benefit determination. These determinations shall be known as concurrent care decisions. In such a case, the Claims Administrator shall notify the Claimant of the adverse concurrent care decision at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Other Health Benefit Claims – Pre-Service Claims

In the case of a pre-service health benefit claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

Other Health Benefit Claims – Post-Service Claims

In the case of a post-service health benefit claim, the Claims Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services which the Claimant has already received.

Disability Benefit Claims

In the case of a claim for disability benefits, the Claims Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision.

The extension notice shall specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the Claimant to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

Calculation of Time Period

For purposes of the time periods specified, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Denial of Initial Claims

If the Claims Administrator denies a claim, it must provide to the Claimant, in writing or by electronic communication:

(a) The specific reasons for the adverse determination;
(b) A reference to the specific plan provisions on which the determination is based;
(c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
(d) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502 (a) following an adverse benefits determination on review;
(e) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits, the following must be provided:

(i) A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination or a statement that the same will be provided upon request by the Claimant and without charge; or
(ii) If the adverse benefit determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances or a statement that the same will be provided upon request by the Claimant and without charge.

In the case of an adverse benefit determination concerning a health claim involving urgent care, the information described in this section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than 3 days after the oral notification.

## II. REVIEW PROCEDURES

### Health and Disability Benefit Claims

In addition to having the right to review documents and submit comments as described above, a Claimant for health or disability benefits has a right to a review which meets the following requirements:

(a) The Plan provides two levels of appeal for all health and disability benefit claims. A claimant has the right to file an appeal to the Plan within 180 days from the date of the initial notice and within 30 days of the date of a second adverse benefit determination notice. The claimant's appeal request should include the patient's name, identification number, and any additional documentation to be reviewed.

(b) The Plan provides for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(c) The Plan provides that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(d) The Plan provides for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit review determination;

(e) The Plan provides that the health care professional engaged for purposes of consultation be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(f) The Plan provides in the case of a claim involving urgent care, for an expedited review process pursuant to which:

(i) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(ii) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

## III. DEADLINE FOR REVIEW DECISIONS

Urgent Health Benefit Claims

This Plan will have two levels of appeal. In case of urgent care health claims, the Claims Administrator shall notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.

Pre-Service Health Benefit Claims

This Plan will have two levels of appeal. In the case of a pre-service health claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination on review with respect to any one of such two appeals, not later than 15 days after receipt of the Claimant's request for review of the adverse determination.

Post-Service Health Benefit Claims

This Plan will have two levels of appeal. In the case of a post-service health claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination on review with respect to any one of such two appeals, not later than 30 days after receipt of the Claimant's request for review of the adverse determination.

Disability Benefit Claims

In the case of disability claims, the decision on review will be made within 45 days after the Claims Administrator's receipt of a request for review; unless special circumstances require an extension of time for processing is required written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

Calculation of Time Periods

For purposes of the time periods specified in this Section, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the benefit determination on review shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds.

Manner and Content of Notice of Decision on Review

Upon completion of its review of an adverse initial claim determination, the Claims Administrator will provide the Claimant with written or electronic notification of a plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall contain:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the benefit determination is based;

(c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;

(d) A statement describing the Claimant's right to bring an action for judicial review under ERISA §502(a);

(e) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided without charge to the Claimant upon request;

(f) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

## IV. MISCELLANEOUS

Failure of Plan to Follow Procedures

If the Plan fails to follow the claims procedures required by this Article, a Claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedy under ERISA section 502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Preemption of State Law

With respect to any insured benefit under this Plan, nothing in this Section shall be construed to supercede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of this Section.

Statute of Limitations

Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 12 months after the final review decision by the Claims Administrator has been rendered (or deemed rendered).

## PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This is your Health Information Privacy Notice from Teamsters Local 922-Employers Health Trust (referred to as "Health Trust" or "we"). This notice is effective January 1, 2008. This notice is solely for your information. You do not need to take any action.

This notice provides you with information about the way in which the Health Trust will protect Personal Health Information ("PHI") that we have about you. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also explains your rights with respect to PHI.

The Health Insurance Portability and Accountability Act ("HIPAA") requires the Health Trust to: Keep PHI about you private; provide you this notice of our legal duties and privacy notices with respect to your PHI; and follow the terms of the notice that are currently in effect.

### Use and Disclosure of PHI

The Health Trust obtains PHI in the course of providing and/or administering health insurance benefits for you. In administering your benefits, the Health Trust may use and/or disclose PHI about you and your dependents. The following are some examples, however, not every use or disclosure in a category will be listed:

- **For Health Care Payment Purposes:** For example, the Health Trust may use and disclose PHI to administer and process payment of benefits under your insurance coverage, determine eligibility for coverage, claims or billing information, conduct utilization reviews, or to another entity or health care provider for its payment purposes.

- **For Health Care Operations Purposes:** For example, the Health Trust may use and disclose PHI for underwriting and rating of the plan, audits of your claims, quality of care reviews, investigation of fraud, performance measurements, care coordination, investigate and respond to complaints or appeals, provider treatment, review and provision of services.

- **For Treatment Purposes.** For example, the Health Trust may use and disclose information PHI to health care providers to assist in their treatment of you. We do not provide health care treatment to you directly.

- **For Health Services.** For example, the Health Trust may use your medical information to contact you to give you information about treatment alternatives or other health related benefits and services that may be of interest to you as part of large case management or other insurance related services.

- **For Data Aggregation Purposes.** For example, the Health Trust may combine PHI about many insured participant to make plan benefit decisions, and the appropriate premium rate to charge.

- **To You About Dependents.** For example, the Health Trust may use and disclose PHI about your dependents for any purpose identified herein. We may provide an explanation of benefits for you or any of your dependents to you.

- **To Business Associates.** For example, the Health trust may disclose PHI to administrators who are contracted with us who may use the PHI to administer health insurance benefits on

our behalf and such administrators may further disclose PHI to their contractors or vendors as necessary for the administration of health insurance benefits.

- If your state has adopted a more stringent standard regarding any of the above uses or disclosures of your PHI, those standards will be applied.

**Additional Uses or Disclosures**. The Health Trust may also disclose PHI about you for the following purposes:

- To comply with legal proceedings, such as a court or administrative order, subpoena or discovery requests
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To the Department of Health and Human Services for the investigation of compliance with HIPAA or to fulfill another lawful request.
- To federal officials for lawful intelligence, counterintelligence, national security purposes and to protect the president.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.
- In accordance with a valid authorization signed by you.

## Your Rights Regarding PHI That We Maintain About You

You have various rights as a consumer under HIPAA concerning your PHI. You may exercise any of these rights by writing to the Health Trust in care of **Carday Associates Inc, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046. ATTN: HIPAA Privacy.**

- You have the right to inspect and copy your PHI that we maintain. If you request a copy of the information, the Health Trust may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- You have the right to ask the Health Trust to amend the PHI that is contained in a "designated record set", e.g., information used to make enrollment, eligibility, payment, claims adjudication and other decisions. You have the right to request an amendment for as long as we maintain the PHI. Requests must be made in writing and include the reason for the request. The Health Trust may deny the request if the PHI is accurate and complete or if we did not create the PHI.

- You have the right to request a list of our disclosures of the PHI. Your request must state a time period, may not include dates before January 1, 2008 and may not exceed a period of six years prior to the date of your request. If you request more than one list in a year, the Health Trust may charge you the cost of providing the list. The Health Trust will notify you of the cost and you may withdraw or modify your request before any costs are incurred. Any list of disclosures provided will not include disclosures made for payment, treatment or healthcare operations; made to you or persons involved in your care; incidental disclosures, authorized disclosures, for national security or intelligence purposes or to correctional institutions.

- You have the right to request to restrict the way the Health Trust use or disclose PHI regarding treatment, payment or health care operations. You also have the right to request to restrict the PHI we disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. Your request must be in writing and state (1) what information you want to restrict; (2) whether you want to restrict our use, disclosure or both; and (3) to whom you want the restrictions to apply

- Uses and disclosures of your PHI, other than those listed above, require prior written authorization from you. You may revoke that authorization at any time by writing to us at the address at the end of this notice.

- You have the right to request that we communicate personal information to you in a certain way or at a certain location. Your request must specify how or where you wish to be contacted. We will comply with reasonable requests.

- You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. You may request a paper copy of this notice any of the above described by calling us at 1-410-872-9500.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with the Health Trust. When filing a complaint, include your name, address and telephone number and we will respond. All complaints must be submitted in writing to **Carday Associates Inc, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046.** You may also contact the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

## Changes To This Notice

We reserve the right to modify this Privacy Notice and our privacy policies at any time. If We make any modifications, the new terms and policies will apply to all PHI Personal Information before and after the effective date of the modifications that We maintain. If We make material changes, We will send a new notice to the insured/subscribers.

If you have any questions regarding this notice, please call 1 410-872-9500 or send your written questions to the address at the end of this notice. Please include your name, the name of your insurance plan, your policy/ID number or copy of ID card, your address and telephone number and we will respond.

## HIPAA SECURITY STANDARDS

**Plan Sponsor Obligations -** Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

b. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

c. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

    2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter or more frequently upon the Plan's request.

## STATEMENT OF ERISA RIGHTS

### Your Rights

As a participant in Teamsters Local 922-Employers Health Trust you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following.

You can examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Employee Benefits Security Administration.

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

The plan administrator is required by law to furnish each participant with a copy of the summary of his/her annual financial report.

You may also obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to be eligible for a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

### Continue Group Health Plan Coverage

You can 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 on the rules governing your COBRA continuation coverage rights.

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

## Prudent Actions by Plan Fiduciaries

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

## Enforce Your Rights

If your claim for a (pension, 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 plan and do not receive it 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about your plan, you should contact the plan admistitrator: **Carday Associates Inc, 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046 or call 410-872-9500.** If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.