Milwaukee Drivers Health and Welfare Trust Fund
10020 W. Greenfield Avenue – Milwaukee, WI 53214 – Phone 414-258-2336 or 800-255-3340

Important information About Your Health and Welfare Benefits

April 2018

Dear Active and Retired Participants:

As Trustees of the Milwaukee Drivers Health and Welfare Trust Fund (the "Plan"), we value your service and are proud to offer coverage to help meet the health care needs for you and your family. We are committed to keeping you informed and want to make you aware of changes made to the Plan to comply with new disability claims and appeals requirements issued by the Department of Labor (the "DOL") for disability claims and appeals filed on or after April 1, 2018. The claims and appeals procedure under the Plan is explained in this Summary of Material Modifications (SMM).

Be aware that the entire Claims and Appeal Section in the Plan was recently restated and is summarized below.

❖ General Information

The Plan's internal claims and appeal procedures apply to medical, mental health, substance abuse, dental, vision, prescription drug, weekly accident and sickness, accidental death and dismemberment and life insurance benefits. A claim must be submitted in writing (or electronic format) on a form provided by the Plan or one of the Plan's Providers to the Fund Office within 12 months from the date of service or loss.

The Plan's internal claims and appeal procedures provide you with full, fair and fast claim review and ensure that Plan provisions are applied consistently to all claims. The Plan is required to consult with a health care professional who has the appropriate training and experience when reviewing a claim that is denied based, in whole or in part, on a medical judgement (such as a determination that a service is not medically necessary or appropriate, or it is experimental or investigative).

The internal claims process pertains to determinations made about whether your request for benefits (the "initial claim") is payable. If your initial claim for benefits is denied (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

The Trustees have the power to delegate responsibility for the administration of the Plan to the Fund Administrator and/or another designee, such as other fiduciaries, claims administrators and other individuals. Such Fund Administrator or other designee has the discretionary authority to interpret the terms of the Plan and any relevant facts to the determination and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any such interpretation or determination made under this discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

❖ **What you should know**

You should know the following terms:

- "Days" refers to calendar days, not business days.
- An "adverse benefit determination" means:
  - ❖ A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of your eligibility to participate in the Plan or a determination that a benefit is not a covered service;
  - ❖ A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered service or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not medically necessary or appropriate, or experimental or investigational; or
  - ❖ A rescission of coverage, whether or not there is an adverse effect on any particular health or weekly accident and sickness benefit. An adverse benefit determination does not include rescissions of coverage with respect to life insurance and accidental death and dismemberment insurance benefits.
- A "health care professional" means a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.
- A "Claim" is a request that you make for a Plan benefit or your authorized representative in accordance with the Plan's internal claims procedures.

You should know the different types of claims:

- Health Benefit Claims are filed for medical, mental health, substance abuse, dental, vision and prescription drug benefits. A Health Benefit Claim can be a Pre-Service Claim, Urgent Care Claim, Concurrent Claim, or Post-Service Claim.
  - ❖ Pre-Service Claims are applicable to medical, mental health and substance abuse benefits that require approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for medical, mental health and substance abuse benefits.
  - ❖ Urgent Care Claims are applicable to medical, mental health and substance abuse care or treatment that
    - Could seriously jeopardize your life or health or your ability to regain maximum function, or
    - In the opinion of your attending health care provider with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for you to obtain the pre-approval, or the pre-approval process would jeopardize your life or health.

- ❖ Concurrent Claims are applicable to medical, mental health, substance abuse, dental, and prescription drug benefits, which have been reconsidered after an initial approval and results in a reduction or termination of the benefit. A Concurrent Claim can also pertain to a request for an extension of a previously approved treatment or service.
- ❖ Post-Service Claims are applicable to medical, mental health, substance abuse, dental, vision, hearing and is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered a Post-Service Claim.

- o A Weekly Accident and Sickness Benefit claim is a request for benefits during a period of disability. Weekly Accident and Sickness Claims are filed after you suffer a disability and benefits are paid if the Fund Office determines that you have suffered a disability as defined by the terms of the Plan.

- o A Life Insurance and Accidental Death and Dismemberment Insurance claim is a request by your beneficiary for benefit payment upon your death. A claim for Accidental Death and Dismemberment benefit is filed by you after you have provided the Plan with proof of your bodily loss.

- o In order to trigger the Plan's internal claims procedure process, the claim must:
  - ❖ Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
  - ❖ Be received by the Fund Office;
  - ❖ Name the specific individual participant and his/her Social Security Number;
  - ❖ Name a specific patient and include the patient's date of birth;
  - ❖ Name a specific medical condition or symptom;
  - ❖ Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
  - ❖ Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
  - ❖ When another plan or social insurance program (such as Medicare) is a payer, include a copy of the other Plan's or social insurance program's Explanation of Benefits (EOB) statement along with the submitted claim.

- o Timeframes to make the initial determination on the claim.

  The time for making a decision on your initial claim starts as soon as the claim is received by the Fund Office if it is filed in accordance with the Plan's internal claims filing procedures, regardless of whether the Plan has all of the information necessary to make a decision on your claim. You, your authorized representative or a network provider may file your claim. If a network provider files your claim, the provider will not automatically be considered your authorized representative.

❖ Health Care Claims

The Plan will provide you, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. The new or additional evidence or rationale will be provided to you as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) in order to give you a reasonable opportunity to respond to the information prior to that date.

- Your Pre-Service claim will be decided no later than fifteen (15) days after it is received by the Fund Office. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the control of the Fund Office (such as in the case where the medical reviewer is unable to meet the deadline because certain information/documentation has not been provided). You will be given written (or electronic, if an applicable) notification of the extension before the expiration of the initial fifteen (15) day determination period.

  If you improperly file a Pre-Service Claim, you will be notified in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after the Fund Office received the claim. The notice will describe the proper procedures for filing a Pre-Service Claim and you must re-file your claim to begin the Pre-Service Claim determination process.

  If your claim cannot be processed due to insufficient information, you will be notified in writing (or electronically, as applicable) of the information that is needed before the end of the initial fifteen (15) day determination period. You will have 45 days after your receipt of the notification to provide the information. The initial fifteen (15) day determination period will be suspended until the earlier of the date you provide the information or the end of the 45-day period you had to provide the information. If you do not provide the information within the 45-day period, your claim will be denied based on the information that it has at that time. If you provide the information timely, the Fund Office has fifteen (15) days to make and notify you in writing (or electronically, as applicable) of the decision on your claim.

- For an Urgent Care Claim, your health care professional with knowledge your medical condition can determine that your claim constitutes an Urgent Care Claim and your health care professional will be considered by the Plan to be your authorized representative. In this case, you do not need to complete the Plan's written authorized representative form.

  Your Urgent Care Claim will be decided as soon as possible, but in no event later than 72 hours after the Fund Office receives your claim. The decision will be orally communicated telephonically to your health care professional. The decision will also be confirmed in

writing (or electronically, as applicable) no later than three (3) days after the oral notification.

If you improperly file an Urgent Care Claim, you and your health care professional will be notified as soon as possible, but in no event later than 24 hours after the Fund Office received your claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim and you must re-file the claim to begin the Urgent Care Claim determination process.

If your claim cannot be processed due to insufficient information, you or your health care professional will be notified of the specific information is that is needed to make a decision as soon as possible and no later than 24 hours after the Fund Office received your claim. You will have at least 48 hours following your receipt of the notification to provide the additional information. If you do not provide the information during that period, your claim will be denied based on the information that it has at that time. A decision will be made no later than 48 hours after the Fund Office received the specific information or the end of the period you had to provide the information, whichever is earlier.

You will be provided with written (or electronic, as applicable) notification if a decision is made to reduce or terminate an approved course of treatment with respect to your Concurrent Claim. The notification will be provided sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination on the review of the decision to reduce or terminate the previously approved course of treatment.

If your Concurrent Claim is an Urgent Care Claim, it will be processed in accordance with the appeals procedures and timeframes described above for Urgent Care Claims.

If your Concurrent Claim is not an Urgent Care Claim, it will be processed according to the appeals procedures and timeframes described above for a Pre-Service or Post-Service Claim.

You will be notified orally followed by written (or electronic, as applicable) confirmation no later than three (3) calendar days after the oral notification if your Concurrent Care Claim is approved or denied.

- Your Post-Service Claims for treatments or services will be decided no later than 30 days after the claim is received by the Fund Office. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if you claim is denied (in whole or in part).

  If a decision cannot be made on your claim for reasons beyond the control of the Fund, the time to decide your claim may be extended by fifteen (15) days (such as in the case where a medical reviewer cannot meet the 30-day review deadline because information needed to make the decision has not been received to). You will be given written (or electronic, as applicable) notification before the initial 30-day determination period ends.

If your claim cannot be processed due to insufficient information, the Fund Office will notify you in writing (or electronically, as applicable) of the information that is needed to make a decision before the initial 30-day determination period ends. You will have 45 days after you receive the notification to provide the information. If you do not provide the information by that time, your claim will be denied based on the information the Fund Office has at that time. The initial 30-day determination period will be suspended until the date you provide the information or the end of the 45-day period you had to provide the information, whichever is earlier. After that time, the Fund Office has fifteen (15) days to make and communicate, in writing (or electronically, as applicable) it decision on your claim.

- Weekly Sickness and Accident Claims

  Your Weekly Sickness and Accident benefit claim will be decided no later than 45 days after the Fund Office receives it. You will be notified in writing (or electronically, as applicable) within 45-days of the Fund Office's receipt if your claim is denied (in whole or in part).

  If a decision cannot be made on your claim because of reasons beyond the control of the Fund Office, the initial 45-day determination period may be extended by two separate 30-day periods. In such a case, you will be notified of the first 30-day extension before the end of the initial 45-day determination period. If the second 30-day extension period is needed, you will be notified of the extension before the end of the first 30-day extension period. In both cases, the notification will provide you the reasons for the delay and the date when you may expect to receive a decision.

  If your claim cannot be processed due to insufficient information, you will be notified in writing (or electronically, as applicable) of the information that is needed before the expiration of the initial 45-day determination period. You will have 45 days after you receive the notice to provide the information. If you do not provide the information during that 45-day period, your claim will be denied based on the information the Fund Office has at that time. The initial 45-day determination period is suspended until the earlier of the date you provide the information or the date the 45-day period that you had to provide the information ends. The Fund Office then has 30 days to make and notify you of its decision in writing (or electronically, as applicable).

  If you are a UPS Employee, you must apply for Long-Term Disability (LTD) Benefits from UPS in order to continue to receive disability benefits beyond the standard 26 weeks. If you expect to be off work for more than 26 weeks, you must submit a claim to Aetna (1-866-825-0186) within 60 days after your short-term benefits end, in order for you to be eligible for the UPS LTD Benefits.

- Life Insurance and Accidental Death and Dismemberment Insurance

  You will receive written (or electronic, as applicable) notice of the decision on your claim within 90 days of the Fund Office's receipt of your claim. If additional time or information is required to make a determination on your claim, for reasons beyond the control of the Fund Office, you will be notified in writing (or electronically, as applicable) within the initial 90-day

determination period. The 90-day period may be extended up to an additional 90 days.

- **Notice of an Adverse Benefit Determination**

If the Fund Office initially denies your claim, in whole or in part, you will be given a notice of the adverse benefit determination. The notice of adverse benefit determination will be provided in writing (or electronically, as applicable) within the timeframe specified above for a particular type of claim and must:

- Identify the claim involved (and for health benefit claims, include the date of service, health care provider, claim amount (if applicable), denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (and for health benefit claims, include a statement that the you have the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- With respect to health and Weekly Accident and Sickness benefit claims, the opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to the initial claim for benefits;
- Provide an explanation of the Plan's internal appeal process along with time limits and information about how to initiate an appeal;
- Contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;
- With respect to health and Weekly Accident and Sickness benefit claims, if the denial was based on an internal rule, guideline, protocol, standard, or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;
- If the denial of a health care claim and Weekly Accident and Sickness claim was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;
- With respect to Weekly Accident and Sickness claims, a discussion of the Plan's initial claim decision, including the basis for disagreeing with:
  - Any disability determination by the Social Security Administration (SSA);
  - The views of the treating health care professional or vocational expert evaluating you, to the extent the Plan does not follow such views as presented by you; or

- The views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;

❖ For Urgent Care health benefit claims, the notice will describe the expedited internal appeal process applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and

❖ With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes.

➢ **Reviews on Appeals**

o Appeal Request Deadline

If your initial health care claim or Weekly Accident and Sickness claim is denied (in whole or in part) and you disagree with the, you or your authorized representative may request a review (an appeal) of the adverse benefit determination. You must request an appeal no later than 180 calendar days following your receipt of the notice of adverse benefit determination. An appeal will not be accepted if filed after this 180-day period.

If your initial life insurance and accidental death and dismemberment benefit claim is denied and you disagree with the decision, you or your authorized representative may request an appeal no later than 60 calendar days after you received the notice of adverse benefit determination. An appeal will not be accepted if filed after this 60-day period.

o Appeals Procedures

Your request for an appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate for the review on appeal, as well as any written issues and comments. As a part of its appeals process, the Plan will provide you with:

- The opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;
- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;
- With respect to health and Weekly Accident and Sickness benefit appeals, the Plan will automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence and testimony;
- A full and fair review by the Plan that takes into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted or considered in the initial claim determination;

- With respect to health and Weekly Accident and Sickness benefit claims, the Plan will automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim before it can deny your claim on appeal. You will automatically be provided with the new or additional evidence or rationale as soon as possible once it becomes available to the Plan. The information will be provided sufficiently in advance of the date that the notice of an adverse determination on appeal is scheduled to be provided to you, so that you have a reasonable opportunity to respond to the Plan regarding such evidence.

  If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide you a reasonable opportunity to respond to it, then the period for providing a notice of a final adverse benefit determination will be delayed (suspended) until you have had a reasonable opportunity to respond to the information. After you respond (or do not respond after having a reasonable opportunity to do so) to the information, the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies;

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- With respect to health and Weekly Accident and Sickness benefit claims appeals, continued coverage during the pendency of the appeal process; and

- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the fiduciary or fiduciaries will:

  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and

  - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

  - The Plan will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

- Appeal Determination Timeframes
  - Health Care Claims
    - A determination on your Pre-Service Claim will be made and a written (or electronic, as applicable) notification will be provided to you within 30 days from the date your written request for an appeal is received by the Plan.
    - The appeal of your Urgent Care Claim is expedited and you (or your health care professional) will receive written notice of the decision on the approval or denial of the expedited appeal no later than within 72 hours of the Fund Office receive your (oral or written) appeal request.
    - The determination on your Concurrent Claim on appeal will be made and you will be notified orally or in writing as soon as possible before the benefit is reduced or the treatment terminated.
    - An appeal determination will be made on your Post-Service Claims no later than the date of the Trustees' meeting immediately following the Plan's receipt of your written request for a review on appeal, unless the request for an appeal review is filed within 30 calendar days preceding the date of such meeting. In that case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require an extension of time to make the decision, an appeal determination will be made not later than the third meeting following the Plan's receipt of your written request for review. You will be provided with a written (or electronic, as applicable) notice of the extension describing the special circumstances and date the appeal determination will be made. You will be notified in writing (or electronically, as applicable) of the benefit determination no later than five (5) calendar days after the benefit determination is made.

  - Weekly Accident and Sickness Benefit Claims

    Appeal determination will be made no later than the date of the meeting immediately following the Plan's receipt of your written request for an appeal, unless the request for an appeal review is filed within 30 calendar days preceding the date of such meeting. In that case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for review. If special circumstances (such as the need to hold a hearing) require an extension of time to make a decision, a benefit determination shall be made not later than the third meeting following the Plan's receipt of your written request for review. You will be provided notice in writing (or electronic, as applicable) describing the special circumstances for the extension and the date the appeal determination will be made. You will be notified of the

benefit determination no later than five (5) calendar days after the benefit determination is made.

- ❖ Life Insurance and Accidental Death and Dismemberment Insurance Claims

  A determination of your appeal will be made and provided to you in writing (or electronic, as applicable) within 60 days from the date your written request for a review on appeal is received by the Plan.

- o Notice of Adverse Benefit Determination Upon Appeal

You will be provided with a written (or electronic, as applicable) notice of the appeal determination that includes:

- ❖ The specific reason(s) for the adverse benefit determination upon appeal, including:
  - ▪ The denial code (if any) applicable to a health benefit claim and its corresponding meaning,
  - ▪ A description of the Plan's standard (if any) that was used in denying the claim, and
  - ▪ A discussion of the decision;
- ❖ Reference the specific Plan provision(s) on which the denial is based;
- ❖ A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- ❖ A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- ❖ If the denial of a health or Weekly Accident and Sickness benefit claim was based on an internal rule, guideline, protocol, standard, or similar criteria, you must be provided that such rule, guideline, protocol, standard or criteria will be provided free of charge; or alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criterion of the Plan do not exist;
- ❖ If the denial of a health benefit claim or a Weekly Accident and Sickness claim was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request;
- ❖ With respect to Weekly Accident and Sickness claims, a discussion of the Plan's initial claim decision, including the basis for disagreeing with
  - ▪ Any disability determination by the Social Security Administration (SSA);
  - ▪ The views of a treating health care professional or vocational expert evaluating you, to the extent the Plan does not follow such views as presented by you; or
  - ▪ The views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless

of whether or not the advice was relied upon by the Plan in making the adverse benefit determination; and

- ❖ With respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the internal claims and appeals process.

- ➢ **Authorized Representative**

The Plan considers an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file an initial claim and appeal an adverse benefit determination under the Plan. A health care professional who is part of the claim appeal is also considered your authorized representative under the Plan. In this case you do not need to complete designate the health care professional as such. Your health care provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

To designate someone as your authorized representative, you must submit a written statement declaring that the person is authorized to act on your behalf. The designation form must provide the representative's name, address, phone number, and email address.

If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.* notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is your legal spouse, parent, grandparent, or child over the age of 18).

Once you designate someone as your authorized representative, all future claims and appeals-related correspondence will be routed to the authorized representative instead of to you. A designation of an authorized representative is honored by the Plan for one (1) year before a new authorization is required or until the designation is revoked, or as mandated by a court order.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

- ➢ **Elimination of Conflict of Interest**

With respect to health and Weekly Accident and Sickness benefits; to ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators, medical professionals and vocational experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

- ➢ **Facility of Payment**

If it is determined that you cannot submit a claim or prove that you paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees or any

other fiduciary, appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, this Plan must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximum). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans (for example, the provision of preventive health services without any cost sharing). The Plan already complies with the Affordable Care Act requirement prohibiting pre-existing condition limitations.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please take some time to review this announcement and the enclosed Schedules. If you are married, share this information with your spouse. Contact the Fund Office at 414-258-2336, or toll free at 800-255-3340, if you have any questions about the benefits described in this notice.

For more information about the Mental Health Parity & Addiction Equity Act, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or www.dol.gov/ebsa/mentalhealthparity.

Sincerely,

Your Board of Trustees

Employee Trustees
William Carroll, Patrick Tappa, Daniel Kutcher

Employer Trustees
Todd Wian, John Engler, Joseph Lierz

This announcement, which serves as a Summary of Material Modifications, contains only highlights of the changes to the Milwaukee Drivers Health and Welfare Trust Fund claims and appeal procedures. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

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