Local 710 Health, Welfare and Pension Funds

9000 W. 187TH STREET, SUITE 200
MOKENA, ILLINOIS 60448
TELEPHONE 773/254-2500
www.710hwp.org

December 1, 2025

Dear Participant:

The Board of Trustees of the International Brotherhood of Teamsters Local No. 710 Health and Welfare Fund is pleased to announce multiple **new benefits**. Please find and read the attached Summary of Material Modifications.

NEW BENEFITS

- HRA FOR ACTIVE PARTICIPANTS – Effective 1/1/2026
- MARC CUBAN COST PLUS PROGRAM – BENZAVVY ONLY Effective 11/1/25
- DENTAL – CHANGE OF NETWORK PROVIDER – Effective 3/1/26
  DELTA DENTAL OF IL PPO PLUS PREMIER
- RETIREE HEALTH PLAN ENROLLMENT CHANGES – Effective 10/1/25
- RETIREE HEALTH CARE PREMIUMS CHANGE – Effective 1/1/26

Enclosed is the 2026 Enrollment Form for the Teamsters Local 710 Health and Welfare Fund ("Fund"). It is essential that you fill out this form completely with all information that is requested. Under the terms of the Fund, you are required to enroll all your dependents, as the term is defined in the Fund's Summary Plan Description. For your convenience, an abbreviated form of the Fund's definition of a "dependent" is set forth below.

DEFINITION OF DEPENDENT:

1. **Your spouse**. The Fund defines a "Spouse" as the person to whom you are legally married under the laws of the state or country in which you were married.
2. **Your Child**. The Fund defines a "Child" as an individual who is under age 26 and is:

A. A natural or adopted child of a Participant.
B. A stepchild, that is, the child of the Participant's Spouse;
C. A child who has been placed with the Participant for adoption. The term "placed for adoption," means the assumption and retention of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation. The Participant must provide the Fund with written updates about the progress of the adoption process at least once every six months.
D. A Disabled Child: For purposes of this Plan, a Disabled Child is a Child who is incapable of independent self-support; the Disabled Child is

unmarried; the Disabled Child's Earned Income does not exceed a yearly maximum of $12,000; the Disabled Child was Eligible for Benefits Coverage before reaching age 26; and the Disabled Child was mentally or permanently physically handicapped before reaching age 26.

Please return the enclosed Enrollment Form to this office no later than February 1, 2026. If you fail to submit a fully completed form by February 1, 2026 payment for your claims may be delayed or, in some cases, denied.

In addition to the Enrollment Form, we are also providing you with the information described below.

- The 2026 Summary of Benefits and Coverage is enclosed for your review.
- The 2026 Chip Notice.
- The Health Reimbursement arrangement (HRA) summary.

REQUIRED NOTICES:

- Your **WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998** Notice appears in your Summary Plan Description, effective February 1, 2018, and can be found on our website at www.710hwp.org. Pursuant to the Women's Health and Cancer Rights Act of 1998, the Plan provides coverage for:

    - All stages of reconstruction of the breast on which the mastectomy has been performed.
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Such coverage may be subject to annual Deductibles and Coinsurance provisions as may be deemed appropriate and are consistent with those established for other Benefits under the plan or coverage.

If you have any questions, please contact the Fund office at 773-254-2500.

Sincerely,
The Board of Trustees

Para obtener asistencia en Espanol, llame al 773-254-2500

INTERNATIONAL BROTHERHOOD OF TEAMSTERS LOCAL NO. 710 HEALTH & WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the International Brotherhood of Teamsters Local No. 710 Health & Welfare Fund (the "Fund") is pleased to announce several exciting benefit improvements, as described in this Summary of Material Modifications. Please keep this document with your Summary Plan Description and other important papers so that you may refer to it in the future when you have questions about your benefits under the Fund.

The benefit improvements described below are effective on the dates set forth below.

1. **HRA for Active Participants**

   Effective January 1, 2026, the Board of Trustees has adopted a Health Reimbursement Arrangement (or "HRA") benefit for active participants who have group health coverage under the Fund. The HRA provides for reimbursement of eligible, out-of-pocket medical expenses incurred by participants, the participants' spouse and the participants' covered dependent children. **Attached is a description of the HRA in an easy to read "Question and Answer" format.** This information covers the HRA's design, eligibility rules for participation, reimbursements available under the HRA, and other details about how the HRA works.

   The Fund has engaged a vendor called WEX to provide debit cards to you for reimbursement of your medical expenses under the HRA. Please watch your mail for more detailed information from WEX.

2. **Marc Cuban Cost Plus Program**

   The Board of Trustees has approved an arrangement with the Marc Cuban Cost Plus Program (or "MC Program") to give Fund participants access to Benzavvy, a high-cost diabetes drug, at a zero-dollar ($0) cost to the participant. **Effective November 1, 2025, SavRx, the Fund's prescription benefits manager, will process all prescription fills for Benzavvy by using the MC Program, which will result in the participant obtaining this drug with no out-of-pocket costs.** If you are currently taking Benzavvy for your medical conditions, or are eligible to change to it, you will receive a separate communication from the Fund with information on how to take advantage of the MC Program to obtain this drug at zero-dollar cost to you.

3. **Dental Plan – Change to Network Provider**

   The Board of Trustees has approved a new dental network provider for your Dental benefits under the Fund. **Effective March 1, 2026, the dental network provider will be Delta Dental of Illinois, (Delta Dental Premier and Deltal Dental PPO).** On and after that date, the Fund will use Delta Dental of Illinois fee schedule to determine the benefits to be paid for dental services. None of your other dental benefits or any other

terms and conditions applicable to your dental benefits under the Plan have changed. Please go to www.deltadentalil.com/find-a-provider/dental/ for a current list of participating dental providers in the Delta Dental network.

4. **Retiree Health Plan – Enrollment of Spouses and Dependent Children**

Effective October 1, 2025, the Board of Trustees has amended the Retiree Health Plan to add the following language to the end of Section 3.1.c (Eligibility) relating to the enrollment of spouses and dependent children in the Retiree Health Plan by participants who are on workers' compensation when they reach age 65:

If you are on workers' compensation when you attain age 65, you may enroll your Spouse and Child/Children in the Plan on your later retirement, provided that:

- you, your Spouse and your Child/Children remained continuously enrolled in a group health plan without any break in coverage during the period of your absence from work due to a work-related injury through the date of your actual retirement, and
- you retire immediately upon the cessation of employer contributions to the Fund on your behalf and enroll your Spouse and Child/Children in the Plan effective at the time of your retirement.

5. **Retiree Health Care Premiums.**

The Board of Trustees has reduced the premium charged to participants for coverage under the Fund's Retiree Health Plan. **Effective January 1, 2026, the new premium will be $350.00 for a single person and $400.00 for 2 or more persons**. The new reduced premium will apply to any participant who is currently enrolled in the Retiree Health Plan as of January 1, 2026, and to any new participant who enrolls on or after that date.

If you have any questions about these benefit improvements or any of your benefits under the Fund, please call the Fund Office at (773) 254-2500.

Sincerely,

THE BOARD OF TRUSTEES OF THE INTERNATIONAL BROTHERHOOD OF TEAMSTERS LOCAL NO. 710 HEALTH & WELFARE FUND

December 1, 2025

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 710hwp.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.710hwp.org.com or call 1-773-254-2500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$300 per Individual $900 per Family**	Generally, you must pay all of the costs from the providers up to the deductible amount before this plan begins to pay. If you have other family members on this plan, each family member must meet their own deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, most Preventive care is covered before you meet your deductible.	For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https:\\healthcare.gov/preventive-care-benefits/.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**For Network providers: $2,000 Individual/$6,000 Family; For Out-of-Network providers: $9,450 Individual/$18,900 Family**	The Out-of-Pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Non-covered expenses	Even though you pay these expenses, they don't count toward your Out-of-Pocket limit unless they are claims paid in accordance with the "No Surprises Act."
Will you pay less if you use a network provider?	Yes. Go to https://www.bcbs.com/find-a-doctor	This plan uses a provider network. You will pay less if you use a provider in the plan's networks. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (
Do you need a referral to see a specialist?	No.	

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Specialist visit	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Preventive care/screening/ immunization	no charge	25% coinsurance; deductible applies	
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Imaging (CT/PET scans, MRIs)	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Savrx.com	Generic drugs	No charge	No charge	
	Preferred brand drugs	25% coinsurance	25% coinsurance	
	Non-preferred brand drugs	45% coinsurance	45% coinsurance	
	Specialty drugs	25% co-insurance max of $200 per script	not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Physician/surgeon fees	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you need immediate medical attention	Emergency room care	15% coinsurance; deductible applies	15% coinsurance; deductible applies*	
	Emergency medical transportation	15% coinsurance; deductible applies	15% coinsurance; deductible applies*	
	Urgent care	15% coinsurance; deductible applies	15% coinsurance; deductible applies*	
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance; deductible applies	20% coinsurance; deductible applies*	
	Physician/surgeon fees	5% coinsurance; deductible applies	20% coinsurance; deductible applies*	

*For more information about limitations and exceptions, see the plan or policy document at https://710hwp.org/app/uploads/2018/03/2018-Health-and-Welfare-spd.pdf. Also, for Emergency Services in an Out-of-Network Provider or Ancillary Services from a Non-Network Provider in a Network facility, you are responsible

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

■ The plan's overall deductible	$300
■ Specialist *[cost sharing]*	15%
■ Hospital (facility) *[cost sharing]*	5%
■ Other *[cost sharing]*	15%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	5%
What isn't covered	
Limits or exclusions	none
The total Peg would pay is	**$620**

■ The plan's overall deductible	$300
■ Specialist *[cost sharing]*	15%
■ Hospital (facility) *[cost sharing]*	5%
■ Other *[cost sharing]*	%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	15%
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$795**

■ The plan's overall deductible	$300
■ Specialist *[cost sharing]*	15%
■ Hospital (facility) *[cost sharing]*	15%
■ Other *[cost sharing]*	%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	0
Coinsurance	15%
15%What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$375**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Inpatient services	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you are pregnant	Office visits	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Childbirth/delivery professional services	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Childbirth/delivery facility services	5% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you need help recovering or have other special health needs	Home health care	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Rehabilitation services	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Habilitation services	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Skilled nursing care	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
	Durable medical equipment	15% coinsurance; deductible applies	25% coinsurance; deductible applies	$15,000 max payment per calendar year, excludes vehicle and home modifications, exercise, and bathroom equipment
	Hospice services	15% coinsurance; deductible applies	25% coinsurance; deductible applies	
If your child needs dental or eye care	Children's eye exam	paid in full	$40	VSP (800) 877-7195 vsp.com
	Children's glasses	up to $150		
	Children's dental check-up	20% coinsurance	30% coinsurance	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Hearing Aids

*For more information about limitations and exceptions, see the plan or policy document at https://710hwp.org/app/uploads/2018/03/2018-Health-and-Welfare-spd.pdf. Also, for Emergency Services in an Out-of-Network Provider or Ancillary Services from a Non-Network Provider in a Network facility, you are responsible

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 773-254-2500.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 773-254-2500.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[773-254-2500.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 773-254-2500.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, see the plan or policy document at https://710hwp.org/app/uploads/2018/03/2018-Health-and-Welfare-spd.pdf. Also, for Emergency Services in an Out-of-Network Provider or Ancillary Services from a Non-Network Provider in a Network facility, you are responsible

INTERNATIONAL BROTHERHOOD OF TEAMSTERS LOCAL NO. 710
HEALTH & WELFARE FUND

HEALTH REIMBURSEMENT ARRANGEMENT FOR ACTIVE PARTICIPANTS

SUMMARY

INTRODUCTION

Effective January 1, 2026, the Fund will offer a health reimbursement arrangement (called, an "HRA") to all active Fund participants who have coverage under the Fund's Group Health Plan. An HRA is a medical plan that provides for reimbursement of Eligible Medical Expenses incurred by Participants and the Participants' Spouse and Dependents. Participants who are covered under the Fund on account of their active employment will have coverage under the Fund's Group Health Plan as well as the HRA.

QUESTIONS AND ANSWERS

1. What is a Health Reimbursement Arrangement?

An HRA is a medical plan to assist Participants in paying for otherwise unreimbursed medical expenses incurred by the Participants and the Participants' Spouse and Dependents.

2. Who is eligible to participate in the HRA?

Individuals who have coverage under the Fund's Group Health Plan on account of their active employment will be eligible to participate in the HRA.

3. When will participation in the HRA begin?

An individual who is enrolled in coverage under the Fund's Group Health Plan on account of their active employment on January 1, 2026, will become covered under the HRA on that date. After January 1, 2026, an individual will begin participation in the HRA at the time of his or her enrollment in the Fund's Group Health Plan on account of active employment.

4. What is an HRA Account?

Upon beginning participation in the HRA, the Fund will establish an account for the Participant ("HRA Account"). The Participant can use the HRA Account for reimbursement of Eligible Medical Expenses incurred by the Participant and the Participant's Spouse and Dependents.

Reimbursements for Eligible Medical Expenses incurred by the Participant and the Participant's Spouse and Dependents, and submitted to the HRA for reimbursement, will be charged against the Participant's HRA Account.

The HRA Account for each Participant in the HRA is merely a recordkeeping account for the purpose of keeping track of contributions, reimbursements, and remaining amounts available for reimbursement.

The Fund will ***not*** create a separate fund or account for this purpose or otherwise segregate any assets for the benefit of the Participant.

5. What amount will be credited to the HRA Account each year?

The amount credited to a Participant's HRA Account each Plan Year is called the Annual Benefit. The Annual Benefit will be determined in the sole and absolute discretion of the Board of Trustees of the Fund. Any change to the Annual Benefit will be communicated to the Participants in writing in advance of any such change.

For the 2026 calendar year (and thereafter until changed by the Board of Trustees), the Annual Benefit will be $1,000. The Annual Benefit will be allocated to Participants' HRA Accounts on a monthly prorated basis. That is, an amount equal to $83.33 will be allocated to a Participant's HRA Account for each month during the calendar year in which the Participant is an active employee of a contributing employer to the Fund.

6. Are participants permitted to make contributions to the HRA?

Participants are not permitted to make any contributions to the HRA. The HRA is funded solely from contributions to the Fund by contributing employers.

7. What happens to unused amounts in the HRA Account at the end of the calendar year?

Any unused amounts in the participant's HRA Account at the end of the calendar year will remain in the participant's HRA Account (that is, unused amounts are "rolled over" to the next year) and will remain in the Participant's account until the amounts in the HRA Account have been exhausted by reimbursements to the participant for Eligible Medical Expenses of the Participant and the Participant's Spouse and Dependents.

The amount available for reimbursement at any time is the amount credited to the Participant's HRA Account as of that date in the calendar year, plus any unused amounts rolled over from prior calendar years, and minus any prior reimbursements from the HRA Account for Eligible Medical Expenses.

8. What happens to the Participant's HRA Account if the Participant terminates employment?

If a Participant terminates employment and ceases active participation in the Fund during the year, the monthly allocations to the Participant's HRA Account will cease, subject to a COBRA election. However, the former employee will remain a Participant in the HRA solely for purposes of reimbursement of Eligible Medical Expenses until the amount credited to the Participant's HRA Account at the time of his termination of employment is fully depleted. A former employee or beneficiary may use the amount in the HRA Account to pay the COBRA premium.

9. What happens to a Participant's HRA Account if the Participant dies before the amount is depleted?

If a Participant dies, the Participant's surviving Spouse and Dependents may submit claims for medical expenses incurred by them until the funds in the HRA Account are depleted.

10. What are Eligible Medical Expenses?

"Eligible Medical Expenses" means expenses incurred by a Participant or the Participant's Spouse or Dependents for medically necessary health care. For purposes of the HRA, medically necessary health care means amounts paid for "medical care" as defined in Section 213(d) of the Internal Revenue Code, including, for example, amounts incurred (deductibles, copayments, coinsurance) for certain hospital bills, doctor and dental bills, prescription drugs and vision care. Use the following link for more information regarding Eligible Medical Expenses: https://www.wexinc.com/resources/benefits-toolkit/eligible-expenses/.

Eligible medical expenses shall not include any of the following: (1) health insurance premiums for individual policies or for any other group health plan (including the Group Health Plan sponsored by the Fund); (2) any expenses that are not eligible for reimbursement under Section 213(d) of the Internal Revenue Code; and (3) any other expenses as determined by the Board of Trustees in its sole discretion.

The Fund reserves the right, in consultation with advisors, to deny reimbursement of expenses if the health care service for which reimbursement is sought is not medically necessary. In making medical necessity determinations, the Board of Trustees of the Fund, in consultation with its advisors, will look to what is commonly and customarily considered appropriate health care treatment in the United States.

11. When are medical expenses incurred?

Medical expenses are incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical expenses incurred before the effective date of the HRA (January 1, 2026), or before an individual first begins participation in the HRA, are not eligible for reimbursement.

12. Are there other limitations on reimbursement of medical expenses?

Medical expenses may be reimbursed from the Participant's HRA Account only to the extent that the Participant (or the Participant's Spouse or Dependent) is not reimbursed for the expense through the Fund's Group Health Plan, other group health coverage, any insurance, or any other accident or health plan. If only a portion of a medical expense has been reimbursed elsewhere (e.g., because the other plan imposes co-payment or deductible limitations), the HRA Account may reimburse the remaining portion of such expense, if it otherwise meets the requirements of the HRA.

The HRA Account cannot be used to reimburse the Participant for any medical expenses incurred prior to the effective date of the HRA (January 1, 2026) or prior to the Participant's participation in the HRA.

You should consult your tax professional regarding amounts received under the HRA.

13. How do I use my HRA Debit Card to pay for Eligible Medical Expenses?

The Fund has contracted with a vendor called WEX to provide you with a debit card ("HRA Debit Card") to use for Eligible Medical Expenses at certain retailers and providers. You will receive two HRA Debit Cards from WEX for you to use, as well as instructions on how to access your WEX online account and the WEX app on your mobile device.

Each time you swipe your HRA Debit Card at an eligible retailer or provider, your available HRA balance will be electronically debited to pay for the Eligible Medical Expense. According to IRS regulations, you must still substantiate certain expenses to confirm that they are for Eligible Medical Expenses. When an expense on your HRA debit card needs to be substantiated, WEX will send you a request for documentation, either by email or by mail if your email is not on file with WEX. Simply log in to your WEX online account or WEX mobile app to upload the documentation (e.g., detailed receipt) showing the date, type, provider and cost of service.

14. How do I submit claims for reimbursement of Eligible Medical Expenses if I do not use my HRA Debit Card at the retailer or provider?

If you do not use your HRA Debit Card to pay for your medical expenses, you may submit claims to WEX for reimbursement of Eligible Medical Expenses incurred by you, your Spouse or your Dependents. You may submit these claims for reimbursement by logging into your WEX online account or the WEX app on your mobile device to upload the claim, including a detailed receipt showing the date, type, provider and cost of service. You may also submit your claim to WEX by mail or fax.

Mail:
WEX
P.O. Box 2926
Fargo, ND 58108-2926

Fax: 866-451-3245

All claims must be submitted no later than one year following the date on which the medical expense was incurred.

WEX will respond to your claim for reimbursement in accordance with its standard internal procedures for responding to claims for benefits under the HRA. For more information, please call WEX, toll-free, at 866-451-3399 or write to WEX at the above address.

15. What information is required for a claim for reimbursement?

For a claim for reimbursement, the Participant must submit the following: (1) documentation of the medical expenses; and (2) a certification that (i) no other insurance covers the expenses, (ii) no other claim for reimbursement for such expenses has been submitted to any other plan or coverage, and (iii) no deduction for such expenses has previously been taken under Section 213 of the Internal Revenue Code. For certain claims, a "medical necessity" form must be submitted. WEX will contact you with more information if the "medical necessity" form applies to your claim.

Appropriate documentation may include receipts, invoices, bills, insurance records, and any other necessary information to support the claim. You may also submit your Explanation of Benefits to WEX

which will include the necessary information for your claim. Each claim must clearly indicate the date on which the medical expense was incurred, the type of service, the provider and the cost of the service. For a medicine or drug, the Participant must submit either a copy of the prescription along with the receipt showing the date of the sale and the amount of the charge, ***or*** a receipt from the pharmacy that identifies the name of the person to whom the prescription applies, the date and amount of the purchase and an Rx number.

16. How should a Participant appeal the denial of a claim for benefits?

WEX is responsible for processing all appeals of denied claims for benefits under the HRA. If WEX denies your claim under the HRA, you may submit an appeal to WEX, including the reasons for your request for review, within 180 days of the first denial date. You may want to review this short video on how to submit an appeal of a claim denial: https://app.screencast.com/MZT0GZfnqdSap

WEX will make a decision on the appeal in accordance with its standard internal appeals procedures. For more information, on the process for an appeal and your rights on denial of your claim and the appeal of the denial of your claim, please reach out to WEX, toll-free, by phone at 866-451-3399 or by fax at 866-451-3245. You may also write to WEX at P.O. Box 2926, Fargo, ND 58108-2926.

17. How should an individual appeal the denial of eligibility for coverage under the HRA?

The Fund will handle all eligibility determinations. If the Fund determines that you are not eligible for coverage under the HRA, you may appeal this decision to the Board of Trustees by following the procedures set forth in Section 22 in the SPD (Claim Appeals) for appealing an eligibility determination. The Board of Trustees will respond to the appeal regarding your eligibility in the manner and within the time period as set forth in Section 22 of the SPD. Please refer to Section 22 of the SPD for detailed information on appealing eligibility determinations.

18. How are the expenses of the HRA paid?

All expenses of the HRA will be paid solely by the Fund. It is the responsibility of the Board of Trustees, in consultation with the various professional advisors it may hire (attorneys, recordkeepers, third-party administrators, accountants and other consultants), to ensure that the HRA is operated in the best interests of the Participants and beneficiaries.

19. Termination and Amendments

Although the Board of Trustees hopes to continue providing this benefit in the future, the Board of Trustees reserves the right to terminate the HRA at any time and for any reason in its sole discretion. In the event of the termination of the HRA, all then current Participants will cease participation in the HRA and will cease to be eligible for any reimbursements from the HRA for any medical expenses, whenever incurred, except to the extent otherwise determined by the Board of Trustees.

The Board of Trustees may change, amend, or alter any provision of the HRA at any time and for any reason in its sole and absolute discretion, including without limitation the amount and allocation of the Annual Benefit.

All Participants will receive written notice of any changes or amendments to the HRA in advance of the effective date of any change.

20. HRA Interpretation

The Board of Trustees has the sole and absolute discretion to determine eligibility to participate in the HRA. The Board of Trustees also has the sole and absolute discretion to make determinations regarding the eligibility of an expense for reimbursement under the HRA. All determinations by the Board of Trustees shall be made in a non-discriminatory manner and consistent with applicable laws. In making such decisions, the Board of Trustees has the sole and absolute discretion to determine the relevant facts, to apply the law to the facts, and to construe and interpret the terms of the HRA. The decisions of the Board of Trustees with respect to eligibility to participate in the HRA and with respect to medical expenses reimbursable hereunder shall be final and binding in accordance with applicable law. All determinations of the Board of Trustees with respect to any matter hereunder shall be conclusive and binding on all persons and entitled to the maximum deference permitted under the law.

21. Definitions

"Dependent" means any individual (a) who is the Participant's natural child, stepchild, legally adopted child (or child lawfully placed for adoption) or eligible foster child (as defined in Code §152(f)(1)) and (b) who has not reached age 26. An unmarried child who is physically or mentally disabled is covered under the HRA regardless of age, if he or she was disabled before the age of 19 and if the Participant claims the child as a dependent on the Participant's federal income tax return for the Plan Year.

"Eligible Medical Expenses" has the meaning set forth in Q&A-10.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"Group Health Plan" means the health care plan or plans that the Fund maintains for its Participants (and for the Participants' Spouse and Dependents who may be eligible under the terms of such plans) and that provide "minimum value" within the meaning of the Patient Protection and Affordable Care Act (ACA). The Fund may substitute, add, subtract or revise at any time the menu of such plans and/or the benefits, terms, and conditions of such plans.

"HRA Account" means the HRA Account described in Q&A-4.

"HRA Debit Card" has the meaning set forth in Q&A-13.

"Participant" means an individual who has coverage under the Fund's Group Health Plan on account of his or her active employment with a contributing employer to the Fund.

"Plan Year" means the 12-month period beginning January 1 and ending December 31, except in the case of a short plan year which includes the initial Plan Year, a year in which the Plan Year is changed or the year in which the HRA is terminated, in which case the Plan Year shall be the entire short plan year.

"Spouse" means an individual who is legally married to a Participant as determined under applicable

state law (and who is treated as a spouse under the Internal Revenue Code).

22. Opt-Out Rights

The HRA constitutes minimum essential coverage, as defined under Section 5000A of the Internal Revenue Code, for purposes of complying with the individual mandate under the Patient Protection and Affordable Care Act (ACA). Enrollment in the HRA will preclude an individual from claiming premium tax credit (premium subsidy) under section 36B of the Internal Revenue Code for individual coverage obtained through the Health Insurance Marketplace. The U.S. Department of Labor requires that employees be permitted to either irrevocably suspend their HRA for a fixed period of time *or* permanently opt-out of the HRA by forfeiting their account balance and waiving any future contributions. Electing either option would preserve the eligibility of the individual to claim a premium subsidy for coverage obtained through the Health Insurance Marketplace.

If you wish to assure your eligibility for premium subsidies for coverage obtained through the Health Insurance Marketplace, you may want to elect to opt out of the HRA for a fixed period of time or permanently by forfeiting your account balance and waiving any future reimbursements of amounts available to you. If you choose to suspend your HRA, you, your Spouse and your Dependents will cease to have access to the HRA during the suspension and will be ineligible for reimbursement of any Eligible Medical Expenses incurred during the suspension. If you wish to reactivate your suspended account for the following Plan Year, you must provide notice of your intent in writing.

The Board of Trustees does not provide any tax or legal advice to Participants and makes no commitment or guarantee that any amounts paid to or for the benefit of a Participant, Spouse or Dependents under the HRA will be excludable from gross income for federal, state or local income tax purposes. You should contact your financial and tax advisors for further information.

23. Non-Assignment of Benefits and Rights

Except as may otherwise be required by applicable law, the right to receive any benefit payments under any provision of this HRA is personal to the Participant, or to the Participant's Spouse or Dependents, as applicable. As such, the HRA does not recognize any assignment, in whole or in part, to any person or entity, including without limitation to a healthcare provider, for any reason, including the right to payment of reimbursements, the right to pursue or appeal a claim, or any other right to which the Participant, the Participant's Spouse or Participant's Dependents may be entitled under the HRA, ERISA or other applicable law, procedure or regulation. No benefits or coverage under the HRA may be transferred by the Participant, the Participant's Spouse or Participant's Dependents to any other person or entity at any time. Under no circumstances will the HRA's direct payment of any amounts to any person or entity constitute a waiver of this non-assignment provision with respect to any party, including an in- or out-of-network provider, nor will any such direct payment make any party an assignee to the Participant's rights, or to the rights of the Participant's Spouse or Dependents, under the HRA, or confer on any provider any rights under the HRA or ERISA.

CONCLUSION

The Board of Trustees hopes that this information has answered your questions about the HRA offered under the Teamsters Local Union 710 Health and Welfare Fund and has explained how to obtain

reimbursement of Eligible Medical Expenses incurred by you and your Spouse and Dependents. Again, please keep this information with your other important documents so that you can refer to it when you have questions about the HRA.

WEX Benefits Card

Our benefits debit card is the fastest and most convenient way to access your funds and pay for eligible expenses. Just one debit card is all you need for your card-eligible benefits with us.

While the IRS requires documentation for certain spending and reimbursement benefits, we automate some of that substantiation through:

IIAS approval: If a merchant uses the Inventory Information Approval System (IIAS), the debit card will automatically approve eligible expenses. You can view a list of IIAS merchants at www.sig-is.org/card-holders/store-locator.

Copayments: If your employer provides us copayment amounts for your insurance plans, we can auto-approve expenses that match these copayment amounts.

Recurring claims: If you use your debit card for a purchase that requires substantiation, once the claim has been approved and you make that same purchase for the same dollar amount at that merchant, the recurring claim will be automatically approved.

How do I get a card?

We'll automatically mail you two debit cards to the address listed in your account the first time you enroll. If you're already enrolled, continue using the debit card you have.

Additional cards

You can request additional debit cards for your spouse or dependents from your online account. Log in, under Accounts select Banking/Cards.

Expiring debit card

We will automatically mail you a new debit card 30 or more days prior.

Lost or stolen cards

If your debit card is lost or stolen, you can report it in your online account or mobile app and request a new card.