SUMMARY PLAN DESCRIPTION

of the

Plan of Benefits

of the

TEAMSTERS HEALTH
AND WELFARE FUND
OF PHILADELPHIA AND VICINITY

HMO

March 2013

This Summary Plan Description ("SPD" or "Booklet") constitutes the Fund's Plan document. This Booklet contains the Fund's complete Health and Welfare Benefit program as of the date of publication. The only benefits to which you are entitled are those stated in this booklet, and are determined by the rate of contribution as defined in the Collective Bargaining Agreement between your Employer and Union. For those Members enrolled in the HMO Plan, your hospital and medical/ surgical benefits are those set forth in the Aetna Member Handbook which is incorporated into this document. From time to time, the Fund's Trustees may amend your Plan, the details of which are set forth in this Booklet. Should that occur, the Fund routinely advises you of such changes in the Fund's newsletter or by way of special bulletins.

The only person authorized to advise you of your rights under this Plan is the Fund Administrator, William J. Einhorn, or his specific designee.

Reliance upon information from any other source is at your own risk.

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Reach us on the Web at www.teamsterfunds.com

Among other employees, the Health & Welfare Fund covers
employees represented by these Teamsters Locals

Local 107 Local 115 Local 312 Local 326 Local 331 Local 384
Local 463 Local 500 Local 623 Local 628 Local 676 Local 929

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(Legal process may also be served upon a Trustee)
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Dear Participants: March 2013

Several years have passed since our last SPD was published. In the intervening years, many amendments to the Fund's plan of benefits and new types of benefit programs have been adopted by your Board of Trustees, including several mandated by the Patient Protection Affordable Care Act (the Affordable Care Act). This updated SPD incorporates those changes, as well as others, into a single source for your reference.

The "Dual Option" medical program, the Dental PPO, Vision PPO, Behavioral Health and Disease Management Programs have served as models upon which other benefit plans have relied and copied. The Fund's service agreements with Horizon Blue Cross and Aetna provide members with a permanent identification card, good anywhere in the country and at the same time, have streamlined hospital claim processing with significant savings to the Fund.

You can help conserve your valuable benefits by:

- Discussing fees with your physician. He or she estimates what he or she thinks you can pay. If you do not act concerned, he or she may overestimate.
- Requesting outpatient hospital care whenever possible.
- Questioning what appears to be unnecessary hospital treatment or charges as you would if you were paying the bill. Remember, your medical coverage has a annual limit!
- Requesting that your physician not keep you in the hospital for any longer than necessary.
- Following your physician’s advice regarding steps to take care of your medical condition.
- Taking advantage of the services offered through the Fund’s Disease Management program.

Take the time to read the material in this booklet. These are valuable benefits that are of critical importance to you and your family. Every effort has been made to describe your benefit coverage in easy-to-understand language. Nevertheless, health coverage is a complicated item that oftentimes does not lend itself to easily described terms and concepts. For that reason, the Fund maintains a Member Services Department staffed with highly trained personnel, well versed in the Fund's plans, and ready to assist you in answering your questions and benefit inquiries.

We hope you will agree that these are valuable benefits to be used wisely. Get the most value for each of your Fund dollars by being an *aware, informed and concerned* health benefits consumer.

Sincerely,

THE BOARD OF TRUSTEES

William Hamilton, Jr., Local 107 (Union Co-Chairman)
Howard Wells, Local 676
Robert "Rocky" Bryan, Jr., Local 929

Kenneth F. Leedy (Employer Co-Chairman)
Bob Schaeffer, Jr., Transport Employers Assoc.
Tom J. Ventura, YRC Worldwide, Inc.

WHAT TYPES OF BENEFITS ARE OFFERED THROUGH THE FUND?

The Teamsters Health and Welfare Fund of Philadelphia and Vicinity provides the following types of benefits to eligible Members and their dependent beneficiaries:

1. Medical benefits

2. Prescription drug coverage;

3. Behavioral health and substance abuse treatment;

4. Dental benefits;

5. Short terms disability benefits;

6. Vision benefits; and

7. Life insurance and accidental death and dismemberment benefits.

All of the benefits provided through the Fund are subject to certain eligibility provisions and exclusions, which are set forth in more detail in this Summary Plan Description, which also serves as the Fund's Plan Document.

HOW ELIGIBILITY TO PARTICIPATE IN THE FUND WORKS

I. WHEN DOES A FUND MEMBER BECOME ELIGIBLE TO PARTICIPATE IN THE FUND?

There are two ways a Fund Member becomes eligible to receive Fund benefits, both of which depend upon the terms of the Member's Collective Bargaining Agreement with his or her Employer. If your[1] Employer is required to make contributions to the Fund on your behalf in the form of a *monthly premium* (instead of a stated amount per hour or day), then you will be eligible for benefits during the month in which the premium is due to be paid by your Employer. This is called "same month eligibility."

If, on the other hand, your Employer makes contributions to the Fund based on an hourly or daily rate, then you are subject to the Fund's "regular eligibility" provisions. The following qualifying schedule illustrates how regular eligibility works:

If your Employer makes contributions to the Fund on your behalf for at least 15 days during the month of :	Or, if your Employer makes contributions on your behalf for 180 days during the months of:	Then you will be eligible for Fund benefits during the month of:
November	December through November	January
December	January through December	February
January	February though January	March
February	March through February	April
March	April through March	May
April	May through April	June
May	June through May	July
June	July through June	August
July	August through July	September
August	September through August	October
September	October through September	November
October	November through October	December

II. WHICH TYPES OF DEPENDENTS ARE COVERED BENEFICIARIES UNDER THE FUND, AND WHEN DO THEY BECOME ELIGIBLE FOR FUND BENEFITS?

Certain members of your family qualify as Dependent beneficiaries under the terms of the Fund. They are as follows:

A. Your Spouse (as defined herein), as long as you are not separated, which means you are living separate and apart (even under the same roof) with an intent to abandon or terminate the marital relationship.

B. Your dependent children, which include your natural or adopted, adult, non-handicapped children who have not reached the age of twenty-six (26), whether married or unmarried, provided through December 31, 2013, said adult children are not eligible for other employer-sponsored health plans coverage (other than through the Plan covering your spouse).

C. Your wholly dependent, unmarried children who are physically or mentally incapable of self-support upon attaining age twenty-six (26) will continue to be covered PROVIDED you furnish the Fund office with proof of this incapacity BEFORE their coverage terminates at age twenty-six (26). You should request the appropriate form from the Fund office. Thereafter, yearly certifications are required to verify the continuing nature of the dependent's handicapped status.

D. Your wholly dependent parents, provided that you are unmarried and have no other dependents and such parents are living in your household. The Fund's coverage will be secondary for parents who are eligible to apply for benefits under any medical assistance program for the aged provided by a State or the Federal Government.

[1] The words "you" and "your" in this SPD refer to Fund Members, generally, and in some cases their Dependent beneficiaries.

There are a few exceptions to these general rules, which are important to note. First, any individual who is a full-time Member of the Armed Forces or who is eligible for coverage as an Employee under this plan is not eligible to be a Dependent under this Fund. Second, when both a husband and wife are covered by the Fund as eligible Members, Fund deductibles, coinsurance, and co-payments will not be taken. Beyond that, payment will be determined based upon Fund allowances (UCR, etc.) and under Coordination of Benefits (see General Provisions and Definitions section).

A SPECIAL NOTE FOR "SINGLE" EMPLOYEES:

Some collective bargaining agreements provide for "employee only" health and welfare benefit coverage, which the Fund refers to as "Single" employee status. If you are or become a "Single" employee, as determined by the Fund, the benefits described in this booklet are limited to you, the employee. Contact the Fund if you are unsure as to your status as a "Family" or "Single" employee. NO COVERAGE IS PROVIDED FOR THE SPOUSE OR DEPENDENT CHILDREN OF A "SINGLE" EMPLOYEE.

III. HOW DOES A MEMBER OR DEPENDENT BENEFICIARY LOSE HIS OR HER ELIGIBILITY FOR FUND BENEFITS?

There are circumstances when a Fund Member or his or her Dependent beneficiary may lose their eligibility for Fund benefits. Those circumstances are described below:

A. Loss of Participant Eligibility

Your eligibility automatically terminates if any of the following events take place:

- When you have less than the required number of contribution days to your credit in accordance with the qualifying schedule for regular eligibility on page 2 and do not qualify for the Extension of Benefits Provisions on page 5; or
- When you cease to be a Member of a class of employees covered by your Employer's Collective Bargaining Agreement with a participating Local Union, or otherwise no longer qualify as a Member as defined herein, (except if you leave Covered Employment prior to retirement, you may continue to exhaust earned eligibility credits for a period not to exceed two (2) months); or
- When you become self-employed outside the scope of a Collective Bargaining Agreement; or
- When the benefit program is terminated; or
- Immediately upon the date on which any Participating Local Union and Contributing Employer(s) agree that the then Contributing Employer(s) shall no longer make contributions to the Fund on your behalf.

NOTE: YOUR EMPLOYER'S ACTIONS ALSO AFFECT YOUR ELIGIBILITY!

A Member's eligibility and his or her dependents' eligibility will be suspended automatically if his or her Employer becomes more than two (2) months delinquent in remitting contractually required contributions to the Fund. Eligibility for Fund benefits will be reinstated if and when the Member's Employer remits all delinquent contributions to the Fund, provided that the Member is otherwise eligible for such benefits.

Also, if your collective bargaining agreement expires and it is not promptly replaced by an interim agreement or new collective bargaining agreement, the Fund has no choice but to suspend your benefits until a new agreement is put into place.

No matter what else might be written in this Booklet, a Member will not be eligible for benefits incurred during any Benefit period in which:

A. His or her Employer is not a Contributing Employer, or

B. His or her Employer is making contributions or payments of any kind to any party (other than this Fund) for the purpose of providing Health and Welfare benefits to the Member which duplicate in any way the benefits provided under this Fund.

B. Loss of Dependent Eligibility

A Dependent beneficiary's eligibility for Fund benefits will automatically terminate if any of the following events take place:

1. When the Member's eligibility terminates; or

2. When a dependent enters full-time military, naval or air service; or

3. When a dependent ceases to be a "dependent" as defined herein; or

4. In the case of children:

   a. When a Member's child(ren) attain the age of 26 years, except children who are physically or mentally incapable of self-support; or

   b. When a dependent child becomes eligible as an employee under a group health plan sponsored by any employer.

NOTE: IF YOUR FAMILY STATUS CHANGES

It is important that you give prompt, written, notice to the Fund office on a Census Card of any change in your Family Members, such as marriage, birth of a child, death of your spouse, divorce, or separation as these events are what is known as a "change in status." (Furthermore, a description of the procedures governing qualified medical child support order determinations can be obtained, without charge, from the Fund office.) The failure to report any change in your Family Members may result in a delay of payment of a claim at a future date or may adversely affect your COBRA right to continuation coverage, which is described below.

Census Cards are always available at the Fund office or on the Fund's web site, www.teamsterfunds.com. In certain situations you may be required to submit a certified copy of your most recent federal income tax return and other necessary documents in order to establish proof of dependency for a particular Family Member when a change in status occurs. Similarly, it is most important that you immediately notify the Fund of any change in your address.

IV. THERE ARE WAYS TO CONTINUE RECEIVING FUND BENEFITS AFTER OTHERWISE BECOMING INELIGIBLE FOR THEM

There are three separate ways a Fund Member and Dependent beneficiary may continue to receive Fund benefits after he or she becomes ineligible for them. One such method is a result of the Fund's design, while the others are required under federal law.

A. The Fund's Extension of Benefits Provisions

Should a Member lose eligibility because he or she has less than the required number of contribution days to his or her credit as set forth in the qualifying schedule of eligibility, then MEDICAL or DENTAL expenses incurred after the Member or Dependent is no longer eligible for Fund benefits will be considered covered expenses related to a previous eligible claim and payable under this Plan provided the following conditions are satisfied:

1. The current actual charges are related to a diagnosis which was initially treated while the patient was eligible for benefits, and

2. The current actual charges were incurred within ninety (90) days of the initial treatment (that is, first date of service by a medical service provider) of the related injury or disease.

B. COBRA Continuation Coverage

In some cases, should you and/or your dependents become ineligible for coverage under the Fund's Plan of Benefits, you have certain rights, under certain conditions, to continue your coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Under this law, there are circumstances under which you can receive a temporary extension of your health care coverage at group rates. This extension applies to you and your dependents if you and they were covered by the Fund on the day before your or their coverage ended. COBRA refers to these people as "Qualified Beneficiaries."

A Qualified Beneficiary need not show evidence of good health in order to continue coverage. However, the Qualified Beneficiary is obligated to pay a set amount as a premium for this continuation of coverage. The premium that must be paid may be different than the contribution rate being paid by your Employer. The COBRA premium rates are formulated by the Fund's Actuary in accordance with formulas defined in the federal COBRA law. Pro rated credits are given in those cases where the Employer has made some contributions on your behalf, but not enough for you to qualify for normal eligibility.

You have the right to extend your coverage if the coverage ends because:

1. You leave employment with an Employer for reasons other than gross misconduct on your part; or
2. You no longer meet the eligibility requirements.

Your spouse has the right to extend coverage if:

1. You die;
2. You leave employment as described above, or no longer meet the eligibility requirements;
3. You are divorced or separated; or
4. You become eligible for Medicare.

Your dependent children have the right to this extended coverage if:

1. You die;
2. You leave employment as described above, or no longer meet the eligibility requirements;
3. You are divorced or separated (step-children only);
4. You become eligible for Medicare; or
5. They are no longer considered dependents under the provisions of the Fund's Plan of Benefits.

It is the responsibility of the person who will lose coverage to inform the Administrator of a divorce, separation or a loss of dependent child status. The Administrator must be notified, in writing, within sixty (60) days after one of these events occur. If the Administrator is not notified, then that person will not be able to elect to continue his or her other coverage.

Once the Administrator is notified of an event that affects the coverage of a Qualified Beneficiary, the Qualified Beneficiary will be notified that he or she has the right to choose continuation coverage. He or she then has at least sixty (60) days from the date he or she would lose coverage to let the Administrator know that he or she wants to continue coverage. If the Qualified Beneficiary did not choose it, the right to continue the group health coverage would then end. If he or she does choose it, he or she will be offered the right to continue the same coverage he or she was receiving the day before he or she lost coverage, except for the Death Benefit, Accidental Death and Dismemberment Benefit and Weekly Disability Income Benefits. Each Qualified Beneficiary can make a separate choice on whether to continue coverage. However, one person can make an effective choice to continue coverage for everybody. You can choose to continue only your core benefits - hospital, medical, surgical and prescription drug benefits - or these benefits plus your non-core benefits - vision and dental benefits.

1. Certificate of Former Coverage

If you or your dependents lose coverage under the Plan, you will receive a certificate of former coverage. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may request another copy of the certificate within 24 months of losing coverage.

If coverage ended because you left employment, or no longer meet the eligibility requirements, coverage may continue for up to eighteen (18) months. If coverage ended for any other reason, then coverage may be continued for up to thirty-six (36) months. These time periods may be shortened if:

a. The Fund no longer provides group health coverage for any employee;
b. You do not pay the required premium in a timely fashion;
c. You are later employed and are covered by another group health plan that does not contain any exclusion or limitation with respect to a pre-existing medical condition that is applied by the plan;
d. You become eligible for Medicare; or
e. You are divorced, subsequently remarry and are covered under your new spouse's group health plan.

2. Special Rule for Multiple Qualifying Events

If you elect continuation coverage following a termination of employment or reduction in hours and, during the 18 month period of continuation coverage, a second event (other than a bankruptcy proceeding) occurs that would have caused you to lose coverage under the Plan (if you had not lost coverage already), you may be given the opportunity to extend the period of continuation coverage to a total of 36 months. If you elected continuation coverage as the spouse or dependent of a covered employee who experienced a termination of employment or reduction in hours and, during the continuation period the employee or former employee becomes entitled to Medicare, you may be given the opportunity to extend coverage for 36 months from your initial qualifying event.

3. Special Rule for Medicare Recipients

If your Spouse was eligible for or receiving Medicare prior to your qualifying event, then your Spouse may continue his or her coverage under COBRA for up to 36 months. Your continuation coverage, however, may not exceed 18 months in such a situation. If you and your Spouse <u>were not</u> eligible for Medicare prior to your qualifying event, and you become eligible for Medicare during your COBRA continuation period, your continuation coverage will terminate but your Spouse will be able to continue his or her coverage for 18 months or until your Spouse becomes eligible for Medicare, whichever is sooner.

4. Special Rule for Totally Disabled Qualified Beneficiaries

The 18-month period of continuation coverage may be extended for an additional 11 months (up to a total of 29 months), for any individual who is determined to have been disabled (for Social Security purposes) at the time your work hours were reduced, or your employment ended, or any time during the first sixty (60) days of the 18 month period during which you are enrolled in the COBRA program. To qualify for this additional coverage, the individual must provide the Plan with notice, within sixty (60) days of

the date of the determination and before the end of the 18-month coverage period, of Social Security's disability determination, and must remain disabled throughout the additional coverage period. The premium cost for COBRA continuation during the additional coverage period will be approximately 50 percent higher.

If you have any questions about this continuation coverage, please contact the Fund office.

C. Continuation Rights Related to Military Service

If you are a Member of any of the United States Uniformed Services (i.e., Army, Navy, Air Force, Marines, Coast Guard, and Public Health Service), and you are deployed on active duty, you have certain rights to continue or suspend your health and welfare benefits under the Fund's plan of benefits. Those rights are governed under the Uniformed Services Employment and Reemployment Rights Act, which is commonly referred to as "USERRA." Because the Fund is a multiemployer plan, your USERRA continuation rights differ slightly from those provided under a single employer plan. Generally speaking, and assuming your Employer is not required to make contributions on your behalf during your deployment, you have three (3) separate options regarding your health and welfare benefits during a period of active duty with one of the Uniformed Services. ***REGARDLESS OF WHICH OPTION YOU CHOOSE TO ELECT, IT IS CRITICALLY IMPORTANT THAT YOU AND YOUR EMPLOYER CONTACT THE FUND OFFICE TO NOTIFY US OF YOUR DEPLOYMENT AND THAT YOU DISCUSS YOUR CONTINUATION OPTIONS WITH ONE OF THE FUND'S MEMBER SERVICE REPRESENTATIVES.***

Your first option, which also happens to be the Fund's default option, is that you may suspend your eligibility beginning with the first full month following your deployment date. Under this option, you and your dependent beneficiaries will have your eligibility for Fund benefits suspended during your period of service. Upon your return from active duty, your benefits will be reinstated at no cost to you provided that you have sufficient banked eligibility from the period of time preceding your active duty to be eligible for Fund benefits. If you do not have sufficient banked eligibility, you will still be eligible for immediate reinstatement in the Fund, but you will be required to pay for your coverage until you have sufficient work history to be eligible for Fund benefits.

Your second option is to run out your eligibility using the Fund's twelve month look back described on page 2 during your deployment and to suspend your eligibility thereafter. Under this option, your eligibility will continue until such time as you do not have sufficient work history in the preceding twelve months to confer eligibility for fund benefits on you. Once your eligibility runs out, your benefits will be suspended unless you pay for continuation coverage. When you return from active duty, you will still be eligible for immediate reinstatement in the Fund, but you will be required to pay for your coverage until you have sufficient work history to be eligible for Fund benefits. If you do not notify the Fund of your deployment and you or your dependents use your health benefits while deployed, you will be deemed to have elected this option.

Your third option is to save your banked eligibility during the period of active duty, but to continue your health and welfare benefits during your deployment by paying for them. Once you return from active duty, you can cease to pay for your benefits by using your banked eligibility provided you have sufficient banked eligibility from the period of time preceding your active duty to be eligible for Fund benefits. If you do not have sufficient banked eligibility, you will still be eligible, but you will be required to pay for your coverage until you have sufficient work history to be eligible for Fund benefits.

ATTENTION!

Each of the above options assumes your Employer is not required under your collective bargaining agreement to make health and welfare contributions to the Fund on your behalf during your deployment. If your collective bargaining agreement requires your Employer to make Health and Welfare contributions on your behalf during your deployment, you should contact the Fund office to discuss how those contributions will affect your eligibility during your period of active duty.

THE FUND'S MEDICAL PROGRAM AND HOW IT WORKS

If you have received a copy of this document, then you have elected to participate in the Fund's HMO program for medical benefits. The Fund's HMO program requires you to make a smaller financial investment in your health care than the Fund's PPO program, but requires you to, among other things, see an in-network physician to obtain coverage and to obtain a referral before seeing a specialist.

Both of the Fund's medical programs are self-insured, which means that Fund medical benefits are paid out of a trust fund that is funded through the contributions of all of the Fund's participating Employers for the benefit of the Fund's Members and beneficiaries subject to the terms and conditions of this SPD. As a result, the Fund's medical program has been designed to offer a cost-effective, but comprehensive plan of benefits that keeps its Members and beneficiaries healthy through disease management and providing access to a broad network of medical providers and facilities.

The Fund's HMO program participates in the Aetna HMO program. This means that any Aetna participating medical provider in the United States is an "in-network" physician for purposes of the plan. A list of in-network healthcare providers is available at http://www.aetna.com. Non-Aetna providers are considered "out-of-network" providers for purposes of the medical plan. The costs you incur in receiving medical treatment will vary depending on whether you see an in-network or out-of-network medical provider.

Additional details regarding the HMO program are set forth in Aetna Member Handbook document, which is attached to this Booklet as an Appendix. To the extent this Booklet and the Appendix conflict, the terms of this booklet control.

PRESCRIPTION DRUG COVERAGE AND BEHAVIORAL HEALTH BENEFITS ARE COVERED ELSEWHERE

The Fund provides prescription drug coverage and behavioral health (i.e., mental health and substance abuse) benefits to Fund Members and beneficiaries. Those benefits <u>are not</u> part of the HMO program. They are separate benefits that are discussed elsewhere in this SPD.

I. THE PATIENT PROTECTION AFFORDABLE CARE ACT

Our Plan is a “grandfathered health plan” under 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 your plan 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 William Einhorn, Administrator, at the following address:

Teamsters Health & Welfare Fund
of Philadelphia and Vicinity
6981 North Park Drive, Suite 400
Pennsauken, NJ 08109

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

II. HOW THE HMO PROGRAM WORKS

Under the HMO program, your benefits are not subject to a deductible or coinsurance, but they are subject to co-payments and an out-of-pocket limit. In addition, some of the covered services in the HMO program are offered at no expense to you. You are required to obtain a referral in order to see a specialist. Out of network benefits are not covered under the HMO program.

A. Deductibles, Coinsurance, Co-Payments, and the Out-of-Pocket Limit

The specific co-payments and out of pocket limits applicable to you are set forth in the Aetna Member Handbook. As such, it is important to understand what those terms mean to you. A "co-payment" is a fixed amount (for example, $10) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. Once you satisfy your out-of-pocket limit, you are no longer responsible for copayments, but you are still responsible for health care the Fund does not cover.

B. In-Network versus Out-of-Network Care

An in-network health care provider is one who has agreed to accept the pre-negotiated allowable charges as payment in full for the services rendered. This means that the healthcare provider may not bill you for any charges in excess of the applicable co-payment for the service rendered. Such additional charges are referred to as "balance billed charges." If you receive any balance billing from an in-network health care provider, please contact Aetna member services for assistance.

Out-of-network providers have not agreed in advance to accept the Fund's allowable charges as payment in full for the services rendered to you. Under the HMO program, the Fund will not pay out-of-network providers for services rendered to Fund Members and their Dependent beneficiaries. You will be responsible for all charges you or your Dependent beneficiaries incur with an out-of-network provider.

EXAMPLE: IN-NETWORK VS. OUT-OF-NETWORK PROVIDERS

1. In-Network Example

Bill goes to Dr. Smith, an in-network provider, because he thinks he has the flu. Bill has a $10 co-payment for the office visit and Dr. Smith bills the Fund $150 for the visit. The Fund's allowable charge for the office visit is $100. The Fund will pay Dr. Smith $90 for the office visit, and Dr. Smith will accept the $100 he has received from Bill and the Fund as payment in full for his services rendered.

2. Out-of-Network Example

Maria goes to Dr. Jones, an out-of-network provider, because she thinks she has the flu. Dr. Jones bills the Fund $150 for the visit. The Fund's allowable charge for the office visit is $0 because Dr. Jones is an out-of-network physician. The Fund will not pay Dr. Smith for the office visit. Maria will be responsible for $150 for the office visit.

C. Some of the HMO Program's Key Features

The HMO program has several other key features that the Fund believes provide an exceptional value to Fund Members and their beneficiaries. Here are just some of the highlights of the program's in-network benefits:

1. Women over 40 may receive an annual mammogram with no out-of-pocket expense to them;

2. Women receive an annual routine gynecological examination without the need for a referral with a $20 copayment;

3. Men over the age of 40 may receive an annual prostate screening with no out-of-pocket expense;

4. No copayment for hospice care, home health care, and preauthorized durable medical equipment (DME); and

5. Numerous other benefits discussed in the Aetna Member Handbook.

Coverage for these benefits and other medical benefits is set forth in the Aetna Member Handbook appended to this Summary Plan Description. Please refer to that booklet for a description of these coverages, their limitations and applicable patient deductible, co-insurance and co-payment obligations.

D. Disease Management Program

The Fund has contracted with HealthCare Strategies to facilitate a Disease Management program, known as HealthReach. The purpose of the program is to educate members and their families concerning their individual health issues and, at the same time, monitor the quality of care our Members are receiving to be sure that they are getting the best service for the dollars the Fund and Members are spending for health care.

Based upon claims filed with the Fund, a HealthReach Care Counselor (a Registered Nurse) from HealthCare Strategies contacts the patient to ensure that the patient understands his/her medical condition and helps to coordinate his or her health care needs. Educational materials are provided to the patient. In some cases, the Care Counselor will contact the patient's treating doctors.

Participation in the Disease Management program has been mandatory since September 1, 2005. Plan Members and beneficiaries are REQUIRED to participate in the HealthReach program to ensure that the Fund is paying for appropriate services. If the patient refuses to participate in the program and cooperate with the HealthReach Care Counselor, a $500 penalty deductible (in addition to any other applicable deductible, co-insurance or co-payment) will be applied during each Plan Year to medical claims received after the patient receives final notice to contact the HealthReach Care Counselor.

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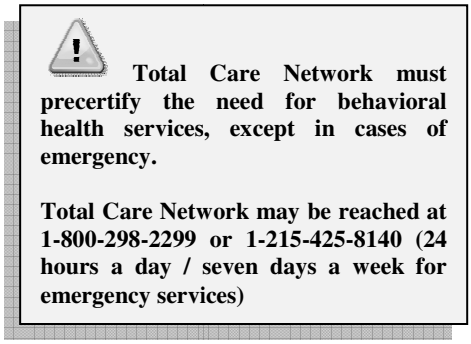
THE FUND'S BEHAVIORAL HEALTH PROGRAM AND HOW IT WORKS

Behavioral Health benefits (for the treatment of mental health and alcohol/substance abuse issues) must be coordinated, in advance through Total Care Network ("TCN"), the Fund's Behavioral Health Administrator. Total Care Network may be reached at 1-800-298-2299 or 1-215-425-8140 (24 hours a day / seven days a week for emergency services). This benefit is administered through both in and out-of-network of providers.

I. IN-NETWORK VERSUS OUT-OF-NETWORK CARE

The Fund, through Total Care Network, has contracted with a panel of licensed behavioral health providers. Providers on this panel have agreed to accept the Fund's allowance for particular behavioral health services as payment in full with no balance billing to the patient and without any up-front deductible or copayment. You will, however, be responsible for services excluded from coverage or which exceed the overall maximum benefit allowance for the patient for the plan year. Names of participating behavioral health providers may be obtained, without charge, from Total Care Network.



An out-of-network behavioral health provider is any licensed behavioral health provider of your choice that is not an in-network provider. The benefit payable will be limited to 80% of the Fund's allowance for participating providers. As a result, you may be subject to balance billing from an out-of-network provider.

II. MENTAL HEALTH/PSYCHIATRIC CARE

Benefits for the treatment of mental illness and serious mental illness are based on the services provided and reported by the provider. Those services provided by and reported by the provider as mental health/psychiatric services are subject to the mental health/psychiatric limitations in this program. When a provider renders medical care, other than mental health/psychiatric care, for a covered person with mental illness or serious mental illness, payment for such medical care will be based on the medical benefits available, and will not be subject to the mental health/psychiatric limitations in this program.

Preauthorization information must be submitted by the provider to TCN for review and evaluation so that a plan of treatment may be precertified for the covered person. Precertification must be obtained for all treatments, other than emergency care, in order to verify eligibility and to assure the medical appropriateness/necessity of the proposed treatment based on the nature and severity of the covered person's condition. In appropriate cases, a personal assessment by a preferred professional provider may be provided by the Fund at no cost to the covered person to accommodate the precertification process. **Emergency care is exempt from the requirements for precertification and will be considered preferred care.** However, emergency admissions or services must be reviewed and authorized within one business day of the admission or services, or as soon as possible thereafter as determined by the Fund and/or its Behavioral Health Administrator.

A. Inpatient Treatment

Benefits are provided, subject to the benefit period limitations stated in the Schedule of Benefits, for an inpatient admission for treatment of mental illness and serious mental illness. Inpatient visits for the treatment of mental illness and serious mental illness are covered when performed by a licensed professional provider/preferred facility provider.

For treatment of serious mental illness, the covered person may trade on a one (1) for two (2) basis, inpatient days for additional outpatient partial hospitalization days and outpatient facility/professional visits.

Covered services include treatments such as: psychiatric visits, psychiatric consultations, individual, family and Fund assessments, psychotherapy, electroconvulsive therapy and psychopharmacologic management.

B. Outpatient Treatment

Benefits are provided, subject to the benefit period limitations shown in the Schedule of Benefits for outpatient treatment of mental illness and serious mental illness. Outpatient mental health/psychiatric services shall be covered for the full number of outpatient session visits or an equivalent number of partial hospitalization visits per benefit period. Partial hospitalization is considered inpatient treatment. For treatment of mental illness, the covered person may trade off: (a) on a one (1) for two (2) basis, inpatient days for additional separate partial hospitalization services; or (b) on a one (1) for two (2) basis, inpatient days for additional outpatient visits. See the Schedule of Benefits for limits on the number of inpatient days that may be exchanged in any benefit period. For the treatment of serious mental illness, the covered person may trade on a one (1) for two (2) basis, inpatient days for additional outpatient partial hospitalization days/outpatient session visits. For maximum benefits, treatment must be performed by a preferred professional provider/preferred facility provider. All preferred outpatient services must be precertified by TCN.

Covered services include treatments such as: psychiatric visits, psychiatric consultations, individual, family and Fund assessments, psychotherapy electroconvulsive therapy, psychopharmacologic management, neuropsychiatric testing, and psychoanalysis. Benefits are not payable for the following services:

a. vocational or religious counseling;

b. activities that are primarily of an educational nature;

c. treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as primal therapy, rolfing or structural integration, bioenergetic therapy, and obesity control therapy; and

d. psychological testing.

C. Benefit Period Maximums for Mental Health/Psychiatric Care

All inpatient and outpatient mental health/psychiatric services for both mental illness and serious mental illness are covered up to the maximum day and visit limitations per benefit period specified in the Schedule of Benefits, below. Non-preferred benefit period maximums are part of, not separate from, preferred benefit period maximums.

III. TREATMENT FOR ALCOHOL OR DRUG ABUSE AND DEPENDENCY

Alcohol or drug abuse and dependency means a pattern of pathological use of alcohol or other drugs which causes impairment in social and/or occupational functioning and which results in a psychological dependency evidenced by physical tolerance or withdrawal. Benefits are payable for the care and treatment of alcohol or drug abuse and dependency provided by a hospital or facility provider, subject to the maximums shown in the Schedule of Benefits, according to the provisions outlined below. For maximum benefits, treatment must be received from a preferred provider.

Preauthorization information must be submitted by the provider to Total Care Network for review and evaluation so a plan of treatment may be precertified for the covered person. Precertification must be obtained for all treatments other than emergency care in order to verify eligibility and to assure the medical appropriateness/necessity of the proposed treatment based on the nature and severity of the covered person's condition. In appropriate cases, a personal assessment by a preferred professional provider may be provided by the Fund at no cost to the covered person to accommodate the precertification process.

If a patient is facing a crisis and is currently in treatment, contact should be made with the patient's therapist because he/she is most familiar with the patient's condition. **Emergency care is exempt from the requirements for precertification and will be considered preferred care.** However, emergency admissions or services must be reviewed and authorized within one business day of the admission or service, or as soon as possible as determined by the Behavioral Health Administrator.

A. Inpatient Detoxification

Inpatient covered services for detoxification shall be covered for 7 days per admission for detoxification with a lifetime maximum of 4 admissions for detoxification per covered person. Covered services are limited to:

1. Lodging and dietary services;
2. Physician, psychological, nurse, certified addictions counselor and trained staff services;
3. Diagnostic x-rays;
4. Psychiatric and medical laboratory testing;
5. Drug, medicines, use of equipment and supplies.

B. Hospital and Non-Hospital Residential Treatment

Hospital or non-hospital residential treatment of alcohol or drug abuse and dependency shall be covered on the same basis as any other illness covered under the program, but services are limited to 30 days per calendar year. Additional days may be available as specified below in "Outpatient Alcohol or Drug Services." There is a lifetime maximum of 90 days per covered person. Covered services include:

- Lodging and dietary services;
- Physician, psychological, nurse, certified addictions counselor and trained staff services;
- Rehabilitation therapy and counseling;
- Family counseling and intervention;
- Psychiatric and medical laboratory testing;
- Drug, medicines, use of equipment and supplies.

C. Outpatient Alcohol or Drug Services

Outpatient alcohol or drug services shall be covered for 30 full outpatient sessions or an equivalent number of partial hospitalization visits per calendar year. Benefits are available for an additional 30 separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a 2 to 1 basis to receive up to 15 more days of non-hospital residential alcohol or drug treatment (i.e., the covered person may trade off on a 2 for 1 basis, up to 30 separate sessions of outpatient services per year, in order to receive up to 15 additional days of hospital and non-hospital residential alcohol or drug abuse treatment days). Any benefits exchanged or traded off under terms of this provision are subject to, and do not increase, the overall lifetime maximum.

There is a lifetime maximum of 120 full session visits or an equivalent number of partial hospitalization visits per covered person. Partial hospitalization is considered as inpatient treatment. Covered services include:

1. Physician, psychological, nurse, certified addictions counselor and trained staff services;
2. Rehabilitation therapy and counseling
3. Family counseling and intervention;
4. Psychiatric and medical laboratory testing;

5. Drug, medicines, use of equipment and supplies.

IV. BEHAVIORAL HEALTH SUMMARY OF BENEFITS

	In-Network	Out-of-Network
Psychiatric Care:		
Inpatient; Lifetime maximum of 50 days (in or out-of-network combined)	100%, up to 30 days per Benefit Period	80% of allowance, up to 20 days per Benefit Period
Outpatient	100% of allowance, max of 30 visits per Benefit Period	80% of allowance, max of 20 visits per Benefit Period
Alcohol/Drug Abuse Treatment:		
Inpatient Detoxification – 7 days per admission; lifetime maximum of 4 confinements	100%	80% of allowance
Residential Care – 30 days per Benefit Period; Lifetime maximum of 90 days	100%	80% of allowance
Outpatient care – 30 full session visits; Lifetime maximum of 120 visits	100%	80% of allowance

Failure to precertify non-preferred inpatient services will result in a $1,000 reduction in benefits payable for selected services.

Remember: you must contact Total Care Network at 1-800-298-2299 to coordinate Behavioral Health/Substance Abuse services.

A Note Regarding the Mental Health Parity Act:

The Fund's plan of benefits will not be subject to the federal Mental Health Parity and Addiction Equity Act until January 1, 2016 because the last collective bargaining agreement applicable to the Fund entered into before the effective date of that law does not expire until 2015.

THE FUND'S PRESCRIPTION DRUG PROGRAM

The Fund provides benefits for prescription drugs or refills of them when dispensed by a pharmacy pursuant to a physician's prescription. These benefits are subject to a patient co-pay for each prescription or refill. Consult the Summary of Benefits Schedule, below, for further details. In addition, benefits are provided for insulin, disposable syringes to be used in administering the insulin (whether or not you have a prescription for the insulin or these disposable syringes) and other diabetic supplies.

I. HOW THE PRESCRIPTION DRUG PROGRAM WORKS

The Fund has contracted with a pharmacy benefits manger (PBM) to provide its members and their covered dependents with affordable prescription drug benefits. The Fund's current PBM is OptumRx. All Fund members and their covered dependents should have an OptumRx membership card in addition to his or her Aetna Card. If you do not have such a card, please contact the Fund office for assistance.

When you go to a pharmacy to have a prescription filled, you should present your PBM card to the pharmacy staff. Your card will be scanned and the appropriate co-payment applied to your purchase(s). The amount of your co-pay will depend on the type of prescription you have filled. Additional information regarding the co-payment amounts is set forth below in the Summary of Benefits Schedule, below.

II. MAIL ORDER PROGRAM

The Fund's prescription drug program also has a mail order option that can make purchasing your prescription drugs even more affordable. If you have been prescribed a maintenance medication, you may use the Fund's mail order program to order a 90-day supply of your medication for a single co-payment. Additional information about the mail order program is available from the Fund office or on the Fund's website.

EXAMPLE:

Adam has been prescribed medication to treat his blood pressure. That medication is a maintenance medication under prescription drug program formulary and is available as a generic. Adam receives a 90 day prescription for his medication from his physician and utilizes the Fund's mail order program. In response, Adam is charged a $3 co-payment for 90 days of medication, instead of $3 every 30 days if he went to a retail pharmacy to have his prescription refilled.

III. THE PRESCRIPTION DRUG PROGRAM'S LIMITATIONS

The Fund's prescription drug program is subject to certain limitations and exclusions. For example, the Fund will not pay any of the cost for:

1. vitamins (whether formulary or non-formulary);
2. cosmetics or other health and beauty aids
3. bandages and similar supplies
4. dietary aids
5. support garments (other than compression stockings as provided in the Summary of Benefits schedule)
6. prescription drugs prescribed for smoking cessation
7. other non-prescription substances
8. therapeutic devices and appliances
9. drugs available over-the-counter (except proton pump inhibitors and non-sedating antihistamines that are prescribed in lieu of non-over-the-counter equivalents)
10. contraceptives, unless pre-approved by the Fund, for the treatment of a medical condition
11. medications to treat erectile dysfunction unless such dysfunction is secondary to another medical condition and is preapproved by the Fund
12. drugs or compound drugs that have not been approved by the Federal Food and Drug Administration
13. administration or injection of any drug
14. hypodermic needles and syringes (other than described above)

In addition to the above items, the Fund will not pay for the refill of covered prescription drugs in excess of the number of refills specified by the physician, or any refill dispensed after one year from the date of the physician's latest order. The program does not cover drugs otherwise provided for under the Fund's Hospital, Medical and Surgical program, nor does it cover drugs otherwise provided for under any government program or law or workmen's compensation or occupational disease laws. The Fund also does not cover more than a 34 day supply of any covered prescription drug, except for certain maintenance drugs that are eligible to be filled for a 90 day supply under the mail order program described above.

Pre-approval is required for any prescription for (1) injectible drugs that cost more than $1,500 (OptumRx approval required); (2) drugs for which the cost of a one month supply exceeds $1,500 (Fund approval required); (3) drugs to treat erectile dysfunction (which will only be approved by the Fund in those cases in which the condition is secondary to another medical condition); or (4) newly released drugs that have not been approved by the Federal Drug Administration for more than six (6) months (Fund approval required).

A NOTE ABOUT INJECTIBLES

Regardless of whether they are going to be administered by a healthcare provider in a clinical setting, injectible medication or treatment, with the exception of insulin and oncology related products, must generally be purchased through the Plan's prescription drug program in order for them to be covered by the Plan. Thus, if your physician intends to administer an injectible medication or treatment to you, you must purchase it yourself through OptumRx's specialty pharmacy and take it to your healthcare provider to be administered or have it shipped directly to your provider.

STEP THERAPY:

Your pharmacy benefits plan includes OptumRx's step-therapy program. Step-therapy is a type of precertification. Under the step-therapy program, certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. Certain over the counter "prerequisite therapy" medications, such as non-sedating antihistamines (e.g., Allegra and Claritin), may purchased at the generic copay price when they are purchased subject to a prescription at a participating pharmacy. However, if it is medically necessary for you to use a step-therapy medication as initial therapy without trying a prerequisite therapy drug, your doctor can request coverage of the step-therapy medication as a medical exception by contacting OptumRx at the telephone number listed on your OptumRx ID card. Any prescription strength non-sedating antihistamines will not be eligible for a generic co-pay, but rather will be billed at the third-tier co-pay.

YOUR PHARMACY CARD IS ONLY VALID AS LONG AS YOU MAINTAIN YOUR ELIGIBILITY. SHOULD YOU USE YOUR CARD WHEN YOU ARE INELIGIBLE, YOU WILL BE LIABLE FOR THE CHARGES. DRUGS DISPENSED PRIOR TO THE EFFECTIVE DATE OF COVERAGE UNDER THIS PLAN OR AFTER THE DATE SUCH COVERAGE TERMINATES ARE NOT COVERED.

LIMITATIONS ON COVERAGE FOR THE DRUG SUBOXONE

EFFECTIVE MARCH 1, 2013, THE FUND WILL COVER A SINGLE COURSE OF TREATMENT UTILIZING THE DRUG SUBOXONE FOR A PERIOD NOT TO EXCEED THREE (3) MONTHS PER LIFETIME.

IV. PRESCRIPTION DRUG SUMMARY OF BENEFITS SCHEDULE

Type of Drug	Copayment
Generic	$3.00
Formulary Drugs (Preferred)	$10.00
Non-Formulary Drugs (Non-Preferred)	50% of the drug cost with a *minimum* copayment of $30.00 and a *maximum* of $40.00

A current listing of the Fund's prescription drug formulary and maintenance drug formulary is available on the Fund's website at http://www.teamsterfunds.com and is also available upon request from the Fund office.

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THE FUND'S DENTAL PROGRAM

The Fund maintains a dental program for its Members and their beneficiaries. The dental benefits provided are equal to the actual charges made by a dentist for care and treatment, but will not exceed the allowed amount listed for each procedure in the Summary of Benefits Schedule. The dental benefit, like the medical and behavioral health benefits, is administered through both in-network and out-of-network of dentists.

I. IN-NETWORK VS. OUT-OF-NETWORK

A. In-Network

The Fund has contracted with a panel of dentists practicing general dentistry as well as in the specialized fields of dentistry. Dentists on this panel have agreed to accept the Fund's allowance for particular dental services as payment in full with no balance billing to the patient, unless a copayment applies to the service. You will, however, be responsible for services excluded from coverage or which exceed the overall maximum benefit allowance for the patient for the plan year. A listing of the panel members can be obtained, without charge, from the Fund office or on the Fund's web site.

B. Out-of-Network

The Fund's maximum allowance for out-of-network dentist is that which is shown in the Summary of Benefits Schedule and you may be responsible for any balance charged by the provider if the dentist declines to accept the Fund's allowance as payment in full.

II. BENEFITS PROVIDED

The Fund has a complete "Dental Table of Allowances." Please write the Fund or check the Fund's website (www.teamsterfunds.com) if you want to know the Schedule of Allowances for any procedure not listed in the Summary of Benefits Schedule. You should contact the Fund office before you start any non-emergency work to obtain the appropriate claim forms and to ensure that you are covered for benefits.

BENEFITS ARE PAYABLE ONLY IF YOU ARE ELIGIBLE AT THE TIME EACH PROCEDURE IS PERFORMED.

A. Annual Allowances

Family Member Calendar Year Maximum.....$2,000
(*This maximum does not include any orthodontia payments*)

Orthodontia – Per Eligible Dependent Lifetime Maximum…….....$3,400

(Orthodontia benefits available only for dependent children between the ages of 10 and 18, inclusive. Phase I orthodontia expenses are generally not covered, but may be covered based upon a predetermination/precertification. Any approved Phase I orthodontia expenses are applied against the Family Member Lifetime Orthodontia Maximum.)

A SPECIAL NOTE REGARDING ORTHODONTIA BENEFITS

Orthodontic care is available only to your unmarried dependent children between the ages of 10 and 18 inclusive. Full cases, requiring 24 or more months of care, will be paid at the maximum benefit. Partial cases will be paid at a lesser allowance. All cases must be rated by the Fund's orthodontic consultants. The Fund's maximum allowance and payment schedule for orthodontia care is shown in the Summary of Benefits Schedule. Orthodontic benefits are a lifetime benefit and not included in calculating the patient's yearly dental maximum. Orthodontia benefits are paid on a quarterly basis and will be prorated if a Member is ineligible for part of the quarter in question.

B. Schedule of Dental Benefits

The Fund has set allowances for all covered dental procedures. As previously noted, a complete listing of those covered procedures and allowances may be obtained at the Fund office or from the Fund's web site (www.teamsterfunds.com). The maximum allowance may not exceed the fee actually charged for the procedure. This Table of Allowances will apply to all. For any procedure which has an allowance that is different from Members or Dependents over the age of 14 and for Dependent Children between the ages of 0 and 14, the description indicates "adult" or "child."

No payment will be made until the required dental claim form has been completed by the attending dentist and approved by the Fund. Benefit payments will be calculated with reference to the dental allowances set by the Fund's Trustees, less any applicable patient copayment. The following patient copayments apply to dental procedures:

Service	Copayment
Preventative services (yearly and periodic exams, x-rays, cleanings)	$0
Restorative services (amalgam and composite fillings, etc.)	$0
Fixed prosthodontics (crowns and bridges)	$30 per tooth
Removable prosthodontics (full or partial dentures)	$50 per unit
Periodontal surgery	$25 per quadrant
Endodontic surgery (root canal, etc.)	$25 per tooth
Oral surgery	$25 per tooth
Orthodontic care	$100 per case

C. Dental Benefit Limitations

EMERGENCY CARE: If you have a dental emergency, you may go directly to your dentist for emergency treatment. However, the Fund will pay only for dental treatment in accordance with the Dental Table of Allowances available on the Fund's website and from the Fund office.

If you are in an automobile accident, the Fund is your secondary carrier if a claim related to that accident arises. In other words, the Fund will only consider for payment those charges not paid under your automobile insurance policy and in certain cases only up to a certain limit. (See "Automobile Insurance" under General Provisions and Definitions.) Also, please remember that the Fund has the right of subrogation when you are involved in any accident and where you recover any expenses which have been paid to you under this Plan from a third party.

No dental expense benefits are provided for the following:

1. Routine dental examinations performed more frequently than once in any six (6) consecutive month period.

2. Prophylaxis (cleaning of teeth) expenses in excess of the amount shown in the Summary of Benefits Schedule more often than once during any six (6) month period.

3. Dental treatments and services in connection with dentures, bridgework, and crowns will not be covered:

   a. If the work in making the denture, bridge or crown started prior to the effective date of coverage of the individual; however, insertions occurring while the member is eligible will be covered; or

   b. If expenses are for more than one denture, either full or partial, or for any bridge or crown within any five year period.

4. Treatment by other than a licensed dentist, except charges for dental prophylaxis (cleaning of teeth) under the direction of a licensed dentist.

5. Orthodontic care falling outside of the age and lifetime maximum limitations (see above for details).

THE FUND'S DISABILITY BENEFITS PROGRAM

I. THE PROGRAM

If you, prior to retirement, become disabled from a non-occupational accidental injury or disease, and will be prevented by such disability from performing any and every duty pertaining to your occupation, payment will be made to you as determined from the Summary of Benefits Schedule. Any such payment is limited to a maximum period of 26 weeks during any one continuous period of disability whether from one or more causes and is contingent upon receipt of a Weekly Disability claim form, containing proof of disability satisfactory to the Trustees. Benefits are payable only while you are under the care of, and treated personally by, a legally qualified physician or surgeon.

Successive periods of disability will be considered as having occurred during one period of disability unless the subsequent period is due to causes completely and entirely unrelated to the prior accident or disease or unless the prior and subsequent periods are separated by a resumption of active employment for a period of thirty (30) or more full calendar days.

Disability benefits are available to Fund Members only. Spouses and other Dependent beneficiaries are ineligible for disability benefits.

II. LIMITATIONS

The Fund's disability benefit program, like its other programs, is subject to certain limitations. **First**, a disability, to be covered, must commence while you are eligible for Fund benefits. The beginning date of your claim (disability) is determined from the date you are first seen and treated by a physician for it, which may differ from the date of your injury. **Second**, this benefit is paid in lieu of wages; thus, you must not be earning wages from your Employer in order to be eligible for this benefit. **Third**, your weekly disability benefit will be reduced by any short-term disability or wage loss benefit payable to you under any applicable automobile no-fault policy, program, or any other law or regulation. This includes, without limitation, any disability benefits provided under state law such as New Jersey's temporary disability benefits, or those benefits provided under federal law such as Social Security Disability Insurance ("SSDI"). **Fourth**, weekly disability benefits will not be payable to a Member whose disability resulted from participation in or in consequence of having participated in an illegal act which is in violation of any federal or state criminal statute relating to the possession of controlled substances. **Fifth**, you must be under the care of a legally qualified physician or surgeon and receiving appropriate care and treatment for your condition.

III. SUMMARY OF BENEFITS

Weekly disability benefits are payable as follows:

1. $250.00 per week; or
2. $50 per work day

If, however, you work for a New Jersey Employer covered under the New Jersey Temporary Disability Law, you will receive a benefit equal to ½ of the disability payment indicated above. Disability benefits will commence on the first work day if the disability results from an accident or hospitalization. Benefits will commence on the sixth work day if the disability is a result of a sickness or pregnancy. Weekly disability benefits are payable for a maximum of 26 weeks. The Fund will pay you weekly disability benefits upon the initial denial of a workers' compensation claim, if you execute a Fund approved subrogation agreement.

THE FUND'S LIFE INSURANCE PROGRAM

I. HOW THE LIFE INSURANCE PROGRAM WORKS

The Fund maintains a life insurance program for your benefit and your beneficiaries' benefit in the event of a Member or Dependent beneficiary's death from a covered cause. In the event of your death from a covered cause, a "death benefit" will be paid to the Member's designated beneficiary of record. In the event of the death of any other eligible dependent from a covered cause, payment will be made directly to the Member.

Oftentimes, the "death benefit" is used to defray the costs of burying a loved one. As a result, a payment of all or a portion of the death benefit may be made directly to a funeral home, provided the Fund receives from the beneficiary of record an appropriate, written and signed assignment of benefits. A funeral home can usually assist in furnishing the necessary paperwork.

Unlike other benefits offered through the Fund's program that are self-insured, the death benefit for active employees and their dependents is a fully-insured benefit purchased by the Fund on a group basis through the Aetna Life Insurance Company. The amount of payment is that shown in the Summary of Benefits Schedule. Additional details regarding the Fund's death benefits are found in the Summary of Benefits Schedule as well as in the Aetna Life Insurance Company document, which may be requested from the Fund office.

II. CONTINUANCE OF MEMBER DEATH BENEFIT IN THE EVENT OF TOTAL DISABILITY

If, while he or she is eligible, a Member becomes totally disabled, his or her death benefit coverage as determined from the Summary of Benefits Schedule will continue after his or her eligibility stops provided:

1. The Member provides the Fund with written proof, satisfactory to the Trustees or Administrator, that he or she is Totally Disabled. THIS WRITTEN PROOF MUST BE PROVIDED TO THE FUND WITHIN SIX MONTHS OF THE DATE ON WHICH THE PARTICIPANT FIRST RECEIVED ORAL OR WRITTEN NOTICE FROM THE SOCIAL SECURITY ADMINISTRATION, A PHYSICIAN, A HEALTH PROVIDER, OR ANY OTHER SOURCE THAT HE OR SHE IS TOTALLY DISABLED. Contact the Fund office for this special form.

2. During the last three months of each subsequent year that the Member remains Totally Disabled, he or she must provide the Fund with written proof of his or her continuing disability. This written proof must be in a form satisfactory to the Trustees or the Administrator.

3. If the Member dies before the expiration of the six month period set forth in paragraph 1, above, then within one year of his or her death the Member's beneficiary of record must provide the Fund with written proof, satisfactory to the Trustees or Administrator, that the Member remained Totally Disabled from the onset of the total disability through the date of his or her death.

4. This benefit does not apply in the case of a spouse or other beneficiary of a Member.

If you apply for disability benefits from the Social Security Administration at any time after you cease working, then you must send a copy of your application and all supporting documentation to the Fund within ninety (90) days after you file the application with the Social Security Administration.

III. BENEFICIARIES

Each Member has the sole right to designate the beneficiary to whom his or her Death Benefit shall be payable. This designation is one of the records which the Fund office maintains along with census information. A Member may change his or her designation at any time, but must do so in writing. Any changes in beneficiary will take effect on the day the signed request is received in the Fund office, but never before then.

If a Member has more than one beneficiary when he or she dies, and he or she has not specified their respective interests, they all share equally. If any beneficiary dies before the Member, the deceased beneficiary's rights and interest will automatically terminate.

If a designated beneficiary does not file a claim for Death Benefits within one year from the date of the Member's death and the whereabouts of this designated beneficiary are unknown, the Fund shall insert an advertisement in a newspaper of general circulation in the last known place of residence of this designated beneficiary as shown by the Fund's records, to the effect that if the designated beneficiary does not file a claim within ten (10) days of the advertisement, the Trustees will pay the Death Benefit, without interest, to the Member's estate or next of kin as set forth below.

If the Member has not designated a beneficiary or the beneficiary he or she named is no longer living, or fails to file a Death Benefit claim after the advertisement described above, then the Fund may, at its option, pay an amount not to exceed $1,000.00 to any person or persons who may have incurred expenses in connection with your last illness or burial. The balance of the member's Death Benefit, if any, shall be paid to:

1. Your surviving spouse, or, if none
2. Equally to your surviving children, or, if none,
3. Your parent(s), or, if none
4. Your surviving sibling(s), or, if none,
5. The personal representative of your estate without restriction to the foregoing order.

In this regard, the term “sibling” shall include only those persons who share at least one parent with the decedent, either by birth or legal adoption. Furthermore, if any person to whom the death benefit is payable has not reached the age of eighteen (18) as of the time of payment and for whom a guardian of the estate of the minor has not been appointed, then in such event the Fund shall establish a trust account of the benefit of the minor at a federally regulated bank or similar institution.

IV. BENEFITS

The following benefits are payable under the Fund's life insurance program:

Event	Amount Payable
Death of Member	$20,000
Death of Member when death benefit continues in force on Member during a period of total disability	$3,000
Death of Spouse	$1,500
Death of Dependent Child in accordance with age as follows:	
----Over 14 days, but less than six months	$300
----Six months, but less than two years	$600
----Two years, but less than three years	$1,200
----Greater than three years	$1,500

THE FUND'S ACCIDENTAL DEATH & DISMEMBERMENT ("AD&D") PROGRAM

I. HOW THE PROGRAM WORKS

If, as a result of external, violent and Accidental Bodily Injury, a Member suffers the loss of life, limb or sight, and if such loss occurs within twenty-six (26) weeks following the date of the accident, the Fund will pay AD&D benefits as specified in the Summary of Benefits Schedule upon receipt of proof of such loss satisfactory to the Fund's Trustees or Administrator.

AD&D benefits will be paid for each loss without regard to previous losses, provided that the total amount payable due to two or more losses sustained by you in all accidents does not exceed the principal sum as determined in the Summary of Benefits Schedule.

Unlike other benefits offered through the Fund's program that are self-insured, the accidental death and dismemberment benefit, like the life insurance benefit, is a fully-insured benefit purchased by the Fund on a group basis through the Aetna Life Insurance Company.

II. BENEFITS PROVIDED

AD&D benefits are payable subject to the following qualifying schedule:

Losses Covered	Amount of Benefit
Loss of Life	$20,000
Both Hands or Both Feet	$20,000
Sight of Both Eyes	$20,000
One Hand and One Foot	$20,000
One Hand and Sight of One Eye	$20,000
One Foot and Sight of One Eye	$20,000
One Hand or One Foot	$10,000
Sight of One Eye	$10,000

"Loss of Sight" means: Total and irrecoverable loss of sight. Loss of Hand or Foot means: Loss by severance at or above wrist or ankle.

III. LIMITATIONS

The AD&D benefit is subject to the following limitations:

A. The Claim Date is the date of death or, in the event of loss of sight or dismemberment, the date of the accident; and

B. Accidental Death and Dismemberment does not cover any loss resulting from or caused directly, in whole or in part, by

1. Disease or bodily or mental infirmity or medical or surgical treatment thereof,
2. Ptomaine or bacterial infections, except pyogenic infections occurring with and through an accidental wound,
3. Suicide or intentionally self-inflicted injury, while sane or insane,
4. Participation in or in consequence of having participated in an illegal act which is in violation of any federal or state criminal statute, including driving a motor vehicle while intoxicated
5. Flying, unless you were a passenger on a commercial airline, or
6. War or any act of war, whether declared or undeclared, or insurrection, or
7. Drug overdose, whether intentional or unintentional.

THE FUND'S VISION CARE PROGRAM AND HOW IT WORKS

I. GENERAL INFORMATION

The Fund's vision care benefit, like the medical, dental, and behavioral health benefits, is administered through both in and out-of-network (see note below) eye doctors. In-Network providers have agreed to accept the Fund's reimbursement rates as payment in full for covered services, while out-of-network providers have not. The Fund will send to you, without charge, a list of doctors who have agreed to accept the Fund's allowance as payment in full when particular material is selected. This listing is also available on the Fund's web site. Thus, your services with an out-of-network provider MAY be subject to balance billing for charges in excess of the Fund's allowance for the following services.

TYPE OF BENEFIT	AMOUNT OF BENEFIT
Eye Examination (one every 24 months)	$40
Frames (one pair every 24 months)	$27
Lenses (one pair every 24 months)	
----Single Vision	$33
----Bifocal	$37
----Trifocal	$42
----Lenticular	$115
Contact lenses (one pair every 24 months)	$60

II. LIMITATIONS

Benefits under this program are payable only for services rendered every twenty-four (24) months. Lenticular Lenses are covered only when they are prescribed in connection with cataract surgery. A Plan Member or Dependent beneficiary will be eligible for a new pair of glasses following cataract surgery even if it has been less than twenty-four (24) months since the Member or Dependent beneficiary obtained a new pair of lenses.

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GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL OF THE FUND'S BENEFITS

In addition to the limitations and exclusions specific to each type of benefit the Fund offers, there are certain general limitations and exclusions that each Fund Member and Dependent beneficiary should be aware of.

I. IMPORTANT NOTE REGARDING THE RELATIONSHIP BETWEEN THE FUND AND HEALTH CARE PROVIDERS

No health care provider is an agent or representative of the Fund. The Fund does not control or direct the provision of health care services and/or supplies to Fund members or their covered dependents by anyone. The Fund makes no representation or guarantee of any kind concerning the quality of health care services or supplies furnished by any provider.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan of Benefits. The statement also applies to all entities (their agents, representatives and employees) that contract with the Fund to offer preferred provider networks or other health-related supplies to Fund members and their covered dependents. Nothing in this Plan affects the ability of a health care provider to disclose alternative treatment options to a Fund Member or covered dependent. Although subject to benefit allowances and limitations in the Plan with regard to payment, the choice of a provider and/or treatment remains with the patient.

II. GENERAL EXCLUSIONS

In addition to the exclusions provided elsewhere in this Booklet or the exclusions set forth in the Aetna HMO booklet, benefits are not payable for the following:

A. Charges arising from, or occurring in the course of, any gainful occupation or employment, unless the Fund receives a copy of a final order from the appropriate court or other agency determining that a claim is not covered under the applicable workers' compensation statute. This exclusion applies regardless of whether a claim is actually made or filed under any applicable workers' compensation statute or program.

B. Charges for services or supplies which are not Medically Necessary or Medically Appropriate as determined by the Fund, its Claims Administrator and/or its Medical Consultant.

C. Charges for treatments or procedures that are experimental or investigative.

D. Charges for treatments which are not approved by the Member or Dependent beneficiary's attending physician.

E. Charges which are not Usual, Customary and Reasonable as determined by the Fund's Trustee or Administrator.

F. Charges in excess of the payment the provider of service accepted as payment in full from any other source.

G. Charges for custodial care or for maintenance of chronic conditions.

H. Charges for services rendered by a Member of the patient's immediate family (including in-laws).

I. Charges that are made only because this coverage exists, or charges that no covered individual is legally obligated to pay.

J. Charges for treatments, services and/or supplies provided, ordered or required by the United States government, or any other government (including court-ordered treatment).

K. Charges resulting from war or service connected injuries or diseases.

L. Charges associated with any treatment for weight reduction.

M. Charges for hearing aids or the examination and fitting of hearing aids.

N. Charges to the extent that they are recovered from any person or organization other than an insurer of the patient.

O. Charges for cosmetic treatment and/or surgery for purposes other than breast reconstruction following a mastectomy, correction of damages caused by accidental injury, or for correction of a birth defect, provided that the patient was covered under this Plan on the date of the accident or date of birth and is still eligible as of the date of the cosmetic treatment or surgery.

NOTE:

SURGERY GENERALLY CONSIDERED COSMETIC IN NATURE (EVEN THOUGH FOR MEDICAL REASONS) REQUIRES PRIOR APPROVAL.

P. Charges for the diagnosis and treatment of dislocations, strains, sprains or misplacements of the skeletal structure (pertaining to the skeleton) or musculature (the system of muscles), except for the first fifteen (15) visits with a physician in any calendar year or when requiring the administration of a general anesthesia, an opening or cutting operation, or confinement in a hospital.

Q. Charges for orthotic shoe inserts (unless specifically covered under your Summary of Benefits Schedule).

R. Charges for immunizations and vaccines (unless specifically covered under the Aetna HMO Program)

S. Charges for eye exercises, psychological testing, and learning disabilities, school or DOT physicals.

T. Charges for Counseling, including marriage counseling or group therapy.

U. Charges for treatment of temporomandibular joint dysfunction in excess of any coverage under the Fund's Dental Benefit Plan.

V. Charges for sex change operations.

W. Charges for penile prosthetic devices.

X. Charges for the surgical correction of myopia, including without limitation Lasik.

Y. Charges for oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions.

Z. Charges for treatment of infertility, including, but not limited to, in-vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and/or reversal of a sterilization procedure.

AA. Charges for any other medical, dental, vision, or pharmacy service except as provided in your appropriate Summary of Benefits Schedule.

BB. Charges related to genetic counseling or genetic testing, except when such charges are incurred to determine the efficacy of certain medications or course(s) of treatment.

CC. Charges for diabetic shoes are not covered.

Also, benefits will only be paid in accordance with provisions of the Fund's various Plans. For example, Vision Care is provided for under its Vision Care Plan and will not be provided under any other provision of the Plan unless specifically included in such other Plan provision.

III. IMPORTANT LIMITATIONS REGARDING MOTOR VEHICLE ACCIDENTS AND THE FUND'S SUBROGATION RIGHTS, GENERALLY

A. Motor Vehicle Accidents

All Members and beneficiaries must understand that the Fund is your secondary source of benefits when an automobile accident claim arises. In other words, the Fund will only consider for payment those charges not paid under your automobile insurance policy and in certain cases only up to a certain limit. (See "Automobile Insurance" under General Provisions and Definitions.)

B. Subrogation/Reimbursement

Keep in mind that the Fund has the right of subrogation when you are involved in any accident and/or where you recover any expenses which have been paid to you under this Plan from a third party. This means, generally, that the Fund may recover from you any benefits it has paid on your behalf if you recover from any third party. This includes, without limitation, motor vehicle accident recoveries, personal injury suits, and medical malpractice claims.

The following specific rule applies to any situation in which the Fund makes any full or partial payment to or on behalf of a Member or Dependent (other than for death benefits) who subsequently recovers from any other source additional payments or benefits in any way related to the accident, illness, or treatment for which the Fund made full or partial payment:

1. Upon any such subsequent recovery by or on behalf of a Member or Dependent beneficiary, from any person or persons, party or parties, insurance company, firm, corporation, or government agency, whether by suit, judgment, settlement, compromise, or otherwise, the Fund, with or without the signing of a subrogation/reimbursement agreement, shall be entitled to immediate reimbursement to the extent of benefits paid to or on behalf of the Member or Dependent.

2. The Fund shall be first reimbursed fully by or on behalf of such Member or Dependent to the extent of benefits paid from the monies paid by any person or persons, party or parties, insurance company, firm, employee benefit plan, corporation, or government agency and the balance of monies, if any, then remaining from such subsequent recovery shall be retained by or on behalf of the Member or Dependent.

3. The Member or eligible dependent shall hold, as a fiduciary in constructive trust for the benefit of the Fund, any monies so recovered that are subject to the Fund’s subrogation/reimbursement lien or these provisions.

4. All Members and Dependents are obligated to cooperate with the Fund in its efforts to enforce its subrogation rights and to refrain from any actions which interfere with those efforts. This duty of cooperation includes (but is not limited to) the obligation to sign a subrogation/reimbursement agreement in a form prescribed by the Fund.

5. The Fund shall have the right to take all appropriate actions necessary to enforce its subrogation rights in the event that a Member or Dependent refuses to sign a subrogation/reimbursement agreement, refuses to reimburse the Fund in accordance with the Fund's subrogation rights, or takes any other action inconsistent with the Fund's subrogation rights. In such situations, the Fund's options shall include, without limitation: the right in appropriate cases to deny benefits to an individual who refuses to sign a subrogation/reimbursement agreement; to institute legal actions to recover sums wrongfully withheld or to obtain other relief; and/or to offset wrongfully withheld sums against future benefit payments otherwise owed the individual who retains such sums.

6. The Fund may pay counsel fees in an amount not to exceed 20% in order to protect the Fund's subrogation interests.

HOW TO FILE A CLAIM FOR FUND BENEFITS AND APPEAL A DENIAL OF A CLAIM

I. HOW TO FILE A CLAIM FOR FUND BENEFITS

A. Medical Benefits

The medical plan identification card is the easiest way to file a claim for medical benefits. Generally, a health care provider will submit medical or dental claims on a Member or Dependent beneficiary's behalf in accordance with the information on the medical plan identification card. The Fund accepts universal claim forms from health care providers. In the event a healthcare provider does not submit a claim with the Fund directly, claim forms are available on the Fund's website, from the Fund office, or participating Employers in some cases.

In those limited circumstances in which a paper claim form is required, Members and beneficiaries can help us process claims in a speedy and accurate fashion by providing the necessary information. Just check the appropriate block at the top of the claim form and follow the instructions provided to obtain benefits. Much of the delay in processing claims is directly related to incomplete or incorrectly completed claim forms being submitted to the Fund or Aetna.

B. Dental Benefits

Because most of the Fund's eligible Members have been receiving dental treatment on a regular basis, all that is generally needed to obtain the dental benefits the Plan provides is to have the dentist submit a claim to the Fund. Additionally, a Dental Claim Form can be obtained from the Fund office or may be printed off from the Fund's web site (www.teamsterfunds.com). If, however, any of the following conditions exist, a Member or Dependent beneficiary may be required to be examined by a dentist selected by the Fund prior to beginning treatment:

1. Orthodontia (Braces) are anticipated (only for children between the ages of 10 and 18, inclusive).
2. You are randomly selected as a part of the Fund's Dental Audit Procedure.
3. Periodontal Care is anticipated.
4. Temporomandibular Joint Disorders.

C. Pharmacy Benefits

The Member or Dependent beneficiary's Prescription Drug Card should be used when filling prescriptions at a pharmacy. If the pharmacy does not accept the card, the prescription may still be filled or refilled. Simply file a completed "Direct Pay Card" with the Fund. The "Direct Pay Cards" are obtained from the Fund office for reimbursement by the Fund's Pharmacy Benefits Manager. Keep in mind that when using the "Direct Pay Cards" a Member's or Dependent beneficiary's out-of-pocket expense may be larger because the druggist is charging whatever the market will bear, but the Pharmacy Benefits Manager will only pay the Usual, Customary and Reasonable allowance for the prescription.

D. Vision Benefits

The Vision Form may be obtained from the Fund office or through the Fund's website.

E. Death and AD&D Benefits

1. **Death or Dismemberment of the Participant** - Use Aetna's death benefit claim form. Complete the form and attach a certified copy of the death certificate as well as any other requested information. A copy of the claim form is available from the Fund office.

2. **Death of Spouse** - Use Aetna's death benefit claim form. Complete the form and attach a certified copy of the death certificate as well as any other requested information, including a copy of the marriage certificate.

3. **Death of a Child** - Use Aetna's death benefit claim form. Complete the form and attach a certified copy of the death certificate as well as any other requested information, as well as a copy of the child's birth certificate or other documents conferring parental rights to you under applicable law (e.g., a court order confirming an adoption of a child).

4. **For Member Total Disability Extended Death Benefits** – There is a special form that may be obtained only from the Fund office. This form must be completed yearly in order to qualify for coverage.

F. Weekly Disability Benefits

Please complete the Fund's disability benefit claim form. Be very certain to have the treating doctor complete his or her section in full, excluding his or her charges for services (the doctor's charges must be submitted on a separate medical claim form). The covered Employer must also complete the Company Statement section on the back of the claim form.

G. General Instructions for Completing Claim Forms

Claim forms may be obtained from the Fund office or through the Fund's web site (www.teamsterfunds.com). A separate claim form for each Family Member submitting a claim for benefits is required. Likewise, a separate claim form should be used for each Provider of Service. Each charge submitted should be checked and any errors reported to the Fund immediately.

NOTE: It is important to be careful completing claim forms. Make sure each appropriate section is completed in full. A great deal of the delay in processing a claim is the result of the Fund having to return claims to busy physicians or members for missing information. Be particularly accurate when writing names, dates of birth, social security numbers, accident information, etc.

If the payment is to be made directly to the Provider of Service, sign the appropriate "Assignment of Benefits Statement" contained on the claim form. If payment is to be made to a Member or Dependent beneficiary, please attach an original, itemized bill (not a copy) on the physician's or hospital's stationary to the claim form, along with a paid receipt to verify charges and payment. The physician should provide a detailed bill listing the following: diagnosis, dates of treatment, treatment performed, and charges for each treatment.

II. HOW SOON SHOULD YOU FILE YOUR CLAIM?

For all claims, written proof of loss or claim must be furnished to the Fund within ninety (90) days after the date of such loss or claim. Failure to furnish said proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time; provided, however, that the Fund's liability position has not been prejudiced by the late filing.

All benefits provided by the Fund will be paid promptly upon receipt of a qualifying proof of loss. Any benefit payable for loss of the Member's life will be payable to the Member's designated beneficiary; other benefits will be payable to the Member, or the Member may assign these other benefits to the provider of service. In the event of an overpayment, either to you or to a "provider of service" on your behalf or on a Family Member's behalf, the Fund reserves the right to reduce subsequent benefit payments by the amount of such overpayment.

No claim will be honored or payable unless the claim is received in and filed with the Fund office prior to December 31 of the third year immediately following the year in which the loss was incurred or services were rendered. In addition, a medical claim form submitted outside of the deadlines required by an in-network healthcare provider's Member agreement with Aetna will not be honored under the Plan. No action at law or in equity shall be brought to recover Fund benefits prior to the Member's or Dependent beneficiary's exhaustion of the claim appeal process set forth in this SPD, nor shall such action be brought at all unless brought prior to December 31 of the third year immediately following the year in which the loss was incurred.

III. CLAIM REVIEW / CLAIM APPEAL PROCEDURE

The Trustees maintain reasonable claim procedures for the Fund as required by law. They have therefore established the following claims review and appeal procedures in order to adjudicate claims for Fund benefits. The Trustees and the Fund's Administrator have the discretion and authority to interpret the terms of the Fund's plan documents, including without limitation this SPD, the Agreement and Declaration of Trust establishing this Fund and all restatements thereof, and the collective bargaining agreements establishing contributing Employer participation in the Fund, and to determine eligibility for Fund benefits to the greatest extent permitted by applicable law.

A. Precertification or Preauthorization Contact

A Claimant who wishes to precertify or preauthorize a form of medical treatment as required by this Plan should contact Aetna ("Aetna") at the telephone number found on the reverse side of the Member's identification card.

B. Authorized Representative

A Claimant for benefits under this Plan may appoint an authorized representative to act on the Claimant's behalf in pursuing a claim or an appeal from an adverse benefit determination. Any person who wishes to be recognized by the Plan as the authorized representative of a Claimant should contact the Fund office.

C. Filing of Claims

Any Member, former Member, dependent or beneficiary (designated or contingent) under the Plan ("Claimant"), may file a written claim for benefits with the Trustees through the Fund office, as described in Section I, above.

D. Notification on Denial of Claim

In the event of an adverse benefit determination, the Plan or Aetna will send the Claimant a written notification containing specific reasons for the adverse benefit determination. The written notification will contain specific reference to pertinent Plan provisions on which the adverse benefit determination is based. In addition, the written notification will contain a description of any additional material or information necessary for the Claimant to perfect the claim, as well as an explanation of why such material or information is necessary. Furthermore, the notification shall provide appropriate information as to the steps to be taken if the Claimant wishes to seek review of the adverse benefit determination.

The Fund or Aetna will provide notice of a benefit determination within the following time frames:

1. Urgent Care Claims

In the case of a claim involving urgent care, the Plan or Aetna 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 has failed 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 Plan or Aetna shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of specific information necessary to complete the claim. 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 Plan or Aetna shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the Claimant to provide the specified additional information.

2. Concurrent Care Decision

If the Plan or Aetna has approved an ongoing course of treatment to be provided over a period of time or a number of treatments:

(a) Any reduction or termination by the Plan or Aetna of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan or Aetna shall notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and to obtain a determination on review that the adverse benefit determination before the benefit is reduced or terminated.

(b) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments concerning a claim involving urgent care shall be decided as soon as possible, taking into account medical exigencies, and the Plan or Aetna 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.

3. Pre-Service Claims

In the case of a pre-service claim, the Plan or Aetna 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 or Aetna. This period may be extended one time by the Plan or Aetna for up to 15 days, provided the Plan or Aetna both determine that such an extension is necessary due to matters beyond the control of the Plan or Aetna, 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 or Aetna 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 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 this specified information.

4. Post-Service Claims

In the case of a post-service claim, the Plan 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 or Aetna for up to 15 days, provided that the Plan or Aetna determine that such an extension is necessary due to matters beyond the control of the Plan or Aetna 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 or Aetna 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 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.

5. Disability Claims

In the case of a claim for disability benefits under this Plan, the Plan 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 Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies 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 Plan determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan 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. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

6. Death and AD&D Claims

Because the Fund's death and AD&D benefits are a fully insured benefit, Aetna Life Insurance Company will notify the person seeking payment of such benefits of any adverse benefit determination and the process by which that person may seek a review of the determination under the Aetna policy.

G. Right of Review (Appeals)

1. Full and Fair Review

A Claimant who receives an adverse benefit determination with respect to any claim shall have the right to a full and fair review of that determination as required by law. For purposes of this Plan, an "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the determination of a Claimant's eligibility to participate in the Plan, and including a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review as well as a failure to cover an item or service for which benefits are otherwise provided because the service is determined to be experimental or investigational or not medically necessary or appropriate.

2. Time Frame for Seeking Review of an Adverse Benefit Determination

A Claimant may request review of an adverse benefit determination before the Fund's Claim Review Committee within 180 days of the Claimant's receipt of notification of that determination. Such a review should be initiated in writing, addressed to the Fund office.

3. Rules Applicable to a Review of an Adverse Benefit Determination

The following procedures shall apply to any review sought by a Claimant concerning an adverse benefit determination under this Plan:

a. The Claimant shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.

b. The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits. A document, record or other information is relevant to a claim if: it was relied upon in making the benefit determination; submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; or demonstrates compliance with the administrative process and safeguards required herein or by applicable law.

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

d. The review shall not give deference to the initial adverse benefit determination and will be conducted by an appropriate fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject to the appeal nor the subordinate of any such individual.

e. If the adverse benefit determination was 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, then the appropriate Plan fiduciary shall consult with a health care professional who has the appropriate training and experience in the relevant field.

f. The review process shall identify the medical or vocational expert, if any, whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

g. If a health care professional was consulted in connection with the adverse benefit determination, that person shall not be consulted in connection with the review of the adverse benefit determination.

h. In the case of a claim involving urgent care, there shall be provided an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's adverse benefit determination on review, shall be transmitted between the Plan or Aetna and the Claimant or Claimant's authorized representative by telephone, facsimile or other available similarly expeditious methods.

4. Right to Hearing Before Trustees' Appeals Committee

In the event that a Claimant is not satisfied with the outcome of its initial appeal of an adverse benefit determination before the Claim Review Committee, the Claimant may file a second-level appeal with the Trustees' Appeal Committee within 90 days of the denial of the initial appeal of the adverse benefit determination. The Trustees' Appeal Committee consists of at least two (2) Trustees designated by the Plan's Board of Trustees. A Claimant or Claimant's authorized representative may appear before this committee to present any evidence or argument in support of the claim review.

5. Content of Claim Review Determination

Each claim review determination shall be signed by the Fund's Administrator at the Claim Review Committee level, and by at least the two (2) Trustee members of the Appeal Committee authorized by the full Board of Trustees to resolve such claim review at the second level. The content of each determination will include: the specific reason or reasons for the adverse benefit determination; reference to the specific Plan provision on which the adverse benefit determination is based; a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits; and after the second level appeal a statement regarding whether the Claimant has exhausted his or her administrative remedies under the terms of this Plan, as well as any other information required by law.

6. Time Frames for Claim Review Determination

The following time frames shall apply to any rulings upon a requested claim review:

a. Urgent Care Claims. In the case of a claim involving urgent care, the Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the Plan's benefit 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.

b. Pre-Service Claims. In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the Plan of the Claimant's request for review of the adverse benefit determination period.

c. Post-Service Claims. In the case of a post-service claim reviewed by the Trustees' Appeal Committee, the ruling on the claim review shall not be made later than the date of the Trustees' Meeting that immediately follows the Plan's receipt of the request for review, unless the request for review was filed within 30 days preceding the date of such Meeting. In such a case, a benefit determination may be made no later than the date of the second Trustees' Meeting following the Plan's receipt of

the request for review. If special circumstances (such as the need to hold a hearing) require a further extension for processing, a benefit determination shall be rendered not later than the third Trustees' Meeting following the Plan's receipt of the claim review. If such an extension of time for review is required because of special circumstances, the Plan shall notify the Claimant in writing of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan shall notify the Claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

d. Disability Claims. In the case of a claim for disability benefits under this Plan reviewed by the Trustees' Appeal Committee, a ruling on the claim review shall be made not later than the date of the Meeting of the Trustees that immediately follows the Plan's receipt of the claim review, unless the claim review is filed within 30 days preceding the date of such Meeting. In such case, a benefit determination may be made by not later than the date of the second Meeting following the Plan's receipt of the request for review. If the special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third Meeting of the Trustees following the Plan's receipt of the request for review. If such an extension of time for a review is required because of special circumstances, the Plan shall notify the Claimant, in writing, of the extension, describing the special circumstances and the date by which the benefit determination shall be made prior to commencement of the extension period.

7. Furnishing Documents

In the case of an adverse benefit determination on review, the Plan shall provide such access to, and copies of, documents, records and other information as appropriate and required by law.

8. Definitions

The following definitions shall apply herein:

a. A claim involving "urgent care" means any claim for medical care or treatment with respect to which the application of the time period 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 paid that cannot be adequately managed without the care or treatment that is the subject of the claim.

b. "Pre-service claim" means any claim in which receipt of the benefit is conditioned, in whole or in part, upon precertification or preauthorization by the Plan.

c. The term "post-service claim" means any claim that is not a pre-service claim.

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GENERAL PROVISIONS AND DEFINITIONS

In addition to those terms defined in the Aetna HMO booklet, the following terms are defined as follows for purposes of this SPD.

Accidental Bodily Injury: For an injury to be considered an accident, the injury must have resulted from some external, violent and unforeseen happening.

Actual Charges: Means covered charges up to the Usual, Customary and Reasonable charges as defined in this Section, and never to exceed the payment the provider of service accepted as payment in full from any other source.

Assignment: The Member or his/her Spouse have the right to authorize the Fund to pay a Family Member's benefits directly to the physician or hospital who provided the Family Member with covered care and treatment. Except for this, however, you may not assign, alienate, anticipate or commute any benefits which a Family Member is entitled to receive from the Plan and, further, except as may be prescribed by law, none of your benefits shall be subject to any attachments or garnishments of or for your debts and/or contracts, etc., except for recovery of overpayments made on a Family Member's behalf by the Fund, as described under the HOW SOON SHOULD YOU FILE YOU CLAIM paragraph in the How To File a Claim section of this Booklet.

Automobile Insurance: Where an injury is caused by an accident that is covered by a State-required Automobile Insurance Law, the coverage under this Plan is secondary and the automobile insurance or Assigned Claims Plan is responsible to pay the covered charges for that injury first. The Plan will then cover the balance of the covered charges that were not covered by the automobile insurance, up to the maximum benefit level set forth in the applicable summary of benefits schedule.

Special additional exclusions apply in the case of No-Fault insurance policies that are governed by the New Jersey No-Fault Law, as amended by the New Jersey Insurance Freedom of Choice and Cost Containment Act. Participants, dependents and beneficiaries who are injured in the course of an automobile accident and who are also covered by an automobile insurance policy governed by the New Jersey No-Fault Law, as amended by the New Jersey Automobile Insurance Freedom of Choice and Cost Containment Act, may only be reimbursed under the Plan by the Fund up to a maximum of $1,000 per accident for Covered Expenses and, in the case of an eligible Member, only up to a Weekly Disability maximum of $62.50 per week up to the Plan maximum of twenty-six (26) weeks.

Benefit Period: Benefit Period shall mean the Plan Year which begins on January 1 and ends on December 31 of each year.

Claim Forms: The Fund, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such are not furnished within 30 days after the giving of notice, the claimant shall be deemed to have complied with the requirements of the Fund for submitting proof.

Claim Review Procedure: See " **HOW TO FILE A CLAIM FOR FUND BENEFITS AND APPEAL A DENIAL OF A CLAIM**" in this Booklet.

Collective Bargaining Agreement: The contract between a local union and a Contributing Employer through which the Employer is obligated to make contributions to the Fund on behalf of the employees covered by that Collective Bargaining Agreement.

Contributing Employer: An Employer whose signed Collective Bargaining Agreement requires the Employer to make contributions to the Fund on behalf of the employees covered by the terms of that Collective Bargaining Agreement.

Coordination of Benefits (C.O.B.): The Teamsters Health and Welfare Fund's Plan provides for Coordination of Benefits. This means that should a Family Member be entitled to any medical, dental, vision, disability or pharmacy benefits from another source, benefits under this Plan may be reduced to an amount, which together with all such other coverage under any other plan or policy, will not exceed 100% of any Usual, Customary and Reasonable item of expense covered under this Plan or any other such plan. The Fund has special rules for coordinating benefits with respect to automobile insurance. These rules are explained under the heading "Automobile Insurance" which is defined earlier in this section. In all other cases in which a Family Member, on whose behalf a claim is submitted, is covered under one or more group plans for health benefits in addition to the Fund's Plan, benefits will

be coordinated so that the Member may receive up to 100% of the Reasonable and Customary Charges in accordance with the following priorities of payment:

If the other plan providing benefits for a person covered under the Fund's Plan does not have a coordination of benefits or duplication of benefits provision, benefits payable for covered expenses under the other plan will be paid in full before any benefits are paid by the Fund's Plan.

If the other plan providing benefits for a person covered under the Fund's Plan does have a coordination or non-duplication provision, the following rules will apply for determining whether the Fund or the other plan will provide primary coverage. For the purposes of these rules, the plan which provides "primary coverage" shall be obligated to provide benefits to the fullest extent of its coverage before any other plan is obligated to cover the benefits in question. The plan which provides "secondary coverage" shall not be obligated to provide benefits until the "primary coverage" is exhausted.

Dependent Spouses: In each case, the other plan will provide primary coverage for the dependent spouse (who may also be referred to as a "Dependent beneficiary"), and the Fund will provide secondary coverage for the dependent spouse. A spouse who (i) works full-time (defined as regularly scheduled to work 32 or more hours per week), and (ii) who is eligible to participate in group health coverage sponsored by his/her Employer must enroll in that coverage except if the spouse must pay 100% of the premium for such coverage. If the spouse is required to enroll in such coverage, but does not, the Fund will provide secondary coverage and only to the extent as if the other coverage was in effect as of the date services were rendered to the patient/spouse.

Dependent Children:

If a dependent child (alternatively referred to as a "Dependent beneficiary") is gainfully employed and is covered by another plan as a result of that employment, then no coverage is available under the Fund's plan for such dependent child.

If the paragraph above is not applicable and the Member and the child's other parent are married to each other and not separated, then the "birthday rule" shall apply. Under the birthday rule, the Fund will provide primary coverage if the Member's birthday occurs before the spouse's birthday during the calendar year. For example, if the Member was born in June and the spouse in September, then the Fund will provide primary coverage and the spouse's plan will provide secondary coverage. On the other hand, if the spouse's birthday occurred earlier in the calendar year than the Member's birthday, then the spouse's plan will provide primary coverage and the Fund will provide secondary coverage. If the Member and the spouse have the same birthday in the calendar year, then the plan which covered the individual for whom the claim is made for the longer period of time shall be primary.

If the Member and the child's other parent are either separated or divorced from each other, then the following rules shall apply.

If there is a court order which establishes or apportions the parents' respective obligations to provide for the medical, dental or other health care expenses of any such child, then benefits will be apportioned in accordance with the provisions of the court order, provided that such court order cannot grant benefits which are not otherwise provided by the Fund.

In the absence of such a court order establishing such financial responsibility, the following shall be the order of payment of benefits for such dependent child:

Parents Separated or Divorced - Not Remarried	Parents Separated or Divorced and Remarried
1. Plan covering Parent with Custody	1. Plan covering Parent with Custody
2. Plan covering Parent without Custody	2. Plan covering Step-Parent with Custody
	3. Plan covering Parent without Custody

The Fund's Plan will not provide any benefit if the person for whom the claim is made is a pensioner, or the dependent of a pensioner who is gainfully employed and his employer provides him with health insurance or the person for whom the claim is made is not a Member, or an eligible dependent of a Member.

If the rules set forth above do not establish the order of benefit payment, the plan which covered the person for whom the claim is made for the longer period of time shall be considered the primary source of benefits.

***Medicare Coverage*:** For Covered Expenses incurred by Members and/or Dependents age 65 through 69 years, except for dependents age 65 through 69 of Members over age 69, the coverage provided by the Fund is primary. In those cases where the Member is actively at work, the Fund's coverage is primary. In all other situations, Medicare coverage is primary and the Fund is secondary.

Under no circumstances will the Fund pay any benefits as the primary plan when a Member or the dependent of a Member has elected to make the Fund the primary plan by waving coverage under any other plan. This provision shall be effective regardless of whether the dependent waived enrollment in such other plan (when required to enroll in circumstances described in paragraph g. below) or, if enrolled, sought or secured services outside of the required network of providers of such other plan.

If a group plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed a benefit payment.

Benefits otherwise payable under the Fund's Plan shall be reduced in accordance with the above priorities of payment to the extent necessary so that the sum of such reduced benefits payable under all group plans shall not exceed the total of the Usual, Customary and Reasonable charges for the service provided.

If a dependent spouse is employed full time (defined as being regularly scheduled to work 32 or more hours each week) and is eligible to enjoy group coverage through his/her employer at less than 100% of the cost to him/her, the spouse must enroll for such coverage (single coverage only). Furthermore, if such coverage exists for the spouse, the spouse may not waive coverage in lieu of a salary increase or other financial remuneration.

If the Member's spouse or other eligible dependents are subject to coordination of benefits, the Fund employs a "C.O.B. Bank" that will reimburse the member for certain co-payments and other out of pocket expenses incurred by the spouse or other eligible dependents in receiving medical treatment. In order to be eligible for reimbursement, the charges must be supported by a receipt and relate to services that were covered under the spouse's health plan. Additional information regarding the C.O.B. bank is available by calling the Fund's office.

Counseling: Counseling is not a covered benefit unless it is performed by a Physician as defined in this Booklet. In addition, the counseling must be related to the patient being treated for a mental illness and/or functional nervous disorder, drug abuse and alcoholism. The counseling must also be performed in a non-group setting, unless the other Members are Family Members, in which case the Fund would still only provide a single individual benefit allowance per session.

Covered Expenses: Only actual charges for an item or service which is specifically listed as a covered benefit under a provision of the Plan which is covered by your specific Summary of Benefits Schedule which accompanies this Booklet.

Deductible: A specified amount of Covered Expenses for the Covered Services that is incurred by the Covered Person before the Fund will assume any liability.

Dependent: (See Eligibility Provisions in the front of this Booklet.)

Family Member: (See Eligibility Provisions in the front of this Booklet.)

Fraud: No benefits under this Plan will be paid if the person on whose account, or by whom the benefit is claimed, or the provider of service attempts to perpetrate a fraud upon or misrepresents a fact to the Fund with respect to any such claim. In the case of such conduct, the Board of Trustees, may, in its sole and exclusive discretion, pay no further benefits to the Member, dependent or beneficiary involved as to the particular claim or as to any other claims arising during a period of not more than one year after the discovery of such fraud, attempted fraud or misrepresentation. The Fund shall have the right to fully recover any amounts, with interest, improperly paid by the Fund by reason of fraud, attempted fraud or misrepresentation of fact by a Member, dependent, beneficiary or provider of service and to pursue all other legal remedies. The Board of Trustees shall have the right to finally determine whether or not a fraud has been attempted or committed upon the Fund or if a misrepresentation of fact has been made, and its decision shall be final, conclusive and binding upon all persons.

Fund: The Teamsters Health and Welfare Fund of Philadelphia and Vicinity.

Group Therapy: Is not covered unless the only other Members in the "group" are other Family Members. In addition the therapy must be performed by a physician as defined in this Booklet and be related to treatment of a mental illness, a functional nervous disorder, drug abuse or alcoholism. Regardless of the number of Family Members participating in the therapy session, only a single individual allowance will be made per session.

Hospital(s): An acute care institution which meets the following requirements:

Is licensed as a **Hospital** by the State in which it is located, and the primary function of the institution is providing inpatient medical care and treatment through medical diagnostic and major surgical facilities on its premises under the supervision of a staff of physicians, and with 24 hour a day nursing service, and

Is not owned or operated by the United States Government or by a State (or political subdivision thereof) unless there is an unconditional requirement that persons receiving care must pay for such care.

However, "**Hospital**" does not include a Nursing Home or an institution, or part of one, used primarily as a facility for convalescence, rehabilitation, treatment of mental illness or functional nervous disorders, a place for the aged, a rest home, a place for alcoholics, or place for drug addicts.

Inpatient: An individual who, while confined in a Hospital or Special Care Facility, is assigned to a bed in any department of the institution other than its outpatient department and for whom a charge for room and board is made.

Legend Drugs: Drugs, biologicals, and compounded prescriptions which, by Federal Law can be dispensed only pursuant to a prescription, and are required to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription."

Maternity Coverage: Maternity coverage under the Plan available to female members and the female spouses of members. Under federal law, the Fund may not restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Fund may not, under federal law, require that a provider obtain authorization from the Fund for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medically Appropriate or Medically Necessary: Means services or supplies that are:

A. appropriate for the symptoms and diagnosis or treatment of the Family Member's condition, illness, disease or injury; and

B. required for the diagnosis, or the direct care and treatment of the Family Member's condition, illness, disease or injury; and

C. in accordance with standards of good medical practice as generally recognized and accepted by the medical community; and

D. not primarily for the convenience of either the Family Member's family or a provider of medical services; and

E. the most efficient and economical supply or level of service that can safely be provided to the Family Member. When applied to hospitalization, this further means that the Family Member requires acute care as a bed patient due to the nature of the services rendered or the Family Member's conditions, and the Family Member cannot receive safe and adequate care in some other setting without adversely affecting the Family Member's condition or quality of medical care.

Medicare: To the extent permitted by law, Medicare benefits will be taken into account for any Member or Dependent while they are eligible to apply for Medicare, whether or not they actually apply. The Fund will determine a Family Member's benefit allowance, if any, based upon the applicable Medicare statutes and regulations.

Member (or Eligible Member or Participant): An individual who has satisfied the eligibility requirements based on contributions made on his/her behalf by his Employer to the Fund and has qualified for the benefit program. Members include the

following types of employees: (1) an employee covered by a collective bargaining agreement or participation agreement that requires his/her employer to contribute to the Fund on his/her behalf, and/or (2) an employee of a Labor Union or trade association which contributes to the Fund on his/her behalf.

The masculine pronoun whenever used shall include the feminine pronoun and the singular shall include the plural where appropriate.

Participating Local Union: A union with whom any of the contributing Employers have entered into a signed Collective Bargaining Agreement, as a requirement of which, the Employer is obligated to make contributions to the Fund on behalf of the employees covered by that Collective Bargaining Agreement.

Physical Examination: The Fund reserves the right to examine at its own expense and as often as necessary, any person whose injury or sickness is the basis of a claim and, in the case of any death claim, to have an autopsy made.

Physician: Means a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a doctor of chiropractic medicine (D.C.), a doctor of dental surgery (D.D.S.), a doctor of dental medicine (D.M.D.), a doctor of podiatric medicine (D.P.M.), and optometrist (O.D.). A clinical psychologist (Ph.D., M.S., or M.A. or L.S.W.), when providing treatment for mental illness or functional nervous disorders, shall also be considered a physician.

Plan: Means this Booklet, the Aetna HMO booklet appended hereto, and any modifications thereto published by the Teamsters Health and Welfare Fund of Philadelphia and Vicinity duly adopted by the Fund's Board of Trustees in accordance with their authority set forth in the Agreement and Declaration of Trust establishing the Fund. Additionally, the Trustees of the Fund, by unanimous action, may terminate, suspend, withdraw, amend or modify the benefits available under the Fund, in whole or in part, at any time and without any prior notice. Any such termination, suspension, withdrawal, amendment or modification of benefits shall not require the consent of any Employer, union, Member or Dependent, nor shall such action require individual notice to any such person or organization.

Prescription: A written order of a physician or where permitted by law, an oral order of a physician, for legend drugs to the extent that such order is within the scope of such physician's license.

Special Care Facility: An institute other than a Hospital (as defined in this Booklet) which:

1. specializes in physical rehabilitation of injured or sick patients, or
2. specializes in the diagnosis and treatment of mental illness or functional nervous disorders, or
3. specializes in the diagnosis and treatment of alcoholism, drug addiction or mental and nervous disorders.
4. In addition, to qualify as a **Special Care Facility**, an institution must be:
5. legally licensed to give medical treatment, and
6. operated under the supervision of a physician, and
7. offer nursing service by registered graduated nurses or licensed practical nurses.

However, the term "**Special Care Facility**" does not include an institution or part of one that is used mainly as a facility for rest, convalescence, or for the aged.

Spouse: Means either your lawful wife or your lawful husband; however, separated spouses are not covered. A married couple is "separated" if they are living separate and apart with an intent to terminate or abandon the marital relationship.

Summary of Benefits Schedule: This is the various sections that accompany this Booklet that contain the actual allowances for your various benefits. This includes a partial listing of covered dental allowances. You may write the or call the Fund office to learn the allowance of any covered procedure not listed, or you may check the Fund's website (www.teamsterfunds.com). The maximum allowance may not exceed the fee actually charged for the procedure.

Totally Disabled:

For Member: You are prevented from engaging in your customary occupation solely because of injury or disease and are performing no work of any kind for pay or profit.

For Dependent: Your dependent is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health solely because of injury or disease.

Usual, Customary and Reasonable Allowance (or "UCR"): The benefit allowance for a procedure or service performed by a Physician or other medical service provider, taking into account the most consistent charge by an individual physician or provider of service to patients for a given service, the range of usual charges for a given service billed by most physicians or providers of service with similar training and experience within a given area, and the complexity of treatment of the particular case.

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IMPORTANT INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT ("ERISA")

Plan Year: The Plan Year starts on January 1 and ends on December 31, and consists of an entire calendar year for the purposes of accounting and preparing the reporting and disclosure information which must be submitted to the United States Department of Labor and other regulatory bodies.

Plan Funding: The Plan is funded through Employer contributions, the amount of which is specified in the Collective Bargaining Agreement between your Employer and your Local Union. The Plan is maintained by more than ten Collective Bargaining Agreements which are between, among others, the Teamsters Locals 107, 115, 312, 326, 331, 384, 463, 500, 623, 628, 676 and 929 and various Employer associations that have entered into labor contracts with these Local Unions. Other groups participate in the benefit program by reason of Participation Agreements. Applicable collective bargaining agreements may be reviewed at the Fund office.

Benefits provided under the Plan, other than death benefits, are self-insured and paid directly from the corpus of the Trust Fund.

Upon written request, the Administrator will furnish you with information as to whether a particular Employer participates in the Plan and, if so, its address.

Types of Benefits: This Plan provides comprehensive Hospitalization, Surgical, Medical, Dental, Vision, Death and Dismemberment, Short-term Weekly Disability and Prescription Drug Benefits. Please refer to the Table of Contents and the Summary of Benefits Schedule for more information concerning the benefits provided under this Plan. The Trustees retain the right to amend or terminate the Plan or Plan Benefits set forth in this booklet to the fullest extent provided by law.

Your Rights Under ERISA: As a Member in the Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, provided that all Plan Members shall be entitled to:

- Receive Information About Your Plan and Benefits

- 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, if any, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, insurance contracts, if any, 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.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Member with a copy of this summary annual report.

- 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.

- A reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have credible 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 subjected to a preexisting condition exclusion for 12 months (18 months for late

enrollees) after your enrollment date in your coverage. The Fund's Plan does not contain any exclusions for preexisting conditions.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for Plan Members, 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 Members and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights: If your claim for a benefit under this Plan 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 them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these fees. If you lose, the court may order you to pay these costs and fees. For example: If it finds your claim is frivolous.

Assistance with Your Questions: If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

HIPAA PRIVACY PRACTICES

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

I. USE AND DISCLOSURE OF HEALTH INFORMATION

The Teamsters Health & Welfare Fund of Philadelphia and Vicinity (the "Fund") may use your health information, that is, information that constitutes "protected health information" as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Fund has established a policy to guard against unnecessary disclosure of your health information. Please note that, under the Privacy Rule, "protected health information" does not include information relating to weekly disability or life insurance benefits.

IN ADDITION TO OTHER USES AND DISCLOSURES PERMITTED UNDER HIPAA, THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

A. To Make or Obtain Payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other trust funds, health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other the Funds to coordinate payment of benefits.

B. To Conduct Health Care Operations. The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants. Health care operations includes such activities as:

- Quality assessment and improvement activities.

- Member Service activities relating to claim eligibility and payment. Benefit eligibility of a family member may be disclosed to the Member or spouse (or, in the case of a non-mentally handicapped dependent child over the age of 18, to that dependent child). Limited information (such as whether a claim has been received or paid) regarding your claims may be disclosed, upon appropriate authentication, to your spouse, unless you advise us that no information should be released to your spouse except upon an express written authorization. Claims information relating to dependent children under the age of 18 may be disclosed to the parent or legal guardian of that child. Claims information relating to covered dependents over the age of 18 may be disclosed only to that dependent, unless the dependent authorizes the disclosure of claims information to someone else, including the parent or legal guardian of that dependent. Claims information relating to a mentally handicapped dependent child over the age of 18 may be disclosed to the parent or legal guardian of that child.

- Activities designed to improve health or reduce health care costs.

- Clinical guideline and protocol development, case management and care coordination.

- Contacting health care providers and participants with information about treatment alternatives and other related functions.

- Health care professional competence or qualifications review and performance evaluation.

- Accreditation, certification, licensing or credentialing activities.

- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.

- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.

- Business planning and development including cost management and planning related analyses and formulary development.

- Business management and general administrative activities of the Fund, including customer service and resolution of internal grievances.

For example, The Fund may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

C. For Treatment Alternatives. The Fund may use and disclose your health information to Fund consultants to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

D. For Distribution of Health-Related Benefits and Services. The Fund may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

E. For Disclosure to the Plan Sponsor. The Fund may disclose your health information to the plan sponsor (the Fund's Board of Trustees) for plan administration functions performed by the plan sponsor on behalf of the Fund. The Fund also may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from other the Funds or modify, amend or terminate the plan.

F. When Legally Required. The Fund will disclose your health information when it is required to do so by any federal, state or local law.

G. To Conduct Health Oversight Activities. The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

H. In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Fund makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

I. For Law Enforcement Purposes. As permitted or required by state law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

J. In the Event of a Serious Threat to Health or Safety. The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

K. For Specified Government Functions. In certain circumstances, federal regulations require the Fund use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

L. For Worker's Compensation. The Fund may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

II. AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Fund will not disclose your health information other than upon your written authorization. This includes uses and disclosures of protected health information relating to psychotherapy, for marketing purposes, and/or sales of protected health information. An authorization must contain certain language and, for that reason, the Fund has developed an appropriate form that is available in the Fund office or on the Fund's web site. Such authorizations are limited by the event (such as a claim) and by time. Blanket authorizations for general disclosures are not permitted under HIPAA's Privacy Rule. If you authorize the Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

III. YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that The Fund maintains:

A. Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request, unless the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which payment in full has been made by someone or something other than the Fund. If you wish to make a request for restrictions, please contact the Fund's Privacy Officer whose name and address appears at the end of this Notice.

B. Right to Receive Confidential Communications. You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The Fund will attempt to honor your reasonable requests for confidential communications.

C. Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be signed, made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice and must include identify the person designated by you to inspect your protected health information and where to send the copy of protected health information. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

D. Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

E. Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Fund for any reason other than for (1) treatment, payment or health care operations, (2) disclosures made under circumstances described in this Notice, or (3) disclosures which you authorized. The request must be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

F. Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy,

please contact Fund's Privacy Officer whose name and address appears at the end of this Notice. ***You also may obtain a copy of the current version of the Fund's Notice at its web site, www.teamsterfunds.com.***

IV. DUTIES OF THE FUND

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify affected individuals following a breach of unsecured protected health information. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

V. CONTACT PERSON

The Fund has designated William J. Einhorn, the Fund's Administrator as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at the following:

William J. Einhorn, Privacy Officer
Teamsters Health & Welfare Fund of Philadelphia and Vicinity
6981 N. Park Drive, Suite 400
Pennsauken, NJ 08109
856-382-2470
856-382-2401 (fax)

VI. EFFECTIVE DATE

This Notice is effective March 26, 2013**.**

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICER IDENTIFIED ABOVE.

APPENDIX A

Aetna HMO Plan

Welcome!

Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured. An extensive network of participating physicians and hospitals is available to provide you with easy access to medical care 24 hours a day, 7 days a week.

We believe that through the appropriate use of health resources, we can work together to keep you healthy and to control the rising costs of medical care for everyone.

Your Health Maintenance Organization (HMO) benefits program is self-funded by your Health & Welfare Fund and administered by Aetna Life Insurance Company (Aetna).*

We wish you the best of health.

** As used in this booklet, "HMO" refers to HMO-type benefits that are self-funded by your Health & Welfare Fund.*

How to Use Your Summary Plan Description

This booklet is your guide to the benefits available through your Health & Welfare Fund's HMO Plan. Please read it carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a Plan participant.

If you cannot find the answer to your question(s) in the booklet, call the Member Services toll-free number on your ID card. A trained representative will be happy to help you. For more information, go to the "Member Services" section later in this book.

Tips for New Plan Participants

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician's name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See "In Case of Medical Emergency" for emergency care guidelines.

Table of Contents

How the Plan Works

Plan participants have access to a network of participating Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

Each participant in the Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will help you access appropriate care.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when medically necessary, your PCP will refer you to other doctors or facilities for treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment. Except for PCP, direct access and emergency services, **you must have a prior written or electronic referral from your PCP to receive coverage for all services and any necessary follow-up treatment**.

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You may also obtain routine gynecological exams from participating providers without a referral from your PCP. You are responsible for the copayment shown in the "Copayment Schedule."

Specialty and Facility Care

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. **Except for those benefits described in this booklet as direct access benefits and emergency care, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides**.

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the copayment shown in the "Copayment Schedule."

Once your copayments (excluding prescription drug and dental copays) reach the **annual out-of-pocket maximum**, the Plan pays 100% of your covered expenses for the remainder of that calendar year.

To avoid costly and unnecessary bills, follow these steps:

- **Consult your PCP first** when you need routine medical care. If your PCP deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible participant in the Plan.
- Certain services require **both** a referral from your PCP **and** prior authorization from Aetna. Your PCP is responsible for obtaining authorization from Aetna for in-network covered services.
- **Review the referral** with your PCP. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services**.

- If it is not an emergency and you go to a doctor or facility **without your PCP's prior written or electronic referral, you must pay the bill yourself**.
- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.

Remember: You cannot request referrals **after** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from Aetna (when applicable) **before** seeking specialty or hospital care.

Some PCPs are affiliated with integrated delivery systems (IDS) or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by non-affiliated physicians or facilities. Services provided by non-affiliated providers may require prior authorization from Aetna and/or the IDS or other provider group. Check with your PCP or call the Member Services number that appears on your ID card to find out if prior authorization is necessary.

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID card.

It is easy to obtain information about providers in Aetna's network using the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, go to **www.aetna.com/docfind.** Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

Your ID Card

When you join the Plan, you will receive two (2) member ID cards. Your ID card lists the telephone number of the Aetna PCP you have chosen. If you change your PCP, you will automatically receive a new card displaying the change.

Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services at nonparticipating facilities. If your card is lost or stolen, please notify Aetna immediately.

Copayment Schedule

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a "direct access" benefit.

Type of Service or Supply	Benefit Level
Annual Maximum	$2 Million per patient
Plan Deductible	None
Annual Out of Pocket Limit	
Individual	$ 440
Family	None
Primary and Preventive Care	
PCP Office Visits	$ 10 copay per visit
After Hours/Home Visits/Emergency Visits	$ 15 copay per visit
Routine Examinations	$ 10 copay per visit
Routine Child and Well-Baby Care	$ 10 copay per visit
Immunizations	100% after office visit copay
Routine Gynecological Exams	$20 copay per visit - direct access (no referral) to participating providers for one routine exam and Pap smear per 365-day period
Routine Mammogram	No copay - one annual mammogram for women age 40 and over
Prostate Screening	No copay – one annual prostate screening for men age 40 and over
Routine Hearing Screenings	Covered when performed as part of a routine exam by PCP. Subject to office visit copay
Hearing Aids	Not covered
Specialty and Outpatient Care	
Specialist Office Visits	$20 copay per visit
Prenatal Care	$20 copay for the first OB visit
Infertility Services	Not Covered
Advanced Reproductive Technology	Not Covered
Allergy Testing	100% after office visit copay
Allergy Treatment Routine injections at PCP's office, with or without physician encounter	No copay
X-rays and Lab Tests	No copay with referral
Therapy (speech, occupational, physical)	No copay with referral
Chiropractic Care	$20 copay per visit – 15 visits per year
Home Health Care	No copay
Hospice Care	No copay
Durable Medical Equipment (DME)	No copay - must be approved in advance by Aetna
Prosthetic Devices	No copay - some prostheses must be approved in advance by Aetna
Prosthetic Wigs	$450 maximum. One (1) wig per lifetime for diagnosis of hair loss due to chemotherapy.
Nutritional Supplements: Specifically formulated for therapeutic treatment of phenylektonuria, branch-chain ketonuria, galactosemia and homocystinuria.	Covered at 100%. Foods must not be the patient's sole source of nutrition.
Cervical cancer (HPV) Vaccine	3 injections covered with $35 copay. Also subject to office visit copay

Type of Service or Supply	Benefit Level
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	No copay
Skilled Nursing Facilities	No copay
Hospice Facility	No copay
Surgery and Anesthesia	
Inpatient Surgery	No copay
Outpatient Surgery	No copay
Mental and Nervous Conditions	Covered under a separate Health & Welfare Fund Program – Contact Total Care Network at 1-800-298-2299
Treatment of Alcohol and Drug Abuse	Covered under a separate Health & Welfare Fund Program – Contact Total Care Network at 1-800-298-2299
Emergency Care	
Emergency Room	$ 100 copay (waived if admitted)
Urgent Care	$ 50
Non-emergency use of the Emergency Room	No coverage
Ambulance	No copay when medically necessary
Prescription Drugs	Covered under the Health & Welfare Fund's Prescription Drug Program administered by Express Scripts, Inc. Refer to the main portion of the Fund's Summary Plan Description describing the coverage available
Dental Benefits	Covered under the Health & Welfare Fund's Dental Program. Refer to the main portion of the Fund's Summary Plan Description describing the coverage available
Vision Benefits	Covered under the Health & Welfare Fund's Vision Program. Refer to the main portion of the Fund's Summary Plan Description describing the coverage available. Aetna's Discount Vision Program is also available.

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of your illness or condition. Refer to the "Glossary" section for the definition of "medically necessary."

Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval.

Primary and Preventive Care

One of the Plan's goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable copayment) if provided by your PCP or on referral from your PCP:

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Routine physical examinations, as recommended by your PCP.
- Well-child care from birth, including immunizations and booster doses, as recommended by your PCP.
- Health education counseling and information.
- Annual prostate screening (PSA) and digital exam for males age 40 and over, and for males considered to be at high risk who are under age 40, as directed by physician.
- Routine gynecological examinations and Pap smears performed by your PCP. You may also visit a participating gynecologist for a routine GYN exam and Pap smear without a referral.
- Routine mammograms for female Plan participants age 40 or over.
- Annual mammography screening for asymptomatic women age 40 and older. Annual screening is covered for younger women who are judged to be at high risk by their PCP.
  Note: Diagnostic mammography for women with signs or symptoms of breast disease is covered as medically necessary.
- Routine immunizations (except those required for travel or work).
- Routine hearing screenings performed by your PCP as part of a routine physical examination.
- Injections, including routine allergy desensitization injections.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. You must have a prior written or electronic referral from your PCP in order to receive coverage for any non-emergency services the specialist or facility provides.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.

- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see "In Case of Emergency").
- Home health services provided by a participating home health care agency, including:
  - skilled nursing services provided or supervised by an RN.
  - services of a home health aide for skilled care.
  - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.
- Outpatient hospice services for a Plan participant who is terminally ill, including:
  - counseling and emotional support.
  - home visits by nurses and social workers.
  - pain management and symptom control.
  - instruction and supervision of a family member.

  Note: The Plan does **not** cover the following hospice services:
  - bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
  - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
  - respite care when the patient's family or usual caretaker cannot, or will not, attend to the patient's needs.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and orthodontogenic cysts).
- Reconstructive breast surgery following a mastectomy, including:
  - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
  - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and

  physical therapy to treat the complications of the mastectomy, including lymphedema.
- Services to diagnose the underlying medical cause of infertility. You may obtain the following diagnostic infertility services from a participating gynecologist or infertility specialist ***with*** a referral from your PCP:
  - initial evaluation, including history, physical exam and laboratory studies performed at an appropriate participating laboratory,
  - evaluation of ovulatory function,
  - ultrasound of ovaries at an appropriate participating radiology facility,
  - postcoital test,
  - hysterosalpingogram,
  - endometrial biopsy, and
  - hysteroscopy.

  Semen analysis at an appropriate participating laboratory is covered for male Plan participants; a referral from your PCP is necessary.
- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Certain prosthetics require preauthorization by Aetna.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury, and preauthorized by Aetna.

  The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:
  - they are needed due to a change in your physical condition, or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

The request for any type of DME must be made by your physician and coordinated through the Aetna Patient Management Department.

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you receive the benefits listed below.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
  - cardiac rehabilitation, and
  - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Non-experimental, non-investigational transplants. All transplants must be ordered by your PCP and participating specialist and approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Maternity

Maternity coverage is available only to the employee or to the employee’s spouse. Maternity coverage is not available to dependent daughters of an employee.

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. If the employee does not enjoy family coverage under the Plan, charges for the newborn baby are not covered. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may – **after consulting with you** – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or on DocFind (see "Provider Information").

Note: Your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. They must request approval (precertification) for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Behavioral Health

Your mental health/substance abuse benefits are provided under a separate benefits program administered by the Health & Welfare Fund and Total Care Network. Participants should contact Total Care Network at 1-800-298-2299 to access these benefits.

Prescription Drugs

Your prescription drug benefits are provided under a separate benefits program administered by the Health & Welfare Fund and Express Scripts, Inc. Participants should refer to the main portion of the Summary Plan Description for a description of the coverage and copayments relating to these benefits.

Dental Benefits

Your dental benefits are provided under a separate benefits program administered by the Health & Welfare Fund. Participants should refer to the main portion of the Summary Plan Description for a description of the coverage, limitations and copayments relating to these benefits.

Vision Benefits

Your vision program benefits are provided under a separate benefits program administered by the Health & Welfare Fund. Participants should refer to the main portion of the Summary Plan Description for a description of the coverage and limitations relating to these benefits. In addition, Aetna HMO participants have access to the Aetna Vision Discounts program. For more information regarding this program, participants should contact the Member Services Center at the telephone number listed on your ID card.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by Aetna.
- Blood, blood plasma, or other blood derivatives or substitutes.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:

  - reconstructive surgery to correct the results of an injury.
  - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function, provided that the patient was covered under the Fund's benefit program at the time of birth.
  - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
  Dental care and treatment, except as specified under "Your Benefits".
- Durable medical equipment (DME) which has not been prescribed by your treating physician ***and*** approved by Aetna.
- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.
  This exclusion will not apply to drugs:

  - that have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
  - that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
  - that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

  Refer to the "Glossary" for a definition of "experimental or investigational."

  False teeth.

  Hair analysis.

  Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.

- Immunizations related to travel or work.
- Implantable drugs.
- Services for the treatment of Infertility. In addition, the Plan does not cover:
  - purchase of donor sperm and any charges for the storage of sperm.
  - purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
  - cryopreservation and storage of cryopreserved embryos.
  - all charges associated with a gestational carrier program (surrogate parenting) for the Plan participant or the gestational carrier.
  - drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary.
  - injectable infertility drugs.
  - the costs for home ovulation prediction kits.
  - services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal.
- Oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics. These items are not covered under the Aetna Plan, but are covered under a separate program administered by the Fund.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips.
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Prescription drugs and medicines, except those administered while you are an inpatient in a health care facility.
- Private duty or special nursing care.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
  - obtaining or continuing employment,
  - obtaining or maintaining any license issued by a municipality, state or federal government,
  - securing insurance coverage,
  - travel, and
  - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.

- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
  - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health,
  - needles, syringes and other injectable aids (except for diabetics),
  - drugs related to treatments not covered by the Plan, and
  - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.
- Specific non-standard allergy services and supplies, including (but not limited to):
  - skin titration (wrinkle method),
  - cytotoxicity testing (Bryan's Test),
  - treatment of non-specific candida sensitivity, and
  - urine autoinjections.
- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
  - primal therapy.
  - chelation therapy.
  - rolfing.
  - psychodrama.
  - megavitamin therapy.
  - purging.
  - bioenergetic therapy.
  - vision perception training.
  - carbon dioxide therapy.
- Thermograms and thermography.
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to medical treatment of the retarded individual as described under "Your Benefits."
- Treatment of sickness or injury covered by a worker's compensation act or occupational disease law, or by United States Longshoreman's and Harbor Worker's Compensation Act.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - treatment performed by placing a prosthesis directly on the teeth,
  - surgical and non-surgical medical and dental services, and
- Voluntary abortions, except in cases involving rape, incest or where the life of the mother is threatened.
- Weight reduction programs and dietary supplements.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

In Case of Medical Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

> *An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:*
>
> - *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
> - *Serious impairment to bodily function; or*
> - *Serious dysfunction of any bodily organ or part.*

Some examples of emergencies are:

- Heart attack or suspected heart attack.
- Poisoning.
- Severe shortness of breath.
- Uncontrolled or severe bleeding.
- Suspected overdose of medication.
- Severe burns.
- High fever (especially in infants).
- Loss of consciousness.

Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your PCP first, if possible. Your PCP is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.
2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
4. All follow-up care must be coordinated by your PCP.
5. If you go to an emergency facility for treatment that Aetna determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

Follow-Up Care After Emergencies

All follow-up care should be coordinated by your PCP. You must have a referral from your PCP **and** approval from Aetna to receive follow-up care from a nonparticipating provider. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and

- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Urgent care from participating providers within your service area is covered if your PCP is not reasonably available to provide services to you. You should first seek care through your PCP. Referrals to participating urgent care providers are not required, but the care must be urgent, non-preventive or non-routine.

Some examples of urgent medical conditions are:

- Severe vomiting.
- Earaches.
- Sore throat.
- Fever.

Follow-up care provided by your PCP is covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered with a **prior written or electronic referral** from your PCP, subject to the specialist copay shown in the "Copayment Schedule."

What to Do Outside Your Aetna Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, or an urgent care center. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP before receiving treatment from a non-participating urgent care provider.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a customer service professional (CSP) can take this information over the telephone.

Special Programs

Alternative Health Care Programs

Natural Alternatives - If you are interested in alternative therapies such as acupuncture or massage therapy, Aetna has a program to meet your needs. Aetna's Natural Alternatives program offers you special rates on alternative therapies, including visits to acupuncturists, chiropractors, massage therapists and nutritional counselors.

Vitamin Advantage™ - You can save on vitamins and nutritional supplements purchased through mail order, over the phone, by fax, or over the Internet.

Natural Products - You also can save on many health-related products, including aromatherapy, foot care and natural body care products.

You may place orders by mail, telephone, fax or Internet to receive savings on health-related products offered through these programs.

To Find Out More - Call the Member Services number on your ID card, or visit Aetna on the web at **http://www.aetna.com/products/natural_alt_99.html**. There you can find a listing of participating providers, vendors and the latest additions to the product list. Visit the website often — these programs are growing!

Natural Alternatives is not available in all states.

Fitness Program

Aetna offers Plan participants access to discounted fitness services provided by GlobalFit™. Plan participants can join the GlobalFit network and receive discounts on their health club membership rate. The Fitness Program offers Plan participants:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit;
- Free guest passes to allow you to sample facilities before selecting a club* to join;
- Guest privileges at other participating GlobalFit health clubs,* and
- Discounts on certain home exercise equipment.

** Not available at all clubs.*

To view a list of included clubs, visit the GlobalFit website at **www.globalfit.com/fitness**. If you would like to speak with a GlobalFit representative, you can call GlobalFit at 1-800-298-7800.

Member Health Education Programs

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's innovative Member Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Member Health Education Programs, call the toll-free number on your ID card or visit **http://www.aetna.com/products/health_education.html**.

Adolescent Immunization

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent a newsletter that includes examination and immunization schedule recommended for these age groups. This reminder is in the form of a newsletter provided by Merck & Co., Inc.

Preventive Reminders

Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats. Each year, Aetna sends a preventive health care reminder to households with a member who is particularly vulnerable to one or more of these diseases – adults who are age 50 and older, children ages 6-23 months, and people over age 2 with a chronic condition such as asthma, congestive heart failure, or chronic renal failure.

The reminder stresses the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Cancer Screening Programs

Early detection and treatment is important in helping our members lead longer, healthier lives. Member Health Education provides members with an important means of early detection.

Breast Cancer Screening

Beginning annually at age 40, each female Plan participant is sent information that stresses the importance of mammography, breast self-examination and annual gynecological exams. The mailer also includes information about menopause and heart disease. The mailer may also include information on participating mammography centers or information for women who have chosen a primary care physician with a capitated radiology office.

Cervical

Gynecological examinations and Pap smears are vital to women's health because they are often the first step in the detection and treatment of abnormalities. This program reminds female members, starting at 18 years of age, to get exams and Pap smears on a regular basis. Annually, female members are sent information stressing the importance of annual gynecological exams, direct access to care, as well as instructions on how to perform breast self-examination.

Colorectal

The colorectal cancer cure rate can exceed 80 percent when detected early. We encourage you to discuss questions about colorectal cancer screening with your physician. Together you and your physician can choose the most appropriate method of colorectal cancer screening. Aetna sends annual reminders stressing the importance of completing appropriate colorectal cancer screening.

Childhood Immunization Program

Children need immunizations to protect them from a number of dangerous childhood diseases that could have very serious complications. Vaccines have been proven to be powerful tools for preventing certain diseases. It has been shown over time that the risks of serious illness from not vaccinating children far outweigh any risk of reaction to immunization. The common childhood diseases that vaccinations can guard against are:

- Measles
- Mumps
- Rubella
- Polio
- Pertussis (whooping cough)
- Diphtheria
- Tetanus
- Haemophilus influenzae type B
- Hepatitis B
- Varicella (chicken pox)

To promote good health through prevention, the Childhood Immunization Program sends immunization reminders to parents of children covered under this Plan.

An 18-month reminder is sent to families encouraging parents to schedule immunization visits with their pediatrician or family doctor if their child is not already fully immunized. This reminder contains a list of immunizations recommended at 18 months. * The objective of this reminder is to help promote timely childhood immunizations and to stress the importance of completing immunizations.

If you have questions about specific vaccinations, please call your pediatrician or your family doctor.

* *Source: Office of Prevention and Health Promotion, in cooperation with the agencies of Public Health Services, U.S. Department of Health and Human Services. Center for Disease Control and Prevention (CDC), American Association of Pediatrics (AAP), and Advisory Committee on Immunization Practices.*

Informed Health® Line

Informed Health® Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.

Informed Health Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the nation.

Backed by the Healthwise® Knowledgebase™ (a computerized database of over 1900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

Numbers-to-Know™ -- Hypertension and Cholesterol Management

Aetna created *Numbers To Know*™ to promote blood pressure and cholesterol monitoring. The *Numbers To Know* mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication and dosage information.

Hypertension and high cholesterol are never "cured" but may be controlled with lifestyle changes and adherence to a treatment plan. You can help to stay "heart healthy" by monitoring your blood pressure and blood cholesterol numbers.

Numbers To Know can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol and work with your physician to develop an appropriate treatment plan.

Transplant Expenses

Once it has been determined that you or one of your dependents may require an organ transplant, you, or your **physician** should call the Aetna precertification department to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements found in the Certification for Admissions sections of this document. Organ means solid organ; stem cell; bone marrow; and tissue.

Benefits may vary if an **Institute of Excellence** (**IOE**) facility or non-**IOE** is used. In addition, some expenses listed below are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will be covered at the non-preferred level. Please read each section carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

Charges for activating the donor search process with national registries.

Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your: biological parent, sibling or child.

Inpatient and outpatient expenses directly related to a transplant**.**

Charges made by a **physician** or transplant team.

Charges made by a **hospital,** outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program and subject to a maximum of $25,000 per transplant occurrence.

Related supplies and services provided by the **IOE** facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.

3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.

4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

Heart

Lung

Heart/ Lung

Simultaneous Pancreas Kidney (SPK)

Pancreas

Kidney

Liver

Intestine

Bone Marrow/Stem Cell transplant

Multiple organs replaced during one transplant surgery

Tandem transplants (Stem Cell)

Sequential transplants

Re-transplant of same organ type within 180 days of the first transplant

Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

Autologous Blood/Bone Marrow transplant followed by Allogenic Blood/Bone Marrow transplant (when not part of a tandem transplant)

Allogenic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant)

Re-transplant after 180 days of the first transplant

Pancreas transplant following a kidney transplant

A transplant necessitated by an additional organ failure during the original transplant surgery/process.

More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g. a liver transplant with subsequent heart transplant).

Limitations

The transplant coverage does not include charges for:

Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.

Services and supplies furnished to a donor when recipient is not a covered person.

Home infusion therapy after the Transplant Occurrence.

Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.

Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.

Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Women's Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care.

Support for Women With Breast Cancer

Aetna's Breast Health Education Center helps women make informed choices when they've been newly-diagnosed with breast cancer. A dedicated breast cancer nurse consultant provides the following services:

Breast cancer information

Second opinion options

Information about community resources

Benefit eligibility

Help with accessing participating providers for:

Wigs

Lymphedema pumps

Call 1-888-322-8742 to reach Aetna's Breast Health Education Center.

Confidential Genetic Testing for Breast and Ovarian Cancers

Aetna covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test.

Direct Access for OB/GYN Visits

This program allows a female Plan participant to visit any participating gynecologist for one routine well-woman exam (including a Pap smear) per year, without a referral from her PCP. The Plan also covers additional visits for treatment of gynecological problems and follow-up care, without a PCP referral. Participating general gynecologists may also refer a woman directly for appropriate gynecological services without the patient having to go back to her participating PCP.

If your gynecologist is affiliated with an IDS or provider group, such as an independent practice association (IPA), you may be required to coordinate your care through that IDS or provider group.

Beginning Right Maternity Program™

The Moms-to-Babies™ maternity management program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Educational materials on prenatal care, labor and delivery, postpartum depression and breastfeeding
- Specialized information for Dad or partner
- Web-based materials and access to program services through Women's Health Online
- Care coordination by trained obstetrical nurses
- Access to Smoke-free Moms-to-be® smoking cessation program for pregnant women
- Preterm labor education
- Access to breastfeeding support services

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and Moms-to-Babies case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, ***Pregnancy Risk Assessment***, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

InteliHealth®

InteliHealth is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via **www.intelihealth.com**.

Clinical Policy Bulletins

Aetna uses Clinical Policy Bulletins (CPBs) as a guide when making clinical determinations about health care coverage. CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. The CPBs are posted on Aetna's website at **www.aetna.com.**

Federal Notices

This section describes laws and plan provisions that apply to reproductive and women's health issues.

The Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the follow procedures for a person receiving benefits for an **appropriate** mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

For answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call Aetna's Member Services at the number shown on your ID card.

Claim Procedures

A claim occurs whenever a Plan participant requests:

- An authorization or referral from a participating provider or Aetna; or
- Payment for items or services received.

Because you are a participant in an HMO-type plan, you do not need to submit a claim for most of your covered healthcare expenses. However, if you receive a bill for covered services, the bill must be submitted promptly to Aetna for payment. Send the itemized bill for payment with your identification number clearly marked to the address shown on your ID card.

Aetna will make a decision on your claim. For **concurrent care** claims, Aetna will send you written notification of an affirmative benefit determination. For other types of claims, you may only receive written notice if Aetna makes an **adverse benefit determination**.

Adverse benefit determinations are decisions Aetna makes that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
  - it is not included in the list of covered benefits,
  - it is specifically excluded,
  - a Plan limitation has been reached, or
  - it is not medically necessary.

Aetna will provide you with written notices of adverse benefit determinations within the time frames shown below. These time frames may be extended under certain limited circumstances. The notice you receive from Aetna will provide important information that will assist you in making an appeal of the adverse benefit determination, if you wish to do so. Please see "Complaints and Appeals" for more information about appeals.

Type of Claim	**Response Time**
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours
Pre-service claim: a claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care.	15 calendar days
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Urgent care claim - as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours prior to the expiration of the approved treatment Other claims - 15 calendar days
Concurrent care claim reduction or termination: a decision to reduce or terminate a course of treatment that was previously approved.	With enough advance notice to allow the Plan participant to appeal
Post-service claim: a claim for a benefit that is not a pre-service	30 calendar days

claim.	

Extensions of Time Frames

The time periods described in the chart may be extended.

For urgent care claims: If Aetna does not have sufficient information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after the additional information is provided.

For non-urgent pre-service and post-service claims: The time frames may be extended for up to 15 additional days for reasons beyond the plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended. If you fail to provide the information, your claim will be denied.

If an extension is necessary because Aetna needs more information to process your post service claim, Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information. Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier). If you fail to provide the information, your claim will be denied.

Grievances and Appeals

The Plan has procedures for you to follow if you are dissatisfied with a decision that Aetna has made or with the operation of the Plan. The process depends on the type of complaint you have. There are two categories of complaints:

- Quality of care or operational issues; and
- Adverse benefit determinations.

Complaints about quality of care or operational issues are called **grievances**. Complaints about adverse benefit determinations are called **appeals**.

Grievances

Quality of care or operational issues arise if you are dissatisfied with the service received from Aetna or want to complain about a participating provider. To make a complaint about a quality of care or operational issue (called a grievance), call or write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written decision within 30 calendar days of the receipt of the grievance, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will specify what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

Aetna will send you written notice of an adverse benefit determination. The notice will give the reason for the decision and will explain what steps you must take if you wish to appeal. The notice will also tell you about your rights to receive additional information that may be relevant to the appeal. Requests for appeal must be made in writing within 90 days from the receipt of the notice. However, appeals of adverse benefit determinations involving urgent care may be made orally.

If the Plan's appeals process upholds the original adverse benefit determination, you may have the right to pursue an external review of your claim. See “External Review” for more information.

The Plan provides for two levels of appeal. If you are dissatisfied with the outcome of your level one appeal and wish to file a level two appeal, your appeal must be filed no later than 60 days following receipt of the level one notice of adverse benefit determination. The following chart summarizes some information about how appeals are handled for different types of claims.

Type of Claim	**Level One Appeal: Response Time From Receipt of Appeal**	**Level Two Appeal: Response Time From Receipt of Appeal**
Urgent care claim: a claim for medical care or treatment where delay could: • Seriously jeopardize your life or health, or your ability to regain maximum function; or • Subject you to severe pain that cannot be adequately managed without the requested care or treatment.	36 hours Review provided by Plan personnel not involved in making the adverse benefit determination.	36 hours Review provided by Plan personnel not involved in making the adverse benefit determination.
Pre-service claim: a claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	15 calendar days Review provided by Plan personnel not	15 calendar days Review provided by Plan personnel not involved in making the adverse

	involved in making the adverse benefit determination.	benefit determination.
Concurrent care claim extension: a request to extend a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim, depending on the circumstances.	Treated like an urgent care claim or a pre-service claim, depending on the circumstances.
Post-service claim: a claim for a benefit that is not a pre-service claim.	30 calendar days Review provided by Plan personnel not involved in making the adverse benefit determination.	30 calendar days Review provided by Plan personnel not involved in making the adverse benefit determination.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. However, in case of an urgent care claim or a pre-service claim, a physician familiar with the case may represent you in the appeal.

Depending on the type of appeal, you and/or an authorized representative may attend the Level Two appeal hearing and question the representative of the Plan and any other witnesses, and present your case. The hearing will be informal. You may bring your physician or other experts to testify. The Plan also has the right to present witnesses.

Claim Fiduciary

Your Health & Welfare Fund has complete discretionary authority to review all denied claims for benefits under the Plan. This includes, but is not limited to, determining whether hospital or medical treatment is, or is not, medically necessary. In exercising its responsibilities, your Health & Welfare Fund has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Construe any disputed or doubtful terms of the Plan.

Your Health & Welfare Fund has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. Your Health & Welfare Fund may not abuse its discretionary authority by acting arbitrarily and capriciously.

Your Health & Welfare Fund is responsible for making reports and disclosures required by applicable laws and regulations.

Member Services

Member Services Department

Customer service professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the Member Services toll-free number on your ID card to:

- Ask questions about benefits and coverage;
- Notify Aetna of changes in your name or telephone number;
- Change your PCP; or
- Notify Aetna about an emergency.

Please call your PCP's office directly with questions about appointments, hours of service or medical matters.

Internet Access

You can access Aetna on the internet at **http://www.aetna.com/members/member_services.html** to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

- Find answers to common questions;
- Change your PCP;
- Order a new ID card; or
- Contact the Member Services department with questions.

Please be sure to include your ID number, Social Security number and e-mail address.

InteliHealth®

InteliHealth is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via **www.intelihealth.com**.

Aetna Navigator™

Aetna Navigator provides a single location for the health and medical issues that matter most to you.

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from InteliHealth®. Access Aetna Navigator™ through the Aetna Internet website home page or directly **via www.aetnanavigator.com**.

When you visit the website, you can see some of Aetna Navigator's distinct features:

- A wealth of health information from InteliHealth, a premier provider of online consumer-based health, wellness and disease-specific information.
- Online customer service functions that allow you to change your primary care physician or primary care dentist, order ID cards and send e-mail inquiries to Member Services.

- Interactive “Cool Tools,” including a medical dictionary, allergy and asthma quizzes, a pregnancy due-date calculator and a heart and breath odometer. To access “Cool Tools,” look under “Health Tools.”
- A preventive care planner that includes recommendations for screenings and immunizations.

Plan participants with certain Aetna plans may also create password-protected Web pages that are personalized to their health care interests. They have access to the features listed above as well as other options including:

- A personal “benefits snapshot” and claims summary.
- DocFind-A-Specialist, Aetna’s enhanced online provider directory that helps Plan participants select a specialist based on personal needs and preferences.
- An online survey that allows you to receive customized information based on your personal health interests.

Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you chose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at **www.aetna.com**. Select DocFind from the drop-down menu under Quick Tools, then under "How do I learn more about:" select the type of plan you're enrolled in.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your PCP for non-emergency referrals to specialist or hospital care.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your PCP before getting care at an emergency facility, unless a delay would be detrimental to your health.

- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.
- Pay the copayments required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Glossary

Annual out-of-pocket maximum - means the maximum amount a Plan participant must pay toward covered expenses in a calendar year. Once you reach your annual out-of-pocket maximum, the Plan pays 100% of covered expenses for the remainder of the calendar year. Copays (except prescription drug, behavioral health and dental copays) apply toward the annual out-of-pocket maximum.

Certain expenses do ***not*** apply toward the annual out-of-pocket maximum:

Charges for services that are not covered by the Plan.
Copayments for prescription drugs, behavioral health or dental benefits.

Companion - means a person whose presence as a companion or caregiver is necessary to enable a National Medical Excellence (NME) patient to:

- Receive services from an NME Program provider on an inpatient or outpatient basis; or
- Travel to and from an NME Program provider to receive covered services.

Copayment (copay) - means the fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the "Copayment Schedule."

Cosmetic surgery - means any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered services and supplies (covered expenses) - means the types of medically necessary services and supplies described in "Your Benefits."

Custodial care - means any service or supply, including room and board, which:

- Is furnished mainly to help you meet your routine daily needs; or
- Can be furnished by someone who has no professional health care training or skills; or
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

Detoxification - means the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Durable medical equipment (DME) - means equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

Experimental or investigational - means services or supplies that are determined by Aetna to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

Home health services - means those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

Hospice care - means a program of care that is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by Aetna; and
- Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 6 months to live.

Hospital - means an institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

Infertility - means:

- For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.

- For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

Medical services - means those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.

Medically necessary - means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the "Your Benefits" section of this booklet. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining whether a service or supply is medically necessary, Aetna will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

Mental or nervous condition - means a condition which manifests signs and/or symptoms that are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication. Mental or behavioral disorders and conditions include, but are not limited to:

- Psychosis;
- Affective disorders;
- Anxiety disorders;
- Personality disorders;
- Obsessive-compulsive disorders;
- Attention disorders with or without hyperactivity; and
- Other psychological, emotional, nervous, behavioral or stress-related abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, whether or not caused or in any way resulting from chemical imbalance, physical trauma, or a physical or medical condition.

NME patient - means a person who:

- Requires any National Medical Excellence procedure or treatment covered by the Plan;
- Is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a facility designated by Aetna as the most appropriate facility.

Outpatient - means:

A Plan participant who is registered at a practitioner's office or recognized health care facility, but not as an inpatient; or Services and supplies provided in such a setting.

Partial hospitalization - means medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.

Participating provider - means a provider that has entered into a contractual agreement with Aetna to provide services to Plan participants.

Physician - means a duly licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.

Plan benefits - means the medical services, hospital services, and other services and care to which a Plan participant is entitled, as described in this booklet.

Plan participant - means an employee or covered dependent.

Primary Care Physician (PCP) - means a participating physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; initiates their referral for specialist care; and maintains continuity of patient care.

Provider - means a physician, health professional, hospital, skilled nursing facility, home health agency, or other recognized entity or person licensed to provide hospital or medical services to Plan participants.

Referral - means specific written or electronic direction or instruction from a Plan participant's PCP, in conformance with Aetna's policies and procedures, which directs the Plan participant to a participating provider for medically necessary care.

Service area - means the geographic area, established by Aetna and approved by the appropriate regulatory authority, in which a Plan participant must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan.

Skilled nursing facility - means an institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist - means a physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Substance abuse - means any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Terminal illness - means an illness of a Plan participant, which has been diagnosed by a physician and for which they have a prognosis of six (6) months or less to live.

Urgent medical condition - means a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.

All services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between Aetna Life Insurance Company and your Health & Welfare Fund. The information herein is believed accurate as of the date of publication and is subject to change without notice.