SUMMARY PLAN DESCRIPTION

of the Plan of Benefits of the

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY

July 1, 2019

This Summary Plan Description constitutes the Fund's Plan document. It is effective as of July 1, 2019. This Summary Plan Description 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 Summary Plan Description and are determined by the rate of contribution as defined in the Collective Bargaining Agreement between your Employer and Union. Certain benefits are described more fully in the Enhanced Benefit Guide, which is incorporated by reference in this document. From time to time, the Fund's Trustees may amend your Plan, the details of which will be set forth in this Summary Plan Description or in another written document. 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, or his or her specific designee or successor. Reliance upon information from any other source is at your own risk.

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The Health and Welfare Fund covers employees represented by these Teamsters Locals:

Local 107 Local 115 Local 312 Local 326 Local 331 Local 384 Local 169
Local 463 Local 500 Local 623 Local 628 Local 676 Local 929

In addition, the Health and Welfare Fund covers eligible employees of the Health and Welfare Fund.

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Dear Participants: July 1, 2019

Several years have passed since our last Summary Plan Description 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 Affordable Care Act and other laws. This updated Summary Plan Description 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 its Claims Administrators for the Medical Program provide Members with an identification card and 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.
- 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 Summary Plan Description as well as the Enhanced Benefits Guide. 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. (Union Co-Chairman)
Howard Wells
Robert "Rocky" Bryan, Jr.
Daniel Schmidt
William J. Einhorn
Tom J. Ventura

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 Dependents:

1. Medical benefits

2. Prescription drug coverage;

3. Behavioral health and substance abuse treatment;

4. Dental benefits;

5. Short term 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 or in the Enhanced Benefits Guide. You can find an updated list of the applicable administrators, vendors, and insurers in the Enhanced Benefits Guide.

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ELIGIBILITY PROVISIONS

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

There are two ways that you[1] can become eligible to receive Fund benefits, both of which depend upon the terms of the Collective Bargaining Agreement between your union and your Employer and the Fund's requirements. If a Collective Bargaining Agreement requires your Employer to make contributions to the Fund on your behalf on the 5th or 10th day of a month, 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 you have had 12 or more months employment with an Employer that make contributions in the form of a monthly premium and you do not have sufficient days contributed in the month in which the claim was incurred, you will continue to be eligible for benefits if you have at least 180 days employment with the Employer during the previous 12-month period.

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 through 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

Notwithstanding the foregoing, in all events the Fund will offer you medical coverage within the time frame required by the Affordable Care Act.

[1] The words "you" and "your" in this Summary Plan Description refer to Members, generally, and in some cases their Dependents.

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 Dependents under the terms of the Fund. They are as follows:

A. Your Spouse.

B. Your children, which include your natural, adopted, or stepchildren who have not reached the age of 26; children who a court order requires coverage; and children for whom a Member is appointed legal guardian by a court as eligible Dependents.

C. Your unmarried child who is physically or mentally incapable of self-support who has reached age 26 will continue to be eligible as a Dependent provided (i) the child is your tax dependent under applicable provisions of the Internal Revenue Code and (ii) you furnish the Fund office with proof of this incapacity BEFORE their coverage terminates at age 26. You should request the appropriate form from the Fund office. Thereafter, the Fund requires you to certify on an annual basis to verify the continuing nature of the child's disability and status as your tax dependent.

D. One or more of your natural parents if (i) you are unmarried and have no other Dependents covered under the Fund and (ii) such parent is living in your household and (iii) such parent is your tax dependent under applicable provisions of the Internal Revenue Code.

When a Member and his or her Spouse are both covered by the Fund as eligible Members, Fund deductibles, coinsurance, and co-payments will not apply. 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 Summary Plan Description are limited to you, the employee. Contact the Fund if you are unsure as to your status as a "Family" or "Single" employee. IF THIS IS THE CASE, NO COVERAGE IS PROVIDED FOR THE SPOUSE OR CHILDREN OF A "SINGLE" EMPLOYEE, EVEN IF THEY MEET THE DEFINITION OF "DEPENDENT."

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

There are circumstances when a Member or his or her Dependent 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:

1. When you have fewer 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];

2. When you cease to be a member of a class of employees covered by a Collective Bargaining Agreement between a Contributing Employer and participating Local Union, or otherwise no longer qualify as a Member as defined herein, (except that, if you leave covered employment prior to retirement, you may continue to exhaust earned eligibility credits for a period not to exceed two months);

3. If you terminate employment and your former employer indicates that you are collecting a benefit under a defined benefit pension plan;

4. If you become employed (including self-employment) outside the scope of an applicable Collective Bargaining Agreement after terminating employment with an employer that is a Contributing Employer;

5. If your employer that is a Contributing Employer is delinquent for 60 or more days in making contributions to the Fund, your benefits will be suspended until your employer becomes current in its contributions.

6. When the applicable benefit program is terminated; or

7. Immediately upon the date on which the Fund determines that your Contributing Employer(s) is not required to make contributions to the Fund on your behalf.

B. Loss of Dependent Eligibility

A Dependent'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 ceases to meet the eligibility requirements to be a Dependent, as set forth in this document.

NOTE: IF YOUR FAMILY STATUS CHANGES

It is important that you give prompt, written, notice to the Fund office on a census form of any change in your Family Members due to events such as marriage, birth of a child, death, or divorce, 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 right to continuation coverage, which is described below.

Census forms are 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 tax 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 Member and Dependent 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 fewer than the required number of contribution days to his or her credit as set forth on page [2], then medical and 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 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 group health coverage provided by the Fund, you have certain rights, under certain conditions, to continue such coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 or "COBRA."

You may have the right to continue your and your Dependents' coverage to the extent that you or they were covered by the Fund on the day before your or their, as applicable, coverage ended. COBRA refers to these people as "Qualified Beneficiaries."

You need not show evidence of good health in order to continue coverage through COBRA. However, you are obligated to pay the full cost of this continuation coverage. The cost of coverage that you must pay may be different than the contribution rate that your Employer pays. The Fund's actuary formulates the COBRA rates in accordance with formulas provided under COBRA. In certain cases, your COBRA premium may be reduced on a pro-rata basis for certain months if a Contributing Employer has made contributions on your behalf.

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

1. You leave employment with an Employer for reasons other than gross misconduct on your part; or
2. Your work hours are reduced below what is required to remain eligible for coverage.

Your Spouse has the right to extend coverage if your Spouse's coverage ends because:

1. You die;
2. You leave employment or work hours are reduced, as described above;
3. You become divorced; or
4. You become entitled to Medicare.

Your child has the right to this extended coverage if your child's coverage ends because:

1. You die;
2. You leave employment or work hours are reduced, as described above;
3. You become divorced;
4. You become entitled to Medicare; or

5. The child is no longer considered a Dependent as set forth in the Eligibility section of this document.

It is the responsibility of the person who will lose coverage to inform the Fund Administrator of a divorce, loss of employment, or loss of a child's eligibility. The Fund Administrator must be notified, in writing, within 60 days after the later of: (1) the date of the qualifying event; and (2) the date on which the person loses (or would lose) coverage under the terms of the Fund as a result of the qualifying event. If the Fund Administrator is not notified within that time period, then that person will not be able to elect to continue his or her coverage under COBRA.

Once the Fund 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 60 days from the date he or she would lose coverage to let the Fund 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 group health coverage he or she was receiving the day before he or she lost coverage. 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 group health benefits - hospital, medical, surgical and prescription drug benefits - or these benefits plus your non-core benefits - vision and dental benefits.

If coverage ended because you left employment, or no longer meet the eligibility requirements, coverage may continue for up to 18 months. If coverage ended for any other reason, then coverage may be continued for up to 36 months. These 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.

1. Cost of COBRA Coverage

Each qualified beneficiary is generally required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the Fund for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA

premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

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 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 you and your Spouse were not entitled to Medicare prior to your qualifying event, and you become entitled to 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 entitled to 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 under the Social Security Act at the time your work hours were reduced or your employment ended, or any time during the first 60 days of your COBRA coverage. To qualify for this additional coverage, the individual must provide the Fund with notice, within 60 days of the latest to occur of (1) the date of the Social Security determination, (2) the date of your qualifying event, (3) the date on which the individual would otherwise lose coverage due to the qualifying event or (4) the date the Fund notifies the individual of the individuals responsibilities under this special rule.. The premium cost for COBRA continuation during the additional coverage period may be up to 150% of the cost of coverage to the Fund. If you have any questions about this continuation coverage, 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 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 if you do not elect one of the other options, is that you may suspend your eligibility beginning with the first full month following your deployment date. Under this option, you and your Dependents 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 12-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 12 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 options on the preceding pages assumes your Employer is not required under a Collective Bargaining Agreement to make contributions to the Fund on your behalf during your deployment. If a Collective Bargaining Agreement requires your Employer to make contributions on your behalf during your deployment, you should contact the Fund office to discuss how those contributions will affect your options during your period of active duty.

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THE FUND'S MEDICAL PROGRAM AND HOW IT WORKS

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 Summary Plan Description. 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 provides prescription drug coverage, behavioral health benefits (i.e., mental health and substance abuse), dental benefits and vision benefits to Fund participants and beneficiaries. These benefits <u>are not</u> part of the medical program. They are separate benefits that are discussed elsewhere in this Summary Plan Description and the Enhanced Benefits Guide.

I. HOW THE MEDICAL PROGRAM WORKS

Under the medical program, your benefits are subject to a deductible, co-payments, coinsurance, and an out-of-pocket limit. You are not, however, required to obtain a referral in order to see a specialist. Likewise, the Fund has developed several programs to minimize your out of pocket expense when you need routine lab work, radiology examinations (e.g., x-rays or MRIs), and diabetic supplies. In addition, some of the covered services in the medical program are offered at no expense to you.

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

The specific deductibles, co-payments, and coinsurance provisions, and out of pocket limits applicable to you are set forth in the Your Medical Benefits section below. As such, it is important to understand what those terms mean to you. A "co-payment" is a fixed amount 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. A "deductible" is the amount you owe for health care services the Fund covers before the Fund begins to pay. The deductible does not apply to services subject to co-payments. After you satisfy your deductible, you are responsible for coinsurance, which is your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service. Once you satisfy your out-of-pocket limit, which does not include your deductible, for the year, you are no longer responsible for coinsurance, but you are still responsible for co-payments, balanced billed charges, any penalties, or 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, deductible, or coinsurance 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, contact the Fund office 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. The Fund will pay most out-of-network Providers a percentage of its allowable charges and you will be responsible for the balance of those allowable charges as well as deductible and coinsurance. If an out-of-network Provider elects not to accept the Fund's allowable charges as payment in full, you will be responsible for paying any balance billed charges from the healthcare Provider.

The Fund's "allowable charge" for an out-of-network service is generally the higher of the Fund's in-network allowance for such services or the Resource-Based Relative Value Scale allowance then prevailing in the Philadelphia region for such services. For more information about the out-of-network allowable charge, contact the Fund office. If you had no choice in the selection of an out-of-network Provider or Facility, the allowable charge for such services is the Plan's in-network allowable charge for such expenses or the billed charges, whichever is lower. The Fund's "allowable charge" for an out-of-network Assistant Surgeon is 20% of the in-network allowance for the surgical procedure performed by the primary surgeon.

IN-NETWORK PROVIDER EXAMPLE:

Bill goes to Dr. Smith, an in-network provider, because he thinks he has the flu. Bill has a $30 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 $70 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.

OUT-OF-NETWORK PROVIDER 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 $100. Assuming Maria has satisfied her out-of-network deductible of $500, the Fund will pay Dr. Smith $80, which is 80% of the allowable charge, for the office visit. Maria will be responsible for at least $20 (20% of the allowable charge) and up to $70 if Dr. Jones declines to accept the Fund's allowable charge as payment in full and engages in balance billing.

C. Some of the Medical Program's Key Features

In addition to eliminating the need to obtain a referral to see specialists, the medical program has several other key features that the Fund believes provide a value to Members and their Dependents. Here are just some of the highlights of the program's in-network benefits:

1. Women may receive an annual mammogram with no out-of-pocket expense to them (additional screenings are subject to deductibles and coinsurance);

2. Women receive an annual routine gynecological examination with no out-of-pocket expense (additional examinations are subject to deductibles and coinsurance).

3. Men over the age of 50 may receive an annual prostate screening with no out-of-pocket expense (additional screenings are subject to deductibles and coinsurance);

4. Pediatric immunizations are covered with no out-of-pocket expense; and

5. Certain other benefits discussed in the Your Medical Benefits section.

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 Participants concerning their individual health issues and, at the same time, monitor the quality of care Participants 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 Nurse Counselor 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 is mandatory for all Covered Persons. Members and Dependents are REQUIRED to participate in the HealthReach program to ensure that the Fund is paying for appropriate services. If a Cover Person refuses to participate in the program and cooperate with the HealthReach Nurse 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 Covered Person receives final notice to contact the

HealthReach Nurse Counselor. The Fund is committed to helping you achieve your best health.

E. Wellness Program

The Fund offers all Members and their Spouses will be offered an opportunity to participate in a wellness screening from March through September of each year. The wellness screening will measure the individual's blood pressure, weight, height, waist size, glucose (blood sugar), and cholesterol. The wellness program vendor will share the results of the wellness screening with the individual who was screened as well as with the Fund's disease management vendor for analysis. Neither your Employer, the Fund Administrator, nor the Trustees will receive your or any participant's individual wellness screening results.

Those individuals or married couples who choose not to participate in this wellness program for a plan year described in the paragraph immediately above will only be eligible to participate in an alternative medical and prescription drug benefit program in the next plan year. The alternative medical and prescription drug benefit program is called the "Teamsters Health and Welfare Fund Gold Plan" (the "Gold Plan"). Those who participate in the wellness program will remain in the Fund's primary medical and prescription drug benefit program, which is called the Teamsters Health and Welfare Fund Platinum Plan (the "Platinum Plan"). The Gold Plan will generally provide the same benefits as the Platinum Plan subject to a higher out of pocket expense.

A Participant and his or her Dependent beneficiaries enrolled in the Gold Plan will remain in the Gold Plan for a minimum of one full calendar year.

All participants will be required, in addition to the wellness screening requirements set forth above, to obtain at least one preventive dental examination/check-up beginning January through September each year in order to remain in the Platinum Plan in the following plan year.

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YOUR MEDICAL BENEFITS

I. PRIMARY AND PREVENTIVE CARE SERVICES

A Covered Person is entitled to benefits for Primary Care and "Preventive Care" covered services when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for covered services and any Pre-certification and other cost-sharing requirements are specified in the Summary of Benefits Schedule.

"Preventive Care" services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when the Covered Person has no symptoms of disease. Services performed to treat an illness or injury are not covered as Preventive Care under this benefit.

The Claims Administrator periodically reviews the covered services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of covered services are subject to change. The Claims Administrator reserves the right to modify the schedule at any time after written notice of the change has been given to the Covered Person.

A. Office Visits

Medical care visits for the examination, diagnosis and treatment of an illness or injury by a Primary Care Provider. For the purpose of this benefit, "Office Visits" include medical care visits to a Provider's office, medical care visits by a Provider to a Covered Person's residence, or medical care consultations by a Provider on an Outpatient basis.

B. Pediatric Preventive Care

The following services described below are required under the Affordable Care Act (ACA) with no cost-sharing for the patient.

Pediatric Preventive Care includes the following:

1. **Physical Examination, Routine History, Routine Diagnostic Tests**. Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, is limited to Covered Persons under 18 years of age.

2. **Blood Lead Screening.** This blood test detects elevated lead levels in the blood.

3. **Hemoglobin/Hematocrit**. This blood test measures the size, shape, number and content of red blood cells.

4. **Rubella Titer Test**. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the child has ever been immunized. Children are covered for one test and immunization between 11 and 17 years of age.

5. **Urinalysis**. This test detects numerous abnormalities.

C. Pediatric Immunizations

The following services described below are required under the Affordable Care Act (ACA) with no cost-sharing for the patient. Coverage will be provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with the Standards of the (Advisory Committee on Immunization Practices of the Center for Disease Control) U.S. Department of Health and Human Services. Benefits are limited to Covered Persons under 21 years of age.

D. Adult Preventive Care

The following services described below are required under the Affordable Care Act (ACA) with no cost-sharing for the patient.

1. **Physical Examination, Routine History**. Well person care, which generally includes a medical history, height and weight measurement, physical examination and counseling, plus necessary Diagnostic Services, is limited to Covered Persons 18 years of age or older.

2. **Adult Tetanus Toxoid (TD)**. This immunization provides immunity against tetanus and diphtheria.

3. **Blood Cholesterol Test**. This blood test measures the total serum cholesterol level. High blood cholesterol is one of the risk factors for coronary artery disease.

4. **Complete Blood Count (CBC)**. This blood test checks the red and white blood cell levels, hemoglobin and hematocrit.

5. **Fecal Occult Blood Test**. This test checks for the presence of blood in the feces which is an early indicator of colorectal cancer.

6. **Flexible Sigmoidoscopy**. This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope.

7. **Influenza Vaccine**. This vaccine provides immunization against influenza type A and B viruses.

8. **Pneumococcal Vaccine**. This vaccine provides immunization against pneumococcal disease. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis.

9. **Prostate Specific Antigen (PSA)**. This blood test may be used to detect tumors of the prostate.

10. **Routine Colonoscopy**. This test detects colorectal cancer by use of a flexible fiberoptic colonoscope.

11. **Rubella Titer Test**. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the adult has ever been immunized.

12. **Thyroid Function Test**. Test detects hyperthyroidism and hypothyroidism.

13. **Urinalysis**. This test detects numerous abnormalities.

14. **Varicella Vaccine**. This vaccine is recommended for women of childbearing age who have not been previously exposed to the chicken pox virus.

15. **Osteoporosis Screening (Bone Mineral Density Testing or BMDT)**. Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

16. **Fasting Blood Glucose Test**. This test is used for detection of diabetes.

17. **Abdominal Aortic Aneurysm Screening**. One test per lifetime is recommended for men with a smoking history.

E. Routine Gynecological Examination, Pap Smear

Female Covered Persons are covered for one routine gynecological examination each calendar year, including a pelvic examination and clinical breast examination; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

F. Mammograms

Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service Provider who is properly certified by the appropriate state or federal agency in accordance with applicable law.

G. High Risk Immunizations

Benefits are payable for certain immunizations provided to Covered Persons that the Claims Administrator determines to be at "high risk."

H. Therapeutic Injections

Therapeutic injections required in the treatment of an injury or illness.

I. Allergy Injections

Benefits are provided for allergy extracts and allergy injections.

The Claims Administrator periodically reviews the schedule of covered services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of services is subject to change.

Therefore, the Claims Administrator reserves the right to modify this schedule from time to time.

II. INPATIENT SERVICES

A Covered Person is entitled to benefits for covered services while an Inpatient in a Facility Provider, when deemed Medically Appropriate/Medically Necessary and billed for by a Facility Provider. Payment allowances for covered services and any Pre-certification and other cost-sharing requirements are specified in the Summary of Benefits Schedule.

All Inpatient admissions, other than an Emergency admission, must be pre-certified by the Claims Administrator in accordance with the requirements contained in the Managed Care section of this booklet. Emergency admissions must be reviewed within two business days of the admission or as soon as reasonably possible. A concurrent review is required for any continued length of stay beyond what has been pre-certified by the Claims Administrator.

A. HOSPITAL SERVICES

ROOM AND BOARD

Benefits will be paid for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

1. an average semi-private room, as designated by the Hospital; or a private room, when designated by the Claims Administrator as semi-private for the purposes of this coverage in Hospitals having primarily private rooms;

2. a private room, when Medically Appropriate/Medically Necessary;

3. a Special Care Unit, such as Intensive or Coronary Care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;

4. a bed in a general ward; and

5. nursery facilities.

Benefits are provided for up to the number of days specified in the Summary of Benefits Schedule.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one day.

Days available under this coverage shall be allowed only during uninterrupted stays in a Hospital. Benefits shall not be provided: (1) during the absence of a Covered Person who interrupts his stay and remains past midnight of the day on which the interruption occurred; or (2) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

ANCILLARY SERVICES

Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including but not limited to the following:

1. meals, including special meals or dietary services as required by the patient's condition;

2. use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;

3. casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;

4. oxygen and oxygen therapy;

5. administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as may be provided within this coverage;

6. anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;

7. Physical Therapy, Cardiac Rehabilitation Therapy, Respiratory Therapy, hydrotherapy, Speech Therapy, and/or Occupational Therapy when administered by a person who is appropriately licensed and authorized to perform such services;

8. Radiation Therapy;

9. Chemotherapy;

10. all drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals;

11. use of Special Care Units, including but not limited to, Intensive or Coronary Care; and

12. Preadmission testing.

Subject to the Exclusions, conditions and limitations of this coverage, a Covered Person is entitled to benefits for covered services when: (1) deemed Medically Appropriate/Medically Necessary and (2) billed for by a Provider.

B. MEDICAL CARE

Medical Care provided by the Professional Provider in charge of the case to a Covered Person who is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility for a condition not related to Surgery, pregnancy, Radiation Therapy, or mental illness, except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

1. Concurrent Care

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations or Medical Care routinely performed in the pre-or post-operative or pre-or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

2. Consultations

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by Facility Provider's rules and regulations. Benefits are limited to one consultation per consultant during any inpatient confinement.

C. SKILLED NURSING FACILITY

Benefits are provided for a Skilled Nursing Facility, when Medically Appropriate/Medically Necessary as determined by the Claims Administrator, up to the Maximum days specified in the Summary of Benefits Schedule. The Covered Person must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Facility. For maximum benefits, admission to a Skilled Nursing Facility must be pre-certified as an Inpatient admission.

Medically Necessary Professional Provider visits in a Skilled Nursing Facility are provided as shown in the Summary of Benefits Schedule.

No benefits are payable:

1. when confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person;

2. for the treatment of alcohol and drug addiction, and mental illness; or

3. after the covered person has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine custodial care.

INPATIENT / OUTPATIENT BENEFITS

A Covered Person is entitled to benefits for covered services either while an Inpatient in a Facility Provider or on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Pre-certification and other cost-sharing requirements are specified in the Summary of Benefits Schedule.

D. BLOOD

Benefits shall be payable for the administration of blood and blood processing from donors. Benefits shall be payable for autologous blood drawing, storage or transfusion - i.e., an individual having his own blood drawn and stored for personal use, such as self-donation in advance of planned Surgery.

Benefits shall be payable for whole blood, blood plasma and blood derivatives, which are not classified as drugs in the official formularies and which have not been replaced by a donor.

E. HOSPICE SERVICES

When the Covered Person's attending Physician certifies that the Covered Person has a terminal illness with a medical prognosis of six months or less and when the Covered Person elects to receive care primarily to relieve pain, the Covered Person shall be eligible for Hospice benefits. Hospice Care is primarily comfort care, including pain relief, physical care, counseling and other services that will help the Covered Person cope with a terminal illness rather than cure it. Hospice Care provides services to make the Covered Person as comfortable and pain-free as possible. When a Covered Person elects to receive Hospice Care, benefits for treatment provided to cure the terminal illness are no longer provided. However, the Covered Person may elect to revoke the election of Hospice Care at any time.

Respite Care: When Hospice Care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the Covered Person's home. Up to seven days of such care every six months will be covered. Benefits for Covered Hospice Services shall be provided until the earlier of the Covered Person's death or discharge from Hospice Care.

Special Hospice Services Exclusions: No Hospice Care benefits will be provided for:

1. Services and supplies for which there is no charge;

2. Research studies directed to life lengthening methods of treatment;

3. Services or expenses incurred in regard to the Covered Person's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property);

4. Care provided by family members, relatives, and friends; and

5. Private Duty Nursing care.

F. MATERNITY/OB-GYN / FAMILY SERVICES

1. Maternity/Obstetrical Care

Services rendered in the care and management of a pregnancy is a Covered Expense under this Plan as specified in the Summary of Benefits Schedule. Benefits payable for a delivery shall include pre- and post-natal care. Maternity care Inpatient benefits will be provided for 48 hours for vaginal deliveries and 96 hours for cesarean deliveries, except where otherwise approved by the Claims Administrator.

In the event of early post-partum discharge from an Inpatient admission, benefits are provided for Home Health Care as provided for in the Home Health Care subsection.

2. Therapeutic Abortions

Facility services provided by a Hospital or Birth Center and services performed by a Professional Provider for the voluntary termination of a pregnancy by a Member or Member's spouse are a Covered Expense: (a) when necessary to avert the death of the mother, and (b) for termination of pregnancy related to either rape or incest.

G. BEHAVIORAL HEALTH SERVICES

Coverage for Behavioral Health services (including treatment of psychiatric conditions and alcohol and drug abuse), is not provided under the Medical Program, and the Medical Program Claims Administrator plays no role in the administration of Behavior Health services for the Fund. The details of the Behavioral Health program appear starting on page [41]. See the Enhanced Benefits Guide for detailed information on the Behavioral Health program Claims Administrator.

H. SURGICAL SERVICES

Surgery benefits will be provided for services rendered by a Professional Provider and/or Facility Provider for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure.

Also covered is (1) the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and (2) coverage for the following when performed subsequent to mastectomy: surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy.

Coverage is also provided for: (a) the initial and subsequent insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and (b) the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Covered surgical procedures shall include routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

1. Hospital Admission for Dental Procedures or Dental Surgery

Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Covered Person has an existing non-dental physical disorder or condition and hospitalization is Medically Appropriate/Medically Necessary to ensure the patient's health. Coverage for such hospitalization does not imply coverage of the dental procedures or Surgery performed during such a confinement. Only oral surgical procedures specifically identified as covered under the "Oral Surgery" terms of this Plan will be covered during such a confinement.

2. Oral Surgery

Benefits will be payable for covered services provided by a Professional Provider and/or Facility Provider for:

a. Orthognathic surgery – surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:

   (1) The initial treatment of Accidental Injury/trauma (i.e. fractured facial bones and fractured jaws), in order to restore proper function.

(2) In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.

(3) In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic surgery will decrease airway resistance, improve breathing, or restore swallowing.

b. Other oral surgery – defined as surgery on or involving the teeth, mouth, tongue, lips, gums and contiguous structures. Benefits will be provided only for:

(1) Surgical removal of impacted teeth which are completely covered by bone.

(2) The surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and

(3) Surgical removal of teeth prior to cardiac surgery, radiation therapy or organ transplantation.

3. **Assistant at Surgery**

Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered surgery. The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Claims Administrator.

Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

4. **Anesthesia**

Administration of Anesthesia in connection with the performance of covered services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider.

5. **Second Surgical Opinion (Voluntary)**

Consultations for Surgery by a Professional Provider to determine the Medical Necessity of an elective surgical procedure. Elective Surgery is surgery which is not of an emergency or life-threatening nature.

Such covered services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery. One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation.

6. **Outpatient Benefits**

A Covered Person is entitled to benefits for covered services on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for covered services and any Pre-certification and other cost-sharing requirements are specified in the Summary of Benefits Schedule.

I. TRANSPLANT SERVICES

When a Covered Person is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Inpatient and Outpatient transplants which are beyond the Experimental or Investigative stage.

Inpatient and Outpatient transplants require pre-certification with the following exceptions: transplantation of cornea or skin. Benefits are also provided for those services to the Covered Person which are directly and specifically related to the covered transplantation. This includes services for the examination of such transplanted organs, marrow or tissue and the processing of blood provided to a Covered Person.

1. When both the recipient and the donor are Covered Persons, each is entitled to the benefits of this coverage. Benefits for the donor will be charged against the recipient's coverage under this coverage.

2. When only the recipient is a Covered Person, only the recipient is entitled to this coverage.

3. When only the donor is a Covered Person, the donor is not entitled to the benefits of this coverage.

4. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

J. AMBULANCE

Ambulance services, which are Medically Appropriate/Medically Necessary as determined by the Claims Administrator, for local transportation in a specially designed and equipped vehicle used only to transport the sick or injured are a Covered Expense. All out-of-network, non-emergency ambulance services must be pre-certified.

The Ambulance must be transporting the Covered Person:

1. from a Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital;

2. between Hospital and Skilled Nursing Facility or between Hospitals.

3. If there is no Hospital in the local area that can provide services Medically Appropriate/Medically Necessary for the Covered Person's condition, then ambulance service means transportation to the closest Hospital outside the local area that can provide the necessary service.

4. Air or sea ambulance transportation benefits are payable only if the Claims Administrator determines that the patient's condition, and the distance to the nearest Facility Provider able to treat the patient's condition, justify the use of air instead of another means of transportation.

K. DAY REHABILITATION PROGRAM

Subject to the limits shown in the Summary of Benefits Schedule, benefits will be provided for a Medically Appropriate/Medically Necessary Day Rehabilitation Program when provided by a Facility Provider under the following conditions:

1. The Covered Person requires intensive Therapy services, such as Physical, Occupational and/or Speech Therapy five days per week for four to seven hours per day;

2. The Covered Person has the ability to communicate (verbally or non-verbally) his/her needs; the ability to consistently follow directions and to manage his/her own behavior with minimal to moderate intervention by professional staff;

3. The Covered Person is willing to participate in a Day Rehabilitation Program; and

4. The Covered Person’s family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

L. DIABETIC EDUCATION PROGRAM

Benefits are provided for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a Professional Provider legally authorized to prescribe such items under law.

The attending Physician must certify that a Covered Person requires diabetic education on an Outpatient basis under the following circumstances: (1) upon the initial diagnosis of diabetes; (2) a significant change in the patient's symptoms or condition; or (3) the introduction of new medication or a therapeutic process in the treatment or management of the patient's symptoms or condition.

Covered services include Outpatient sessions that include, but may not be limited to, the following information:

1. initial assessment of the patient's needs;
2. family involvement and/or social support;
3. psychological adjustment for the patient;
4. general facts/overview on diabetes;
5. nutrition including its impact on blood glucose levels;
6. exercise and activity;
7. medications;
8. monitoring and use of the monitoring results;
9. prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
10. use of community resources; and
11. pregnancy and gestational diabetes, if applicable.

M. DIABETIC EQUIPMENT AND SUPPLIES

Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance or pre-certification requirements applicable to Durable Medical Equipment benefits. See the Enhanced Benefits Guide for information on the Fund's cost savings program for diabetic equipment and supplies.

1. Diabetic Equipment

    a. blood glucose monitors;
    b. insulin pumps;
    c. insulin infusion devices; and
    d. orthotics and podiatric appliances for the prevention of complications associated with diabetes.

Pre-certification is required for the purchase of equipment that exceeds $1,000 of the billed amount. The applicable Deductible, Copayment and/or Coinsurance amounts will apply to this benefit.

2. Diabetic Supplies

Insulin, oral agents and other Diabetic Supplies are covered under the Fund's free-standing prescription drug program.

N. DIAGNOSTIC SERVICES

The following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider.

1. Diagnostic X-ray, consisting of radiology, ultrasound, and nuclear medicine;

2. Diagnostic laboratory and pathology tests.

3. Diagnostic medical procedures consisting of ECG, EEG, and other diagnostic medical procedures approved by the Claims Administrator; and

4. Allergy testing, consisting of percutaneous, intracutaneous, or patch tests.

See the Enhanced Benefits Guide for information on certain Diagnostic Services that require pre-certification.

O. DURABLE MEDICAL EQUIPMENT

Benefits will be provided for the rental (but not to exceed the total allowance of purchase) or, at the option of the Claims Administrator, the purchase of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use, when determined to be Medically Appropriate/Medically Necessary by the Claims Administrator. Although an item may be classified as Durable Medical Equipment, it may not be covered in every instance.

Durable Medical Equipment, as defined in the "Provisions and Definitions" section of this booklet, includes equipment that meets the criteria of (a) – (d) below.

(a) It is durable and can withstand repeated use. An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature are not considered "durable". (For examples, see (d) under "Exclusions" below).

(b) It customarily and primarily serves a medical purpose.

(c) It is generally not useful to a person without an illness or injury. The item must be expected to make a meaningful contribution to the treatment of the patient's illness, injury, or to the improvement of a malformed body part.

(d) It is appropriate for home use.

EXCLUSIONS:

Examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:

1. Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems; bed-wetting alarms; and ramps;

2. Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants;

3. Equipment inappropriate for home use. This is an item that generally requires professional supervision for proper operation, such as diathermy machines, medcolator, pulse tachometer, data transmission devices used for telemedicine purposes, translift chairs and traction units;

4. Non-reusable supplies other than a supply that is an integral part of the DME item required for the DME function. This means the equipment (i) is not durable or (ii) is not a component of the DME. Items not covered include, but are not limited to: incontinence pads, lamb's wool pads, ace bandages, antiembolism stockings; catheters (non-urinary), face masks (surgical), disposable gloves, disposable sheets and bags, and irrigating kits;

5. Equipment that is not primarily medical in nature. Equipment which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" in nature. This is true even though the item may have some medically related use. Such items include but are not limited to ear plugs, exercise equipment, ice pack, speech teaching machines, strollers, feeding chairs, silverware/utensils; toileting systems; electronically-controlled heating and cooling units for pain relief; toilet seats; bathtub lifts; stair glides; and elevators;

6. Equipment with features of a medical nature which are not required by the patient's condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medically Appropriate/Medically Necessary and realistically feasible alternative item that serves essentially the same purpose;

7. Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider;

8. Services not primarily billed for by a Provider such as delivery, set-up and service activities and installation and labor of rented or purchased equipment; and

9. Modifications to vehicles, dwellings and other structures. This includes (i) any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability; or (ii) any modification made to a vehicle, dwelling or other structure to accommodate a DME item, such as a wheelchair.

Replacement and Repair: The Claims Administrator will provide benefits for the replacement of Durable Medical Equipment: (a) when there has been a change in the Covered Person's condition that requires the replacement, (b) if the equipment breaks because it is defective, or (c) it breaks because it has exceeded its life expectancy, as determined by the manufacturer. If an item breaks and is under warranty, unless it is a rental item, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

The Claims Administrator will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of Durable Medical Equipment, replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning. A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage. The Claims Administrator will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

P. EMERGENCY CARE SERVICES

Benefits for Emergency Care Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility within two days of the Emergency are provided by the Claims Administrator. Emergency Care services are Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for initial treatment of the Emergency. Outpatient follow-up care provided in a Medically Appropriate/Medically Necessary setting (in Emergency Room, other Outpatient Emergency Facility or physician's office) are also covered if received within 14 days of the initial Outpatient Emergency Care, as specified above.

Examples of an Emergency include heart attack, loss of consciousness or respiration, cardiovascular accident, convulsions, severe Accidental Injury, and other acute medical conditions as determined by the Claims Administrator. Should any dispute arise as to whether an Emergency existed or as to the duration of an emergency, the determination by the Claims Administrator shall be final.

Q. HOME HEALTH CARE

Benefits will be provided for the services listed below when performed by a licensed Home Health Care Agency.

- Professional services of appropriately licensed and certified individuals;
- Intermittent Skilled Nursing Care;
- Physical Therapy;
- Speech Therapy;
- Well mother/well baby care following release from an inpatient maternity stay;
- Care within 48 hours following release from an Inpatient admission when the discharge occurs within 48 hours following a mastectomy.

With respect to well mother/well baby care following early release from an inpatient maternity stay, Home Health Care services must be provided within 48 hours if discharge occurs earlier than 48 hours of a vaginal delivery or 96 hours of a cesarean delivery.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include occupational therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the Claims Administrator.

Home health care benefits will be provided only when prescribed by the Covered Person's attending Physician in a written Plan of Treatment and approved by the Claims Administrator as Medically Appropriate/Medically Necessary.

HOME – means a Covered Person's place of residence (e.g. private residence/domicile, assisted living facility, long-term care facility, skilled nursing facility) at a custodial level of care.

HOMEBOUND – means there exists a normal inability to leave Home due to severe restrictions on the Covered Person's mobility and when leaving the Home: (a) would involve a considerable and taxing effort by the Covered Person; and (b) the Covered Person is unable to use transportation without another's assistance. A child, unlicensed driver or an individual who cannot drive will not automatically be considered Homebound but must meet both requirements (a) and (b).

EXCLUSIONS:

No Home Health Care benefits will be provided for services and supplies in connection with home health services for the following:

- custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
- rental or purchase of Durable Medical Equipment;
- rental or purchase of medical appliances (e.g. braces) and prosthetic devices (e.g. artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices;
- prescription drugs;
- services provided by a member of the patient's Immediate Family or the Immediate family of the patient's spouse;
- patient's transportation, including services provided by voluntary ambulance associations for which the patient is not obligated to pay;
- emergency or non-emergency Ambulance services;
- visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
- services provided to individuals (other than a Covered Person released from an inpatient maternity stay), who are not essentially homebound for medical reasons; and
- visits by any Provider personnel solely for the purpose of assessing an individual's condition and determining whether or not the individual requires and qualifies for home health services and will or will not be provided services by the Provider.

R. MEDICAL FOODS AND NUTRITIONAL FORMULAS

Benefits shall be payable for Medical Foods when provided for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. Coverage is provided when administered on an outpatient basis either orally or through a tube. Benefits are exempt from Deductible requirements.

Benefits are also payable for Nutritional Formulas when: (1) they are the sole source of nutrition for an individual (more than 75% of estimated basal caloric requirement) and the Nutritional Formula is given by way of a tube into the alimentary tract, or (2) the Nutritional Formula is the sole source of nutrition (more than 75% of estimated basal caloric requirement) for an infant or child suffering from Severe Systemic Protein Allergy, refractory to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

Benefits are payable for Medical Foods and Nutritional Formulas when provided through a Durable Medical Equipment Supplier or in connection with Infusion Therapy as provided for in this coverage.

S. NON-SURGICAL DENTAL SERVICES

Benefits will be provided only for the initial treatment of Accidental Injury/trauma (i.e., fractured facial bones and fractured jaws), in order to restore proper function. Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound, Natural Teeth, including the first caps, crowns, bridges and dentures (but not including dental implants), required for the initial treatment for the Accidental Injury/trauma. Also covered is the preparation of the jaws and gums required for initial replacement of Sound, Natural Teeth. (Sound, Natural Teeth are teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental injury/trauma). Injury as a result of chewing or biting is not considered an Accidental Injury. (See the exclusion of dental services in the General Limitations and Exclusions section for more information on what dental services are not covered);

T. PRIVATE DUTY NURSING SERVICES

Benefits will be provided for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Professional Provider. All nursing services must be Medically Appropriate/Medically Necessary as determined by the Claims Administrator and pre-certified.

Benefits are not payable for:

1. nursing care which is primarily custodial in nature; such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, giving oral medication;

2. services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's immediate family;

3. services provided by a home health aide or a nurse's aide.

U. PROSTHETICS

Expenses incurred for prosthetic devices (except dental prostheses) required as a result of illness or injury. Expenses for prosthetic devices are subject to medical review by the Claims Administrator to determine eligibility and Medical

Appropriateness/Medical Necessity. Pre-certification is required for billed amounts that exceed $1,000.

Such expenses may include, but not be limited to:

1. the purchase, fitting, necessary adjustments and repairs of prosthetic devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and

2. the supplies and replacement of parts necessary for the proper functioning of the prosthetic device;

3. breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prosthetics inserted during reconstructive surgery incident and subsequent to mastectomy.

   Coverage limitations on external breast prostheses are as follows:

   a) Post mastectomy, four bras per calendar year are covered;
   b) The useful lifetime expectancy for silicone breast prostheses is two years;
   c) The lifetime expectancy of fabric, foam or fiber-filled breast prostheses is six months; and

4. Benefits are provided for the following visual Prosthetics when Medically Appropriate/Medically Necessary and prescribed for one of the following conditions:

   a) Initial contact lenses prescribed for treatment of infantile glaucoma;
   b) Initial pinhole glasses prescribed for use after surgery for detached retina;
   c) Initial corneal or scleral lenses prescribed (i) in connection with the treatment of keratoconus; or (ii) to reduce a corneal irregularity other than astigmatism;
   d) Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
   e) Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of (i) Accidental Injury; (ii) trauma, or (iii) ocular surgery.

5. Benefits are not provided for:

   a) Lenses which do not require a prescription;
   b) Any lens customization such as, but not limited to tinting, oversize or progressive lenses, antireflective coatings, UV lenses or coatings, scratch resistance coatings, mirror coatings, or polarization;
   c) Deluxe frames;

d) Eyeglass accessories, such as cases, cleaning solution and equipment

The repair and replacement provisions do not apply to Item 4 on the preceding page.

Benefits are not payable for: (a) wigs (except for cranial prostheses for chemotherapy patients) or (b) eyeglasses except as specified in Item 4 above.

Repair and Replacement

Benefits for replacement of a prosthetic device or its parts will be provided: (a) when there has been a significant change in the Covered Person's medical condition that requires the replacement; (b) if the prostheses breaks because it is defective; (c) if the prostheses breaks because it has exceeded its life expectancy, as determined by the manufacturer; or (d) for a Dependent child due to the normal growth process when Medically Necessary.

Benefits include costs incurred to repair prosthetic devices by a Provider when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of a prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning.

A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Fund will not provide benefits for repairs and replacements needed because the prosthetic was abused or misplaced. If a prosthetic device breaks and is under warranty, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

V. RESTORATIVE SERVICES

Benefits shall be provided for Restorative Services, when performed by a Professional Provider in order to restore loss of function of a body part. Restorative Services are any services, other than those specifically detailed under "Therapy Services", provided in accordance with a specific plan of treatment related to the Covered Person's condition which generally involve neuromuscular training as a course of treatments over weeks or months. Examples of Restorative Services include, but are not limited to, manipulative treatment of functional loss from back disorder, therapy treatment of functional loss following foot surgery, and orthoptic/pleoptic therapy.

W. SPECIALIST OFFICE VISIT

Benefits will be provided for Specialist Service medical care. Special Service medical care is care provided in the office by a Professional Provider other than a Primary Care Physician. For the purpose of this benefit, "in the office" includes medical care visits to a Professional Provider's office, medical care visits by a Professional

Provider to a Covered Person's residence, or medical care consultations by a Professional Provider on an Outpatient basis.

X. THERAPY SERVICES

Benefits shall be provided, subject to any benefit maximums set forth in the Benefits Schedule, for the following services prescribed by a Physician and performed by a Professional Provider, a registered, licensed therapist, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Covered Person. Therapy services include:

- Cardiac Rehabilitation Therapy
- Chemotherapy
- Dialysis
- Infusion Therapy
- Occupational Therapy
- Physical Therapy
- Pulmonary Rehabilitation Therapy
- Radiation Therapy
- Respiratory Therapy
- Speech Therapy

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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 Prescription Drug Program 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 manager (PBM) to provide its Members and their covered Dependents with prescription drug benefits. All Members and their Dependents should receive an identification card from the PBM in addition to his or her Medical Program identification card. If you do not have such a card, or lose your card, 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 in the Prescription Drug 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. You may also fill a 90-day supply of non-specialty maintenance medications at retail pharmacies. Additional information about the mail order program is available from the Fund office, on the Fund's website, or in the Enhanced Benefits Guide.

EXAMPLE:

Robert has been prescribed medication to treat his blood pressure. That medication is a maintenance medication under the prescription drug program formulary and is available as a generic. Robert receives a 90-day prescription for his medication from his Physician and uses the Fund's mail order program or fills the prescription at his local retail pharmacy. In response, Robert is charged one co-payment for 90 days of medication, instead of one co-payment every 30 days.

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 Benefits Schedule);
6. other non-prescription substances;
7. therapeutic devices and appliances;
8. drugs available over-the-counter;
9. drugs or compound drugs that have not been approved by the Federal Food and Drug Administration;
10. administration or injection of any drug
11. hypodermic needles and syringes (other than described above);
12. any prescription drug for which the prescribing Physician has prescribed dosage guidelines of the drug's manufacturer or the FDA, unless recommended by the Fund's pharmacy benefit manager;
13. the drug Zohydro® (hydrocodone bitartrate).

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 through the mail order program or at a retail pharmacy. A new-to-market medication is excluded from coverage for the first six months of the medication's launch date, unless the Fund's pharmacy benefits manager provides for a shorter period. **Pre-certification is required for any prescription for drugs for which the cost of a one-month supply exceeds $1,500.**

INJECTABLE / INFUSED MEDICATIONS

Specialty medications are often given by injection or infused to treat complex, chronic conditions and may require special handling, including refrigeration. Specialty

medications will be provided by the specialty pharmacy administrator through the Prescription Drug Program, not the Medical Program. If you or your Physician submits a specialty medication claim to the Medical Program and not to the Prescription Drug Program, the Medical Program will deny your claim and you may be responsible for the full cost of the specialty medication.

STEP THERAPY

The Prescription Drug Program includes the PBM's mandatory step-therapy program. Step therapy is a type of pre-certification. Under the step-therapy program, certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first.

Your PBM identification 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.

IV. PRESCRIPTION DRUG SUMMARY OF BENEFITS SCHEDULE

Type of Drug	Copayment
Tier 1 - Generic	$5 Platinum Plan $10 Gold Plan
Tier 2 - Formulary Non-Specialty Drugs (Preferred)	$15 Platinum Plan $20 Gold Plan
Tier 3 - Non-Formulary Non-Specialty Drugs (Non-Preferred)	50% of the drug cost with a $30 min / $50 max - Platinum Plan $40 min / $60 max - Gold Plan
Tier 4 - Specialty Drugs	$100 Platinum Plan $150 Gold Plan
Annual Prescription Out-of-Pocket Maximum	$1,500 per person / $3,000 per family

You can determine whether a prescription is for a generic, formulary, non-formulary, or specialty medication by referring to the Fund's then-in-effect prescription drug formulary or maintenance drug formulary, as applicable. **Current copies of the Fund's formularies are available on the Fund's website at *www.teamsterfunds.com* or upon request from the Fund office.**

THE FUND'S BEHAVIORAL HEALTH PROGRAM

Treatment of mental health and alcohol/substance abuse conditions must be coordinated, in advance through the Fund's Behavioral Health Administrator. This benefit is administered through both in and out-of-network of Providers. See the Enhanced Benefits Guide for details on the Behavioral Health Program and Behavioral Health Administrator.

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

The Fund 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 the Fund's Behavioral Health Administrator.

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.

Pre-authorization information must be submitted by the Provider to the Behavioral Health Administrator for review and evaluation so that a plan of treatment may be pre-certified for the covered person. Pre-certification 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 an in-network Professional Provider may be provided by the Fund at no cost to the covered person to accommodate the pre-certification process. **Emergency care is exempt from the requirements for pre-certification and will**

be considered in-network 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 Behavioral Health Summary of Benefits section, 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/in-network Facility Provider.

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 Behavioral Health Summary of Benefits section 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 maximum benefits, treatment must be performed by an in-network Professional Provider/in-network Facility Provider. The Behavioral Health Administrator must pre-certify all in-network outpatient services.

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:

1. vocational or religious counseling;

2. activities that are primarily of an educational nature;

3. 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

4. psychological testing.

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, as shown in the Behavioral Health Summary of Benefits section, according to the provisions outlined below. For maximum benefits, treatment must be received from an in-network Provider.

Pre-authorization information must be submitted by the provider to the Behavioral Health Administrator for review and evaluation so a plan of treatment may be pre-certified for the covered person. Pre-certification 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 an in-network Professional Provider may be provided by the Fund at no cost to the covered person to accommodate the pre-certification 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 pre-certification and will be considered in-network 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

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 testing;

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

B. Hospital and Non-Hospital Residential Treatment

Covered services include:

1. Lodging and dietary services;

2. Physician, psychological, nurse, certified addictions counselor and trained staff services;

3. Rehabilitation therapy and counseling;

4. Family counseling and intervention;

5. Psychiatric testing;

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

C. Outpatient Alcohol or Drug Services

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 testing;

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

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IV. BEHAVIORAL HEALTH SUMMARY OF BENEFITS SCHEDULE

	In-Network	Out-of-Network (*EPO Plan see below)
Psychiatric Care:		
Inpatient	Subject to applicable medical plan deductible and coinsurance. See Summary of Benefits Schedule section.	Subject to applicable medical plan deductible and coinsurance. See Summary of Benefits Schedule section.
Outpatient	$20 copay per visit – Platinum Plan / $30 copay per visit – Gold Plan	Subject to applicable medical plan deductible and coinsurance. See Summary of Benefits Schedule section.
Alcohol/Drug Abuse Treatment:		
Inpatient Detoxification Residential Care	Subject to applicable medical plan deductible and coinsurance. See Summary of Benefits Schedule section.	Subject to applicable medical plan deductible and coinsurance. See Summary of Benefits Schedule section.
Outpatient care	$20 copay per visit – Platinum Plan / $30 copay per visit – Gold Plan	Subject to applicable medical plan deductible and coinsurance. See Summary of Benefits Schedule section.

**EPO Plan members have no out-of-network medical benefits.*

**For out of network Behavioral Health benefits, Platinum Plan members will have a $500 deductible per person / $1000 per family and a 20% coinsurance up to $1500 per person. For out-of-network Behavioral Health benefits, Gold Plan members will have a $1000 deductible per person / $2000 per family and a 20% coinsurance up to $2250 per person.*

THE FUND'S DENTAL PROGRAM

The Fund maintains a dental program for its Members and their eligible Dependents. 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 Dental Savings Schedule located in the Enhanced Benefits Guide and on the Fund's website at *www.teamsterfunds.com*. The dental benefit, like the medical and behavioral health benefits, is administered through both in-network and out-of-network of dentists. See the Enhanced Benefits Guide for a full description of the Fund's Dental program.

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 in-network providers can be obtained in the Enhanced Benefits Guide or on the Fund's website.

B. Out-of-Network

The Fund's maximum allowance for out-of-network dentists is that which is shown in the non-participating fee schedule. 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. The non-participating dental fee schedule can be found in the Enhanced Benefits Guide or on the Fund's website.

II. BENEFITS PROVIDED

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

- Does not include any orthodontia payments.

- In compliance with the Affordable Care Act (ACA), this calendar year maximum does not apply to Dependents ***under*** the age of 18 (excluding orthodontia).

B. Schedule of Dental Benefits

The Fund has set allowances for non-participating providers for all covered dental procedures. As previously noted, a complete listing of those covered procedures and allowances may be found in the Enhanced Benefits Guide or on the Fund's website (www.teamsterfunds.com). The maximum allowance may not exceed the fee actually charged for the procedure. 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.

The following patient copayments apply to dental procedures when rendered by an in-network Provider:

Service	Copayment
Preventive 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 • *Full orthodontic treatment is paid over a 24month period and is subject to monthly eligibility;* • *This benefit is available only for dependent children between the ages of 10 and 18, inclusive;* • *For services rendered by an out-of-network Provider, see the dental fee schedule in the Enhanced Benefits Guide.*	$100 per case

C. Dental Benefit Limitations

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 consecutive month period.
2. Prophylaxis (cleaning of teeth) more often than once during any six-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 Participant 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).

In addition, if any of the following conditions exist, a Member or Dependent may be required to be examined by a dentist selected by the Fund prior to beginning treatment for the treatment to be covered:

1. You anticipate that orthodontia (braces) will be required. (Orthodontia is only covered under the Plan for children from age 10 through age 18.)
2. You are requesting coverage for occlusal guards.
3. Periodontal Care.
4. Temporomandibular Joint Disorders.

THE FUND'S VISION CARE PROGRAM

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 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. A listing of the in-network providers can be obtained by contacting the Vision Benefits Administrator located in the Enhanced Benefits Guide or on the Fund's website. 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 12 months)	Up to $40
Frames (one pair every 24 months)	Up to $35
Lenses (one pair every 24 months)	
----Single Vision	Up to $25
----Bifocal	Up to $35
----Trifocal	Up to $65
----Lenticular	Up to $85
----Standard Progressive	Up to $80
Contact lenses (every 24 months)	Up to $80

II. LIMITATIONS

Lenticular Lenses are covered only when they are prescribed in connection with cataract surgery. A Plan Member or Dependent will be eligible for a new pair of glasses following cataract surgery even if it has been less than 24 months since the Member or Dependent obtained a new pair of lenses. For a full description of the Fund's Vision Care Program, see the Enhanced Benefits Guide.

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THE FUND'S DISABILITY BENEFITS PROGRAM

I. THE PROGRAM

If you, prior to retirement, become disabled by reason of a non-occupational accidental injury or disease, and are prevented by such disability from performing any and every duty pertaining to your occupation, payment will be made to you under the Fund's disability benefits program as set forth in the disability benefits program Summary of Benefits. 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 from your treating Physician. Your Physician must certify on the Fund's form that, as of the date of your injury or illness for which you seek disability benefits, you were disabled and completely unable to perform any gainful employment at your regular job or any other job where you are employed. Benefits are payable only while you are under the care of, and treated personally by, a Physician.

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 30 or more full calendar days.

- Disability benefits are available to Members only.
- Continuation forms are to be completed every four weeks regardless of the length of disability estimated by the treating Provider.

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 Physician and receiving appropriate care and treatment for your condition.

III. SUMMARY OF BENEFITS

Weekly disability benefits are payable as follows:

1. $250 per week; or
2. $50 per workday

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 workday if the disability results from an accident or hospitalization. Benefits will commence on the sixth workday 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.

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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's death from a covered cause. In the event of your death from a covered cause, a benefit will be paid to your designated beneficiary of record. In the event of the death of any other of your eligible Dependents from a covered cause, payment will be made directly to you.

The payment of all or a portion of the life insurance benefit may be made directly to a funeral home, at the beneficiary of record's election, 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 life insurance program is a fully insured benefit purchased by the Fund on a group basis through the Fund's life insurance program insurer. The amount of payment is that shown in the life insurance Summary of Benefits Schedule. Additional details regarding the Fund's life insurance benefits are found in the life insurance program Summary of Benefits Schedule as well as in the applicable life insurance policy, which is available at the Fund office.

Upon your termination of employment, you will no longer be eligible for the life insurance program, even if you are "running out" eligibility for other benefits. You may, however, be eligible for the retiree life insurance benefit, as described below.

II. CONTINUANCE OF MEMBER LIFE INSURANCE IN THE EVENT OF TOTAL DISABILITY

If, while employed by a Contributing Employer, a Member becomes Totally Disabled, his or her beneficiary of record is eligible for a life insurance benefit upon the Member's death as set forth below:

1. The Member provides the Fund with written proof, satisfactory to the Trustees 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, 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.

5. This benefit terminates upon the Member reaching age 65.

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 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 life insurance benefits will 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 Life Insurance within one year from the date that the Fund learns of the Member's death and the whereabouts of this designated beneficiary are unknown, the Fund will 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 10 days of the advertisement, the Trustees will pay the life insurance 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 Life Insurance claim after the advertisement described above, then the Fund may, at its option, pay an amount not to exceed $1,000 to any person or persons who may have incurred expenses in connection with the Member's last illness or burial. The balance of the Member's Life Insurance, if any, will be paid to:

1. The Member's surviving spouse, or, if none;

2. Equally to the Member's surviving children, or, if none;

3. The Member's parent(s), or, if none;

4. The Member's surviving sibling(s), or, if none;

5. The personal representative of the Member's estate without restriction to the foregoing order.

In this regard, the term "sibling" includes only those persons who share at least one parent with the decedent, either by birth or legal adoption.

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 upon 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

In addition, the Fund provides a retiree death benefit for former participants in the Fund and their Spouses. In order to be eligible for the retiree life insurance benefit, you must:

- have retired on or after July 1, 1973;
- have been eligible for benefits under the Fund for at least 36 months of the 60 months immediately preceding the effective date of your retirement;
- be eligible to make withdrawals from an Individual Retirement Account ("IRA"), Roth IRA, or other qualified retirement plan without incurring liability for an excise tax for doing so; and
- not be eligible for a death benefit under the life insurance program by reason of total disability.

The retiree life insurance benefit is:

Event	Amount Payable
Death of Member	$1,000
Death of Spouse	$500

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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 26 weeks following the date of the accident, the Fund will pay AD&D benefits as specified in the Benefits Provided section below, upon receipt of proof of such loss satisfactory to the Fund's Trustees or the Fund 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 Benefits Provided section below.

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.

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 requires the total and irrecoverable loss of sight. Loss of hand or foot requires the loss by severance at or above wrist or ankle, as applicable.

III. LIMITATIONS

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

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

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

    a. Disease or bodily or mental infirmity or medical or surgical treatment thereof,

    b. Ptomaine or bacterial infections, except pyogenic infections occurring with and through an accidental wound,

    c. Suicide or intentionally self-inflicted injury, while sane or insane,

    d. 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,

    e. Flying, unless you were a passenger on a commercial airline, or

    f. War or any act of war, whether declared or undeclared, or insurrection, or

    g. Drug overdose, whether intentional or unintentional.

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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 Member and Dependent 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 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 in-network and out-of-network 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 in-network Providers or other health-related supplies to Members and their covered Dependents.

Nothing in this Plan affects the ability of a health care provider to disclose alternative treatment options to a 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 Summary Plan Description, benefits are not payable for the following:

1. 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.

2. Charges for services or supplies which are not Medically Necessary or Medically Appropriate as determined by the Fund or its delegee.

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

4. Charges for treatments which are not approved by the Member's or Dependent's attending Physician.

5. Charges which are not Usual, Customary and Reasonable as determined by the Fund Administrator.

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

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

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

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

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

11. Charges resulting from war or service, connected injuries or diseases.

12. Charges associated with any treatment for weight reduction.

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

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

15. 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. Surgery generally considered cosmetic in nature (even though for medical reasons) requires pre-certification.

16. 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 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.

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

18. Charges for immunizations and vaccines (unless specifically covered under the Medical program).

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

20. Charges for treatment of temporomandibular joint dysfunction in excess of any coverage under the Dental program.

21. Charges for sex change operations.

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

23. 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.

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

25. Charges for specialty injectable medication or treatment, with the exception of oncology related products.

26. Paid or payable by Medicare when Medicare is primary. For purposes of this Plan, a service, supply or charge is “payable under Medicare” when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits.

27. To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty.

28. Which are not billed and performed by a Provider as defined under this coverage as a “Professional Provider” “Facility Provider” or “Ancillary Provider” except as otherwise indicated under the subsections entitled: (a)

"Therapy Services" (that identifies covered therapy services as provided by licensed therapists), and (b) "Ambulance Services."

29. Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a hospital or university.

30. For ambulance services except as specifically provided under this coverage.

31. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

32. For marriage counseling.

33. For equipment costs related to services performed on high cost technological equipment as defined by the Claims Administrator, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by the Claims Administrator.

34. For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasis or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this booklet. Services not covered include, but are not limited to, apicoectomy (dental root resection) prophylaxis of any kind, root canal treatments, soft tissue impactions, partial boney impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated.

35. For dentures, unless for the initial treatment of an Accidental Injury/trauma.

36. For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate.

37. For injury as a result of chewing or biting (neither is considered an Accidental Injury).

38. For palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown nails), fallen arches,

pes planus (flat feet), weak feet, chronic foot strain, and symptomatic complaints of the feet.

39. For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury.

40. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, wigs (except for cranial prostheses for chemotherapy patients, as set forth in this booklet), chairlifts, stair glides, elevators, spa or health club memberships, whirlpool, sauna, hot tub or equivalent device, whether or not recommended by a Provider.

41. For wigs, except for cranial prostheses for chemotherapy patients, as set forth in this booklet.

42. For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated.

43. For preventive services except as specifically provided for under the subsection entitled "Primary and Preventive Care Services" of the Your Medical Benefits section of this booklet.

44. For premarital blood tests.

45. For diagnostic screening examinations, except for mammograms and preventive care as provided in the subsection entitled "Primary and Preventive Care Services" of Your Medical Benefits section of this booklet.

46. For Alternative Therapies/Complementary Medicine, including but not limited to, Acupuncture, Music therapy, Dance therapy, Equestrian/Hippotherapy, Homeopathy, Primal therapy, Rolfing, Psychodrama, vitamin or other dietary supplements and therapy, Naturopathy, Hypnotherapy, Bioenergetic therapy, Qi Gong, Ayurvedic therapy, Aromatherapy, Massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies.

47. For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider.

48. For immunizations required for employment purposes, or for travel.

49. For care in a nursing home, home for the aged, convalescent home, school, institution for special needs children, Custodial Care in a Skilled Nursing Facility.

50. For counseling or consultation with a patient's relatives or Hospital charges for a patient's relatives or guests.

51. For medical supplies such as but not limited to thermometers, ovulation kits, and early pregnancy or home pregnancy testing kits.

52. For home blood pressure machines.

53. As described under "Durable Medical Equipment" in the Your Medical Benefits section of this booklet: for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by the patient's condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment, whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs.

54. For prescription drugs.

55. For amino acid supplements, appetite suppressants or nutritional supplements. Coverage does not include basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the subsection entitled "Medical Foods and Nutritional Formulas" in the section entitled Your Medical Benefits.

56. For Inpatient Private Duty Nursing services.

57. For any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change; Applied Behavioral Analysis, Brain Computer Interface.

58. For charges incurred for expenses in excess of any benefit maximum set forth in the Summary of Benefits Schedule.

59. For Cognitive Rehabilitation Therapy; (Cognitive Rehabilitation Therapy is a therapeutic approach designed to improve cognitive functioning after central nervous system injury or trauma. It includes therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning and problem solving. It utilizes tasks designed to reinforce

or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for the impaired neurologic system).

60. For elective abortions, except (a) to avert the death of the mother, and (b) to terminate a pregnancy that is the result of either rape or incest.

61. For mental health/psychiatric services and treatment for alcohol and drug abuse and dependency. These services may be covered under a separate program provided by the Fund.

62. For cochlear implants.

63. For any other service or treatment except as provided under the coverage.

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 health benefits when an automobile accident claim arises. In other words, the Fund will only consider for payment those charges for health care 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, uninsured motorist claims, workers' compensation claims, 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

life insurance 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, 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, will be entitled to immediate reimbursement to the extent of benefits paid to or on behalf of the Member or Dependent.

2. The Fund will 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 will be retained by or on behalf of the Member or Dependent.

3. The Member or Dependent will 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 will 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 will 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 Program

Your identification card is the easiest way to file a claim for benefits under the Medical Program. Generally, a health care provider will submit medical claims on a Member or Dependent's behalf in accordance with the information on the membership card.

If the Plan requires pre-certification in order to obtain a medical procedure, providers should contact the applicable Claims Administrator at the telephone number found on the reverse side of the Member's or Dependent's membership card. Most in-network providers will obtain pre-certification of medical procedures on behalf of the Member or Dependent but it is ultimately the responsibility of the Member or Dependent, as applicable, to make sure that pre-certification is obtained. See the applicable Summary of Benefits Schedule for information on which medical procedures the Plan requires pre-certification.

You may appoint an authorized representative to act on your behalf in pursuing a claim or an appeal from an adverse benefit determination. Any person who wishes to be recognized by the Fund as your authorized representative should contact the Fund office.

B. Dental Benefits

All that is generally needed to obtain the dental benefits the Plan provides is to have the dentist submit a claim to the Fund. Generally, a Member's dentist will submit dental claims on the Member or Dependent's behalf in accordance with the information on the dental plan identification card. Additionally, a dental claim form can be obtained from the Fund office or may be printed off from the Fund's website at *www.teamsterfunds.com*.

C. Prescription Drug Benefits

The pharmacy benefits identification card is the easiest way to file a claim for prescription benefits. Generally, the pharmacy will submit claims on a Member or Dependent's behalf in accordance with the information on the pharmacy benefits identification card.

D. Vision Benefits

The vision benefits identification card is the easiest way to file a claim for vision benefits. Generally, the provider will submit claims on a Member or Dependent's behalf in accordance with the information on the vision benefits identification card.

E. Life and AD&D Benefits

Once the Fund office is notified of a death, it will send the appropriate forms to the beneficiary on record.

1. **Death or Dismemberment of the Participant** - Complete the form and attach a certified copy of the death certificate as well as any other requested information.

2. **Death of Spouse** - 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** - Complete the form and attach a certified copy of the death certificate along with any other requested information, including 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 Life Insurance Benefits** – Complete the form and attach a certified copy of the death certificate as well as any other requested information.

F. Weekly Disability Benefits

To apply for weekly disability benefits, the Fund's disability benefit claim form must be completed in its entirety. There are three sections to this form; claimant (Member), Provider, and Employer (Company) Statement. The treating Provider must complete his or her section of the form and your Employer must also complete the Company Statement section of the claim form.

G. Behavioral Health Program

The behavioral health benefits identification card is the easiest way to file a claim for behavioral health benefits. Generally, the provider will submit claims on a Member or Dependent's behalf in accordance with the information on the behavioral health benefits identification card.

H. Health Reimbursement Arrangement

See the Health Reimbursement Arrangement Benefit section in the Enhanced Benefits Guide for information on how to file claims for reimbursement under the HRA.

II. ASSIGNMENT OF BENEFITS STATEMENT

Except in the case of self-insured benefit (which cannot be assigned), if the Fund is to make payment to an applicable service provider (if permitted under the Plan), sign the appropriate "Assignment of Benefits Statement" contained on the claim form. If payment is to be made to a Member or Dependent, attach an original, itemized bill (not a copy) to the claim form, along with a paid receipt to verify charges and payment. The service provider should provide a detailed bill listing the following: diagnosis, dates of treatment, treatment performed, and charges for each treatment.

III. HOW SOON SHOULD YOU FILE YOUR CLAIM?

For claims under all benefits offered under the Plan, you must submit to the Fund written proof of loss or claim within one year after the date of such loss or claim. Failure to furnish said proof within such time will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time but only if the Fund is not prejudiced by the late filing.

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, in certain cases, the Member may assign these other benefits to the applicable service provider. In the event of an overpayment, either to you or to a service provider on your behalf or on a Dependent's behalf, the Fund reserves the right to collect such overpayment by any legal means, including by reducing 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 no later than one year from when the expense was incurred that gives rise to the claim. Unless specifically provided in an applicable insurance contract or pursuant to applicable law, a suit for benefits under the Fund must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.

IV. CLAIM REVIEW / CLAIM APPEAL PROCEDURE

General Rules

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 Administrator have the discretion and authority to interpret the terms of the Fund's plan documents, including without limitation to this Summary Plan Description, 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.

Self-Insured Benefits

The applicable Claims Administrator for each of the self-insured benefits offered under the Plan 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 Claims Administrator will notify the claimant of the 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, 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 Claims Administrator will 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 will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

The Claims Administrator, as applicable will 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 Claims Administrator 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 Claims Administrator of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Claims Administrator will 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 will be decided as soon as possible, taking into account medical exigencies, and the Claims Administrator will notify the claimant of the benefit determination, whether adverse or not, within 24 hours prior to the initially approved period of time or number of treatments, 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 Claims Administrator will 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 Claims Administrator. The Claims Administrator may extend this period one time for up to 15 days, provided the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Claims Administrator, 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 Claims Administrator 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 will specifically describe the required information, and the claimant will 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 Claims Administrator will 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. The Claims Administrator may extend this period one time for up to 15 days, provided that the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Fund 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 Fund 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 will

specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

5. Disability Program Claims

In the case of a claim for disability benefits under this Plan, the Claims Administrator will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond its control and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond its control, 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 Claims Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Claims Administrator expects to render a decision. In the case of any extension under this paragraph, the notice of extension will 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 will be afforded at least 45 days within which to provide the specified information.

6. Notification on Denial of Claim

In the event of an adverse benefit determination, the Claims Administrator will send the claimant a written notification containing specific reasons for the adverse benefit determination. The information set forth in the notice will be provided in a manner calculated to be understood by the claimant (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements), and will include the following:

- information sufficient to identify the claim involved, including the date of service, health care provider, and claim amount (if applicable);
- a statement of the specific reason(s) for the adverse benefit determination, including any denial code and its corresponding meaning and any Plan standard used in denying the claim;
- reference(s) to the specific Plan provision(s) on which the decision is based;
- a statement advising the claimant of the right to request diagnosis and treatment codes and their corresponding meanings;
- a description of any additional material or information necessary to perfect the claim and why such information is necessary;

- a description of the Plan procedures and time limits for appeal of the decision, external review rights, the right to obtain information about the claims procedures, and the right to sue in federal court after exhausting the Fund's claims procedures;
- a statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- if the decision involves scientific or clinical judgment, either an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances or a statement that such explanation will be provided at no charge upon request;
- if the decision is based on a Plan standard (such as a medical necessity standard), a description of that standard;
- in the case of an urgent care claim, an explanation of the expedited review methods available for such claims; and
- contact information for the Employee Benefits Security Administration of the U.S. Department of Labor and any applicable state consumer assistance program.

Life and AD&D Insurance Claims

Because the Fund's life and AD&D benefits are fully insured benefits, the insurer 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 insurance policy.

V. Right of Review (Appeals) for Self-Insured Benefits

1. Appeals of Adverse Benefit Determinations

A claimant who receives an adverse benefit determination with respect to any claim will have the right to a full and fair review of that determination as required by applicable law. For self-insured benefits, the Appeals Committee adjudicates all internal appeals. In addition, as described below, after you have exhausted the internal appeals process, you have the voluntary right to an independent external review of certain claims under the Medical Benefits Program.

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

A claimant may request review of an adverse benefit determination 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 apply to any review sought by a claimant concerning an adverse benefit determination under this Plan:

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

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

d) The review will 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 will consult with a health care professional who has the appropriate training and experience in the relevant field.

f) The review process will 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 will not be consulted in connection with the review of the adverse benefit determination.

h) In the case of a claim involving urgent care, there will 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, will be transmitted between the applicable and the claimant or claimant's authorized representative by telephone, facsimile or other available similarly expeditious methods.

4. Second-Level Appeal Before Appeals Committee

In the event that a claimant is not satisfied with the outcome of its initial appeal of an adverse benefit determination, the claimant may file a second-level appeal with the Appeals Committee within 90 days of the denial of the initial appeal of the adverse benefit determination. The Appeals Committee consists of at least two trustees designated by the full Board of Trustees. The two designated trustees will have been involved in making the initial benefit decision. The review by the designated trustees will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision. The designated trustees will give no deference to the initial appeal decision. A claimant or claimant's authorized representative may appear before these trustees to present any evidence or argument in support of the claim review.

5. Content of Claim Review Determination

Each claim review determination will be signed by the Fund Administrator at the Claim Review Committee level, and by at least the two trustee members of the Appeals 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 apply to any rulings upon a requested claim review:

a) Urgent Care Claims. In the case of a claim involving urgent care, the Fund will notify the claimant 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 Fund will notify the claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will 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 Appeal Committee, the ruling on the claim review will 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 will 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 will 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 will notify the claimant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

d) Disability Claims. In the case of a claim for disability benefits under this Fund reviewed by the Appeal Committee, a ruling on the claim review will be made not later than the date of the Trustee's meeting that immediately follows the Fund'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 Fund'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

will be rendered not later than the third Trustee's meeting following the Fund's receipt of the request for review. If such an extension of time for a review is required because of special circumstances, the Fund will 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 commencement of the extension period.

7. External Review of Medical Claims

A Participant may seek an independent external review of an adverse benefit determination of a medical claim under the Medical Program or the HRA after exhausting his or her internal appeals, but before filing a lawsuit in court. Unlike the two internal levels of appeal, the external independent review process is voluntary.

The following types of adverse benefit determinations are subject to independent external review:

- an adverse benefit determination that involves medical judgment; and
- a rescission of coverage under the Fund's plan of benefits.

A Participant seeking an independent external review under this process must file a request for an external review with the Fund within four months after the date of receipt of a notice of a final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

Within five business days following the date of receipt of the external review request, the Fund will complete a preliminary review of the request to determine whether the request is eligible for external review. Within one business day after completion of the preliminary review, the Fund will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and current contact information, including the phone number, for the Employee Benefits Security Administration, a division of the U.S. Department of Labor. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the Fund will allow the Participant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

If the appeal is eligible for external review and the request is properly filed in a timely fashion, the Participant's appeal will be forwarded to a properly accredited Independent Review Organization ("IRO"). The Fund will ensure that the IRO process is not biased and is truly independent. The external review will be conducted at no cost to the Participant requesting review. The assigned IRO will utilize experts where appropriate to make coverage determinations under the plan or coverage. The IRO will

review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim anew and not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of the final external review decision to the Participant and to the Fund.

8. Furnishing Documents

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

9. Definitions

The following definitions in this section:

a) A "claim" is any request for a benefit or benefits made in accordance with these claims procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures. Any request for benefits that is not made in accordance with these claims procedures as described in this summary plan description is considered an incorrectly filed claim.

b) A "claimant" is a Member, former Member, Dependent, or beneficiary (designated or contingent) who makes a request for a Plan benefit or benefits in accordance with the Fund's claims procedures as described in this summary plan description.

c) A claim involving "urgent care" means a pre-service claim for medical care or treatment with respect to which the application of the time period that otherwise applies to pre-service claims could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. On receipt of a pre-service claim, the Fund will make a determination as to whether it involves urgent care; in any event, a claim will be treated as an urgent care claim if a physician with knowledge of the claimant's medical condition indicates that the claim involves urgent care.

d) "Pre-service claim" means any claim in which receipt of the benefit is conditioned, in whole or in part, upon receiving approval in advance of obtaining medical care.

e) "Concurrent care claim" occurs where the Fund approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (i) where reconsideration of previously approved care results in a reduction or termination of the initially approved period of time or number of treatments; and (ii) where an extension is requested beyond the initially approved period of time or number of treatments.

f) "Post-service claim" means any claim that is not a pre-service or concurrent care claim.

g) "External review" means an independent review of an adverse benefit determination (including a final internal adverse benefit determination) conducted in accordance with applicable law.

h) "Rescission of coverage" means a retroactive cancellation of coverage of a Fund benefit, other than for failure to pay premiums.

i) "Advance benefit determination" means a decision on a claim that is (1) a denial, reduction, or termination of; or (2) a failure to provide or make payment (in whole or in part) for a benefit under the Fund. A rescission of coverage is treated as an adverse benefit determination (whether or not the rescission has an adverse effect on any particular benefit at that time).

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GENERAL PROVISIONS AND DEFINITIONS

The following terms are defined as follows for purposes of this Summary Plan Description.

ACCIDENTAL BODILY INJURY - For an injury to be considered an accident, the injury must have resulted from some external, violent and unforeseen happening.

ACCREDITED EDUCATIONAL INSTITUTION - a publicly or privately operated academic institution of higher learning which: (a) provides recognized course or courses of instruction and leads to the conference of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and (b) is duly recognized and declared as such by the appropriate authority of the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education. The definition may include, but is not limited to, colleges and universities, and technical or specialized schools.

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.

AFFORDABLE CARE ACT - The Patient Protection and Affordable Care Act of 2010, as amended, and the regulations and guidance promulgated thereunder.

ALTERNATIVE THERAPIES / COMPLEMENTARY MEDICINE - Complementary and alternative medicine, as defined by the National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM), is a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine. NCCAM categorizes complementary medicine and alternative therapies into the following five classifications: (a) alternative medical systems (e.g., homeopathy, naturopathy, Ayurveda, traditional Chinese medicine); (b) mind-body interventions which include a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms (e.g., meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance); (c) biologically based therapies using natural substances, such as herbs, foods, vitamins or nutritional supplements to prevent and treat illness (e.g., diets, macrobiotics, megavitamin therapy); (d) manipulative and body based methods (e.g., massage, equestrian/hippotherapy); and (e) energy therapies, involving the use of energy fields. The energy therapies are of two types: (1) Biofield therapies - intended to affect energy fields that purportedly surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi Gong, Reiki, and therapeutic touch. (2)

Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields.

AMBULATORY SURGICAL FACILITY - a Facility Provider, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health care, Inc., or by the Claims Administrator and which:

A. has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;

B. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

C. does not provide Inpatient accommodations; and

D. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

ANCILLARY PROVIDER - an individual or entity that provides services, supplies or equipment (such as, but not limited to, Home Infusion Therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the coverage.

ANESTHESIA - consists of the administration of regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

ATTENTION DEFICIT DISORDER - a disease characterized by developmentally inappropriate inattention, impulsiveness and hyperactivity.

AUTOMOBILE INSURANCE - Where an injury is caused by an accident that is covered by a State-required automobile insurance law, health and disability insurance coverage under this Plan is secondary and the automobile insurance or assigned claims plan, as applicable, is responsible to pay the covered charges for care for that injury first. The Plan will then cover the balance of the covered health 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 Automobile Reparation Reform Act, as amended by the New Jersey Insurance Freedom of Choice and Cost Containment Act of 1984.

Members and Dependents 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 law, may only be reimbursed under the Plan 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 26 weeks. In addition, benefits for injuries incurred as a result of a motor vehicle accident covered by an applicable state law, including but not limited to the Pennsylvania Motor Vehicle Financial Responsibility Law, will be paid in accordance with the requirements of such state law.

BENEFIT MAXIMUM - the greatest amount of a specific covered service that a Covered Person may receive.

BENEFIT PERIOD - Benefit Period means the Plan Year, which begins on January 1 and ends on December 31 of each year.

BIRTH CENTER - a Facility Provider approved by the Claims Administrator which (1) is licensed as required in the state where it is situated, (2) is primarily organized and staffed to provide maternity care, and (3) is under the supervision of a Physician or a licensed certified nurse midwife.

CANCER RIGHTS - In accordance with the Women's Health and Cancer Rights Act, the Plan covers the following 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;
- Breast prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedema.

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

CASE MANAGEMENT - Comprehensive Case Management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of Case Management are to facilitate access by the Covered Person to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve Covered Person outcomes. Case Management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.

CERTIFIED REGISTERED NURSE - a certified registered nurse anesthetist, certified registered nurse practitioner, certified entreostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a Facility Provider or by an anesthesiology group.

CLAIMS ADMINISTRATOR - a professional entity, person, or committee that the Fund uses to administer the claims payment and appeals management responsibilities for the self-insured benefits offered under the Plan. In certain cases, the Claims Administrator is the Fund.

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.

CLAIM REVIEW PROCEDURE - See "HOW TO FILE A CLAIM FOR FUND BENEFITS AND APPEAL A DENIAL OF A CLAIM" in this Summary Plan Description.

COLLECTIVE BARGAINING AGREEMENT - The contract, including an interim agreement, 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.

COMPLAINT - any expression of dissatisfaction, verbal or written, by a Covered Person.

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 - The Plan provides for Coordination of Benefits. This means that if a Family Member becomes entitled to any medical, dental, vision, disability or prescription drug 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 charge 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, benefits will be coordinated so that the Member may receive up to 100% of the Usual, Customary and Reasonable charges in accordance with the following priorities of payment:

If the other plan providing benefits for a person covered under the Fund 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 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" will 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" will not be obligated to provide benefits until the "primary coverage" is exhausted.

***Spouses*:** In each case, the other plan will provide primary coverage for the Spouse and the Fund will provide secondary coverage for the 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, is only eligible for coverage under the Fund if the Spouse's employer requires the spouse must pay 100% of the premium for such coverage. If such Spouse is eligible to enroll in such coverage, but does not, the Fund will provide secondary coverage as if and only to the extent that the other coverage was in effect as of the date services were rendered to the Spouse.

***Children*:** If the Member and the child's other parent are married to each other and not separated, then the "birthday rule" will 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 will be primary.

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

If there is a court order that 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 as set forth in this Summary Plan Description.

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

Parents Divorced - Not Remarried	Parents 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

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

***Medicare Coverage*:** In all cases the Fund will comply with the Medicare Secondary Payer Rules. That means that, in all cases where a Member is actively at work, the Fund's coverage will pay Covered Expenses incurred by the Members and his or her Dependents primary and Medicare will pay secondary.

***Miscellaneous Rules*:** Under no circumstances will the Fund pay any benefits as the primary plan when a Member or the Dependent has elected to make the Fund the primary plan by waving coverage under any other employer-based group health plan. This provision will be effective regardless of whether the Dependent waived enrollment in such other plan (when required to enroll in circumstances described above under "Spouses" or, if enrolled, sought or secured services outside of the required network of providers of such other plan.

Benefits otherwise payable by the Fund will 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 does not exceed the Usual, Customary and Reasonable charges for the service provided.

If the Fund pays a Member's Spouse or other eligible Dependents' coverage on a secondary basis pursuant to this Coordination of Benefits provision, 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 that would be payable by the Fund but for this Coordination of Benefits provision. 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 group 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 Summary Plan Description. 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 will still only provide a single individual benefit allowance per session.

COVERED EXPENSES - Only actual charges for an item or service that is specifically listed as a covered benefit under a provision of the Plan which is covered by your specific Summary of Benefits Schedule that is included in or accompanies this Summary Plan Description.

COVERED PERSON - an enrolled Member or his/her Eligible Dependents who have satisfied the specifications of the Schedule of Eligibility.

COVERED SERVICE - a service or supply specified in this booklet for which benefits will be provided by the Claims Administrator.

CUSTODIAL CARE (DOMICILIARY CARE) - provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications, which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

DAY REHABILITATION PROGRAM - is a level of Outpatient care consisting of four to seven hours of daily rehabilitative therapies and other medical services five days per week. Therapies provided may include a combination of therapies, such as Physical Therapy, Occupational Therapy, and Speech Therapy, as otherwise defined in this Plan and other medical services such as nursing services, psychological therapy and Case Management services. Day Rehabilitation sessions also include a combination of one-to-one and group therapy. The Covered Person returns home each evening and for the entire weekend.

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 - Your eligible spouse, child, or wholly dependent parent as defined in the Eligibility Provisions section.

DURABLE MEDICAL EQUIPMENT - is equipment which meets the following criteria:

A. It is durable and can withstand repeated use;

B. It is medical equipment, meaning it is primarily and customarily used to serve a medical purpose;

C. It generally is not useful to a person in the absence of an illness or injury; and

D. It is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to, diabetic supplies, canes, crutches, walkers, commode chairs, home oxygen equipment, hospital beds, traction equipment and wheelchairs.

EMERGENCY - The sudden and unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the Covered Person's health, or in the case of a pregnant Covered Person, the health of the unborn child, in jeopardy;

B. Serious impairment to bodily functions; or

C. Serious dysfunction of any bodily organ or part.

EMERGENCY CARE - covered services and supplies provided by a Hospital or Facility Provider and/or Professional Provider to a Covered Person in or for an Emergency on an Outpatient basis in a Hospital Emergency Room or Outpatient Emergency Facility.

ENHANCED BENEFITS GUIDE - the document or documents that the Fund designates as such and that describes certain benefits that the Fund offers. The Enhanced Benefits Guide is incorporated by reference into, and is a part of, this Summary Plan Description.

ENTERAL NUTRITION - the provision of nutritional requirements through a tube into the stomach or small intestine.

EXPERIMENTAL/INVESTIGATIONAL SERVICES - a drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

A. Is the subject of ongoing Phase I or Phase II Clinical Trials;

B. Is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;

D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the particular diagnosis or treatment of the Covered Person's particular condition; or

E. Is generally recognized by either Reliable Evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia:

- The American Hospital Formulary Service Drug Information, or
- The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental/Investigational.

Any biological product, device, medical treatment or procedure is not considered Experimental/Investigational if it meets all of the criteria listed below:

1. Reliable Evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

2. Reliable Evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.

3. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.

4. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.

5. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

FACILITY PROVIDER - an institution or entity licensed, where required, to provide care. Such facilities include:

- Ambulatory Surgical Facility
- Birth Center
- Free Standing Dialysis Facility
- Free Standing Ambulatory Care Facility
- Home Health Care Agency
- Hospice
- Hospital
- Rehabilitation Hospital
- Short Procedure Unit
- Skilled Nursing Facility

FAMILY MEMBER - A Member and his or her enrolled Dependents.

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 will 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 will 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 will be final, conclusive and binding upon all persons.

FREE STANDING AMBULATORY CARE FACILITY - a Facility Provider, other than a Hospital, which provides treatment or services on an Outpatient or partial basis and is not, other than incidentally, used as an office or clinic for the private practice of

a Physician. This Facility Provider must be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

FREE STANDING DIALYSIS FACILITY - a Facility Provider, licensed or approved by the appropriate governmental agency and approved by the Claims Administrator, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

FUND - The Teamsters Health and Welfare Fund of Philadelphia and Vicinity.

FUND ADMINISTRATOR - The individual or individuals that the trustees appoint to serve in such capacity.

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 Summary Plan Description 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.

HEARING AID - a Prosthetic that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of (a) a microphone to pick up sound, (b) an amplifier to increase the sound, (c) a receiver to transmit the sound to the ear, and (d) a battery for power. A hearing aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a hearing aid can be packaged together into a small self-contained unit or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles: (a) behind-the-ear, (b) in-the-ear, (c) in-the-canal, (d) completely-in-the-canal, and (e) implantable (can be partial or complete). A Hearing Aid is not a cochlear implant.

HOME HEALTH CARE AGENCY - a Facility Provider, approved by the Claims Administrator, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the patient's home in accordance with an approved home health care Plan of Treatment.

HOSPICE - a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be (1) certified by Medicare to provide Hospice services or accredited as a Hospice by the appropriate regulatory agency; and (2) appropriately licensed in the state where it is located.

HOSPITAL(S): An acute care institution that:

1. 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

2. 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.

IDENTIFICATION CARD - the currently effective card for an applicable benefit issued to you which must be presented when a covered service is requested.

INCURRED - a charge shall be considered incurred on the date you or your Covered Dependent receives the service or supply for which the charge is made.

INDEPENDENT CLINICAL LABORATORY - a laboratory that performs clinical pathology procedure and that is not affiliated or associated with a Hospital, Physician or Facility Provider.

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."

LICENSED PRACTICAL NURSE (LPN) - a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

MAINTENANCE - Continuation of care and management of the patient when the maximum therapeutic value of a Medically Appropriate/Medically Necessary treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, the provision of covered services for a condition ceases to be of therapeutic value and is no longer Medically Appropriate/Medically Necessary. This includes Maintenance services that seek to prevent disease, promote health and prolong and enhance the quality of life.

MATERNITY COVERAGE - Under federal law, the Fund may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, 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).

MAXIMUM - a limit on the amount of covered services that you may receive. The Maximum may apply to all covered services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less deductibles, coinsurance and Copayment amounts paid by Covered Persons for the Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Claims Administrator to the Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.

MEDICAL CARE - services rendered by a Professional Provider within the scope of his license for the treatment of an illness or injury.

MEDICAL FOODS - Liquid nutritional products which are specifically formulated to treat one of the following genetic diseases; phenylketonuria, branched-chain ketonuria, galactosemia, or homocystinuria.

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 enroll in 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 employee of a Contributing Employer to the Fund who has satisfied the eligibility requirements based on contributions made on his/her behalf by such Contributing Employer 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.

NON-ASSIGNMENT - The right of a Member, Dependent, or other authorized beneficiary to receive any payment under a self-insured benefit offered under the Plan is personal to such individual and is not assignable in whole or in part to any person or entity, including a health care provider, nor may benefits of coverage under the Plan be transferred at any time. Under no circumstances will the Fund's direct payment of any amounts to an in-network Provider or other individual or entity constitute a waiver of this non-assignment provision with respect to any party, including an out-of-network Provider. Any attempt so to assign, either directly or indirectly, including by means of the grant by you or your Dependent or the exercise by any person or entity of a power of attorney or other device, shall be void. No benefit shall be payable from the Plan until you, or such assignment is canceled, cleared, or withdrawn by the Member, Dependent, or named beneficiary in such a manner that is satisfactory to the Trustees.

NUTRITIONAL FORMULA - Liquid nutritional products which are formulated to supplement or replace normal food products.

OUTPATIENT CARE - medical, nursing, counseling or therapeutic treatment provided to a Covered Person who does not require an overnight stay in a Hospital or other inpatient Facility Provider.

PARTICIPATING LOCAL UNION - A union with whom any Contributing Employer has entered into a signed Collective Bargaining Agreement, as a requirement of which, the Contributing Employer is obligated to make contributions to the Fund on behalf of the employees covered by that Collective Bargaining Agreement.

PENALTY - a type of cost-sharing in which the Covered Person is assessed a reduction in benefits payable for failure to obtain Pre-certification of certain covered services.

PERVASIVE DEVELOPMENTAL DISORDERS (PDD) - disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests and activities. Examples are Asperger's syndrome and childhood disintegrative disorder.

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.), or an optometrist (O.D.), who is licensed and otherwise meets the requirements to practice medicine in the jurisdiction where such services are performed. A licensed clinical psychologist (Ph.D., M.S., or M.A., or L.S.W.), when providing treatment for mental illness or functional nervous disorders, will also be considered a Physician.

PLAN - Means this Summary Plan Description, the Enhanced Benefits Guide, 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 will not require the consent of any Employer, union, Member or Dependent, nor will such action require individual notice to any such person or organization.

PLAN ADMINISTRATOR - the person or entity that has discretionary authority or responsibility to control and manage the operation and administration of this Plan in accordance with Employee Retirement Income Security Act (ERISA). The Fund is the Plan Administrator.

PLAN OF TREATMENT - a plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Plan of Treatment should be limited in scope and extent to that care which is Medically Appropriate/Medically Necessary for the Covered Person's diagnosis and condition.

PRE-CERTIFICATION (or PRE-CERTIFY) - prior assessment by the Claims Administrator or a designated agent that proposed services, such as hospitalization, are Medically Appropriate/Medically Necessary for a particular patient and covered by the

patient's plan. Payment for services depends on whether the patient and the category of service are covered under the individual's plan of coverage.

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.

PREVENTIVE CARE - Services rendered primarily for the purpose of health maintenance and not for the treatment of an illness or injury, including those Health Care Services required to be covered under Section 2713 of the Public Health Service Act and related regulatory guidance. Preventive Care includes (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and (4) with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Specific details on what services are covered as Preventive Care are set forth in the Enhanced Benefits Guide. They are available at no charge from the Fund Office.

PRIMARY CARE SERVICES - basic, routine medical care traditionally provided to individuals with common illnesses and injuries and chronic illnesses.

PRIMARY CARE PROVIDER - a Professional Provider (General Practice, Family Practice, Internal Medicine, or Pediatricians).

PRIVATE DUTY NURSING - Medically Appropriate/Medically Necessary Outpatient continuous skilled nursing services provided to a Covered Person by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

PROFESSIONAL PROVIDER - a person or practitioner licensed where required and performing services within the scope of such licensure. Professional Providers are:

A.	Audiologist	G.	Optometrist
B.	Certified Registered Nurse	H.	Physical Therapist
C.	Chiropractor	I.	Physician
D.	Dentist	J.	Podiatrist
E.	Independent Clinical Laboratory	K.	Speech-language Pathologist
F.	Nurse Midwife	L.	Teacher of the hearing impaired

PROSTHETICS - devices (except dental prosthetics), which replace all or part of: (1) an absent body organ including contiguous tissue; or (2) the function of a permanently inoperative or malfunctioning body organ.

PROVIDER - a Facility Provider, Professional Provider or Ancillary Provider, licensed where required.

REGISTERED NURSE (R.N.) - a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.

REHABILITATION HOSPITAL - a Facility Provider, approved by the Claims Administrator and licensed by the appropriate regulatory agency, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

RESTORATIVE SERVICES - courses of treatments prescribed or provided by Professional Providers to restore loss of function of a body part. Restorative services generally involve neuromuscular training as a course of treatments over weeks or months. Examples of restorative services include, but are not limited to:

A. Manipulative treatment of functional loss from back disorder;
B. Therapy treatment of functional loss following foot surgery;
C. Orthoptic/Pleoptic therapy.

SEVERE SYSTEMIC PROTEIN ALLERGY - means allergic symptoms to ingested proteins of sufficient magnitude to cause weight loss or failure to gain weight, skin rash, respiratory symptoms, and gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

SHORT PROCEDURE UNIT - a unit which is approved by the Claims Administrator and which is designed to handle either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient stay in the absence of a Short Procedure Unit.

SKILLED NURSING FACILITY - an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of mental illness, tuberculosis, or Alcohol or Drug Abuse, which:

A. Is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations;

B. Is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or

C. Is otherwise acceptable to the Claims Administrator.

SPECIALIST SERVICES - all Professional Provider services providing medical or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

SPECIAL CARE FACILITY - An institute other than a Hospital (as defined in this Summary Plan Description) that:

A. Specializes in physical rehabilitation of injured or sick patients,
B. Specializes in the diagnosis and treatment of mental illness or functional nervous disorders, or
C. Specializes in the diagnosis and treatment of alcoholism, drug addiction, or mental and nervous disorders.

In addition, to qualify as a Special Care Facility, an institution must be:

D. Legally licensed to give medical treatment,
E. Operated under the supervision of a Physician, and
F. 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 an individual who is treated as a spouse for federal tax purposes. An individual who is divorced from a Member is specifically excluded from the definition of Spouse. The Fund may require documentation of an individual's status as a Spouse.

SUMMARY OF BENEFITS SCHEDULE - This includes the various sections that are included or accompany this Summary Plan Description that contain the actual allowances for your various benefits.

SURGERY - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered surgery.

THERAPY SERVICE - the following services or supplies prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Covered Person:

A. **Cardiac Rehabilitation Therapy** - Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

B. **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.

C. **Dialysis** - The treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

D. **Infusion Therapy** - Treatment including, but not limited to infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.

E. **Occupational Therapy** - Medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational therapy also includes medically prescribed treatment concerned with improving the Covered Person's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

F. **Physical Therapy** - Medically prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

G. **Pulmonary Rehabilitation Therapy** - Multidisciplinary treatment which combines physical therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

H. **Radiation Therapy** - The treatment of disease by X-Ray, gamma ray, accelerated particles, mesons, neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.

I. **Respiratory Therapy** - Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

J. **Speech Therapy** - Medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

TOTALLY DISABLED - ***If you are a 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 as determined by the Social Security Administration. ***If you are a Dependent***: You are 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.

URGENT CARE - Medically Appropriate/Medically Necessary covered services provided in order to treat an unexpected illness or Accidental Injury that is not life-or limb-threatening. Such covered services must be required in order to prevent a serious deterioration in the Covered Person's health if treatment were delayed.

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 Number: 501.

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 Collective Bargaining Agreements which are between, among others, the Teamsters Locals 107, 115, 169, 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 life insurance benefits, are self-insured and paid directly from the corpus of a trust fund.

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

Types of Benefits: The Fund provides comprehensive Hospitalization, Surgical, Medical, Dental, Vision, Behavioral Health, Life, Accidental Death and Dismemberment, Short-term Disability and Prescription Drug benefits. 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 Summary Plan Description to the fullest extent provided by law.

Your Rights Under ERISA: As a participant 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 Fund participants shall be entitled to:

Receive Information About the Fund and Your Benefits

- Examine, without charge, at the Fund Administrator's office, and at other specified locations, such as worksites and union halls, all documents governing the Fund, including insurance contracts, if any, Collective Bargaining

Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Fund 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 Fund Administrator, copies of documents governing the operation of the Fund, including insurance contracts, if any, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Fund Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

- Continue health care coverage for yourself or Dependents if there is a loss of coverage under the Fund 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 Fund on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Fund Fiduciaries: In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Fund. The people who operate the Fund, called "fiduciaries" of the Fund, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights: If your claim for a benefit under the Fund 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 Fund documents or the latest annual report from the Fund and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Fund 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 Fund 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 Fund fiduciaries misuse the Fund'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 the Fund, you should contact the Fund 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 Fund 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.

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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. 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, 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, 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 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, 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 Maria Scheeler, 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:

Maria Scheeler, Privacy Officer
Teamsters Health & Welfare Fund of Philadelphia and Vicinity
2500 McClellan Avenue, Suite 140
Pennsauken, NJ 08109
856-382-2422
856-382-2401 (fax)

VI. EFFECTIVE DATE

This Notice is effective July1, 2019**.**

If you have any questions regarding this notice, please contact the privacy officer identified above.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

THIS NOTICE EXPLAINS IMPORTANT PROVISIONS OF THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998. PLEASE REVIEW IT CAREFULLY.

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As specified in this Act, a participant or beneficiary with coverage under the Plan of Benefits of the Teamsters Health and Welfare Fund of Philadelphia and Vicinity who elect breast reconstruction in connection with a mastectomy also will be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Of course, the coverage will be provided in a manner determined in consultation with the attending physician and the patient. Deductibles and coinsurances established for other benefits under your Plan also apply to these reconstructive surgery benefits. The Women's Health and Cancer Rights Act of 1998 applies to your benefits immediately.

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SUMMARY OF BENEFITS SCHEDULE UNDER THE MEDICAL PROGRAM - PPO PLAN

The following schedule of medical benefits applies to the Horizon PPO Plan. This schedule does not include information about the Behavioral Health or Prescription Drug Programs, which are describe elsewhere in this Summary Plan Description or in the Enhanced Benefits Guide.

BENEFIT PERIODS AND PARTICULARS (Horizon PPO)

Benefit Period	Calendar Year
Program Deductible	
In-Network Care	$250 Platinum Plan - per person / benefit period $500 Gold Plan - per person / benefit period
Out-Of-Network Care	$500 Platinum Plan - per person / benefit period $1000 Gold Plan - per person / benefit period This deductible applies to all services, except emergency care service, pediatric immunizations, and Preventive Care.
Family Deductible	The family deductible amount is equal to two times the individual deductible. In each benefit period, it will be applied for all Family Members covered. A deductible will not be applied to any covered individual Family Member once that covered person has satisfied the individual deductible, or the family deductible has been satisfied for all covered Family Members combined.
Deductible Carryover	Expenses incurred for covered expenses in the last three months of a benefit period which were applied to that benefit period's deductible will be applied to the deductible of the next benefit period.
Coinsurance (Covered Person's Liability)	10% (In-Network Care) 20% (Out-Of-Network Care) of allowable charges, except coinsurance does not apply to emergency care services.

Annual Coinsurance Out-of-Pocket Limit	
In-Network Care	$500 Platinum Plan / $750 Gold Plan per person per benefit period
Out-Of-Network Care	$1,500 Platinum Plan / $2,250 Gold Plan per person per benefit period When a covered person reaches the coinsurance out-of-pocket limit in one benefit period, the coinsurance percentage will be reduced to 0% for the balance of that benefit period. The dollar amounts specified will not include any expense incurred for any deductible, penalty or copayment amount.
Copayment	
Primary Care Physician	$20 Platinum Plan / $30 Gold Plan
Specialist	$30 Platinum Plan / $40 Gold Plan
Annual Overall Out-of-Pocket Maximum for Medical Program (In-Network and Out-Of-Network)	$5,000 per person / $10,000 per family
Annual Maximum	None.

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SUMMARY OF BENEFITS SCHEDULE (Horizon PPO)

SERVICES	IN-NETWORK	OUT-OF-NETWORK (% of Allowable Charge unless otherwise stated)
HOSPITAL		
Inpatient Services: Maximum of 365 days for in-network services; 70 days maximum for out-of-network services per illness. The out-of-network days maximum is part of, not separate from, the in-network days maximum. **Note:** Pre-certification is required for all inpatient services.	90%	80%
Outpatient Services	90%	80% (unless unreasonable under circumstances to use In-Network Provider, then paid at 90% of allowable expense)
EMERGENCY CARE (Facility Charges)		
Services within two days of emergency certification of services must take place within two business days of service, or as soon as reasonably possible, as determined by the Fund.	100%, less $100 copay; waived if admitted	100%, less $100 copay; waived if admitted
Follow-up emergency room care within 14 days of initial treatment.	100%, less $100 copayment	100%, less $100 copayment
SURGICAL SERVICES	90%	80%
ASSISTANT SURGEON 20% of the in-network allowance for the surgical procedure performed by the primary surgeon.	90%	80%

SERVICES	IN-NETWORK	OUT-OF-NETWORK (% of Allowable Charge unless otherwise stated)
ANESTHESIA	90%	80%
SECOND SURGICAL OPINION Voluntary	90%	80%
MEDICAL CARE Inpatient Care Concurrent Care (Inpatient consultations are limited to one consultation per consultant per confinement)	90%	80%
DIAGNOSTIC SERVICES - OUTPATIENT X-ray, Radiology, Ultrasound and Nuclear Medicine, ECG, EEG, Laboratory, Pathology, Other	90%	80%
ALLERGY TESTING	90%	80%
THERAPY - OUTPATIENT		
Radiation Therapy, Chemotherapy and Dialysis Therapy	90%	80%
Infusion Therapy See Injectable/Infused Medications on page [39].	90%	80%
Respiratory Therapy	100%, less specialist copay per session	80%
Cardiac Rehabilitation Therapy 36 In-Network/Out-Of-Network sessions per benefit period.	100%, less specialist copay per session	80%
Pulmonary Rehabilitation Therapy (12 In-Network/Out-Of-Network sessions per benefit period)	100%, less specialist copay per session	80%

SERVICES	IN-NETWORK	OUT-OF-NETWORK (% of Allowable Charge unless otherwise stated)
Physical, Occupational, Speech Therapy	100%, less specialist copay per session per therapy	80%
RESTORATIVE SERVICES		
-- Chiropractic (services limited to 15 sessions per benefit period)	100%, less specialist copay per session	80%
-- Orthoptic/Pleoptic (services limited to 8 visits per lifetime)	100%, less specialist copay per session	80%
MATERNITY SERVICES		
Obstetrical/Maternity Care	90%	80%
-- Hospital Stay	90%	80%
-- Labor and Delivery	100%, less specialist copayment	80%
Abortions (only to avert the death of the mother or in the case of pregnancies resulting from rape or incest)	90%	80%
Newborn Care (from the date of birth to mother's discharge from the hospital)	90%	80%
SKILLED NURSING FACILITY CARE (Hospital day limit maximum applies; pre-certification required)	90%	80%

SERVICES	IN-NETWORK	OUT-OF-NETWORK (% of Allowable Charge unless otherwise stated)
SKILLED NURSING FACILITY CARE (CONTINUED)		
Physician visit limits per benefit period: 2 visits during first week of confinement and one visit per week for each consecutive week of confinement thereafter.	90%	80%
DURABLE MEDICAL/ SURGICAL EQUIPMENT/ PROSTHETICS Pre-certification is required for supplies including all rentals and for the purchase of items with billed amount that exceeds $1,000.	90%	80%
Foot Orthotics (covered once every 24 months)	90%	80%
HOME HEALTH CARE Only covered if following a one-day hospitalization. Pre-certification is required.	90%	80%
HOSPICE CARE Respite Care - maximum of seven days every six months.	90%	80%
AMBULANCE Air Ambulance – must provide sufficient medical records documenting need.	90%	80%
MEDICAL FOODS AND NUTRITIONAL FORMULAS Medical Foods benefits must be pre-certified by the Fund office.	90%	80%

SERVICES	IN-NETWORK	OUT-OF-NETWORK (% of Allowable Charge unless otherwise stated)
TRANSPLANT SERVICES See Transplant Services on page [26] regarding donor coverage.	90%	80%
OUTPATIENT PRIVATE DUTY NURSING	90%	80%
URGENT CARE CENTERS	$50 copay per visit	80%
RETAIL WALK-IN CLINICS	$10 copay per visit	80%
PRIMARY CARE Home, office, outpatient visits and outpatient consultation with general practitioner or family physician.	100%, less primary care copay per visit	80%
Pediatric immunizations (copayments, deductibles and maximum amounts do not apply to this benefit).	100%	80%
Preventive Care with general practitioner or family physician	100%	80%
Specialist	100%, less specialist copayment per visit	80%
Routine annual Gynecological Exam and Pap Smears (copayments, deductibles and maximum amounts do not apply to this benefit).	100%	80%
Annual screening Mammogram (copayments, deductibles and maximum amounts do not apply to this benefit).	100%	80%
Therapeutic Injections	90%	80%
Allergy Extract/Injections	100%	80%

SERVICES	IN-NETWORK	OUT-OF-NETWORK (% of Allowable Charge unless otherwise stated)
Compression Stockings (one pair every six months)	90%	80%

COVERED SERVICES LIMITATION

Services	Limitations
Inpatient Admissions/Services Skilled Nursing Facility Care Transplant Services	Failure to pre-certify in-network services will result in a $1,000 reduction in benefits payable for these services.
Outpatient Services Surgical Services Home Health Care Hospice Care Private Duty Nursing	
Disease Management Program	Non-participation in the Disease Management Program will result in the assessment of a yearly penalty deductible of $500 in addition to all other applicable deductible, co-insurance, and copayment provisions. See Enhanced Benefits Guide for more information.
Wellness Program	Non-participation in the Wellness Program will result in eligibility being restricted to the Gold Plan.

SUMMARY OF BENEFITS SCHEDULE UNDER THE MEDICAL PROGRAM - EPO PLAN

The following schedule of medical benefits applies to the Aetna EPO Plan. This schedule does not include information about the Behavioral Health or Prescription Drug Programs, which we describe elsewhere in this Summary Plan Description or in the Enhanced Benefits Guide.

BENEFIT PERIODS AND PARTICULARS (Aetna EPO - In-Network Care Only)

Benefit Period	Calendar Year
Program Deductible	$100 Platinum Plan / $350 Gold Plan per person per benefit period This deductible applies to all services, except emergency care service, pediatric immunizations, and Preventive Care.
Family Deductible	The family deductible amount is equal to two times the individual deductible. In each benefit period, it will be applied for all Family Members covered. A deductible will not be applied to any covered individual Family Member once that covered person has satisfied the individual deductible, or the family deductible has been satisfied for all covered Family Members combined.
Deductible Carryover	Expenses incurred for covered expenses in the last three months of a benefit period which were applied to that benefit period's deductible will be applied to the deductible of the next benefit period.
Coinsurance (Covered Person's Liability)	10%
Annual Coinsurance Out-of-Pocket Limit	$250 Platinum Plan / $500 Gold Plan per person per benefit period When a covered person reaches the coinsurance out-of-pocket limit in one benefit period, the coinsurance percentage

	will be reduced to 0% for the balance of that benefit period. The dollar amounts specified will not include any expense incurred for any deductible, penalty or copayment amount.
Copayment	
Primary Care Physician	$15 Platinum Plan / $25 Gold Plan
Specialist	$25 Platinum Plan / $35 Gold Plan
Annual Overall Out-of-Pocket Maximum for Medical Program (In-Network and Out-Of-Network)	$5,000 per person / $10,000 per family
Annual Maximum	None.

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SUMMARY OF BENEFITS SCHEDULE (Aetna EPO)

SERVICES	IN-NETWORK
HOSPITAL	
Inpatient Services: Maximum of 365 days for in-network services; 70 days maximum for out-of-network services per illness. **Note**: Pre-certification is required for all inpatient services.	90%
Outpatient Services	90%
EMERGENCY CARE (Facility Charges) Services within two days of emergency certification of services must take place within two business days of service, or as soon as reasonably possible, as determined by the Fund.	100%, less $100 copay; waived if admitted
Follow-up emergency room care within 14 days of initial treatment.	100%, less $100 copay
SURGICAL SERVICES	90%
ASSISTANT SURGEON 20% of the in-network allowance for the surgical procedure performed by the primary surgeon.	90%
ANESTHESIA	90%
SECOND SURGICAL OPINION Voluntary	90%
MEDICAL CARE Inpatient Care	90%

SERVICES	IN-NETWORK
MEDICAL CARE (CONTINUED) Concurrent Care (Inpatient consultations are limited to one consultation per consultant per confinement).	90%
DIAGNOSTIC SERVICES - OUTPATIENT X-ray, Radiology, Ultrasound and Nuclear Medicine, ECG, EEG, Laboratory, Pathology, Other.	90%
ALLERGY TESTING	90%
THERAPY – OUTPATIENT Radiation Therapy, Chemotherapy and Dialysis Therapy	90%
Infusion Therapy See Injectable/Infused Medications on page [39]	90%
Respiratory Therapy	90%
Cardiac Rehabilitation Therapy (36 sessions per benefit period)	90%
Pulmonary Rehabilitation Therapy (12 sessions per benefit period)	90%
Physical, Occupational, Speech Therapy	90%
RESTORATIVE SERVICES -- Chiropractic (services limited to 15 sessions per benefit period)	100%, less specialist copayment per session
-- Orthoptic/Pleoptic (services limited to 8 visits per lifetime)	100%, less specialist copayment per session
MATERNITY SERVICES Obstetrical/Maternity Care -- Hospital Stay	90%
-- Labor and Delivery	100%, less specialist copayment

SERVICES	IN-NETWORK
Abortions (only to avert the death of the mother, or in the case of pregnancies resulting from rape or incest)	90%
Newborn Care (from the date of birth to mother's discharge from the hospital)	90%
SKILLED NURSING FACILITY CARE (Hospital day limit maximum applies; pre-certification required) Physician visit limits per benefit period: 2 visits during first week of confinement and one visit per week for each consecutive week of confinement thereafter.	90%
DURABLE MEDICAL/ SURGICAL EQUIPMENT Pre-certification is required for supplies including all rentals and for the purchase of items with billed amount that exceeds $1,000.	90%
Foot Orthotics (covered once every 24 months)	90%
PROSTHETICS Pre-certification is required for items with a billed amount that exceeds $1,000.	90%
HOME HEALTH CARE Only covered if following a one-day hospitalization. Pre-certification is required.	90%
HOSPICE CARE Respite Care - maximum of seven days every six months.	90%
AMBULANCE Air Ambulance must provide sufficient medical records documenting need.	90%
MEDICAL FOODS AND NUTRITIONAL FORMULAS Medical Foods benefits must be pre-certified.	90%

SERVICES	IN-NETWORK
TRANSPLANT SERVICES See Transplant Services on page [26] regarding donor coverage.	90%
OUTPATIENT PRIVATE DUTY NURSING	90%
URGENT CARE CENTERS	$50 copayment per visit
RETAIL WALK-IN CLINICS	$10 copayment per visit
PRIMARY CARE Home, office, outpatient visits and outpatient consultation with general practitioner or family physician.	100%, less primary care copayment per visit
Pediatric immunizations (copayments, deductibles and maximum amounts do not apply to this benefit).	100%
Preventive Care with general practitioner or family physician.	100%
Specialist	100%, less specialist copayment per visit
Routine annual Gynecological Exam and Pap Smears (copayments, deductibles and maximum amounts do not apply to this benefit).	100%
Annual screening Mammogram (copayments, deductibles and maximum amounts do not apply to this benefit).	100%
Therapeutic Injections	90%
Allergy Extract/Injections	100%
Compression Stockings (one pair every six months)	90%

COVERED SERVICES LIMITATION

Services	Limitations
Inpatient Admissions/Services Skilled Nursing Facility Care Transplant Services	Failure to pre-certify in-network services will result in a $1,000 reduction in benefits payable for these services.
Outpatient Services Surgical Services Home Health Care Hospice Care Private Duty Nursing	
Disease Management Program	Non-participation in the Disease Management Program will result in the assessment of a yearly penalty deductible of $500 in addition to all other applicable deductible, co-insurance, and copayment provisions. See Enhanced Benefits Guide for more information.
Wellness Program	Non-participation in the Wellness Program will result in eligibility being restricted to the Gold Plan.