



TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY

SUMMARY PLAN DESCRIPTION

Restated and Effective January 1, 2025

This Summary Plan Description constitutes the Fund's Plan document. It is effective as of January 1, 2025. 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 Benefits Guide, which is incorporated by reference in this document, and, with this document, together comprise the Plan document and summary plan description. In the event of any conflict between the Enhanced Benefits Guide and this document, the Enhanced Benefits Guide shall control. From time to time, the Fund's Trustees may amend the Plan, the details of which will be set forth in this Summary Plan Description or in another written document. Should that occur, the Fund will advise 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 their specific designee or successor.**
RELIANCE UPON INFORMATION FROM ANY OTHER SOURCE IS AT YOUR OWN RISK

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

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

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

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www.teamsterfunds.com

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INTRODUCTION

The Board of Trustees (referred to hereinafter as "Trustees") of the Teamsters Health and Welfare Fund of Philadelphia and Vicinity is pleased to offer you this combined Plan Document and Summary Plan Description ("SPD"). Because the Plan's terms are complex, it is important that you take the time to acquaint yourself with its provisions.

Only the Trustees are authorized to interpret the Plan. No Employer or Union, nor any representative of any Employer or Union, acting in that capacity, is authorized to interpret the Plan's governing documents. No Employer or Union, nor any representative of any Employer or Union, acting in that capacity, can act as an agent for the Board of Trustees.

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. Dental benefits;
4. Short-term disability benefits;
5. Vision benefits; and
6. 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 SPD or in the Enhanced Benefits Guide. You can find an updated list of the applicable administrators, vendors, and insurers in the Enhanced Benefits Guide.

The "Dual Option" Medical Program, the Dental PPO, Vision PPO, and the 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. If you do not act concerned, they may overestimate the fees for the services provided to you;
- Using in-network Providers as much as possible;
- 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; and
- Taking advantage of the services offered through the Fund's Disease Management program.

Take the time to read the material in this SPD 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 personnel who are well versed in the Fund's plans, and ready to assist you with your questions and benefit inquiries.

The Plan may be amended in the future by the Trustees. Under the Fund's governing documents, the Trustees have the right to modify or eliminate any benefits provided under this Plan. Notice of any such amendments to the Plan will be provided to you in accordance with the requirements of ERISA. If you have any questions about amendments to the Plan made by the Board of Trustees after the publication of this SPD, write or call the Fund Office.

The address for the Fund Office is:

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY - SUMMARY PLAN DESCRIPTION

Teamsters Health and Welfare Fund of Philadelphia and Vicinity

2500 McClellan Avenue, Suite 140

Pennsauken, NJ 08109

The telephone numbers of the Fund Office are:

(856) 382-2400 or (800) 523-2846 - Toll Free

Fax: (856) 382-2402

When words and terms are capitalized in this SPD, it indicates that they have been given a special meaning for the purpose of the SPD. These terms are defined in detail in the [General Provisions and Definitions section of this document](#).

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.

ELIGIBILITY PROVISIONS

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

There are two ways that you¹ can become eligible to receive Fund benefits, both of which depend upon both the terms of the Collective Bargaining Agreement between your union and your Employer, and the Fund's requirements.

If the terms of the Collective Bargaining Agreement require your Employer to contribute to the Fund on your behalf on the fifth or tenth day of a month, you will be eligible for benefits during the month in which the premium is due and paid by your Employer. This is called "same month eligibility."

If you have twelve or more months' employment with an Employer that makes monthly premium contributions and you do not have sufficient days contributed in a month in which a claim is Incurred, you will continue to be eligible for benefits if you have at least 180 days' employment with the Employer during the previous twelve-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 qualifying schedule below 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.

B. 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:

1. Your Spouse.
2. Your children who have not reached the age of 26, which include your natural, adopted, or stepchildren or a child for whom a Member is appointed legal guardian by a court decree.
3. Your unmarried child who is physically or mentally incapable of self-support and 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 the continuing nature of the child's disability and status as your tax dependent on an annual basis.

¹ The words "you" and "your" in this Summary Plan Description refer to Members, generally, and, as applicable, their Dependents.

When a Member and their Spouse are both covered by the Fund as eligible Members, Fund Deductibles, coinsurance, and copayments will not apply. Beyond that, payment will be determined based upon Fund allowances 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 SPD are limited to you, the employee. Contact the Fund if you are unsure as to your status as a "Family" or "Single" employee. If you are classified as a "Single" employee, r your Spouse or children are not eligible for coverage under the Fund, even if they meet the definition of "Dependent."

C. HOW DOES A MEMBER OR DEPENDENT LOSE THEIR ELIGIBILITY FOR FUND BENEFITS?

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

1. Loss of Participant Eligibility

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

- 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 3 and do not qualify for the Extension of Benefits provisions on page 5;
- When you cease to be a member of a class of employees covered by a Collective Bargaining Agreement between a Contributing Employer and a Participating Local Union, or otherwise no longer qualify as a Member as defined herein, (except that, if you leave covered employment or if the Fund determines that your Contributing Employer is not required to make contributions to the Fund on your behalf, you may continue to exhaust earned eligibility credits for a period not to exceed two months;
- 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;
- With respect to a benefit offered under the Fund, when the such benefit program is terminated; or
- 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, except as set forth above.

2. Loss of Dependent Eligibility

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

- When the Member's eligibility terminates; or
- When a Dependent ceases to meet the eligibility requirements to be a Dependent, as set forth in this document.

A SPECIAL 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, marriage or birth certificate, court decree, or other necessary documents in order to establish proof of eligibility 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.

If a Member commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage or obtaining benefits under the Plan, including but not limited to failing to notify the Fund office that they or any of their covered Dependents have become or are otherwise ineligible for coverage, then the Fund may either terminate coverage for the Member

and/or covered Dependents retroactively, may terminate coverage as of a date to be determined at the Fund's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

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

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

1. The Fund's Extension of Benefits Provisions

Should a Member lose eligibility because they have fewer than the required number of contribution days to their credit as set forth on page 3, then medical and dental expenses Incurred after the Member or their Dependent, as applicable, 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:

- The current Actual Charges are related to a diagnosis which was initially treated while the patient was eligible for benefits, and
- 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.

2. 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 to continue such coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, known as "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 plus an administrative fee. 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 federal law. 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:

- You leave employment with an Employer for reasons other than gross misconduct on your part; or
- 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:

- You die;
- You leave employment (other than for gross misconduct) or your work hours are reduced, as described above;
- You become divorced; or
- You become entitled to Medicare.

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

- You die;
- You leave employment (other than for gross misconduct) or your work hours are reduced, as described above;
- You become divorced;
- You become entitled to Medicare; or

- 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 a child's eligibility, or a second qualifying event (as described below). The Fund Administrator will contact you within 14 days of the date your Employer advises us of your loss of employment or reduction in hour, the death of the employee, or the employee becoming covered under Medicare. 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 their coverage under COBRA.

Once the Fund Administrator is notified of an event that affects the coverage of a Qualified Beneficiary, the Fund Administrator will notify the Qualified Beneficiary that they have the right to choose continuation coverage. The Qualified Beneficiary then has at least 60 days from later of the date they would lose coverage or the date that they receive the Fund Administrator's notice to let the Fund Administrator know that they want to continue coverage. The Qualified Beneficiary forever loses their right to continue group health coverage under the Plan if they do not choose continuation coverage by timely informing the Fund Administrator. If they do choose it, they can continue the same group health coverage they were receiving the day before they lost coverage. Each Qualified Beneficiary can make a separate choice to continue coverage. However, the employee can make an effective election to continue coverage for their Spouse and children, and the Spouse can make an election to continue coverage for their children. 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 your work hours are reduced, 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:

- The Fund no longer provides group health coverage for any employee;
- You do not pay the required premium in a timely fashion;
- You become covered by another group health plan (for example, through your or your Spouse's employment) that does not contain any exclusion or limitation with respect to a pre-existing medical condition that is applied by the plan;
- You become eligible for Medicare after electing COBRA coverage; or
- You are divorced, subsequently remarry, and are covered under your new Spouse's group health plan.

a. Cost of COBRA Coverage

Each Qualified Beneficiary is generally required to pay the entire cost of COBRA coverage. The amount a Qualified Beneficiary is required to pay cannot exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost of 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, but not more than annually, during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

b. Special Rule for Second Qualifying Events

If you are a Spouse or Dependent of a Member and elect continuation coverage following a termination of the Member's 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.

c. Special Rule for Medicare Recipients

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of 1) the month after your employment ends; or 2) the month after group health plan coverage based on current employment ends. If you

don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty, and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of your COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

d. 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 individual's 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.

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

e. Continuation Rights Related to Military Service

USERRA Leaves

Eligible members who go on military leave in the uniformed service may have a separate right under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") to continue medical, prescription drug, dental, and vision care benefits through the Fund for yourself and your covered dependents. "Uniformed service" means the performance of active duty in the uniformed services under competent authority. It includes training, full-time National Guard duty, and the time needed for an examination to determine the participant's fitness for duty. 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.** The three options that you have are:

- You may suspend your eligibility beginning with the first full month following deployment. Under this option, you and your Dependents will have your benefits suspended during your military leave. Upon your return, your and your Dependents' benefits will be reinstated provided that you have sufficient banked eligibility from the period prior to your military leave. 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 such coverage until you have a sufficient work history to be eligible for benefits.
- You may run out your eligibility using the 12-month lookback procedure described on page 3 and to suspend your eligibility thereafter. Your coverage will continue until such time as you no longer have sufficient banked eligibility. At such time you may either suspend your benefits until you return from leave of pay for coverage as described below. Upon your return, you will still be eligible for immediate reinstatement in the Fund, but you will be required to pay for such coverage until you have a sufficient work history to be eligible for benefits. This option is the default if the Fund does not learn of the leave until after your leave begins.
- You may elect to save your banked eligibility during the period of military duty but to continue your and your Dependents' by paying for them as described below. Upon your return, your and your Dependents' benefits will be reinstated provided that you have sufficient banked eligibility from the period prior to your military leave. 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 such coverage until you have a sufficient work history to be eligible for benefits.

If you believe you are entitled to continuation of Plan coverage pursuant to USERRA or have any questions regarding this coverage, you should notify the Fund Office.

Continuation of Plan Coverage While on Military Leave

If you are on active military duty for 31 days or less, you and your covered dependents may continue to receive health care coverage during your leave at no cost to you. If you are on active duty for more than 31 days, you may continue coverage for you and your dependents at 100% of the cost

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to the Fund of group coverage (plus a 2% administrative fee) for up to 24 months starting on the day your military leave of absence begins. In these circumstances you may also have the right to continue coverage through COBRA.

Under USERRA an active employee is required to notify the employer (in writing or orally) that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your employer is required to notify the Fund within 30 days after you are reemployed following military service; however, it is a good idea for you to notify the Fund Office, too.

Paying for USERRA Coverage While on Military Leave

If you are required to pay for USERRA coverage, you must do so on a monthly basis. The cost of coverage in the same manner as it determines the cost for COBRA coverage. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if you had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due, starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If you timely elect and pay for USERRA coverage, coverage will be provided retroactive to the date of your departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If you do not pay the full payment by each due date (or within the 30-day grace period), you will lose all USERRA coverage, and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is your responsibility to make timely payments. The Fund will not send notice that payment is due or that it is late, or that USERRA coverage is about to be terminated due to a late or missed payment.

Eligibility for Plan Coverage upon Returning from Military Leave

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility will be reinstated on the day you return to employment with a Contributing Employer, provided that you return to employment within:

- 90 days from the date of discharge if the period of service was more than 180 days;
- 14 days from the date of discharge if the period of service was at least 31 days, but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an Injury caused by active duty, these time limits are extended up to two years.

If you meet the Plan's eligibility requirements at the time you entered the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan upon return from uniformed service, as required under USERRA.



ATTENTION!

Each of the above options 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.

HOW THE FUND'S MEDICAL PROGRAM WORKS

The Medical Program is self-insured, which means that Fund medical benefits are paid out of a trust fund that is funded through the contributions of all of the Fund's participating employers for the benefit of the Fund's Members and beneficiaries, subject to the terms and conditions of this SPD. The Medical Program has been designed to offer a cost-effective, but comprehensive plan of benefits that helps keep its Members and beneficiaries healthy through disease management and providing access to a broad network of medical Providers and facilities.

The Fund also provides Prescription drug coverage dental, and vision benefits to Fund participants and beneficiaries. These benefits are not part of the Medical Program. They are separate benefits that are discussed elsewhere in this SPD and the Enhanced Benefits Guide.

A. HOW THE MEDICAL PROGRAM WORKS

Under the Medical Program, your benefits are subject to a Deductible, copayments, 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 expenses 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.

1. Deductibles, Coinsurance, Copayments, and the Out-of-Pocket Limit

The specific Deductibles, copayments, 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. A "copayment" 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 copayments. 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 copayments, balanced billed charges, any penalties, or health care the Fund does not cover.

2. In-Network Versus Out-of-Network Care

An in-network 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 in-network Provider may not bill you for any charges in excess of the applicable copayment, 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 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 may not pay the full cost for many out-of-network Providers' services, and you may be responsible for the balance of those charges in addition to the applicable 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 out-of-network Provider, except as described below under "Continuing Care When an In-Network Provider Leaves the Network."

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, the allowable charge for such services is the Plan's in-network allowable charge for such expenses or the billed charges, whichever is lower.

IN-NETWORK PROVIDER EXAMPLE: Bill goes to Dr. Smith, an in-network Provider, because they think they have the flu. Bill has a \$30 copayment 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 they have received from Bill and the Fund as payment in full for the services rendered.

OUT-OF-NETWORK PROVIDER EXAMPLE: Maria goes to Dr. Jones, an out-of-network Provider, because they think they have 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 their 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.

3. Continuing Care When an In-Network Provider Leaves the Network

The No Surprises Act protects Continuing Care Patients who are in the process of receiving certain on-going courses of treatment from an in-network Provider and whose in-network Provider leaves or is terminated from the network during the patients' course of treatment.

If you are a Continuing Care Patient, the Fund will:

- a. Notify you that the change in the network status of the Provider and explain your right to elect continued transitional care from the Provider; and
- b. Allow you up to 90 days of continued coverage with benefits paid on the same terms and conditions as if the Provider had remained in the network in order to allow time for you to complete your course of treatment or transition your care to an in-network Provider.

4. Out-of-Network Providers and the No Surprises Act

The No Surprises Act protects you from unexpected, out-of-network balance bills when you receive specified services from out-of-network Providers: Emergency Care, non-Emergency Care provided by out-of-network Providers at in-network facilities, and air ambulance services. Claims for services where No Surprises Act protections apply are hereinafter referred to as "NSA Claims."

- a. *Emergency Care:* Emergency Care provided by an out-of-network Provider or in an out-of-network Hospital Emergency Room or Outpatient Emergency Facility will be covered at the same coinsurance percentage and copayment requirement that would apply if the Emergency Care had been furnished by an in-network Provider. Any coinsurance payments you make with respect to covered non-Emergency Care will count toward your in-network Deductible and in-network out-of-pocket Maximum in the same manner as those received from an in-network Provider. The Fund will pay the out-of-network Facility Provider or Emergency Room the in-network rate for the Emergency Care, less your cost-sharing amounts. The out-of-network Facility Provider or Emergency Room is prohibited from balance billing you for amounts that exceed your cost-sharing responsibility until after you have been stabilized (and even then, you can only be balance billed in certain limited circumstances and with your consent).

OUT-OF-NETWORK EMERGENCY ROOM EXAMPLE: Jessie goes to the Emergency Room at the Springfield Hospital, an out-of-network Facility Provider, because they fell on vacation and twisted their ankle. Springfield bills the Fund \$600 for the visit and services provided. The Fund's allowable charge for the visit and services is \$500. Because the services were for Emergency Care, there is no applicable Deductible. The Fund will pay \$400 for the visit and services, and Jessie will pay the Emergency Room copayment of \$100. Springfield Hospital will not be able to balance bill Jessie for the remaining \$100 they originally billed.

- b. *Non-Emergency Care from Out-of-Network Providers at In-Network Facility Providers:* Similar to Emergency Care, non-Emergency Care or items you receive from an out-of-network Provider working at an in-network Facility Provider will be covered at the same coinsurance percentage and/or copayment requirement that would apply if the care or items had been furnished by an in-network Provider. The Fund will pay the out-of-network Provider the in-network rate for the services you receive, less your cost-sharing amounts, and the out-of-network Provider is generally prohibited from balance billing you for charges that exceed your cost-sharing obligations. Any cost-sharing payments you make with respect to covered non-Emergency Care will count toward your in-network Deductible and out-of-pocket Maximum in the same manner as those received from an in-network Provider.

An exception applies with respect to certain out-of-network Providers who have provided timely notice to the patient and received informed consent to bill the patient for out-of-network services in compliance with the No Surprises Act. The notice must be provided at least 72 hours before the day of the appointment (or three hours in advance of services rendered in the case of a same-day appointment) and include the following:

- Notification that the Provider is an out-of-network Provider;

- Notification of the good faith estimated amount that the Provider may charge for treatment, including a notification that the provision of such estimate or consent to be treated does not constitute a contract with respect to the estimated charges;
- A statement that prior authorization or other care management limitations may be required in advance of receiving such treatment at the Facility Provider; and
- A clear statement that consent to receive such items and services from the out-of-network Provider is optional and that you may instead seek care from an available in-network Provider, and that in such cases your cost-sharing responsibility will not exceed the responsibility that would apply with respect to such treatment that is furnished by a Network Provider.

If notice is required in connection with post-stabilization services being furnished by an out-of-network Provider at an in-network Emergency Room, such notice must also include the names of any in-network Providers at the facility who are able to treat you and explain your option to elect to be referred to one of those available in-network Providers.

If the patient properly consents prior to the receipt of services and the exception applies, the applicable out-of-network coinsurance, the out-of-network Deductible and out-of-pocket Maximum will apply.

This notice and consent exception does not apply to any of the following ancillary services:

- Items and services related to
 - Emergency Care,
 - Anesthesiology,
 - Pathology,
 - Radiology, or
 - Neonatology;
- Items and services provided by assistant surgeons, hospitalists, or intensivists;
- Diagnostic services such as radiology and laboratory services;
- Items and services provided by an out-of-network Provider when there is no in-network Provider available; or
- Items or services required as a result of unforeseen, urgent medical needs that arise when the item or service is furnished, regardless of whether the out-of-network Provider has previously provided notice and received consent for the original treatment.

OUT-OF-NETWORK CARE AT AN IN-NETWORK FACILITY PROVIDER EXAMPLE: Dave, the 16-year-old of Sam, takes a bad fall. Dave hurts their shoulder and has a bad gash on their face. Sam takes Dave to In-Network Memorial Hospital. After Dave is stabilized, the attending Physician determines that Dave needs Surgery to repair a torn rotator cuff, which is not Emergency Care. While the orthopedic surgeon who performs the shoulder Surgery is an in-network Physician, the anesthesiologist is an out-of-network Provider. Anesthesiology services are NSA Claims. Once Sam pays any applicable Deductible, copayment and coinsurance, there will be no further payment responsibility with respect to the anesthesiologist.

Soon after, Sam and Dave decide to get Dave plastic Surgery to minimize the scarring that occurred as a result of the accidental injuries to their face. Although in-network plastic surgeons are available, Sam and Dave decide that they would rather use a uniquely skilled plastic surgeon who can operate at In-Network Memorial Hospital but who is an out-of-network Provider. When the procedure is scheduled, the Provider provides Sam proper notice and Sam consents. Sam will be responsible for the out-of-network Provider's fee in excess of Sam's cost-sharing responsibilities and the payment the Fund will make.

- c. *Air Ambulance Services:* Out-of-network air ambulance services will be covered with the same coinsurance percentage and/or copayment requirement that would apply if the care or items had been furnished by an in-network air ambulance Provider. The Fund will pay the air ambulance Provider the in-network rate, less your cost-sharing amounts, and the out-of-network air ambulance Provider is generally prohibited from balance billing you for charges that exceed your cost-sharing obligations. Any cost-sharing payments you make with respect to covered air ambulance Services will count toward your in-network Deductible and out-of-pocket Maximum in the same manner as those received from an in-network air ambulance Provider.

5. 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:

- a. Women may receive an annual mammogram with no out-of-pocket expense to them (additional screenings are subject to Deductibles and coinsurance);
- b. Women receive an annual routine gynecological examination with no out-of-pocket expense (additional examinations are subject to Deductibles and coinsurance);
- c. 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);
- d. Pediatric immunizations are covered with no out-of-pocket expense; and
- e. Certain other benefits are discussed in the "Your Medical Benefits" section.

YOUR MEDICAL BENEFITS

This section of the SPD describes the benefits provided under the Medical Program. Prescription drug benefits are not covered under the Medical Program. The prescription drug benefits are described in the section entitled "The Fund's Prescription Drug Program."

A. 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 Professional Provider. Payment allowances for Covered Services and any Pre-Certification and cost-sharing requirements are specified in the Summary of Benefits Schedule.

Preventive Care services generally describe health care services intended to detect 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. Preventive Care is generally available to Covered Persons at no out-of-pocket cost.

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 so that the Preventive Care services provided under the Plan comply with the requirements of the Affordable Care Act. Accordingly, the frequency and cost-sharing requirements of Covered Care 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.

1. 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 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.

2. Pediatric Preventive Care

Pediatric Preventive Care services are provided with no cost-sharing for the patient, as currently required by the Affordable Care Act, and include the following:

- a. **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.
- b. **Blood Lead Screening.** This blood test detects elevated lead levels in the blood.
- c. **Hemoglobin/Hematocrit.** This blood test measures the size, shape, number, and content of red blood cells.
- d. **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 covered when it is unsure whether the child has ever been immunized. Children are covered for one test and immunization between eleven and 17 years of age.
- e. **Urinalysis.** This test detects numerous abnormalities.

3. Pediatric Immunizations

Coverage will be provided for those pediatric immunizations, including the immunizing agents, which 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.

4. Adult Preventive Care

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

- a. **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.
- b. **Adult Tetanus Toxoid (TD).** This immunization provides immunity against tetanus and diphtheria.
- c. **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.
- d. **Complete Blood Count (CBC).** This blood test checks the red and white blood cell levels, hemoglobin, and hematocrit.
- e. **Fecal Occult Blood Test.** This test checks for the presence of blood in the feces which is an early indicator of colorectal cancer.
- f. **Flexible Sigmoidoscopy.** This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope.
- g. **Influenza Vaccine.** This vaccine provides immunization against influenza type A and B viruses.
- h. **Pneumococcal Vaccine.** This vaccine provides immunization against pneumococcal disease. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis.
- i. **Prostate Specific Antigen (PSA).** This blood test may be used to detect tumors of the prostate.
- j. **Routine Colonoscopy.** This test detects colorectal cancer by use of a flexible fiberoptic colonoscope.
- k. **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 covered when it is unsure whether the adult has ever been immunized.
- l. **Thyroid Function Test.** This test detects hyperthyroidism and hypothyroidism.
- m. **Urinalysis.** This test detects numerous abnormalities.
- n. **Varicella Vaccine.** This vaccine is covered for women of childbearing age who have not been previously exposed to the chicken pox virus.
- o. **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 minerals 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.
- p. **Fasting Blood Glucose Test.** This test is used for detection of diabetes.
- q. **Abdominal Aortic Aneurysm Screening.** One test per lifetime is covered for men with a smoking history.

5. Routine Gynecological Examination, Pap Smear

Covered Persons may receive 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.

6. Mammograms

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

7. High Risk Immunizations

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

8. Therapeutic Injections

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

9. Allergy Injections

Benefits are provided for allergy extracts and allergy injections. Covered Service

10. COVID-19 Tests and Vaccinations

COVID-19 Diagnostic Testing: The Fund covers COVID-19-related diagnostic tests performed by Providers or Facility Providers at the standard Diagnostic Services cost-share. No pre-authorization is required in order to receive such services. COVID-19 tests that are not used for diagnostic purposes (such as back-to-work or general screening tests) are not covered.

COVID-19 Vaccinations: The Fund covers vaccinations and boosters for COVID-19 as Preventive Care, with no cost-share to a Covered Person.

11. No Limits Based on Preexisting Conditions

The Medical Program does not exclude or limit Covered Services based on pre-existing conditions. Generally, a pre-existing condition is a medical condition that was diagnosed or treated before a person's medical coverage went into effect.

Some Covered Services under the Medical Program may have coverage limits, but plan benefit limits will not be based on a pre-existing condition, including fertility treatment and bariatric Surgery, if applicable. If you have questions about any of your benefits, call the Fund Office.

B. 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.

The Claims Administrator must Pre-Certify all Inpatient admissions, other than Emergency admissions. The Claims Administrator will Pre-Certify admissions in accordance with the requirements contained in the Managed Care section of this SPD. 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.

1. Hospital Services

a. 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:

- 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;
- Private room, when Medically Appropriate/Medically Necessary;
- 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 appropriate level of care for a critically ill patient;
- A bed in a general ward; and
- 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 is counted. If a Covered Person is admitted and discharged on the same day, it is counted as one day.

Days available under this coverage are allowed only during uninterrupted stays in a Hospital. Benefits are not provided: (1) during the absence of a Covered Person who interrupts their 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.

b. 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:

- Meals, including special meals or dietary services as required by the patient's condition;
- Use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
- Casts, surgical dressings, and supplies, devices, or appliances surgically inserted within the body;
- Oxygen and oxygen Therapy;
- 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;
- Anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
- 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;
- Radiation Therapy;
- Chemotherapy;
- 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;
- Use of Special Care Units, including but not limited to, Intensive or Coronary Care; and
- 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.

2. Medical Care

Benefits for Medical Care are payable when such care is 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.

a. Concurrent Care

Concurrent Care includes 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 a 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.

b. Consultations

Consultation services are payable 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 required by the Facility Provider's rules and regulations. Benefits are limited to one consultation per consultant during any inpatient confinement.

3. Skilled Nursing Facility

Benefits are provided for a Skilled Nursing Facility, when Medically Appropriate/Medically Necessary, up to the Maximum days specified in the Summary of Benefits Schedule. A 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 occurring in a Skilled Nursing Facility are payable as shown in the Summary of Benefits Schedule.

No benefits are payable:

- When confinement in a Skilled Nursing Facility is intended solely to assist a Covered Person with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person; or
- After a Covered Person has reached the Maximum level of recovery possible for their particular condition and no longer requires definitive treatment other than routine Custodial Care.

a. 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.

4. Blood

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

Benefits are 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.

5. Hospice Services

When a 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 will be eligible for Hospice benefits. Hospice Care is primarily comfort care, including pain relief, physical care, Counseling, and other services that 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. Benefits for Hospice Services are provided until the earlier of the Covered Person's death or discharge from Hospice Care.

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.

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

- Services and supplies for which there is no charge;
- Research studies directed to life-lengthening methods of treatment;
- Services or expenses related to a Covered Person's personal, legal, and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property);
- Care provided by Family Members, relatives, or friends; and
- Private Duty Nursing care.

6. Maternity / OB-GYN / Family Services

a. Maternity Care/Obstetrical Care

Services rendered in the care and management of a pregnancy are 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.

b. 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 or Dependents 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.

7. Behavioral Health Services

The Plan covers treatment for Behavioral Health conditions. A Covered Person may receive covered treatment as an Inpatient in a Hospital or a substance use disorder center. A Covered Person may also receive covered treatment at a Hospital or a substance use disorders center, or from any Professional Provider.

The benefits for the covered treatment of Behavioral Health conditions are provided on the same basis and subject to the same terms and conditions as for other illnesses.

8. Autism Services

This Plan provides coverage for charges for the screening and diagnosis of autism. If a Covered Person's primary diagnosis is autism, and regardless of anything in the Plan to the contrary, the Plan provides coverage when: (i) the services are for the Medically Appropriate/Medically Necessary Therapy Services described below:

- Occupational Therapy needed to develop the Covered Person's ability to perform the ordinary tasks of daily living;
- Physical Therapy needed to develop the Covered Person's physical functions; and
- Speech Therapy needed to treat the Covered Person's speech impairment.

Notwithstanding anything in the Plan to the contrary, the foregoing Therapy Services will not be subject to benefit visit maximums.

Also, if a Covered Person's primary diagnosis is autism, in addition to coverage for certain Therapy Services, as described above, the Plan also covers Medically Appropriate/Medically Necessary: (a) Behavioral Interventions Based on Applied Behavioral Analysis; and (b) Related Structured Behavioral Plans.

Benefits for these services are payable on the same basis as for other conditions, and they are available under this provision whether or not the services are restorative. Benefits for the above Therapy Services available pursuant to this provision are payable separately from those payable for other conditions and will not operate to reduce the Therapy Services benefits available under the Plan for those other conditions.

9. 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 include routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

a. 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 a 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.

b. Oral Surgery

Benefits will be payable for Covered Services provided for:

- 1) 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:
 - The initial treatment of Accidental Injury/trauma (e.g., fractured facial bones and fractured jaws), in order to restore proper function;
 - In cases where it is documented that a severe congenital defect (e.g., cleft palate) results in speech difficulties that have not responded to non-surgical interventions; and
 - 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.
- 2) Other Surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Benefits will be provided only for:
 - Surgical removal of impacted teeth which are completely covered by bone.
 - The surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and
 - Surgical removal of teeth prior to cardiac Surgery, radiation Therapy, or organ transplantation.

c. Assistant at Surgery

Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery are covered only when the condition of the Covered Person or the type of Surgery requires 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 performs and bills for another surgical procedure during the same operative session.

The 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.

d. Anesthesia

Administration of Anesthesia is payable 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.

e. Second Surgical Opinion (Voluntary)

Consultations for Surgery by a Professional Provider to determine whether an elective surgical procedure is Medically Appropriate/Medically Necessary are covered.

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 covered only in cases when the second opinion disagrees with the first recommendation.

f. Outpatient Benefits

A Covered Person is entitled to benefits for Covered Services on an Outpatient basis when deemed appropriate 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.

10. 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 that are beyond the Experimental or Investigative stage and that are Medically Appropriate/Medically Necessary.

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

When both the recipient and the donor are Covered Persons, each is entitled to the benefits under this provision. Benefits for the donor will be charged against the recipient's coverage. When only the recipient is a Covered Person, only the recipient is entitled to benefits under this provision. When only the donor is a Covered Person, the donor is not entitled to benefits under this provision. 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.

11. Ambulance

Ambulance services, which are Medically Appropriate/Medically Necessary, 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 a Covered Person:
 - From the Covered Person's Home or the scene of an accident or Emergency to the nearest Hospital;
 - Between an Hospital and a Skilled Nursing Facility or between Hospitals;
 - 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; and
 - Air or sea ambulance transportation benefits are payable only if Medically Appropriate/Medically Necessary.

12. 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 for a Covered Person under the following conditions:

- 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;
- The Covered Person has the ability to communicate (verbally or non-verbally) their needs, the ability to consistently follow directions, and the ability to manage their own behavior with minimal to moderate intervention by professional staff;
- The Covered Person is willing to participate in a Day Rehabilitation Program; and
- The Covered Person's family are able to provide adequate support and assistance in the Home and demonstrate the ability to continue the rehabilitation program in the Home.

13. Diabetic Equipment and Supplies

Benefits are provided for diabetic equipment and supplies, 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.

a. Diabetic Equipment

Pre-Certification is required for the purchase of diabetic equipment that exceeds \$1,000. The applicable Deductible, Copayment and/or Coinsurance amounts will apply to this benefit. Diabetic equipment includes the following:

- Blood glucose monitors;
- Insulin pumps;
- Insulin infusion devices; and
- Orthotics and podiatric appliances for the prevention of complications associated with diabetes.

b. Diabetic Supplies

Insulin, oral agents, and other diabetic supplies are covered under the Fund's free-standing Prescription Drug Program and not under the Medical Program.

14. Diagnostic Services

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

- Diagnostic X-ray, consisting of radiology, ultrasound, and nuclear medicine;
- Diagnostic laboratory and pathology tests.
- Diagnostic medical procedures consisting of ECG, EEG, and other diagnostic medical procedures that the Claims Administrator approves; and
- Allergy testing, consisting of percutaneous, intracutaneous, or patch tests.

See the Enhanced Benefits Guide for information on certain Diagnostic Services that require Pre-Certification.

15. 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 Medically Appropriate/Medically Necessary.

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 SPD, includes equipment that meet the following criteria:

- It is durable and 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.”
- It customarily and primarily serves a medical purpose.
- 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.
- It is appropriate for Home use.

a. Exclusions

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

- Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps;
- Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants;
- Equipment inappropriate for Home or personal use. These include equipment that generally requires professional supervision for proper operation, such as diathermy machines, medcolator, pulse tachometer, data transmission devices used for telemedicine purposes, translift chairs, or traction units;
- Non-reusable supplies, other than those that are an integral part of the Durable Medical Equipment or required for its function. This exclusion covers equipment that (i) is not durable or (ii) is not a component of the Durable Medical Equipment. 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;
- 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 packs, 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.
- 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.
- Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider;
- Services not primarily billed for by a Provider such as delivery, set-up, and the service, installation, and labor of rented or purchased equipment; and
- 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 Durable Medical Equipment, such as a wheelchair.

b. Replacement and Repair

The Claims Administrator will provide benefits for the replacement of Durable Medical Equipment: (a) when there has been a change in a 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.

16. Emergency Care Services

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

17. 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; and
- 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 after a vaginal delivery or 96 hours after 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 when Medically Appropriate/Medically Necessary.

a. 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.

18. Medical Foods and Nutritional Formulas

Benefits are 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.

19. Non-Surgical Dental Services

Benefits will be provided only for the initial treatment of Accidental Injury/trauma (e.g., 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, and 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.) Dental services not covered under the Medical Benefit may be covered under the Fund's Dental Benefit, described later in this SPD.

20. 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 Pre-Certified and Medically Appropriate/Medically Necessary.

Benefits are not payable for:

- Nursing care which is primarily custodial in nature, such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, or giving oral medication;
- 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; and
- Services provided by a Home health aide or a nurse's aide.

21. Prosthetics

The Fund covers 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 whether Medically Appropriate/Medically Necessary.

a. Breast Prosthesis

- The purchase, fitting, and 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;
- The supplies and replacement of parts necessary for the proper functioning of the prosthetic device; and
- 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:

- Post-mastectomy, four bras per calendar year are covered;

- Replacement of silicone breast prostheses are covered every two years; and
- Replacement of fabric, foam, or fiber-filled breast prostheses is covered every six months.

b. Eye Prosthesis

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

- Initial contact lenses prescribed for treatment of infantile glaucoma;
- Initial pinhole glasses prescribed for use after Surgery for detached retina;
- Initial corneal or scleral lenses prescribed (i) in connection with the treatment of keratoconus; or (ii) to reduce a corneal irregularity other than astigmatism;
- Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
- 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.

Benefits are not provided for:

- Lenses which do not require a Prescription;
- 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;
- Deluxe frames; and
- Eyeglass accessories, such as cases, cleaning solution and equipment.

c. Exclusions

Benefits are not payable for:

- Wigs (except for cranial prostheses for chemotherapy patients); or
- Eyeglasses except as specified above.

d. 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 a 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.

22. Restorative Services

Benefits are 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.

23. Specialist Office Visit

Benefits will be provided for Specialist Service Medical Care. Specialist 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.

24. Therapy Services

Benefits are provided under the Medical Program, 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 a Covered Person. Therapy services include:

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

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. Prescription drugs administered in an inpatient setting such as a Hospital are covered under the Medical Program as set forth in that portion is the SPD. These benefits are subject to a patient copayment 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.

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.

A. HOW THE PRESCRIPTION DRUG PROGRAM WORKS

The Fund has contracted with a pharmacy benefits manager (PBM), Capital Rx, to provide its Members and their covered Dependents with Prescription drug benefits. All Members and their Dependents should receive an Identification Card from Capital Rx in addition to their 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 copayment applied to your purchase(s). The amount of your copayment will depend on the type of Prescription you have filled. Additional information regarding the copayment amounts is set forth in the Prescription Drug Summary of Benefits Schedule below.

B. 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 copayment. 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 their 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 their medication from their Physician and uses the Fund's mail order program or fills the Prescription at their local retail pharmacy. Robert is charged one copayment for 90 days of medication, instead of one copayment every 30 days.

C. PRESCRIPTION DRUG PROGRAM 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:

- Vitamins (whether formulary or non-formulary);
- Cosmetics or other health and beauty aids;
- Bandages and similar supplies;
- Dietary aids;
- Support garments (other than compression stockings as provided in the benefits schedule);
- Other non-Prescription substances;
- Therapeutic devices and appliances;
- Drugs available over-the-counter, even if obtained with a Prescription;
- Drugs or compound drugs that have not been approved by the Federal Food and Drug Administration (FDA);
- Administration or injection of any drug;
- Hypodermic needles and syringes (except as otherwise provided herein); or

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- Any Prescription drug for which the prescribing Physician has prescribed outside of the dosage guidelines of the drug's manufacturer or the FDA, unless recommended by the fund's pharmacy benefit manager.

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, or Surgical programs, nor does it cover drugs otherwise provided for under any government program or law, or under any workmen's compensation or occupational disease law.

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. Most new-to-market medications are 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.

1. Specialty Medications

Specialty medications are often administered by injection or infusion 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. Capital Rx will work with you to reduce the cost of certain specialty drugs. Contact Capital Rx at 844-752-2779 for more information on this program.

2. 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.

D. PRESCRIPTION DRUG SUMMARY OF BENEFITS SCHEDULE

Type of Drug	Platinum Plan	Gold Plan
Tier 1 – Generic	\$5	\$10
Tier 2 - Formulary Non-Specialty Drugs (Preferred)	\$15	\$20
Tier 3 - Non-Formulary Non-Specialty Drugs (Non-Preferred)	50% of the Drug Cost \$30 Minimum, \$50 Maximum	50% of the Drug Cost \$40 Minimum, \$60 Maximum
Tier 4 - Specialty Drugs	\$100	\$150
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 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 at www.teamsterfunds.com. The dental benefit, like the medical benefit, is provided by both in-network and out-of-network Providers. See the Enhanced Benefits Guide for a full description of the Fund's Dental program.

A. IN-NETWORK VS. OUT-OF-NETWORK

1. 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, in general, no balance billing, unless a copayment applies to the service. You will, however, be responsible for services excluded from coverage, received when you are ineligible, 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.

2. Out-of-Network

The Fund's Maximum allowance for out-of-network dentists is that which is shown in the non-participating fee schedule. In most cases, you will have little to no out-of-pocket expense if you receive dental services at an in-network Provider. 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 or you receive treatment while you are ineligible. The non-participating dental fee schedule can be found in the Enhanced Benefits Guide or on the Fund's website.

B. BENEFITS PROVIDED

Benefits are payable only if you are Eligible at the time each procedure is performed.

1. Calendar Year Maximum

Per Person Family Member Calendar Year Maximum (excludes orthodontia)..... \$3,000

In compliance with the Affordable Care Act, this calendar year Maximum does not apply to Dependents under the age of 18.

2. 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 birth 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:

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\$100 per Case

For services rendered by an out-of-network Provider, see the dental fee schedule in the Enhanced Benefits Guide.

Special Rules for Orthodontia

Orthodontia is only covered for Dependents are 10 to 18.

If you receive orthodontia services at an in-network Provider, you are responsible for paying a \$100 copayment at the time the braces are placed. There is no copayment if you receive orthodontia services at an out-of-network Provider but you may be responsible to pay the difference between the Provider's billed charges and the Fund's allowance for such services.

The Fund will pay the covered amount over a 24-month period. The Fund will not make a payment for any periods that you are ineligible during that 24-month period, and you may be subject to balance billing for any such missed payments.

Special Rules for Dental Implant Procedures

The Dental Program does not cover the following services as part of standard dental benefits related to dental implant procedures:

- Implant abutment (Code 6057)
- Implant crown (Code 6059)
- Cone beam X-ray (Code D0364)

You may, however, be eligible for reimbursement for these services under the Dental Program as set forth below.

You may receive reimbursement under the Dental Program for out-of-pocket expenses that you incur for the implant abutment, crown, and cone beam X-ray, to the extent applicable.

- Reimbursement is subject to the availability of funds within the Covered Person's \$3,000 annual dental maximum.
- The Fund will review claims for reimbursement after the end of the plan year, once all other dental claims have been finalized.
- Claims for reimbursement will be paid no later than March 31 of the plan year following the plan year in which you submitted the claim.

You may receive reimbursement under the Dental Program for out-of-pocket expenses that you incur for the implant abutment, crown, and cone beam X-ray, to the extent applicable.

To be eligible for reimbursement, You must submit receipts no later than the end of the plan year after the plan year In which the claims were incurred. You must include the following with your submission:

- The date of service;
- The amount charged for each service
- The applicable Code for each service; and
- Documentation that is clearly identifiable as originating from the dental provider, such as an official invoice or statement on the provider's letterhead.

3. Dental Benefit Limitations

If you are in a motor vehicle 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 motor vehicle insurance policy. Also, the Fund has the right of subrogation when you are involved in any accident and where you recover any expenses that have been paid to you under this Plan from a third party.

No dental expense benefits are provided for the following:

- Routine dental examinations performed more frequently than once in any six consecutive month period;
- Prophylaxis (cleaning of teeth) more often than once during any six-month period;

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- Work in making dentures, bridges, implants, or crowns started prior to the effective date of coverage;
- Expenses for more than one denture, either full or partial, or for any bridge or crown within any five-year period;
- Treatment by other than a licensed dentist, except charges for dental prophylaxis (cleaning of teeth) under the direction of a licensed dentist; or
- Orthodontic care for an individual under the age of 10 or over the age of 18.

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:

- You anticipate that orthodontia will be required;
- You are requesting coverage for occlusal guards;
- Periodontal Care; and
- Temporomandibular Joint Disorders.

THE FUND'S VISION CARE PROGRAM

A. GENERAL INFORMATION

The Fund's vision care benefit 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.

Eye Examination (One Every Twelve 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

B. LIMITATIONS

Lenticular Lenses are covered only when they are prescribed in connection with cataract Surgery. A 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.

THE FUND'S DISABILITY BENEFITS PROGRAM

A. 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 the Fund Office's 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 for the injury or illness for which you are receiving disability benefits.

Successive periods of disability will be considered a single period of disability unless the cause of the subsequent period is entirely unrelated to the prior accident or disease, or unless the prior and subsequent periods are separated by a period of 30 or more calendar days of active employment.

Disability benefits are available to Members only. In addition to the required weekly disability claim form, the Fund Office must receive a continuation form every four weeks, regardless of the length of disability estimated by the treating Provider. These forms are available from the Fund, or on the Fund's website at www.teamstersfunds.com.

B. 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, to be eligible for this benefit, you cannot be earning wages from your Employer. **Third**, your weekly disability benefit will be reduced by any short-term disability or wage loss benefit payable to you under any applicable motor vehicle 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 that is a 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.

C. SUMMARY OF BENEFITS

Weekly disability benefits are \$50 per workday up to \$250 per week.

If, however, you work for a New Jersey Employer subject to the New Jersey Temporary Disability Law, you will receive a benefit under the Disability Benefit Program 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.

THE FUND'S LIFE INSURANCE PROGRAM

A. HOW THE LIFE INSURANCE PROGRAM WORKS

The Fund maintains a life insurance program for your benefit and your beneficiaries' benefit in the event of your or your 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. This benefit is insured by Dearborn.

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 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 shown in the life insurance Summary of Benefits Schedule. Additional details regarding the Fund's life insurance benefits can be 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.

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

If, while employed by a Contributing Employer, you become Totally Disabled, your beneficiary of record is eligible for a life insurance benefit upon your death as set forth below:

1. You must provide the Fund with written proof, satisfactory to the Trustees, that you are Totally Disabled. THIS WRITTEN PROOF MUST BE PROVIDED TO THE FUND WITHIN SIX MONTHS OF THE DATE ON WHICH YOU FIRST RECEIVED ORAL OR WRITTEN NOTICE FROM THE SOCIAL SECURITY ADMINISTRATION, A PHYSICIAN, A HEALTH PROVIDER, OR ANY OTHER SOURCE THAT YOU ARE TOTALLY DISABLED. Contact the Fund office for this special form.
2. During the last three months of each subsequent year that you remain Totally Disabled, you must further provide the Fund sufficient written proof of your continuing disability. The Fund will provide you with a form that you must use to submit this proof.
3. If you die before the expiration of the six-month period set forth in paragraph 1, above, your beneficiary of record can provide written proof, within one year of your death and satisfactory to the Trustees, that you remained Totally Disabled from the onset of the total disability through the date of your death.
4. This benefit is for Members only and does not apply in the event of your Spouse's or other Dependent's disability.
5. This benefit terminates upon you 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 not later than 90 days after you file the application with the Social Security Administration.

C. BENEFICIARIES

Each Member has the sole right to designate the beneficiary to whom their 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 their 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 they die and has not specified the beneficiaries' respective interests, the beneficiaries all share equally. If any beneficiary dies before the Member, the deceased beneficiary's rights and interest automatically terminate.

If a designated beneficiary does not file a claim for the life insurance benefit within one year of the date that the Fund learns of the Member's death, and if the whereabouts of this designated beneficiary are unknown, the Fund will insert an advertisement in a newspaper of general circulation in the beneficiary's last known place of residence maintained in the Fund's records, to the effect that if the designated beneficiary does

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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 if the beneficiary they named is no longer living or fails to file a timely life insurance claim as described above, 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.

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.

D. BENEFITS

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

Death of Member	\$20,000
Death of Member upon Total Disability.....	\$3,000
Death of Spouse	\$1,500
Death of Dependent Child:	
Over 14 Days, but Less Than Six Months Old.....	\$300
Six Months, but Less Than Two Years Old	\$600
Two Years, but Less Than Three Years Old	\$1,200
Three Years or Older	\$1,500

In addition, the Fund provides a retiree death benefit for former participants in the Fund and their Spouses. 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 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:

Death of Member	\$1,000
Death of Spouse	\$500

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

A. 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. This benefit is insured by Dearborn.

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.

B. BENEFITS PROVIDED

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

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.

C. LIMITATIONS

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

- The claim date is the date of death or, in the event of loss of sight or dismemberment, the date of the accident; and
- The AD&D benefit does not cover any loss resulting from or caused directly, in whole or in part, by:
 - Disease, bodily physical or mental infirmity, or medical or surgical treatment thereof;
 - Ptomaine or bacterial infections, except pyogenic infections occurring with and through an accidental wound;
 - Suicide or intentionally self-inflicted injury, while sane or insane;
 - 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;
 - Flying in an aircraft, unless you were a passenger on a commercial airline, or engaging in other dangerous activities, as determined by Dearborn;
 - War or any act of war, whether declared or undeclared, or insurrection; or
 - Drug overdose, whether intentional or unintentional.

GENERAL LIMITATIONS AND EXCLUSIONS

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.

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

The Fund does not 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 the Plan subjects payment for benefits to allowances and limitations as described herein, the choice of a Provider and/or treatment remains with the patient.

B. GENERAL EXCLUSIONS

In addition to the exclusions provided elsewhere in this SPD, benefits are not payable for the following:

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.

1. Charges for services or supplies which are not Medically Necessary or Medically Appropriate as determined by the Fund or its delegee.
2. Charges for treatments or procedures that are Experimental or Investigative.
3. Charges for treatments which are not approved by the Member's or Dependent's attending Physician.
4. Charges which are not Usual, Customary and Reasonable as determined by the Fund Administrator.
5. Charges in excess of the payment the Provider of service accepted as payment in full from any other source.
6. Charges for Custodial Care or for Maintenance of chronic conditions except as required by applicable law or governmental entity with enforcement authority, or at set forth elsewhere in this SPD.
7. Charges for services rendered by a member of the patient's Immediate Family.
8. Charges that no covered individual is legally obligated to pay.
9. Charges for treatments, services, and/or supplies provided, ordered, or required by the United States government, or any other government (including court-ordered treatment).
10. Charges resulting from war or injuries or diseases connected to a person's military service.
11. Charges associated with any treatment for weight reduction, except certain obesity-related screening and counselling as required by Affordable Care Act.
12. Charges for Hearing Aids or the examination and fitting of Hearing Aids.
13. Charges to the extent that they are recovered from any person or organization other than an insurer of the patient. The Fund may advance payment for benefits when there is an expectation of future recovery from a third party; the Fund retains a primary subrogation interest in any such recovery to the full extent of such payments advanced.
14. 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

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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.

15. 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.
16. Charges for orthotic shoe inserts (unless specifically covered under your Summary of Benefits Schedule).
17. Charges for immunizations and vaccines (unless specifically covered under the Medical program).
18. Charges for eye exercises, psychological testing, learning disabilities, or school or DOT physicals.
19. Charges for treatment of temporomandibular joint dysfunction in excess of any coverage under the Dental program.
20. Charges for sex change operations, except as may be required by law.
21. Charges for the surgical correction of myopia, including, without limitation, Lasik.
22. 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.
23. Charges for any other medical, dental, vision, or pharmacy service except as set forth in this summary plan description.
24. Charges for specialty injectable medication or treatment, with the exception of oncology related products.
25. Services, supplies, or charges that are 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 the applicable premium for, maintains, claims or receives Medicare benefits.
26. 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.
27. Charges that 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), or (b) "Ambulance Services."
28. Services 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.
29. Ambulance services except as specifically described in this SPD.
30. Charges for failure to keep a scheduled visit, or charges for completion of a claim form.
31. For marriage counseling;
32. 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.
33. Except to the extent and as described in the Dental Program section of this SPD, dental services related to the care, filling, removal, or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia, or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth. 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.

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34. Dentures, unless for the initial treatment of an Accidental Injury/trauma.
35. Orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate.
36. Injury as a result of chewing or biting (neither is considered an Accidental Injury).
37. Palliative or cosmetic foot care including for flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone Surgery), calluses, toenails (except Surgery for ingrown nails), fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and symptomatic complaints of the feet.
38. Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury.
39. 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 SPD), chairlifts, stair glides, elevators, spa or health club memberships, whirlpool, sauna, hot tub or equivalent device, whether or not recommended by a Provider.
40. Wigs (except for cranial prostheses for chemotherapy patients, as set forth in this SPD).
41. Eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, except as set forth in the Vision Program section of this SPD.
42. Preventive services except as specifically provided for under the subsection entitled "Primary and Preventive Care Services" of the "Your Medical Benefits" section of this SPD.
43. Premarital blood tests.
44. Diagnostic screening examinations, except for mammograms and Preventive Care as provided in the subsection entitled "Primary and Preventive Care Services" of the "Your Medical Benefits" section of this SPD.
45. Alternative Therapies/Complementary Medicine, including but not limited to, acupuncture, music Therapy, dance Therapy, equestrian/hippo-therapy, homeopathy, primal Therapy, rolfing, psychodrama, vitamin or other dietary supplements and Therapy (except to the extent such are considered "Preventive Care" under the Affordable Care Act), naturopathy, hypnotherapy, bioenergetic Therapy, Qi Gong, Ayurvedic Therapy, aromatherapy, massage Therapy, therapeutic touch, and recreational, wilderness, educational and sleep therapies.
46. 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.
47. Immunizations required for employment or travel.
48. Custodial care in a nursing home, home for the aged, convalescent home, school, institution for special needs children, or a Skilled Nursing Facility.
49. Counseling or consultation with a patient's relatives or Hospital charges for a patient's relatives or guests.
50. Medical supplies such as but not limited to thermometers, ovulation kits, and early pregnancy or home pregnancy testing kits.
51. Home blood pressure machines.
52. As described under "Durable Medical Equipment" in the "Your Medical Benefits" section of this SPD: 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.
53. Prescription drugs, except as described in the Prescription Drug Program section of this SPD.

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- 54. For amino acid supplements, appetite suppressants, or nutritional supplements. Coverage does not include basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, or 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."
- 55. Inpatient Private Duty Nursing services.
- 56. Charges Incurred for expenses in excess of any Benefit Maximum set forth in the Summary of Benefits Schedule.
- 57. 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).
- 58. 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.
- 59. Cochlear implants.
- 60. Any Covered Person who incurs an injury or sickness caused by or resulting from such Covered Person's commission or attempt to commit a felony shall not be entitled to benefits for such injury or sickness. If the Covered Person is subsequently acquitted of such felony, the Trust Fund shall provide reimbursement, as appropriate under the Plan benefit provisions, on a retroactive basis. This exclusion from coverage will not apply to injuries or sicknesses that result from an act of domestic violence against a Covered Person or are the result of a Covered Person's physical or mental health condition, to the extent that the exclusion of such injuries would result in unlawful discrimination under 45 CFR 146.121(a)(1)(ii) and (b)(2).
- 61. Where an injury is caused by an accident that is covered by a State-required motor vehicle (automobile, motorcycle, or other) insurance law, health and disability insurance coverage under this Plan is secondary and the motor vehicle insurance, 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 motor vehicle insurance, up to the Maximum benefit level set forth in the applicable Summary of Benefits Schedule. Any Member who fails to maintain primary motor vehicle insurance coverage in accordance with the requirements of applicable law shall not be entitled to Plan benefits to the extent that such benefits would have been provided or available under such motor vehicle insurance coverage, provided however, that this exclusion is limited to the first \$5,000 of claims resulting from an automobile accident. This reduction in Plan benefits shall also apply to the Member's Dependents, whether or not such Dependents are legally permitted to drive. If the Dependent of a Member, however, has motor vehicle insurance coverage that meets the requirements of applicable law independent of any motor vehicle insurance coverage that the Member has or has not obtained, the benefits available under the Plan shall be coordinated with the Dependent's motor vehicle insurance coverage in accordance with other applicable Plan Provisions. Benefits for injuries incurred in connection with a motor vehicle accident are generally subject to the Fund's coordination of benefits and subrogation provisions described elsewhere in this SPD.
- 62. In general, benefits will only be paid in accordance with provisions of the Fund's various Programs. For example, Vision Care is provided for under its Vision Care Program and will not be provided under any other provision of the Plan unless specifically included in such other Plan provision.

C. IMPORTANT LIMITATIONS REGARDING MOTOR VEHICLE ACCIDENTS AND THE FUND'S SUBROGATION RIGHTS, GENERALLY**1. Motor Vehicle Accidents**

All Members and beneficiaries must understand that the Fund is your secondary source of health benefits when a motor vehicle accident claim arises. In other words, the Fund will only consider for payment those charges for health care not paid under another motor vehicle policy.

2. Subrogation/Reimbursement

In accepting benefits from the Fund, you acknowledge and agree that the Fund has the right of subrogation when you are involved in any accident and/or where you recover from a third party any expenses that have been paid to you or to a Provider on your behalf by this Plan.

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This means, generally, that the Fund may recover from the total amount of any benefits it has paid on your behalf from any recovery you receive 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, including any settlements that you or your attorney receive related to any of the foregoing.

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:

- a. 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 a subrogation/reimbursement agreement signed by any Covered Person, will be entitled to immediate reimbursement to the extent of benefits paid to or on behalf of the Member or Dependent.
- b. 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.
- c. The Member or Dependent, or any attorney representing 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.
- d. All Members and Dependents are required 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.
- e. 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.

In the sole discretion of the Plan Administrator, the Fund may pay counsel fees in an amount not to exceed 20% of a recovery in order to protect the Fund's subrogation interests.

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

A. HOW TO FILE A CLAIM FOR FUND BENEFITS

1. Medical Program

Your medical plan 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 Identification 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 Identification 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.

2. 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 (www.teamsterfunds.com).

3. 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.

4. 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.

5. 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.

- a. **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.
- b. **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.
- c. **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).
- d. **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.

6. 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 their section of the form, and your Employer must also complete the Company Statement section of the claim form.

7. 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.

B. 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.

C. 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.

D. CLAIM REVIEW / CLAIM APPEAL PROCEDURE

1. General Rules

The Trustees have established and maintain the following reasonable claim procedures for the Fund, as required by law, to adjudicate claims for Fund benefits. The Trustees (or, as applicable, their designee) have the sole discretion and authority to interpret the terms of the Fund's plan documents, including without limitation this SPD, the Agreement and Declaration of Trust establishing this Fund and all restatements thereof, and the Collective Bargaining Agreements establishing Contributing Employer participation in the Fund, and to determine eligibility for Fund benefits to the greatest extent permitted by applicable law.

2. 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:

a. 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 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.

b. 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:

- 1) 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.
- 2) 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.

c. 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.

d. 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.

e. 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.

f. 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 Medically appropriate/ Medically necessary 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.

g. 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.

h. 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 or Investigative 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. The claimant or the 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 their 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 their 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 (such as medical necessity or appropriateness, the setting or level of care, or whether a procedure or treatment is Experimental or Investigative);
- A rescission of coverage under the Fund's plan of benefits; and
- Claims to determine compliance with the surprise billing and cost-sharing protections under the No Surprises Act.

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 the information and documents that are timely submitted. 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.

Any decision of an IRO is legally binding on the Fund. It is binding on you only to the extent that other remedies are not available to you under the law.

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 SPD 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 SPD.
- 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 (i) a denial, reduction, or termination of; or (ii) 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).

GENERAL PROVISIONS AND DEFINITIONS

The following terms are defined as follows for purposes of this SPD.

ACCIDENTAL BODILY INJURY

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

ACTUAL CHARGES

Covered charges up to the Usual, Customary and Reasonable charges as defined in this Section, and never to exceed the payment the Provider of the 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/hip-potherapy); 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; and (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.

BEHAVIORAL HEALTH PROVIDER

An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for Behavioral Health conditions under the laws of the jurisdiction where the individual practices.

BEHAVIORAL HEALTH SERVICES

The comprehensive care and treatment of mental health conditions, substance use disorders, and emotional well-being. It encompasses services aimed at promoting mental wellness, preventing and addressing psychological disorders, and supporting recovery through therapies, counseling, medication management, and other interventions.

BEHAVIORAL INTERVENTIONS BASED ON APPLIED BEHAVIORAL ANALYSIS

Interventions or strategies, based on learning theory, that are intended to improve a person's socially important behavior. This is achieved by using instructional and environmental modifications that have been evaluated through scientific research using reliable and objective measurements. These include the empirical identification of functional relations between behavior and environmental factors.

Such intervention strategies include, but are not limited to, chaining; functional analysis; functional assessment; functional communication training; modeling (including video modeling); procedures designed to reduce challenging and dangerous behaviors; prompting; reinforcement systems, including differential reinforcement, shaping, and strategies to promote generalization.

BENEFIT MAXIMUM

The greatest amount of a specific Covered Service that a Covered Person may receive.

BENEFIT PERIOD

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

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A certified Registered Nurse anesthetist, certified Registered Nurse practitioner, certified enteral/ostomy 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.

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.

CONTINUING CARE PATIENT

An individual is a Continuing Care Patient with respect to a Provider or facility if the individual is:

- Undergoing a course of treatment for a "serious and complex condition" from the Provider or facility;
- Undergoing a course of institutional or Inpatient care from the Provider or facility;
- Scheduled to undergo non-elective Surgery from the Provider, including receipt of postoperative care from such Provider or facility with respect to such a Surgery;
- Pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; or
- Determined to be "terminally ill" and receiving treatment for such illness from such Provider or facility.

An individual has a "serious and complex condition" if the individual has a condition that (a) in the case of an acute illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized Medical Care over a prolonged period of time. An individual is "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is six months or less.

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 motor vehicle insurance. 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 provide for coordination of benefits or duplication of benefits provision, benefits payable for Covered Expenses under will be paid by the other plan before any benefits are paid by the Fund.

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY - SUMMARY PLAN DESCRIPTION

- 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 that 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 that 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 their 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 and both parents have group health plan coverage, 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 that 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 that are not otherwise provided by the Fund as set forth in this SPD.

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:

<u>Parents Divorced - Not Remarried</u>	<u>Parents Divorced - Remarried</u>
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 their 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 copayments 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 documented in writing 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 SPD. 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 that is covered by your specific Summary of Benefits Schedule that is included in or accompanies this SPD.

COVERED PERSON

An enrolled Member or their Eligible Dependents who meet the specifications of the Schedule of Eligibility.

COVERED SERVICE

A service or supply specified in this SPD 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 the 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

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 or child as defined in the Eligibility Provisions section.

DURABLE MEDICAL EQUIPMENT

Equipment which meets the following criteria:

- It is durable and can withstand repeated use;
- It is medical equipment, meaning it is primarily and customarily used to serve a medical purpose;
- It generally is not useful to a person in the absence of an illness or injury; and
- It is appropriate for use in a 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:

- Placing the Covered Person's health, or in the case of a pregnant Covered Person, the health of the unborn child, in jeopardy;
- Serious impairment to bodily functions; or
- 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 SPD.

ENTERAL NUTRITION

The provision of nutritional requirements through a tube into the stomach or small intestine.

EXPERIMENTAL OR INVESTIGATIVE

A drug, biological product, device, test, medical treatment, or procedure (collectively referred to below as a "service") that meets any of the following criteria:

- The service is not approved by the appropriate federal regulatory agency for the indication requested (unless it is considered an off-label use or otherwise meets the generally accepted standards of medical practice).;
- There is insufficient evidence published in reputable peer-reviewed publications to assess the safety or effectiveness of the service in the diagnosis or treatment of the Covered Person's particular condition; or
- The service has not demonstrated effectiveness when applied outside of the investigative research setting.

A drug will not be considered Experimental or Investigative 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 must 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 or Investigative.

FACILITY PROVIDER

An entity or institution: that (a) provides health care services within the scope of its license, as defined by applicable law. Such facilities include but are not limited to:

- 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; or
- Skilled Nursing Facility.

FAMILY MEMBER

A Member and their 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

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 SPD 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

An acute care institution that:

- Is licensed as a hospital by the State in which it is located, and the primary function of the institution is providing Inpatient Medical Care and treatment through medical diagnostic and major surgical facilities on its premises under the supervision of a staff of Physicians, and with 24 hour a day nursing service; and
- Is not owned or operated by the United States Government or by a State (or political subdivision thereof) unless there is an unconditional requirement that persons receiving care must pay for such care.

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

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 is considered Incurred on the date you or your Covered Dependent receives the service or supply for which the charge is made.

IMMEDIATE FAMILY

A member's spouse, parent, child, sibling, or in-laws, including mother, father, sister, brother, daughter or son-in-law.

INDEPENDENT CLINICAL LABORATORY

A laboratory that performs clinical pathology procedure and 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 that, 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

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

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mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or their 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 their 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

Services or supplies that are:

- Appropriate for the symptoms and diagnosis or treatment of the Family Member's condition, illness, disease, or injury; and
- Required for the diagnosis, or the direct care and treatment of the Family Member's condition, illness, disease, or injury; and
- In accordance with standards of good medical practice as generally recognized and accepted by the medical community; and
- Not primarily for the convenience of either the Family Member's family or a Provider of medical services; and
- 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 their 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 their employer to contribute to the Fund on their behalf, and/or (2) an employee of a labor union or trade association which contributes to the Fund on their behalf.

Singular pronouns, whenever used, include the plural where appropriate.

NONASSIGNMENT

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

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a power of attorney or other device, is void. No benefit is 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/ 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

This SPD, 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 Trustees are 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 as 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 physician or other health care professional who: (a) is licensed or otherwise authorized to provide health care services in the state or jurisdiction in which the services are furnished; and (b) supervises, coordinates, and maintains continuity of care for Covered Persons.

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.

PROFESSIONAL PROVIDER

A person or practitioner who is certified licensed where required and performing services within the scope of such certification or licensure. The Professional Providers included but are not limited to:

- Audiologist
- Chiropractor
- Dentist
- Lactation Consultant/Lactation Counselor
- Nurse Midwife
- Nurse Practitioner/Clinical Nurse Specialist
- Optometrist
- Pharmacist
- Physical Therapist

- Physician
- Podiatrist
- Psychologist
- Registered Nurse
- Social Worker
- Speech-Language Pathologist
- 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

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:

- Manipulative treatment of functional loss from back disorder;
- Therapy treatment of functional loss following foot Surgery; and
- 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:

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

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

SPECIAL CARE FACILITY

An institute other than a Hospital (as defined in this SPD) that:

- Specializes in physical rehabilitation of injured or sick patients;
- Specializes in the diagnosis and treatment of mental illness or functional nervous disorders; or
- 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:

- Legally licensed to give medical treatment;
- Operated under the supervision of a Physician; and
- 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 SPD 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:

- **Cardiac Rehabilitation Therapy** - Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.
- **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.
- **Dialysis** - The treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.
- **Infusion Therapy** - Treatment including, but not limited to infusion or inhalation, parenteral and Enteral Nutrition, antibiotic Therapy, pain management and hydration Therapy.

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- **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.
- **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.
- **Pulmonary Rehabilitation Therapy** - Multidisciplinary treatment which combines physical Therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.
- **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.
- **Respiratory Therapy** - Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.
- **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.

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 and AD&D 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 Medical, Dental, Vision, 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 SPD 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:

A. 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 SPD. 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.

B. 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 SPD 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.

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.

A. 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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. When Legally Required

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

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

B. 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.

C. YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

D. 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.

E. 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

F. EFFECTIVE DATE

This Notice is effective January 1, 2025. If you have any questions regarding this notice, please contact the privacy officer identified above.

G. 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.

SUMMARY OF BENEFITS SCHEDULE UNDER THE MEDICAL PROGRAM - PPO PLAN (HORIZON PPO)

The following schedule of medical benefits applies to the Horizon PPO Plan. This schedule does not include information about the Prescription Drug Program, which is described elsewhere in this SPD or in the Enhanced Benefits Guide.

	In-Network	Out-of-Network*
Benefit Period	Calendar Year	
Program Deductible	\$200 per Person per Benefit Period - Platinum Plan \$450 per Person per Benefit Period - Gold Plan This Deductible applies to all services, except Emergency Care service, pediatric immunizations, and Preventive Care.	\$450 per Person per Benefit Period - Platinum Plan \$950 per Person per Benefit Period - Gold Plan
Family Deductible	The family Deductible amount is equal to two times the in-dividual 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	10%	20% of Allowable Charges, Except Coinsurance Does Not Apply to Emergency Care Services
Out-of-Pocket Limit	\$500 per Person per Benefit Period - Platinum Plan \$750 per Person per Benefit Period - Gold Plan 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.	\$1,500 per Person per Benefit Period - Platinum Plan \$2,250 per Person per Benefit Period - Gold Plan
Copayment	Primary Care Physician \$20 - Platinum Plan Behavioral Health Provider \$30 - Gold Plan Specialist \$30 - Platinum Plan \$40 - Gold Plan	Coinsurance
Annual Overall Out-of-Pocket Maximum	\$5,000 per Person and \$10,000 per Family	

Hospital Services- Medical Services

Inpatient..... 90% / 80%

There is an allowed Maximum of 365 days for in-network services and 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. Pre-Certification is required for all Inpatient services.

Outpatient..... 90% / 80%

The out-of-network coinsurance amount applies unless unreasonable under circumstances to use In-Network Provider, then paid at 90% of allowable expense.

Emergency Care

Initial Visit 100% less \$100 Copayment

*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 Copayment will be waived if admitted.*

Follow-Up Emergency Room Care..... 100% less \$100 Copayment

Follow-up care must be within 14 days of initial treatment.

Surgical Services..... 90% / 80%

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY - SUMMARY PLAN DESCRIPTION

Assistant Surgeon	90% / 80%
<i>20% of the in-network allowance for the surgical procedure performed by the primary surgeon.</i>	
Anesthesia	90% / 80%
Second Surgical Opinion (Voluntary)	90% / 80%
Medical Care	90% / 80%
Inpatient Care	90% / 80%
Concurrent Care	90% / 80%
<i>Inpatient consultations are limited to one consultation per consultant per confinement.</i>	
Outpatient Diagnostic Services	
X-ray: Radiology, Ultrasound and Nuclear Medicine, ECG, EEG, etc.	90% / 80%
Laboratory, Pathology	90% / 80%
Allergy Testing	90% / 80%
Outpatient Therapy	
Applied Behavioral Analysis Therapy	90% / 80%
Radiation Therapy, Chemotherapy, and Dialysis Therapy	90% / 80%
Infusion Therapy	90% / 80%
Respiratory Therapy	100% / 80%
<i>Specialist Copayment applies to in-network services.</i>	
Cardiac Rehabilitation Therapy	100% / 80%
<i>Specialist Copayment applies to in-network services. Limited to 36 sessions per Benefit Period.</i>	
Pulmonary Rehabilitation Therapy	100% / 80%
<i>Specialist Copayment applies to in-network services. Limited to twelve sessions per Benefit Period.</i>	
Physical, Occupational, and Speech Therapy	100% / 80%
<i>Specialist Copayment applies to in-network services.</i>	
Restorative Services	
Chiropractic Services	100% / 80%
<i>Specialist Copayment applies to in-network services. Limited to 15 sessions per Benefit Period.</i>	
Orthoptic Pleoptic Services	100% / 80%
<i>Specialist Copayment applies to in-network services. Limited to 24 sessions per lifetime.</i>	
Maternity Care	
Obstetrical/Maternity Care	90% / 80%
Hospital Stay	90% / 80%
Labor and Delivery	90% / 80%
Abortions	90% / 80%
<i>Only covered to avert the death of the mother or in the case of pregnancies resulting from rape or incest.</i>	
Newborn Care	90% / 80%
<i>Only covered from the date of birth to mother's discharge from the Hospital.</i>	

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY - SUMMARY PLAN DESCRIPTION

Skilled Nursing Facility	90% / 80%
<i>Hospital day limit Maximum applies; Pre-Certification is required.</i>	
Physician Visits	90% / 80%
<i>Two visits during the first week of confinement and one visit per week for each consecutive week of confinement thereafter.</i>	
Durable Medical / Surgical Equipment / Prosthetics	90% / 80%
<i>Pre-Certification is required for supplies including all rentals and for the purchase of items with billed amount that exceeds \$1,000.</i>	
Foot Orthotics	90% / 80%
<i>Covered once every 24 months.</i>	
Home Health Care	90% / 80%
<i>Only covered if following a one-day hospitalization. Pre-Certification is required.</i>	
Hospice Care	90% / 80%
<i>Respite Care is limited to a Maximum of seven days every six months.</i>	
Ambulance	90% / 80%
<i>Air Ambulance must provide sufficient medical records documenting need.</i>	
Medical Foods And Nutritional Formulas	90% / 80%
<i>Medical Foods benefits must be Pre-Certified by the Fund office.</i>	
Transplant Services	90% / 80%
<i>See "Transplant Services" regarding donor coverage.</i>	
Outpatient Private Duty Nursing	90% / 80%
Urgent Care Centers	\$50 Copayment / 80%
Retail Walk-In Clinics	\$10 Copayment / 80%
Primary Care and Behavioral Health Professional Providers	
Home, Office, Outpatient Visits and Outpatient Consultation	00% / 80%
<i>Copayment applies to in-network services.</i>	
Pediatric Immunizations	100% / 80%
<i>Copayments, Deductibles and Maximum amounts do not apply to this benefit.</i>	
Specialist	100% / 80%
<i>Copayment applies to in-network services.</i>	
Routine Annual Gynecological Exam and Pap Smears	100% / 80%
<i>Copayments, Deductibles and Maximum amounts do not apply to this benefit.</i>	
Annual Screening Mammogram	100% / 80%
<i>Copayments, Deductibles and Maximum amounts do not apply to this benefit.</i>	
Therapeutic Injections	90% / 80%
Allergy Extract / Injections	100% / 80%

COVERED SERVICES LIMITATIONS

Services	Limitations
Inpatient Admissions/Services	
Skilled Nursing Facility Care	Failure to Pre-Certify in-network services will result in a \$1,000 reduction in benefits payable for these services.
Transplant Services	
Outpatient Services	

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY - SUMMARY PLAN DESCRIPTION

Surgical Services Home Health Care Hospice Care Private Duty Nurse	None.
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 – IN-NETWORK ONLY PLAN (HORIZON PPO IN-NETWORK ONLY)

The following schedule of medical benefits applies to the Horizon PPO Plan. This schedule does not include information about the Prescription Drug Program, which is described elsewhere in this SPD or in the Enhanced Benefits Guide.

In-Network	
Benefit Period	Calendar Year
Program Deductible	\$50 per Person per Benefit Period - Platinum Plan \$300 per Person per Benefit Period - Gold Plan 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 in-dividual 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	10%
Out-of-Pocket Limit	\$250 per Person per Benefit Period - Platinum Plan \$500 per Person per Benefit Period - Gold Plan 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
Mental Health /Substance Use Disorder (MH/SUD) Providers	\$25 - Gold Plan
Specialist	\$25 - Platinum Plan \$35 - Gold Plan
Annual Overall Out-of-Pocket Maximum	\$5,000 per Person and \$10,000 per Family

Hospital Services

Inpatient..... 90%

There is an allowed Maximum of 365 days for in-network services and 70 days Maximum for out-of-network services per illness. Pre-Certification is required for all Inpatient services.

Outpatient..... 90%

Emergency Care

Initial Visit 100% less \$100 Copayment

Services within two days of Emergency certification of services must take place within two business days of service, or as soon as reasonably possible. \$100 Copayment will be waived if admitted.

Follow-Up Emergency Room Care 100% less \$100 Copayment

Follow-up care must be within 14 days of initial treatment

Surgical Services..... 90%

Assistant Surgeon 90%

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY - SUMMARY PLAN DESCRIPTION

20% of the in-network allowance for the surgical procedure performed by the primary surgeon.

Anesthesia 90%

Second Surgical Opinion (Voluntary) 90%

Medical Care..... 90%

Inpatient Care 90%

Concurrent Care 90%

Inpatient consultations are limited to one consultation per consultant per confinement.

Outpatient Diagnostic Services

X-ray: Radiology, Ultrasound and Nuclear Medicine, ECG, EEG, etc..... 90%

Laboratory, Pathology 90%

Allergy Testing 90%

Outpatient Therapy

Applied Behavioral Analysis Therapy 90%

Radiation Therapy, Chemotherapy, and Dialysis Therapy 90%

Infusion Therapy 90%

Respiratory Therapy 90%

Cardiac Rehabilitation Therapy 90%

Limited to 36 sessions per Benefit Period.

Pulmonary Rehabilitation Therapy 90%

Limited to twelve sessions per Benefit Period.

Physical, Occupational, and Speech Therapy 90%

Restorative Services

Chiropractic Services..... 100%

Specialist Copayment applies to in-network services. Limited to 15 sessions per Benefit Period.

Orthoptic Pleoptic Services 100%

Specialist Copayment applies to in-network services. Limited to 24 sessions per lifetime.

Maternity Care

Obstetrical/Maternity Care 90%

Hospital Stay..... 90%

Labor and Delivery..... 90%

Abortions 90%

Only covered to avert the death of the mother or in the case of pregnancies resulting from rape or incest.

Newborn Care 90%

Only covered from the date of birth to mother's discharge from the Hospital.

Skilled Nursing Facility 90%

Hospital day limit Maximum applies; Pre-Certification is required.

Physician Visits..... 90%

Two visits during the first week of confinement and one visit per week for each consecutive week of confinement thereafter.

TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA AND VICINITY - SUMMARY PLAN DESCRIPTION

Durable Medical / Surgical Equipment / Prosthetics	90%
<i>Pre-Certification is required for supplies including all rentals and for the purchase of items with billed amount that exceeds \$1,000.</i>	
<i>One pair every six months.</i>	
Foot Orthotics	100%
<i>Covered once every 24 months.</i>	
Home Health Care	90%
<i>Only covered if following a one-day hospitalization. Pre-Certification is required.</i>	
Hospice Care	90%
<i>Respite Care is limited to a Maximum of seven days every six months.</i>	
Ambulance	90%
<i>Air Ambulance must provide sufficient medical records documenting need.</i>	
Medical Foods And Nutritional Formulas	90%
<i>Medical Foods benefits must be Pre-Certified by the Fund office.</i>	
Transplant Services	90%
<i>See "Transplant Services" regarding donor coverage.</i>	
Outpatient Private Duty Nursing	90%
Urgent Care Centers	\$50 Copayment
Retail Walk-In Clinics	\$10 Copayment
Primary Care	
Home, Office, Outpatient Visits and Outpatient Consultation.....	100%
<i>Copayment applies to in-network services.</i>	
Pediatric Immunizations	100%
<i>Copayments, Deductibles and Maximum amounts do not apply to this benefit.</i>	
Specialist	100%
<i>Copayment applies to in-network services.</i>	
Routine Annual Gynecological Exam and Pap Smears	100%
<i>Copayments, Deductibles and Maximum amounts do not apply to this benefit.</i>	
Annual Screening Mammogram	100%
<i>Copayments, Deductibles and Maximum amounts do not apply to this benefit.</i>	
Therapeutic Injections	90%
Allergy Extract / Injections	100%

COVERED SERVICES LIMITATIONS

Services	Limitations
Inpatient Admissions/Services	
Skilled Nursing Facility Care	Failure to Pre-Certify in-network services will result in a \$1,000 reduction in benefits payable for these services.
Transplant Services	
Outpatient Services	
Surgical Services	None.
Home Health Care	
Hospice Care	
Private Duty Nurse	

Wellness Program

Non-participation in the Wellness Program will result in eligibility being restricted to the Gold Plan.