UNITED TEAMSTER FUND

SUMMARY PLAN DESCRIPTION

Effective May 1, 2014

May 1, 2014

The Board of Trustees (the "Trustees") are pleased to provide you with this updated summary of the benefits available under the United Teamster Fund (referred to in this booklet as the "Fund").

These benefits include:

- **Hospital And Medical Benefits,**
- **Prescription Drug Benefits,**
- **Vision Benefits,**
- **Dental Benefits,**
- **Life Insurance, And**
- **Accidental Death & Dismemberment Benefits.**

You should use this booklet to find out:

- **who is eligible for coverage,**
- **the types of benefits that are provided, any limitations on those benefits, and any cost-sharing requirements,**
- **how to make a claim for benefits, and**
- **who to contact for more information.**

This booklet provides a description, written in everyday language, of provisions in effect as of May 1, 2014. This booklet constitutes a summary plan description, or "SPD." Please keep all of this information together in a convenient place, where you will have it for future reference and can share with your family. This SPD serves as both the Summary Plan Description and Plan Document.

The Fund believes it is not a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("Affordable Care Act"). The Fund is not a grandfathered health plan because it has not preserved certain basic health coverage that was in effect when the Affordable Care Act was enacted. Not being a grandfathered health plan means that the Fund has to include

certain consumer protections of the Affordable Care Act, for example, the requirement for the provision of preventive health services without any cost sharing.

If you have any questions about the Fund or your benefits, please contact the Fund Office at (718) 859-1624, (718) 842-1212 or (732) 882-1901.

Sincerely,

The Board Of Trustees

UNITED TEAMSTER FUND

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TABLE OF CONTENTS

GLOSSARY

The following terms have special meanings for the purposes of the Fund. To help you understand them in the context of our Fund, definitions are provided below.

***COBRA*-** The acronym for the *Consolidated Omnibus Budget Reconciliation Act of 1985*. This federal law allows you and your eligible Dependents to continue health care coverage with the Fund at your own expense, provided your coverage was terminated for specific reasons explained later in this booklet.

***Coinsurance*-** The percentage of charges for certain Covered Services that you are required to pay after your Deductible has been met.

***Contributing Employer*-** Any employer who has a collective bargaining agreement with a participating Local of the International Brotherhood of Teamsters and who is required to make contributions to this Fund on behalf of employees.

***Coordination of Benefits ("COB")* -** If you are covered by another Fund or other coverage, the payments will be coordinated so that no more than 100% of your actual expenses are reimbursed. The Fund will only pay for Covered Expenses and will not pay more than the amount it would normally pay if it were primary. In other words, the Fund will not pay more than what it would normally cover under the Maximum Reimbursable Charge.

***Copayment*-** The predetermined amount of money you are required to pay directly to a network provider at the time certain Covered Services are rendered.

***Covered Expenses or Covered Services*-** Covered Expenses or Covered Services include expenses covered under the Fund for treatment, care, services, or supplies, but only to the extent:

- They are Medically Necessary;
- Coverage is not excluded under the terms of the Fund;
- No Fund maximums for those expenses have been reached; and
- The expenses fall within the Fund's Maximum Reimbursable Charge (if applicable).

***Deductible*-** The amount of eligible Out-Of-Pocket Expenses that you must pay each Fund Year before the Fund begins to pay its share of the applicable Coinsurance amount. The Deductible is payable only once in each Fund Year (each May 1 through April 30) and is limited to a maximum amount. There is a separate Deductible for in- and out-of-network services. The Deductible may not apply to all services.

***Dependent*-** A Spouse or child who may be eligible for benefits coverage while you are an employee of the contributing employer, if your employer's contribution level qualifies you for family coverage. A Dependent must meet eligibility requirements in order to be covered for benefits.

***Eligible Expenses*-** Expenses for Medically Necessary services, treatments, procedures and medical supplies that you incur in connection with treatment of an Injury or disease.

***Emergency Room*-** The section of the Hospital where serious, unexpected Sickness or Injury cases, which require immediate attention are treated.

***Emergency Services*-** With respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the patient.

***Essential Health Benefits*-** To the extent covered under the Fund, expenses incurred with respect to Covered Services, in at least the following categories:

- ambulatory patient services,
- Emergency Services,
- hospitalization,
- maternity and newborn care,
- mental health and substance use disorder services, including behavioral health treatment,
- prescription drugs,
- rehabilitative and habilitative services and devices,
- laboratory services,
- preventive & wellness services and chronic disease management and
- pediatric services, including oral and vision care.

***"Experimental" Drugs and Procedures*-** Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided as a "Clinical Trial"; or
- the subject of an ongoing phase I, II or III clinical trial, except as provided as a "Clinical Trial"

Experimental, investigational drugs are all non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and Experimental drugs, except as provided for in the Fund.

***Fund*-** United Teamster Fund.

***Fund Year*-** The period from May 1st through April 30th.

***Hospital*-** The term Hospital means:

- an institution licensed as a Hospital, which maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of mental health and substance abuse or other related Sickness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

A Hospital is *not* an institution which is primarily a place for rest, a place for the aged, or a nursing home. A Hospital is also *not* an institution where care is provided under federal, state or other laws, or the laws of any foreign country**.** A Hospital is not a veteran's facility where care is provided in connection with service related disabilities or a facility operated by the United States (except for emergency care). A Hospital is not a college or university infirmary; or birth centers, operating rooms or surgical centers which are part of a physician's office space.

Hospital Confinement or Confined in a Hospital- A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a physician;
- receiving treatment for mental health and substance abuse services in a partial hospitalization program;
- receiving treatment for mental health and substance abuse services in a mental health or substance abuse residential treatment center.

Injury- An accidental bodily injury.

Legally Qualified Physician, Medical Doctor or Surgeon- A legally qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.). A doctor of podiatry (D.P.M.) or a dentist (D.D.S.) will be recognized as a Legally Qualified Physician only when performing services in his or her specialty, which if performed by an M.D. or D.O. would be covered. For purposes of this Fund, a certified nurse midwife assisting in delivery is considered a Legally Qualified Physician, Medical Doctor, or Surgeon.

Maximum Reimbursable Charge- One of the following, as determined by Cigna and depending on the type of claim:

(i) the lesser of the health care professional's normal charge for a similar service or supply, or 110% of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area; or

(ii) the lesser of the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received.

Medically Necessary- Medically Necessary Covered Services and Supplies are those determined to be:

- required to diagnose or treat a Sickness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Fund or Cigna may compare the cost-effectiveness of alternative services, settings or supplies when determining the least intensive setting.

Motor Vehicle- As used in this booklet, the term "Motor Vehicle" includes, but is not limited to, automobiles, motorcycles, motorbikes, boats, snowmobiles, limited use motorcycles (or "mopeds" or "motor scooters"), motorized scooters, mini-bikes, dirt bikes, go-karts, motor assisted bicycles, jet skis, and all-terrain vehicles ("ATVs").

Non-Participating Pharmacy- A Pharmacy which did not enter into an agreement with the Pharmacy network to provide prescription drugs and does not accept the Fund's prescription card plan.

Other Health Care Facility- A facility other than a Hospital or hospice facility.

Other Health Care Professional- An individual, other than a physician, who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Care Professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses. Other Health Care Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants or Surgical First Assistants.

Out-Of-Pocket Expenses- Coinsurance, Deductibles, Copayments, or fees you must actually pay for Eligible Expenses, which are not reimbursed by the Fund. However, please note that Copayments do not count towards the annual out-of-pocket maximums.

Participant- An individual who is employed by a Contributing Employer and meets the eligibility requirements of this Fund.

Participating Pharmacy- A Pharmacy which has entered into an agreement with Optum RX, Inc. Pharmacy network to provide prescription drugs and accepts the Fund's prescription card plan.

Participating Provider- A provider who has entered into a contract with the Fund, Trustees, Cigna, Optum RX, or Dentcare and agrees to be compensated for services and supplies as covered under this Fund according to the terms of the contract while such contract is in effect.

Pharmacy- An establishment which is registered with the appropriate state licensing agency and at which prescription drugs are regularly compounded and dispensed by a pharmacist.

Sickness- A physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Review Organization- An affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

Urgent Care- Medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. It does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Excluded care include, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Spouse- A person to whom you are legally married under state law.

Waiting Period- The first day of the month following sixty (60) days from the date your employer starts to make contributions on your behalf.

YOUR BENEFITS AT A GLANCE

Effective May 1, 2014

For Active EMPLOYEES AND THEIR COVERED DEPENDENTS*

Hospital And Medical Benefits

- When you receive "In-Network" services, you have an annual Deductible of $250 for employee-only coverage or $500 for employee-and-family coverage. There is also a 20% Coinsurance for certain Covered Services. In addition, there is a $25 copay for primary care office visits and specialist office visits.
- When you receive "Out-of-Network" services, you have an annual Deductible of $3,000 for employee-only coverage or $6,000 for employee-and-family coverage. The Fund then generally covers up to 60% of the Maximum Reimbursable Charge ("MRC"). You are responsible for the remaining 40% of the MRC. If the provider charges more than the MRC, you are responsible for the charges in excess of the reimbursement.
- Note that a $100 copay applies for each Emergency Room visit, whether In-Network or Out-of-Network.
- Hospitalizations are covered up to 365 days for a semi-private room.

*Your entitlement to "employee-only" coverage or "employee-and-family" coverage is Dependent on the rate of contribution made by your Employer. Please call the Fund Office to verify whether you have employee-only coverage or employee-and-family coverage before you attempt to use the Fund to obtain medical services for your Dependents.

Prescription Drug Benefits

- Prescription drugs are only covered at a Participating Pharmacy. There is a $25 co-pay for generic and brand name** drugs and a $50 co-pay for injectable medications. You will receive up to a 30-day supply.
- If you use the mail order service, you have a $35 co-pay for generic and brand name** drugs and a $50 co-pay for injectable medications, but you will receive up to a 90-day supply.

**The Fund has a mandatory generic policy, which means that if you request a brand name drug when a generic equivalent is available, you will be responsible, in addition to your co-pay, for any difference in cost between the brand name and generic drugs.

Dental Benefits

The Fund provides dental benefits through an insurance policy with Dentcare Delivery Systems Inc. ("Dentcare").

Vision Benefits

The Fund will reimburse you up to:

- $15 for an eye exam, and
- $65 for glasses (frames and lenses) or $100 for contacts.

Vision benefits are available once every 12 months.

Life Insurance Benefit Subject To The Exclusions Described Later On In This Booklet

- $10,000 is paid to your named beneficiary if you die while you are a Participant in the Fund.
- If you have Dependent coverage, $5,000 is paid to you if a covered Dependent dies while he/she is covered by the Fund.

For information on filing a claim for benefits, see the section called "Claims And Appeals Procedures."

SUMMARY OF BENEFITS

DEDUCTIBLES, COINSURANCE, AND MAXIMUMS		
Key Features	In-Network	Out-Of-Network
Annual Deductible (For all Covered Services except emergency care)	$250/Single $500/Family	$3,000/Single $6,000/Family
Coinsurance (Percentage you pay)	20%	40%
Annual Maximum Out Of Pocket (For any Fund Year, you will not pay more than)	$3,000/Single $6,000/Family (including Deductible)	$13,000/Single $26,000/Family (including Deductible)
Annual Maximum Paid By The Fund	No maximum	No maximum

The "Deductible" is an initial annual amount that you pay for Out-Of-Network and certain In-Network services before the Fund pays any benefits. You only have to pay the Deductible once in each Fund Year. There is a separate Deductible for in- and out-of-network services. When you are treated by a provider, you are responsible for the Deductible, any applicable copay, and Coinsurance. You are also responsible for any amount above the Maximum Reimbursable Charge ("MRC"). Emergency Room visits are also subject to a $100 copay per visit.

KEY FEATURES		
Eligible Services & Supplies	In-Network	Out-Of-Network
Preventive Care – Age 6 and Over	Fund pays 100%	Not Covered
Well-Woman Care	Fund pays 100%	You pay 40% of MRC after you have met the Deductible
Well-Baby/Well-Child Care (Children through age 5)	Fund pays 100%	You pay 40% of MRC after you have met the Deductible
Immunizations	Fund pays 100%	You pay 40% of MRC after you have met the Deductible
Primary Care Office Visits	You pay $25 copay per visit	You pay 40% of MRC after you have met the Deductible
Specialist Office Visits	You pay $25 copay per visit	You pay 40% of MRC after you have met the Deductible
Mammograms, PSA, PAP Smear, Maternity Screening		
Preventive Care Related Services (*i.e.*, "routine" services)	Fund pays 100%	You pay 40% of MRC after you have met the Deductible

Diagnostic Related Services (*i.e.*, "non-routine" services)	Covered at the same level of benefits as other X-Ray and Laboratory Services (based on place of service). See the "Laboratory Services" and "X-Ray Services" provisions below.	Covered at the same level of benefits as other X-Ray and Laboratory Services (based on place of service). See the "Laboratory Services" and "X-Ray Services" provisions below.
Maternity		
Office Visits	You pay $25 copay for initial visit	You pay 40% of MRC after you have met the Deductible
Inpatient Facility Charges	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40% of MRC after you have met the Deductible
Outpatient Surgical Facility Charges	You pay $100 copay per visit	You pay 40% of MRC after you have met the Deductible
Inpatient And Outpatient Professional Services	Fund pays 100%	You pay 40%* of MRC after you have met the Deductible * Inpatient/Outpatient Professional Services for Anesthesiologist: You pay 20% of MRC, Deductible is waived
Allergy Treatment/Injections	You pay the lesser of $25 copay or actual charge	You pay 40% of MRC per visit after you have met the Deductible
Allergy Serum (Dispensed by the Physician in the Physician's office)	Fund pays 100%	You pay 40% of MRC per visit after you have met the Deductible
Chiropractic Care (Max 25 visits per Fund Year)	You pay $25 copay per visit	You pay 40% of MRC after you have met the Deductible
Routine Foot Disorders (Max 25 visits per Fund Year)	You pay $25 copay per visit	You pay 40% of MRC after you have met the Deductible
Outpatient Surgery		
Facility Charges	You pay $100 copay per visit	You pay 40% of MRC after you have met the Deductible
Professional Services Charges For Surgeons, Radiologists, And Pathologists	Fund pays 100%	You pay 40% of MRC after you have met the Deductible

Professional Services Charges For Services Performed By Anesthesiologists	Fund pays 100%	You pay 20% of MRC, Deductible is waived
Laboratory Services		
At Physician's Office	You pay $25 copay per visit	You pay 40% of MRC after you have met the Deductible
At Outpatient Hospital Facility Or Independent Lab Facility	Fund pays 100%	You pay 40% of MRC after you have met the Deductible
When billed as part of Emergency Room Or Urgent Care Visit	Fund pays 100%	Fund pays 100%
X-Ray Services		
At Physician's Office, Outpatient Hospital Facility, or Independent X-Ray Facility	You pay $50 copay per visit	You pay 40% of MRC after you have met the Deductible
When billed as part of Emergency Room Or Urgent Care Visit	Fund pays 100%	Fund pays 100%
Advanced Radiological Imaging (MRI, MRA, CAT Scan, PET Scan)		
At Physician's Office or Outpatient Facility	You pay $50 copay per visit	You pay 40% of MRC after you have met the Deductible
When billed as part of Emergency Room or Urgent Care Visit	Fund pays 100%	Fund pays 100%
EKG, EEG, EMG, Nerve Conduction Study, and Bone Density Study at Physician's Office, Outpatient Hospital Facility, or Independent Facility	Fund pays 100%	You pay 40% of MRC after you have met the Deductible
Inpatient Hospital Services		
Facility Charges	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40% of MRC after you have met the Deductible
Professional Services Charges for Surgeons, Radiologists, and Pathologists	Fund pays 100%	You pay 40% of MRC after you have met the Deductible
Professional Services Charges for Anesthesiologists	Fund pays 100%	You pay 20% of MRC, Deductible is waived
Inpatient Hospital Physician's Visits/Consultations	Fund pays 100%	You pay 40% of MRC after you have met the Deductible

Ambulance	You pay 20% of MRC after you have met the Deductible	You pay 20% of MRC after you have met the In-Network Deductible
Hospital Emergency Room	You pay $100 copay; copay is waived if you are admitted to the Hospital, then inpatient Hospital charges would apply	You pay $100 copay; copay is waived if you are admitted to the Hospital, then inpatient Hospital charges would apply
Urgent Care Services	You pay $25 copay per visit; copay is waived if you are admitted to the Hospital, then inpatient Hospital charges would apply	You pay 40% of MRC after you have met the Deductible
Surgery Performed by Physician at Physician's Office	Fund pays 100%	You pay 40% of MRC per visit after you have met the Deductible
Inpatient Skilled Nursing Care (Max 60 days per Fund Year)	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40% of MRC after you have met the Deductible
Hospice Care – Inpatient or Outpatient	You pay 20% of MRC after you have met the Deductible	You pay 40% of MRC after you have met the Deductible
Home Health Care (includes outpatient private duty nursing days when approved as Medically Necessary) (Max 40 days per Fund Year; 16 hour max per day)	You pay 20% of MRC after you have met the Deductible	You pay 40% of MRC after you have met the Deductible
Inpatient Rehabilitation Hospital (Max 60 days per Fund Year)	You pay $100 copay per day, to a maximum of $500 per Fund Year, then Fund pays 100%	You pay 40% of MRC after you have met the Deductible
Short-Term Rehabilitative Therapy – Outpatient Physical, Occupational, Cognitive, Speech, and Cardiac Rehabilitation Therapy (Max 60 days per Fund Year for all therapies combined)	You pay $25 copay per visit	You pay 40% of MRC after you have met the Deductible

Durable Medical Equipment	You pay 20% of MRC after you have met the Deductible	You pay 40% of MRC after you have met the Deductible
External Prosthetic Appliances ("EPA")	You pay 20% of MRC, Deductible is waived	You pay 40% of MRC after you have met the Deductible
Inpatient Abortion	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40%* of MRC after you have met the Deductible *For Inpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Outpatient Abortion	Office Visit: You pay $25 copay per visit Surgery – Office Setting: Fund pays 100% Outpatient Surgical Facility: $100 copay per visit	You pay 40%* of MRC after you have met the Deductible *For Outpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Outpatient Chemotherapy	Fund pays 100%	You pay 40% of MRC after you have met the Deductible
Outpatient Radiation Therapy	You pay 20% of MRC after you have met the Deductible	You pay 40% of MRC after you have met the Deductible
Dialysis	Office Visit: You pay $25 copay per visit Outpatient Hospital: Fund pays 100%	Office Visit: You pay 40% of MRC after you have met the Deductible Outpatient Hospital: You pay 40% of MRC after you have met the Deductible
Inpatient Mental Health	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40% of MRC after you have met the Deductible
Outpatient Mental Health	You pay $25 copay per visit	You pay 40% of MRC after you have met the Deductible
Inpatient Substance Abuse		
Administered by Cigna	You pay $100 copay per day,	You pay 40% of MRC after

	to a maximum of $500 per Fund Year	you have met the Deductible
Administered by Fund (30 day maximum per 24 months for inpatient and outpatient substance abuse benefits combined)	Fund pays 100%	Not covered
Outpatient Substance Abuse		
Administered by Cigna	You pay $25 copay per visit	You pay 40% of MRC after you have met the Deductible
Administered by Fund (30 day maximum per 24 months for inpatient and outpatient substance abuse benefits combined)	Fund pays 100%	Not covered
Circumcision (Out-Of-Network charges limited to $5,000 for charges other than Hospital facility fee)	Office: Fund pays 100% Ambulatory Surgicenter or Outpatient Hospital: You pay $100 copay Inpatient: You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40% of MRC after you have met the Deductible
Inpatient Nursery	Fund pays 100%	You pay 40% of MRC after you have met the Deductible
Breast-Feeding Equipment & Supplies	Fund pays 100%	Not covered
Diabetic Supplies	Fund pays 100%	You pay 40% of MRC after you have met the Deductible
Inpatient TMJ (surgical and non-surgical)	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40%* of MRC after you have met the Deductible *For In-patient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Outpatient TMJ (surgical and non-surgical)	Office Visit: You pay $25 copay per visit	You pay 40%* of MRC after you have met the Deductible

	Surgery – Office Setting: Fund pays 100% Outpatient Surgical Facility: $100 copay per visit	*For Outpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Women's Family Planning Services (Inpatient and Outpatient)	Fund pays 100%	You pay 40%* of MRC after you have met the Deductible *For Inpatient and Outpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Men's Inpatient Family Planning Services & Reversal Of Voluntary Sterilization	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40%* of MRC after you have met the Deductible *For Inpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Men's Outpatient Family Planning Services & Reversal Of Voluntary Sterilization	Office Visit: You pay $25 copay per visit Surgery – Office Setting: Fund pays 100% Outpatient Surgical Facility: $100 copay per visit	You pay 40%* of MRC after you have met the Deductible *For Outpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Inpatient Bariatric Surgery	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40%* of MRC after you have met the Deductible *For Inpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Outpatient Bariatric Surgery	Office Visit: You pay $25 copay per visit Outpatient Surgical Facility: $100 copay per visit	You pay 40%* of MRC after you have met the Deductible *For Outpatient Professional Services Performed by Anesthesiologist: You pay

		20% of MRC, Deductible is waived
Inpatient Organ Transplant	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40%* of MRC after you have met the Deductible *For Inpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Outpatient Organ Transplant	Office Visit: You pay $25 copay per visit Outpatient Surgical Facility: $100 copay per visit	You pay 40%* of MRC after you have met the Deductible *For Outpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Limited Inpatient Dental Care (Through Cigna)	You pay $100 copay per day, to a maximum of $500 per Fund Year	You pay 40%* of MRC after you have met the Deductible *For Inpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived
Limited Outpatient Dental Care (Through Cigna)	Office Visit: You pay $25 copay per visit Surgery – Office Setting: Fund pays 100% Outpatient Surgical Facility: $100 copay per visit	You pay 40%* of MRC after you have met the Deductible *For Outpatient Professional Services Performed by Anesthesiologist: You pay 20% of MRC, Deductible is waived

ELIGIBILITY AND PARTICIPATION

Eligibility

You are eligible to participate in the Fund if you work for an employer who is required by the terms of a collective bargaining or other written agreement to make contributions to the Fund on your behalf. Please remember that your eligible Dependents are covered only if your employer contributes for family coverage.

If you are eligible for family coverage, then your legal Spouse and eligible Dependents will be eligible for coverage at the same time that you are if you enroll them at the same time you enroll yourself.

In order for someone to be considered your Spouse, you and your Spouse must be legally married in a jurisdiction that recognizes such marriage. No coverage is provided for domestic partners. A partner that resides with you, to whom you are not legally married, will not be considered to be your Spouse, regardless of the length of time you have been together.

A marriage terminates on the date the judgment of divorce is signed. Coverage for the Spouse will terminate at the end of the month in which the judgment of divorce was signed. At the time of the divorce, the former Spouse has the option of continuing coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called "COBRA." You are responsible for notifying the Fund of a legal separation leading to a divorce. If you fail to notify the Fund that your former Spouse is no longer eligible for benefits you will be committing an act of fraud and you will be responsible for any claims that the Fund pays for your former Spouse. The Trustees reserve the right to terminate your Fund coverage and that of your covered Dependents in the event of fraud or intentional misrepresentation of a material fact, including, but not limited to, your failure to notify the Fund of such legal separation or divorce**.**

When Coverage Starts

Your coverage automatically starts on the first day of the month following sixty (60) days from the date your employer starts to make contributions on your behalf.

How Long Coverage Continues

Once you meet the initial eligibility requirement, your coverage continues on a month-to-month basis.

Dependent Coverage

When you qualify for coverage, the Fund Office will let you know whether your employer contribution level qualifies you for Dependent coverage. If it does, then coverage for your eligible Dependents generally starts at the same time as your coverage if you enroll them at the same time you enroll yourself.

Your "eligible Dependents" include:

- Your legal Spouse.

- Your children up to the end of the month in which the child attains age 26, even if the Dependent child is eligible for health coverage under another health plan.
- Unmarried handicapped Dependent children over age 26 that are incapable of self-support because of mental or physical disability. The disability must have started before the child reached age 26. You must provide the Fund Office with proof of the child's disability within 31 days after the child's 26th birthday.

When you enroll a Dependent you will be asked to provide proof of Dependent status — a birth certificate, a marriage certificate, or other proof of Dependent status. Fraudulently adding Dependents or providing other inaccurate information or misrepresentations to the Fund may result in termination or rescission of your benefits, termination or rescission of your covered family members' benefits, denial of future benefits, legal action against you and/or your covered family members, and set-off from any future benefits the value of benefits the Fund has paid relating to inaccurate information or misrepresentations provided to the Fund.

Newly Acquired Dependents

If you get married, or if you acquire a child by birth, adoption, or placement for adoption, and you are entitled to family coverage, your Dependent will be covered from the date of the marriage, birth, or adoption, provided you file an application form at the Fund Office within 31 days thereafter. If you do not complete the application within 31 days, coverage for your Dependents will be delayed.

Dependent children include the following:

- Your natural children (including children born out of wedlock, but only if proper evidence of paternity is submitted to the Fund Office);
- Your legal Spouse's natural children if they live in your home, are principally Dependent on you for support, and your Spouse has legal custody of them;
- Legally adopted children or step-children;
- Foster children who live with you and are principally Dependent on you for support and maintenance, as long as no other health benefits are being provided by any governmental agency;
- Children required to be recognized as your legal Dependents under a Qualified Medical Child Support Order ("QMCSO").

About QMCSOs

A Qualified Medical Child Support Order, or QMCSO, is an order issued by a court or state administrative agency that requires that medical coverage be provided to a child or children. A QMCSO usually results from a divorce, legal separation or paternity proceeding.

The Fund Office will notify you if a QMCSO is received with regard to your coverage. The Fund's QMCSO procedures are described in greater detail later on in this booklet (see the section called "QMCSO Procedures").

When Coverage Ends

Your coverage ends on the last day of the month:

- you stop working for a Contributing Employer,
- you enter active military service,
- the Fund discontinues group coverage,
- you engage in fraud or intentional misrepresentation of a material fact with regard to your coverage or benefits under the Fund, or
- you no longer meet the eligibility requirements.

If you lose your coverage because of a compensable disability, your coverage will continue for up to six months after your last day of employment with a Contributing Employer. The Fund may require proof of disability from your physician. You must apply for such coverage within 30 days of the onset of your disability.

Coverage for your Dependents ends on the last day of the month in which:

- your coverage ends,
- the Dependent no longer meets the Fund's definition of Dependent,
- for a Dependent Spouse, the date of divorce or legal separation,
- he or she engages in fraud or intentional misrepresentation of a material fact with regard to coverage or benefits under the Fund,
- you die.

If you legally separate or divorce…

You are required to provide prompt notice to the Fund Office if you and your Spouse legally separate or divorce. If you fail to inform the Fund Office of such legal separation or divorce, the Fund may hold you responsible for the costs associated with extending coverage to your Spouse after your legal separation/divorce became final. The Trustees reserve the right to terminate your Fund coverage and that of your covered family members for failure to notify the Fund of such legal separation or divorce.

When your coverage would otherwise end, you may be able to continue coverage by electing COBRA Continuation Coverage. The Fund also has rules for limited extensions of coverage during certain absences, and they are described in the next section.

Continuation Of Coverage During Certain Absences

If you become disabled, your coverage will continue for each month you are "totally disabled" and cannot work, for up to a total of six months. You may be required to submit proof of your disability to the Fund Office.

Family And Medical Leave

If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act ("FMLA"). Under the FMLA, you may take up to 12 weeks of unpaid leave for specified family or medical purposes, such as your own serious medical condition, the birth or adoption of a child, or to provide care for a Spouse, child or parent who is ill. Your employer, not this Fund, will determine if you are eligible for FMLA leave of absence.

If you take FMLA leave, your employer is obligated to continue to contribute to the Fund on your behalf and your coverage, through the Fund, will continue.

During your leave, you may continue all of your medical coverage and other benefits offered through the Fund. You are generally eligible for FMLA leave if you:

- worked for an employer for at least 12 months,
- worked at least 1,250 hours in covered employment over the previous 12 months, and
- worked at a location where at least 50 employees are employed by the employer within 75 miles.

If you do not return to employment following FMLA leave during which coverage was provided, you may be required to provide reimbursement for the cost of coverage received during the leave.

Call your employer if you have questions regarding your eligibility for FMLA leave. Call the Fund Office regarding coverage during such a leave.

If you do not return to work after the end of your FMLA leave, you may be eligible to continue coverage under COBRA described in a later section.

Military Leave

If you are on active military duty for 31 days or less, you will continue to receive health care coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are on active duty for more than 31 days, USERRA permits you to continue health care coverage for you and your Dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA coverage, which is described in the next section. When your coverage ends because of a reduction in hours due to your military service, you and your eligible Dependents may also have COBRA rights. You should contact the Fund Office if you are called up for service in order to determine how the leave affects you and your eligible Dependents' eligibility for Fund benefits and how USERRA protects your rights. In addition, your Dependent(s) may be eligible for health care coverage under the federal program known as TRICARE (which includes the old "CHAMPUS" program). This Fund coordinates its coverage with TRICARE.

Coverage will not be offered for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

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.

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; or
- 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.

Note that, for leaves of absence covered by the FMLA or for qualified military service, your employer must properly grant the leave, make the required notification and any required payment to the Fund. You should contact your employer to confirm that you are eligible for a leave.

Contact your employer if you have questions regarding your eligibility for a leave. Contact the Fund Office if you have any questions regarding Fund coverage during such a leave.

Continuation Of Health Care Under COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), requires that this Fund offer you and your eligible Dependents the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage would otherwise end (called "qualifying events"). Continued coverage under COBRA applies to the medical, Hospital, prescription drug, dental and vision benefits described in this booklet.

You should keep in mind that each individual entitled to coverage as the result of a qualifying event has a right to make his or her own election of coverage. For example, your Spouse or other covered Dependent may elect COBRA coverage even if you do not. In addition, one qualified beneficiary can elect COBRA for others.

Qualifying COBRA Events

The chart below shows when you and your eligible Dependents may qualify for continued coverage under COBRA, when coverage may start and when it ends.

Coverage Ends Because Of This Reason	**These People Would Be Eligible**	**For COBRA Coverage Up To** **(measured from the date coverage is lost)**
Your employment terminates*	You and your covered Spouse and children	18 months **
Your working hours are reduced	You and your covered Spouse and children	18 months **
You die	Your covered Spouse and children	36 months
Your Dependents lose coverage because you divorce or legally separate	Your covered Spouse and children	36 months
Your Dependent child no longer qualifies as an eligible Dependent	Your covered children	36 months
You become entitled to Medicare	Your covered Spouse and children	36 months

* For any reason other than gross misconduct (and including military leave and approved leaves granted according to the FMLA).

** Continued coverage for up to 29 months from the date of initial event may be available to those who by no later than the first 60 days of your qualifying event, are totally disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11 months is available to employees and enrolled Dependents if notice of disability is provided within 60 days after the Social Security Administration determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage.

Proof of good health is NOT required for COBRA coverage.

Newborn And Adopted Children

If you have a newborn child, adopt a child, or have a child placed with you for adoption while continuation coverage under COBRA is in effect and you are eligible for family coverage, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 31 days of the child's birth, adoption or placement for adoption. Legal proof of your relationship to the child must also be provided.

Multiple Qualifying Events

If your covered Dependents experience more than one qualifying event while COBRA coverage is in force, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event.

For example, if your employment ends, you and your covered Dependents may be eligible for 18 months of continued COBRA coverage. If you die (a second qualifying event) during this 18-month period, your covered Dependents may be eligible for an additional period of COBRA continuation coverage. However, the two periods of coverage combined may not exceed a total of 36 months from the date of the first qualifying event (your termination).

This extended period of COBRA continuation coverage is not available to anyone who became your Spouse after the termination of employment or reduction in hours. However, this extended period of coverage is available to any child born to, adopted by, or placed for adoption with you during the 18-month period of continuation coverage.

Also note that if your first qualifying event is a reduction in hours, and then your employment is terminated, the termination of employment is not treated as a second qualifying event (so there is no extension beyond the initial 18-month period of coverage).

When Your Employer Must Notify The Fund Office

Your employer must notify the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement no later than 60 days after your loss of coverage due to one of these events. However, you or your family should also notify the Fund Office if such an event occurs, in order to avoid confusion as to your status.

When You Or Your Beneficiary Must Notify The Fund Office

As a covered employee or qualified beneficiary, you are responsible for providing the Fund Office with timely notice of certain qualifying events. These events include:

- Divorce or legal separation.
- A child losing Dependent status under the Fund.
- The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of an additional 18 months, up to 36 months in total. This second qualifying event could include an employee's death, entitlement to Medicare, divorce or legal separation, or a child losing Dependent status.
- When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.

You must make sure that the Fund Office is notified of any of the events listed above within 60 days of the qualified event. Failure to provide this notice in the form and within the timeframes described below may prevent you and/or your Dependents from obtaining or extending COBRA coverage.

How To Provide Notice

Your notice should be sent to:

United Teamster Fund
2137-2147 Utica Avenue
Brooklyn, New York 11234

Please include the following in your notice:

- your name,
- the names of your Dependents,
- your Social Security number and the Social Security numbers of your Dependents,
- your address, and
- the nature and date of the occurrence you are reporting to the Fund.

When The Notice Must Be Sent

You must provide notice to the Fund within 60 days of the date of the event (and do not forget to provide addresses for both you and the Dependent(s)). **If you do not notify the Fund by the end of the 60-day period, you and your Dependents will not be entitled to continuation coverage.**

Keep the Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Fund Office.

Electing COBRA Coverage

The Fund must notify you and/or your covered Dependents of your right to COBRA coverage within 14 days after it receives timely notice or becomes aware that a qualifying event has occurred. You will have 60 days to respond if you want to continue coverage – measured from the date coverage would otherwise end or, if later, the date the COBRA notice is sent to you.

Paying For COBRA Coverage

You will be charged the full cost of continued coverage under COBRA, plus a 2% administrative fee. (If you are eligible for 29 months of continued coverage due to disability, the law permits the Fund to charge 150% of the full cost of the plan during the 19th to 29th months of coverage.)

It is easiest to make your first payment when you file your COBRA election form, that is, within 60 days from the date your Fund coverage would otherwise end. In no event may your payment be made later than 45 days from the date you mail your signed election form to the Fund Office.

Your first check must cover the period from the date your coverage ended and COBRA coverage began through the current month.

After the first payment all subsequent COBRA payments will be due by the 30th of each month. Keep in mind that the Fund Office does not send bills for COBRA coverage and it is your responsibility to see that your payment is at the Fund Office by the due date.

COBRA premiums are generally reviewed at least once a year and are subject to change.

You will be notified by the Fund Office if the amount of your COBRA payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

When COBRA Coverage Ends

You or your Dependent's continued coverage under COBRA may end for any of the following reasons:

- Coverage has continued for the maximum 18, 29 or 36-month period, measured from the date coverage is lost.
- The Fund terminates. If the coverage is replaced, you may be continued under the new coverage.
- You or your Dependent(s) fail to make the necessary payments on time.
- You or a covered Dependent(s) become covered under another group health fund.
- You or a covered Dependent becomes entitled to benefits under Medicare.
- You or your Dependent(s) are continuing coverage during the 19th to 29th months of a disability, and the disability ends.
- Continuation coverage may also be terminated for any reason that would terminate coverage of any Participant or beneficiary not receiving continuation coverage (such as fraud).

Full details of COBRA continuation coverage will be furnished to you or your eligible Dependents when the Fund Office receives notice that a qualifying event has occurred.

Your Rights Under The Health Insurance Portability And Accountability Act Of 1996 (HIPAA)

Under the federal law called the Health Insurance Portability and Accountability Act of 1996 (commonly called "HIPAA") the Fund is required to provide the following.

Special Enrollment Rights

HIPAA requires that funds like ours allow eligible employees and Dependents who do not already participate in the Fund to obtain coverage if certain events occur. These are known as "qualifying circumstances." (Note that, with regard to Dependents, these rights apply only if you are entitled to family coverage.) Qualifying circumstances occur when:

- You have a change in family status, such as marriage, divorce, birth, adoption, placement for adoption, or death.
- You previously stated in writing that you and/or your Dependents were waiving Fund coverage because of coverage under another medical plan, and that other coverage is lost for any of the following reasons:
    - termination of employment;
    - reduction in hours worked;
    - your Spouse dies;
    - you and your Spouse divorce or legally separate;
    - the other coverage was COBRA continuation coverage, and you or your Dependent reaches the maximum length of time for COBRA continuation coverage; or
    - the other plan terminates because the employer or other sponsor did not pay the premium when due.

Further, under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"), you and your Dependents, if eligible for but not covered under the Fund, are permitted to enroll in the Fund upon:

- losing eligibility for coverage under Medicaid or a state Children's Health Insurance Program ("CHIP") or
- becoming eligible for premium assistance under Medicaid or CHIP.

You or your Dependent must request coverage under the Fund within 60 days of being terminated from Medicaid or CHIP coverage as a result of loss of eligibility, or within 60 days of being determined to be eligible for premium assistance.

More information about these rights is available from the Fund Office at (718) 859-1624, (718) 842-1212 or (732) 882-1901.

Disclosure Of Health Information To The Board Of Trustees

Summary Health Information

The Fund may disclose summary health information (other than genetic information) to the Trustees, if the Trustees requests the summary health information for purposes of:

- obtaining premium bids for providing health coverage under the Fund; or
- modifying, amending, or terminating the Fund.

For this purpose, "summary health information" is information which summarizes the claims history, claims expenses, or type of claims experienced by individuals to whom the Fund has provided benefits and from which the information described at 45 CFR § 164.504(a)(2) has been deleted.

Enrollees

The Fund may disclose to the Trustees whether an individual is participating in the Fund, or is enrolled in or has unenrolled from health coverage offered by the Fund.

Protected Health Information

The Trustees may use or disclose protected health information ("PHI"), provided to the Trustees below, for any administrative function within the Trustees' scope of authority pertaining to the Fund, and as otherwise permitted or required by law.

PHI means health information which:

- is created or received by a health care provider, health plan, employer, or health care clearinghouse (within the meaning of 45 CFR § 160.103);
- relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- identifies the individual (or which can be used to identify the individual).

The Trustees agrees to:

- not use or further disclose the PHI provided to it under this section, other than as permitted or required by the Fund or as required by law;

- ensure that any agents to whom it provides PHI agree to the same restrictions and conditions that apply to the Trustees with respect to such information;

- not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan maintained by the Trustees;

- report to the Fund any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for herein of which it becomes aware;

- make available PHI in accordance with 45 CFR § 164.524;

- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

- make available PHI required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

- make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with all requirements of HIPAA;

- if feasible, return or destroy all PHI that the Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further

uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure adequate separation by implementing the following rules and procedures:

    - The only individuals (other than the Trustees) who will be given access to PHI provided to the Trustees will be the Fund Administrator, the Assistant Fund Administrator, and any other individual whose functions relate to payment under, health care operations of, or other matters pertaining to the Fund in the ordinary course of business.
    - The access to and use of PHI by the above mentioned is limited to the Fund administration functions that the Trustees performs for the Fund.
    - Any failure of the individuals described above to comply with these requirements shall be subject to review of and discipline by the Trustees.

The Fund may disclose PHI to the Trustees to carry out Fund administrative functions, provided that the Trustees furnishes the Fund with a certification that the Fund contains the provisions described herein. The Fund may not disclose genetic information to the Trustees.

Other HIPAA rules: This Fund is a covered entity under HIPAA's privacy regulations. For a copy of the Fund's "Notice of Privacy Practices" please contact the Fund Office.

MEDICAL BENEFITS

This section gives you a brief overview of how your coverage works for you and your covered Dependents.

Overview Of How Coverage Works

If you have been covered by the Fund for a while, you may be accustomed to seeing some benefits described as covered by "Major Medical." We do not use that term now, but the Fund works pretty much the same way it always has. The Fund has contracted with Cigna to offer you Open Access Plus Medical Benefits to provide coverage for care In-Network and Out-Of-Network. Benefits provided through the Cigna network are described as "In-Network." Benefits that are not provided through the Cigna network are described as "Out-Of-Network."

The Fund covers a wide range of health care services, from office visits, to lab tests and x-rays, to major surgery and Hospital care. In order to be covered, the medical expenses must be deemed Medically Necessary. The determination of coverage is at the sole discretion of the Trustees. Most Eligible Expenses or services are covered through either a Cigna network provider or an Out-Of-Network provider.

The Cigna Network Of Providers

The Cigna network consists of doctors, Hospital s and other health care facilities selected by Cigna to provide medical services. When you use a Cigna provider for your medical care, the care is called "In-Network." Here are some of the important points about In-Network care:

- an extensive network of medical care providers to choose from,
- a $250 Deductible for employee-only coverage and a $500 Deductible for employee-and-family coverage,
- a $3,000 annual maximum on Out-Of-Pocket Expenses for employee-only coverage and a $6,000 annual maximum on Out-Of-Pocket Expenses for employee-and-family coverage,
- a Copayment for most covered charges and sometimes a 20% Coinsurance, and
- there are usually no claim forms to file.

Finding A Network Provider

Here is how to find a network participating doctor, Hospital, lab or other network facility near you.

- **Look at Cigna's online directory.** To locate an In-Network doctor, Hospital or other provider in the Cigna network, log on to www.mycigna.com or www.cigna.com and browse the online provider directory.
- **Contact Cigna.** Contact Cigna Customer Service at the phone number listed on the back of your ID card.
- **Contact the Fund Office.** The Fund Office can also help you find an In-Network provider.

The Cigna Network – While you have the option of going to an In-Network provider or an Out-Of-Network provider for your medical care, you pay less when you use In-Network providers.

How Out-Of-Network Care Is Covered

You also have the option of going to an Out-Of-Network provider. When you see a provider that does not participate in Cigna's network, the services are considered "Out-Of-Network". Here are key facts you need to know if you choose to go Out-Of-Network for your medical care:

- You must meet a $3,000 for employee-only coverage or $6,000 for employee-and-family coverage annual Deductible before being reimbursed for Eligible Expenses. (Note that there is a separate $100 Copayment for Emergency Room visits, as described elsewhere.)
- After you have met the annual Deductible, expenses are generally reimbursed at only 60% of the MRC
- You are responsible for paying the balance, which is your Coinsurance.
- There is a $13,000 annual maximum on Out-Of-Pocket Expenses for employee-only coverage and a $26,000 annual maximum on Out-Of-Pocket Expenses for employee-and-family coverage
- You must file a claim form. In most cases, you have to pay the provider when the service is rendered, then submit a claim for reimbursement to Cigna.

You must submit satisfactory proof of each charge for which benefits are being claimed, and each charge used to satisfy the Deductible. Be sure to keep an accurate record of your medical expenses and retain all bills and receipts.

For more information, see the section called, "Your Benefits At A Glance" and "Summary of Benefits."

Special Exception. If you are unable to locate an In-Network provider in your area who can provide you with a service or supply that is covered by the Fund, you must call the number on the back of your Cigna ID card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for such services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Pre-Certification/Prior Authorization/Continued Stay

Pre-Certification Or Prior Authorization

In order for certain services and benefits to be covered by the Fund, you must receive "pre-certification" or "prior authorization." The term "pre-certification" or "prior authorization" means the approval that a Participating Provider must be received from the Cigna Review Organization (if the benefit is administered by Cigna) or the Fund Office (if the benefit is administered by the Fund Office).

Prior approval of services is required for:

- treatment of alcohol and drug addiction/substance abuse benefits;
- the use of operating room facilities at a Hospital for a surgical procedure;
- the use of operating room facilities at an ambulatory facility (outpatient surgeries);
- durable medical equipment costing $500 or more;
- prosthetics and orthotics costing $500 or more;
- certain prescribed medications;
- Hospital stays;
- private duty nursing;
- elective abortion procedures;
- mental health benefits;
- Medically Necessary circumcision if not newborn (more than 30 days old);
- home health care benefits;
- hospice care;
- hyperbaric oxygen benefits;
- injectables/infusions provided in an office setting;
- maternity over allowed days;
- nursery over allowed days;
- surgical by-pass for obesity;
- speech, respiratory, occupational, cardiac, and cognitive therapy;
- physical therapy and rehabilitation;
- skilled nursing facility;
- rehabilitation facility;
- long-term acute care facility;
- transfers between inpatient Hospitals;
- maternity Hospital stays longer than 48 hours (for vaginal delivery) or 96 hours (in the case of cesarean section);
- sleep disorder benefits (testing and treatment); and
- transplant benefits.

Managing Your Care

There are two ways that the Fund helps you manage your medical care, through "preadmission certification/continued stay review for Hospital Confinement" and "case management." Both programs are handled by Cigna.

Pre-Admission Certification/Continued Stay Review For Hospital Confinement

Pre-Admission Certification ("PAC") and Continued Stay Review ("CSR") refer to the process used to certify Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- As a registered bed patient;
- For a partial hospitalization for the treatment of mental health or substance abuse;
- For mental health or substance abuse residential treatment services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 100% for Hospital charges made for each separate admission to the Hospital unless PAC is received prior to the date of admission or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under the Fund for the charges listed below will not include:

- Hospital charges for bed and board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- Any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted. If you fail to pre-certify your Out-Of-Network Hospital stay, a 100% penalty will be applied to your Hospital inpatient charges. Out-Of-Network benefits are denied for any admission reviewed by Cigna and not certified. Out-Of-Network benefits are also denied for any additional days not certified by Cigna.

Case Management

Case management is a service provided through a Cigna Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or as an inpatient in a Hospital or specialized facility. Should the need for case management arise, a case management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses ("RNs") and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to you or your covered Dependent. In addition, case managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

You, your Dependent or an attending Physician can request case management services by calling the toll-free number shown on your ID card during normal business hours, Monday through

Friday. In addition, the Fund, a claim office or a utilization review program may refer an individual for case management.

- The Cigna Review Organization assesses each case to determine whether case management is appropriate.
- You or your Dependent is contacted by an assigned case manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in case management.
- Following an initial assessment, the case manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The case manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other durable medical equipment for the home).
- The case manager also acts as a liaison between the insurer, the patient, his or her family and physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the case manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in case management is strictly voluntary, case management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

HOSPITAL BENEFITS

When you are hospitalized, the Fund covers semiprivate room and board (if you have a private room, the Fund still pays no more than the semiprivate rate). Also covered when you are hospitalized are the types of services and supplies typically required when you are hospitalized, including:

- anesthesia supplies and use of anesthesia equipment (administration only when given by a Hospital employee, otherwise see the section called “Anesthesia”)
- bed and board including special diets,
- dressings,
- drugs and medicines for use in the Hospital,
- electrocardiographic equipment use,
- general nursing care,
- laboratory examinations consistent with the diagnosis and treatment of the condition for which hospitalization is required (note that lab interpretations may be billed independently and therefore may not be covered in full),
- operating room and recovery room use,
- chemotherapy,

- oxygen and equipment used for its administration,
- physiotherapeutic equipment use,
- plaster casts,
- x-ray examinations consistent with the diagnosis and treatment of the condition for which hospitalization is required (note that x-ray interpretations are generally billed separately and are not covered under this benefit).

In-Hospital Medical Expense Benefits

If you are hospitalized for a Sickness that does not require surgery or maternity care, you are eligible for Hospital medical expense benefits. Coverage applies to Sicknesses, such as heart disease, pneumonia, etc.

The in-Hospital medical expense benefit generally does not cover services performed in conjunction with dental work or surgery covered by Workers' Compensation. In addition, benefits are not provided at a veteran's facility for care in connection with a military service related disability or at a Hospital operated by a federal or state agency (except for emergency care).

In-Hospital Coverage

The Fund covers up to 365 days per Hospital Confinement. A "confinement" is a period of hospitalization that is separated from the previous and following confinement by at least 90 days.

Pre-certification is required by Cigna.

Emergency Care

The Fund covers the following Emergency Services:

- The Fund covers emergency first aid rendered within 24 hours after accidental Injury or 72 hours from the onset of Sickness.
- For the use of operating room facilities at the Hospital for a surgical operation, the Hospital must contact Cigna before treatment begins. If Cigna is closed you must contact Cigna as soon as possible after treatment has begun.

You are responsible for a $100 copay for each Emergency Room visit.

Minor Surgery

The Fund's coverage for Emergency Room and minor surgery includes:

- closed reduction of fractured or dislocated bones,
- endoscopies requiring the use of the Hospital's surgical facilities, and
- any incisions or punctures of the skin or other tissue except for inoculation, vaccination, collection of blood, drug administration, or injection.

Surgical Benefits

The Fund provides coverage for surgery that is recommended, approved and performed by a Legally Qualified Physician or Surgeon.

Pre-certification is required.

Multiple surgeries performed In-Network during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery. Multiple surgeries performed Out-Of-Network during one operating session result in payment reduction of 50% to the second surgery of lesser charge and 25% for subsequent surgeries. The most expensive procedure is paid as any other surgery.

Assistant Surgeon: The maximum amount payable will be limited to charges made by an assistant Surgeon that do not exceed a percentage of the Surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the Surgeon prior to any reductions due to Coinsurance or Deductible amounts.)

Co-Surgeon: The maximum amount payable for charges made by co-Surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

Women's Health And Cancer Rights Act Of 1998

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This includes coverage for the following:

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

This coverage is subject to the Fund's standard rules and regulations for payment of benefits.

Pre-Surgical Testing

The Fund also covers diagnostic tests prescribed by your doctor performed in the same Hospital as the surgery.

Maternity Care

The Fund provides Hospital maternity benefits for eligible participants and eligible Dependents. Regular Hospital benefits are paid for normal delivery (including false labor) for at least two days and at least four days for a Caesarian section. Surgery care for a newborn is covered to the same extent as for the mother.

Pre-certification is required for a longer Hospital stay.

Newborns' And Mothers' Health Protection Act Of 1996

The Fund may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable). In any case, the Fund may not, under federal law, require that a provider obtain pre-authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTE**:** There is no coverage for a newborn child of a Dependent child.

Abortion (includes elective and non-elective procedures)

The Fund will pay for semi-private accommodations for up to two days for abortion procedures performed in a Hospital. If tubal ligation is performed during the same period of hospitalization, the Fund will cover a Hospital stay of up to three days.

Pre-certification is required for a Hospital stay related to an abortion procedure.

Hospital Clinics Or Freestanding Clinics

The Fund covers an office visit to a clinic in the same manner as a visit to a physician's office.

Ambulance

Ambulances are covered for emergency transport only. The use of ambulettes or other vehicles for transportation from one facility to another is excluded.

Hospital And Medical Benefit Exclusions

The following expenses are not covered by the Fund:

- all charges not specifically listed as Covered Expenses;
- expenses in excess of the MRC;
- expenses that exceed any Fund benefit limitation or annual maximum;
- Hospital Confinements for custodial or convalescent care, rest cures, or long-term care;
- Hospital Confinements or any period of Hospital Confinement primarily for diagnostic studies;
- hospitalization furnished pursuant to federal, state, or other laws (except Medicaid);
- care for health conditions that are required by state or local law to be treated in a public facility;
- care rendered in a Hospital operated by federal or state government, municipality or agency (except for emergency care);
- care required by state or federal law to be supplied by a public school system or school district;

- ambulance or ambulette service (except for emergency transport as provided elsewhere in this booklet);
- Hospital benefits for services of Physicians or private or special nurses, or other private attendants or their board, except as otherwise provided under this booklet;
- admissions primarily for physical therapy;
- services performed at veteran's facilities for care in connection with a military service related Sickness or Injury;
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available;
- treatment of a Sickness or Injury which is due to war, declared or undeclared;
- assistance in the activities of daily living, including but not limited to, eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care;
- eyeglass lenses and frames and contact lenses (except as otherwise provided for in this booklet);
- routine refraction, eye exercises, and surgical treatment for the correction of a refractive error, including radial keratotomy;
- treatment by acupuncture;
- all non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and Experimental drugs, except as provided elsewhere in this booklet;
- membership costs or fees associated with health clubs and weight loss programs;
- genetic screening or pre-implantation genetic screening;
- dental implants for any condition;
- fees associated with the collection or donation of blood or blood products, except for autolongous donation in anticipation of scheduled services where in the Cigna health plan medical director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery;
- blood administration for the purpose of general improvement in physical condition;
- costs of immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks;
- cosmetics, dietary supplements and health and beauty aids;
- all nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism;
- cosmetic surgery or therapy, except to correct defects caused by traumatic Injury or disease that occurs while covered, such as breast surgery after a mastectomy or lumpectomy (cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance);
- the following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia surgeries, acupressure, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy, and extracorporeal shock wave lithotripsy for musculoskeletal and orthopedic conditions;
- unless otherwise covered as a basic benefit: reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations;

- court ordered treatment or hospitalization, unless such treatment is being sought by an In-Network Physician or otherwise covered elsewhere in this booklet;
- charges for dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition; except for children and limited dental care provided for elsewhere in this booklet;
- private Hospital rooms and/or private duty nursing, except as provided elsewhere in this booklet;
- expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a Participating Provider of the primary plan;
- services for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit;
- telephone, e-mail, and internet consultations and telemedicine;
- massage therapy;
- admissions or continuing hospitalizations primarily for any one of the following: diagnosis, physical therapy, x-ray therapy, radium therapy, transfusions for blood or blood plasma, custodial care, convalescent care, or rest cure;
- nursing care rendered by you or your Spouse, or a child, brother, sister or parent of you or your Spouse;
- services, supplies and equipment provided in connection with elective sterilization, except as specifically provided for elsewhere in this booklet;
- test to determine a donor match;
- services, supplies and equipment provided to the donor of an organ for transplant, unless both the donor and the recipient are eligible Participants and members of the same immediate family;
- infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees), and cryopreservation of donor sperm and eggs;
- any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including but not limited to penile implants), anorgasmia, and premature ejaculation;
- services, supplies and equipment provided in connection with a sex change operation, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such operation;
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible for coverage under the Fund;
- non-medical counseling or ancillary services, including, counseling or ancillary services, including, but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return-to-work services, word hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation;
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which

is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected;

- consumable medical supplies other than ostomy supplies and urinary catheters; excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as provided for elsewhere in this booklet;
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of Sickness or Injury;
- artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs;
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books; and
- any other exclusions listed in “General Exclusions” or elsewhere in this booklet.

PREVENTIVE CARE AND OTHER MEDICAL BENEFITS

Office Visits

The Fund covers visits to the offices of Physicians and specialists.

Well-Woman Care

The Fund covers one well-woman exam per Fund Year.

Annual Physical Exam

The Fund covers one physical exam per Fund Year. Coverage includes lab and x-ray billed by the doctor's office, as well as additional services, such as urinalysis, EKG, and other laboratory tests.

Immunizations

The Fund covers all required immunizations. The Fund also covers the office visits for immunization if charged separately.

Radiation Therapy

The Fund covers deep x-ray therapy and the Physician's component of the charges. Hospital charges for the use of the technical component will be paid on the same basis as for In-Network therapy.

Dialysis

The Fund covers dialysis benefits until you become eligible for such coverage under Medicare. Coverage includes hemodialysis and peritoneal dialysis during an inpatient hospitalization. Outpatient dialysis is covered as follows:

- **At home coverage** – All appropriate and necessary supplies required for home dialysis treatment, as well as the rental of equipment.
- **Coverage in a Hospital or freestanding facility** – Necessary treatment if the facility's dialysis program is approved by the appropriate governmental authorities.

Home Health Care

Home health care includes charges made for home health services when you require skilled care, are unable to obtain the required care as an ambulatory outpatient, and do not require confinement in a Hospital or Other Health Care Facility.

Home health services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is Dependent upon others for nonskilled care and/or custodial services (*e.g.*, bathing, eating, toileting), home health services will be

provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial service's needs.

Home health services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health care aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home health services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing home health services are covered. Home health services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the home health care benefit terms, conditions and benefit limitations. Physical, occupational, and other short-term rehabilitative therapy services provided in the home are not subject to the home health care benefit limitations in the benefit schedule, but are subject to the benefit limitations described under short-term rehabilitative therapy maximum shown in the schedule.

Home health care is subject to a maximum of 40 days per Fund Year.

Pre-certification is required.

Skilled Nursing Facility Care

The Fund covers up to 60 days of inpatient skilled nursing facility care each Fund Year when a Physician determines that the care is "Medically Necessary."

The stay at the skilled nursing facility must be immediately following a Hospital Confinement for a serious Sickness.

Pre-certification is required.

A skilled nursing facility is a licensed institution (other than a Hospital) which specializes in:

- Physical rehabilitation on an inpatient basis or
- Skilled nursing and medical care on an inpatient basis

But only if that institution maintains on the premises all facilities necessary for medical treatment, provides such treatment for compensation under the supervision of Physicians, and provides nurses' services.

Exclusions For Skilled Nursing Facility Care

In addition to the Fund's general exclusions, the following are not covered under the skilled nursing facility care benefit:

- benefits for an employment-related Sickness or accident,
- any service rendered by a person who is a member of the patient's family or who ordinarily lives with the patient, and

- services for any Sickness that is not covered.

Hospice Care

Hospice care includes charges made for a person who has been diagnosed as having six months or fewer to live due to a terminal Sickness. The following hospice care services are provided:

- Hospice facility for bed & board and services & supplies;
- Hospice facility for services provided on an outpatient basis;
- Physician for professional services;
- Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- Pain relief treatment, including drugs, medicines, and medical supplies;
- Other Health Care Facility for:
    - Part-time of intermittent nursing care by or under the supervision of a nurse;
    - Part-time or intermittent services of an Other Health Care Professional;
- Physical, occupational and speech therapy;
- Medical supplies, such as drugs and medicines lawfully dispensed only on the written prescription of a Physician; and
- Laboratory services, but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or hospice facility.

Hospice care services do not include charges:

- For the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- For any period when you or your Dependent is not under the care of a Physician;
- For services or supplies not listed in the hospice care program;
- For any curative or life-prolonging procedures;
- To the extent that any other benefits are payable for those expenses under the Fund;
- For services or supplies that are primarily to aid you or your Dependent in daily living.

Pre-certification is required.

A hospice facility means an institution or part of it which:

- Primarily provides care for terminally ill patients;
- Is accredited by the National Hospice Organization;
- Meets standards established by Cigna; and
- Fulfills any licensing requirements of the state or locality in which it operates.

A terminal Sickness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Visiting Nurse Service

The Fund covers Medically Necessary services provided by registered and licensed practical nurses, for up to 40 outpatient visits and 30 inpatient days per Fund Year. Coverage includes the services of certified home health aides.

Pre-certification is required.

Injection Therapy

The Fund covers injections to the joints, and the cost of drugs subject to a $50 co-pay. Coverage does not include:

- visits for injections of liver, iron and vitamin B-12 for secondary anemia,
- hormone injections for menopause, and
- injections for other non-specific medications, such as penicillin and other antibiotics.

Routine Foot Disorders – Podiatric Services

The Fund covers a maximum of 25 visits each Fund Year for Medically Necessary podiatric services relating to routine foot disorders, including services for treatments arising from diabetes. Covered services include treatment for corns, bunions, calluses, toenails, flat feet, fallen ankles, weak feet, chronic foot strain or systematic foot problems.

Pre-certification is required only for in Hospital surgery.

Short-Term Rehabilitative Therapy Services - Outpatient Physical, Occupational, Cognitive, Speech, Pulmonary, And Cardiac Rehabilitation Therapy

The Fund covers a maximum of 60 days of short-term rehabilitative therapy each Fund Year for all therapies combined (In-Network and Out-Of-Network services combined). Therapy days provided as part of an approved home health care plan accumulate to the short-term rehabilitative therapy maximum.

Pre-certification is required.

The Fund covers short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic, manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Multiple outpatient short-term rehabilitative therapy services provided on the same day constitute one day of service. A separate copay will apply to the services provided by each provider. Services that are provided by a chiropractic Physician are not covered as short-term rehabilitative therapy.

Occupational therapy is covered only if it is provided only for purposes of enabling persons to perform the activities of daily living after an illness or Injury or Sickness. The Fund covers treatment by a speech therapist when requested by a Legally Qualified Physician to restore loss of speech, to correct impairment due to a congenital defect for which corrective surgery has been performed, or for an accident or Sickness (except for a functional nervous disorder).

Hearing Benefits

The Fund covers hearing evaluations by an audiologist and hearing aids prescribed by Legally Qualified Physicians. The Fund covers a maximum of $1,000 every three (3) Fund Years for the purchase and fitting of a hearing aid.

Repair and maintenance are not covered.

Durable Medical Equipment

The Fund covers charges made for the purchase or rental of durable medical equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from your misuse are your responsibility. Coverage for durable medical equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Pre-certification is required for durable medical equipment costing $500 or more.

Durable medical equipment is defined as items which are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to, crutches, Hospital beds, respirators, wheel chairs and dialysis machines.

Durable medical equipment items that are not covered include, but are not limited to:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses;
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas;
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs;
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps;
- **Car/Van Modifications;**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines;
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors;
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

External Prosthetic Appliances And Devices

The Fund covers charges for the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect and are ordered by your Physician. Coverage for external prosthetic appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices include prostheses/prosthetic appliances and devices, orthoses and orthotic devices, braces, and splints.

Breast-Feeding Equipment And Supplies

The Fund covers In-Network breast-feeding equipment and supplies. Coverage is limited to the rental of one breast pump per birth as ordered or prescribed by a Physician. Coverage includes related supplies.

Diabetic Supplies

The Fund covers lancets, glucose test strips, and meters.

TMJ Benefits

The Fund covers both inpatient and outpatient services, as well as surgical and non-surgical services. Appliances and orthodontic treatment are excluded. Coverage for TMJ services is subject to Medical Necessity.

Family Planning Benefits

The Fund covers both inpatient and outpatient services. For women, the Fund covers surgical services, such as tubal ligation and contraceptive devices (*e.g.*, Depo-Provera and Intrauterine Devices ("IUDs")) as ordered or prescribed by a Physician. Diaphragms are also covered when services are provided in the Physician's office. For men, the Fund covers surgical services such as vasectomy.

Bariatric Surgery Benefits

The Fund covers both inpatient and outpatient bariatric surgery. Coverage is subject to Medical Necessity and clinical guidelines and is limited to the treatment of clinically severe obesity, as defined by the body mass index.

Organ Transplant Benefits

The Fund covers both inpatient and outpatient services. Coverage includes services performed at a Lifesource center and a non-Lifesource facility.

Pre-certification is required.

Limited Dental Care Benefits

The Fund covers both inpatient and outpatient services. Coverage is limited to charges made for services or supplies provided or in connection with an accidental Injury to sound natural teeth

provided in a continuous course of treatment started within six (6) months of the accident. "Sound natural teeth" are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

Additional Outpatient Benefits

The following benefits are also available under the Fund subject to any applicable Out-Of-Pocket Expenses you are required to pay:

- Blood and blood plasmas, surgical dressings, casts, trusses, iron lung, oxygen and rental of equipment for its administration.
- Radium and radioactive isotope treatment.
- Licensed health aid from the state where service is provided.

Outpatient/Ambulatory Facility

For an operating room facility other than a Hospital, pre-certification is required.

Mental Health & Substance Abuse Benefits

Mental Health Benefits

Mental health services are services that are required to treat a disorder that impairs behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to mental health will not be considered to be charges made for treatment of mental health.

Mental health benefits are provided under the Fund through Cigna and also through a separate program administered by the Fund Office, D.J. O'Grady.

Pre-certification is required.

Mental Health Benefits Administered By Cigna

Inpatient Mental Health Services

Inpatient mental health services include services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of mental health. Inpatient mental health services include partial hospitalization and mental health residential treatment services.

Case management and utilization review for inpatient services (including both In-Network and Out-Of-Network) is provided by Cigna Behavioral Health.

Partial Hospitalization- Partial hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. Partial hospitalization is subject to the Fund's inpatient mental health benefit.

Mental Health Residential Treatment Services- Mental health residential treatment services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute mental health conditions. Mental health residential treatment services are subject to the Fund's inpatient mental health benefit. Mental health residential treatment services are covered only if approved through Cigna Behavioral Health Case Management.

A mental health residential treatment center is an institution which specializes in the treatment of psychological and social disturbances that are the result of mental health conditions, provides a subacute, structured, psychotherapeutic treatment program under the supervision of physicians, provides 24-hour care, is a facility in which a person lives in an open setting, and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a mental health residential treatment center when she/he is a registered bed patient in a mental health residential treatment center upon the recommendation of a Physician.

Outpatient Mental Health Services

Outpatient mental health services includes the services of providers who are qualified to treat mental health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or mental health intensive outpatient therapy program. Case management and utilization review for outpatient services (In-Network only) are provided by Cigna Behavioral Health. Covered services include, but are not limited to, outpatient treatment of conditions such as anxiety or depression which interferes with daily functioning, emotional adjustment or concerns related to chronic conditions, such as psychosis or depression, emotional reactions associated with marital problems or divorce, child/adolescent problems of conduct or poor impulse control, affective disorders, or acute exacerbation of chronic mental health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A mental health intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program. Intensive outpatient therapy programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week. The intensive outpatient therapy program benefit is covered the same as mental health outpatient visits. The intensive outpatient therapy program is covered only if it is approved through Cigna Behavioral Health Care Management.

Mental Health Exclusions

The following are specifically excluded from mental health services administered by Cigna:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under the Fund.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.

- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children required by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Mental Health Benefits Administered by the Fund

The Fund also provides benefits for the treatment of mental health through a supplemental program administered by the Fund Office, D.J. O'Grady. These benefits are provided on an In-Network basis only and include both inpatient and outpatient services. Pre-certification is required, so you must contact the Fund Office before receiving benefits. If you do not obtain pre-certification from the Fund Office for these benefits, the Fund will not cover your treatment. The Fund Office will make arrangements with professionals in the field for professional evaluation which will be used to determine whether you require inpatient or outpatient treatment. You will then be directed by the Fund Office to an appropriate facility for treatment. Note that treatment under this supplemental program is limited to 25 sessions per calendar year for mental health treatment.

Substance Abuse Benefits

Substance abuse benefits are also provided under the Fund through Cigna and also through a separate program administered by the Fund Office, D.J. O'Grady.

Pre-certification is required.

Substance Abuse Benefits Administered by Cigna

Inpatient Substance Abuse Rehabilitation Services

Inpatient substance abuse rehabilitation services are services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Case management and utilization review for inpatient services (including both In-Network and Out-Of-Network) are provided by Cigna Behavioral Health. Inpatient substance abuse services include partial hospitalization sessions and substance abuse residential treatment services.

Partial Hospitalization- Partial hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. Partial Hospitalization is subject to the Fund's inpatient substance abuse benefit.

Substance Abuse Residential Treatment Services- Substance abuse residential treatment services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute substance abuse conditions. Substance abuse residential treatment services are subject to the Fund's inpatient substance abuse benefit. Substance abuse residential treatment services are covered only if approved through Cigna Behavioral Health Case Management.

A substance abuse residential treatment center means an institution which specializes in the treatment of psychological and social disturbances that are the result of substance abuse, provides a subacute, structured, psychotherapeutic treatment program under the supervision of Physicians, provides 24-hour care in which a person lives in an open setting and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a substance abuse residential treatment center when she/he is a registered bed patient in a substance abuse residential treatment center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Outpatient substance abuse rehabilitation services include services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual or a substance abuse intensive outpatient therapy program. Case management and utilization review for outpatient services (In-Network only) are provided by Cigna Behavioral Health.

A substance abuse intensive outpatient therapy program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient therapy programs provide a combination of daily individual, family and/or group therapy, totaling nine or more hours in a week. The intensive outpatient therapy program benefit is covered the same as substance abuse outpatient visits. The intensive outpatient therapy program is covered only if it is approved through Cigna Behavioral Health Care Management.

Substance Abuse Detoxification Services- Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Substance Abuse Exclusions

The following are specifically excluded from substance abuse services administered by Cigna:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under the Fund.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.

- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children required by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Substance Abuse Benefits Administered by the Fund

The Fund also provides benefits for the treatment of alcohol and drug addiction through a supplemental program administered by the Fund Office, D.J. O'Grady. These benefits are provided on an In-Network basis only and include both inpatient and outpatient services. Pre-certification is required, so you must contact the Fund Office before receiving benefits. If you do not obtain pre-certification from the Fund Office for these benefits, the Fund will not cover your treatment. The Fund Office will make arrangements with professionals in the field for professional evaluation which will be used to determine whether you require inpatient or outpatient treatment. You will then be directed by the Fund Office to an appropriate facility for treatment. Note that treatment under this supplemental program is limited to 30 days per 24 months for substance abuse treatment (inpatient and outpatient combined).

PRESCRIPTION DRUG BENEFITS

How The Prescription Drug Benefit Works

The Fund provides coverage through Optum RX for prescription drugs purchased at a Participating Pharmacy or through the Optum RX mail-order program. Coverage depends on which option you use. The following table summarizes these benefits.

Prescriptions From A Participating Pharmacy (up to 30-day supply)	What You Pay
Generic drugs	$25 copay
Brand name drugs when no generic equivalents are available	$25 copay
Brand name drugs when generic equivalents are available	$25 copay, plus cost difference between brand name and generic
Injectable medications	$50 copay

Prescriptions Through The Mail-Order Program (up to 90-day supply)	What You Pay
Generic drugs	$35 copay
Brand name drugs when no generic equivalents are available	$35 copay
Brand name drugs when generic equivalents are available	$35 copay, plus cost difference between brand name and generic
Injectable medications	$50 copay

What Types Of Prescription Drugs Are Covered?

Covered drugs include all federal or state legend drugs as well as insulin. Insulin syringes, lancets, and test strips are covered only through mail order. There are quantity limitations on certain drugs for the treatment of impotence, migraine headaches, asthma, and allergies as indicated by the manufacturer.

Mandatory Generic Policy

The Fund has a mandatory generic policy, which means that if you request a brand name drug when a generic equivalent is available, you will be responsible for the price difference between the brand and generic, plus the applicable co-payment.

Mandatory Mail-Order For Maintenance Drugs

The mail-order option must be used for drugs that you take on a regular or long-term basis (called "maintenance medications"). You are allowed to fill your initial prescription and to obtain one additional refill at a retail Pharmacy. After these two initial fillings, you must use the mail-order Pharmacy to fill your prescription.

If you lose your Optum RX ID card, you should call the Fund office at (718) 859-1624, (718) 842-1212 or (732) 882-1901 for a replacement card.

Mail Order Refills

Prescription drug refills are not sent automatically. You must complete the refill form included with each shipment from Optum RX and send it with your check or credit card information in the mailer provided. You may also call in your refill request by calling 800-797-9791 or by visiting the web site at, www.optumrx.com. Your order will be held up if your balance due exceeds $50. You should allow two weeks for delivery time.

Prescription Drug Exclusions & Limitations

The following items are not covered by the Fund:

- vitamins;
- dental treatments;
- diet pills;
- food supplements;
- protein drinks;
- fertility treatments;
- medications used for cosmetic purposes;
- over-the counter items such as cold remedies and wound dressings;
- Medications or drugs that are not Medically Necessary;
- Medications or drugs that are covered by, or required to be covered by, Workers Compensation Insurance;
- Medications or drugs that are covered by, or required to be covered by, automobile insurance; and
- Any other exclusion listed under "General Exclusions, Exceptions and Limitations."

Your prescription drug coverage is also subject to the following limitations:

- Oral and injectable contraceptives are covered only for non-contraceptive purposes. You must submit a letter of Medical Necessity to the Fund Office to request authorization for these drugs.
- Vaccines, growth hormones, and some cancer treatments also require a letter of Medical Necessity.

Diabetes Monitoring

The Fund's Trustees are continuously searching for ways to improve the health and welfare of you and your family. As a result of this effort, a new pain free device for diabetes has been brought to our attention.

One of the prominent providers in the industry is Diabetes Support Program who will provide participants and covered family members who have diabetes with Freestyle meter, strips and lancets at **NO COST TO YOU**. The Freestyle monitor allows diabetics to test their blood sugar from their forearms or other body sites without the pain associated with the traditional finger stick test. The meter is rated the most accurate for home testing and is quick and easy to use.

Diabetes Support Program will provide the meter strips and lancets to you at **NO COST AND WILL WAIVE THE COPAY** if you use their services. It is important that diabetics control their blood sugar to live healthy lives and that is why the Trustees feel this benefit is important to you.

Diabetes Support Program will provide diabetic supplies to your home by mail at no cost. They can be reached during the hours of 9:00 a.m. to 5:00 p.m. Monday through Friday at (561) 795-9806.

The company has also assured us that they will answer all questions in a courteous and prompt manner and will assist in any way possible.

Diabetes Support Program does not provide insulin. Insulin should be obtained from the mail order Pharmacy program.

Prescription Drug Benefits Claims

For information on filing prescription drug claims, see the section called "Claims and Appeals Procedures."

VISION BENEFITS

The vision benefits described in this section are administered by Healthplex, Inc. ("Healthplex"). You and, if applicable, your eligible Dependents, can receive the allowance for vision benefits as described below for an eye examination and one pair of eyeglasses once every consecutive twelve months, counting from the last time you received vision benefits.

Note: If you utilize one of the vision care providers on the Fund's panel, you will receive considerable savings as compared to using a provider outside of the panel. You may obtain a list of providers on the Fund's panel from the Fund Office.

How It Works

You can use any provider of your choosing. First call the Fund Office for an optical voucher. You will be required to pay the full cost of services and supplies up front, and the Fund will reimburse you once every consecutive twelve month period starting from the date that you last received the benefit for vision care services, up to the following amounts:

- $15 for eye exams
- $65 for prescription eyeglasses (lenses and frames) *or* up to $100 for prescription contact lenses.

You will only be reimbursed up to the amounts listed above. If your exam, glasses or contacts cost more than the amount listed above, you will be responsible for that additional amount. To get reimbursed for services, submit the completed voucher with the itemized receipt or bill for the vision service attached and send it to the Fund Office.

Keep in mind that medical treatment of the eyes and surgery performed on the eyes may be covered by your medical and/or surgery benefits. See the section called "Hospital Benefits" for more information.

What Is Not Covered

The Fund does not provide coverage for the following:

- sunglasses (plain or prescription);
- any benefits covered, or required to be covered by, or which could be covered by Workers' Compensation insurance;
- benefits payable through "no-fault" insurance law or an uninsured motorist law or other automobile insurance for such expenses;
- services or benefits received from federal, state or municipal agencies or the Veteran's administration; and
- any other exclusion listed in "General Exclusions, Exceptions and Limitations."

DENTAL BENEFITS

Dental benefits are provided for you and, if applicable, your eligible Dependents by the Fund through an insurance policy with Dentcare. The complete terms of these benefits are set forth in the group insurance policy or Certificate of Insurance with DentCare and accompanying riders. Please refer to those documents for details on your coverage.

The maximum dental benefit payable per person per Fund Year is $2,000. The maximum orthodontia limit payable per lifetime is $1,650. The orthodontia limit only applies to children under the age of 19.

Very limited dental coverage is provided by the Fund through the medical benefits administered by Cigna. Please refer to the earlier section of this SPD discussing those benefits for details on your coverage. Where coverage is provided by the Fund through Cigna, the terms of the SPD governing these benefits will govern. Precertification is requirement for benefits administered.

LIFE INSURANCE BENEFITS

Participant Life Insurance

The Fund pays a $10,000 lump sum to your named beneficiary if you die while covered by the Fund. This insurance is provided through the Fund Office.

Covered Loss	Benefit
Life	$10,000

Designating A Beneficiary

To designate or change your beneficiary for your life insurance benefit, you must complete a Designation of Beneficiary Card, which is available at the Fund Office.

If you do not name a beneficiary, or if the person you name dies before you, the benefit will be paid to the following surviving individual(s) in this order:

- your Spouse,
- your children (in equal shares),
- your parents (in equal shares), or
- your sisters and brothers (in equal shares).

If you do not designate a beneficiary and the person(s) listed above are not living at the time of your death, benefits will be paid to your estate.

Dependent Life Insurance

If one of your covered Dependents dies while covered by the Fund, you will receive a $5,000 life insurance benefit.

Life Insurance Exclusions & Limitations

The following exclusions and limitations apply to the life insurance benefit:

- In the untimely event of your death, your beneficiary will receive a lump sum under the life insurance benefit, but **not** an accidental death benefit.
- No benefits will be payable if death occurs as a result of participation in Motor Vehicle races or speed tests.
- No benefits will be payable if death occurs as a result of your intentional violent and/or criminal act or suicide.
- No benefits will be payable if death occurs as a result of the operation of a Motor Vehicle while intoxicated or while the ability to operate such vehicle is impaired by use of a drug, whether legal or otherwise.

- No benefits will be payable if death occurs as a result of the commission of an act that constitutes a felony, or the avoidance of lawful apprehension or arrest by a law enforcement officer.
- No benefits will be payable if death occurs as a result of the operation or occupation of a Motor Vehicle known to be stolen.
- No benefits will be payable if death occurs as a result of the operation of a private passenger vehicle as a public or livery conveyance.
- No benefits will be payable if any other exclusion listed under "General Exclusions, Exceptions and Limitations" is applicable.

Life Insurance Benefits Claims

For information on filing a life insurance claim, see the section called "Claims and Appeals Procedures."

ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

The Fund provides an insurance benefit in the event of your accidental death or serious Injury that occurs solely through external, violent and accidental means. This benefit is in addition to any other benefit you may be eligible to receive. The amount you receive as an Accidental Death & Dismemberment ("AD&D") benefit is based on your specific loss and upon the applicable death benefit.

If your employer is contributing at the highest rate at the time benefits become payable from this Fund, the maximum benefit is up to $10,000 in the event of an accidental death or dismemberment of hands, feet or eyesight when you are off-the-job. If your employer is contributing at a lower rate, the maximum benefit is $7,000.

If the accident results in your death, the benefit is paid to your named beneficiary. If the accident results in dismemberment or loss of sight, the benefit is paid directly to you. The amount of benefit is shown on the "Accidental Death & Dismemberment Benefits" chart below.

Covered Loss	**Benefit**
Life	100% of your maximum benefit
Both hands, or, both feet or sight of both eyes	100% of your maximum benefit
One hand and one foot	100% of your maximum benefit
One hand or foot and the sight of one eye	100% of your maximum benefit
One hand or one foot	50% of your maximum benefit
Sight of one eye	50% of your maximum benefit

Dismemberment means severance of a limb or above the wrist or ankle joint. Loss of sight means the entire and irrevocable loss of sight.

The loss must have occurred within ninety (90) days from the date of the accident. In addition, if one accident results in more than one loss, only one amount - the largest to which you are entitled - is payable.

AD&D benefits cover only off-the-job accidents and do not cover losses caused directly or indirectly by:

- air travel in any capacity other than as a fare paying passenger on a regular commercial airline;
- commission of a felony; or
- intentional self-destruction or intentionally self-inflicted Injury.

Accidental Death & Dismemberment Exclusions & Limitations

The following exclusions and limitations apply to the accidental death & dismemberment benefit:

- In the untimely event of your AD&D, your beneficiary will receive a lump sum under an accidental death benefit, but **not** the life insurance benefit.

- No benefits will be payable if AD&D occurs as a result of participation in Motor Vehicle races or speed tests.
- No benefits will be payable if AD&D occurs as a result of your intentional violent and/or criminal act or suicide.
- No benefits will be payable if AD&D occurs as a result of the operation of a Motor Vehicle while intoxicated or while the ability to operate such vehicle is impaired by use of a drug, whether legal or otherwise.
- No benefits will be payable if AD&D occurs as a result of the commission of an act that constitutes a felony, or the avoidance of lawful apprehension or arrest by a law enforcement officer.
- No benefits will be payable if AD&D occurs as a result of the operation or occupation of a Motor Vehicle known to be stolen.
- No benefits will be payable if AD&D occurs as a result of the operation of a private passenger vehicle as a public or livery conveyance.
- No benefits will be payable if any other exclusion listed under "General Exclusions, Exceptions and Limitations" is applicable.

Accidental Death & Dismemberment Benefit Claims

For information on filing an accidental death & dismemberment claim, see the section called "Claims and Appeals Procedures."

GENERAL EXCLUSIONS, EXCEPTIONS & LIMITATIONS

The Fund does not provide coverage for all types of health-related expenses. In addition to any exclusions already mentioned in various sections of this booklet, no benefits are payable for the following:

- expenses for care that is not Medically Necessary, except as specifically provided in this booklet;
- charges that have been paid for by another insurance carrier (see the "Coordination of Benefits" section);
- expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party;
- charges that would not have been made if coverage did not exist or for charges that neither you nor any of your Dependents are required to pay;
- expenses for services rendered or supplies provided: (i) before the claimant became covered under the Fund, or (ii) after the date the claimant's coverage ends, except under those conditions described elsewhere in this booklet;
- charges for services, treatment or supplies that are received from a dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee or any similar person or group;
- charges for services or treatments to the extent the Fund is prohibited by law or regulation from providing such benefits;
- charges for plastic or cosmetic surgery and therapy and surgery or treatment relating to the consequences as a result of plastic surgery, except as specifically provided in this booklet (the Fund will comply with the Women's Health and Cancer Rights Act of 1998);
- charges for injuries, Sickness, or losses resulting from an act of war, declared or undeclared or participation in a felony, riot or insurrection;
- charges for injuries, Sickness, or losses resulting from accidental bodily Injury arising out of and in the course of the individual's employment, except as specifically provided in this booklet;
- charges for telephone consultations, missed appointments or fees added for filling out a claim form;
- drugs or vitamins which do not require a prescription order even if a prescription order has been written;
- cosmetics, dietary supplements, food supplements, and health or beauty aids regardless of physician authorization;
- charges for injuries, Sickness, or losses that are compensable under any Workers' Compensation law, occupational disease law, or similar legislation, except as provided for under the "Reimbursement & Subrogation of Benefits" section;
- services, supplies and equipment which are not necessary for or consistent with the diagnosis and treatment of the accident, Sickness or Injury or which are not recommended and approved by a Legally Qualified Physician operating within the scope of his or her specialty;
- payment for services for a Sickness or Injury resulting from the commission of or attempt to commit a felony or seeking to avoid lawful apprehension or arrest by a law enforcement officer;

- technology, treatments and any hospitalization in connection with such technology including surgery, treatments, procedures, drugs, biologicals or medical devices which, in the sole discretion of the Fund, are either Experimental, investigational, obsolete or ineffective (see the "Glossary" section for "Experimental Drugs & Procedures");
- medical and Hospital services, supplies and equipment which are paid or provided for because of your (or any person's) past or present service in the armed forces of any government or are paid or provided for under any law of a government;
- expenses for personal services, such as haircuts, shampoos and sets, guest meals and radio/television rentals received in any in-patient or out-patient facility;
- expenses for personal convenience items, such as air conditioners, humidifiers, physical fitness equipment or other such devices which are useful in the absence of Sickness or Injury;
- services involving equipment or facilities used when the rental or construction has not been approved in compliance with applicable state laws or regulations;
- travel or transportation whether or not recommended by a Physician (except for emergency transport specifically provided for in this booklet);
- care in a nursing home or home for the aged;
- custodial care such as sitters, homemaker's services or care in a place that serves you primarily at a residence;
- expenses or losses which are the result of self-inflicted injuries;
- charges for any loss or portion thereof, for which mandatory automobile no-fault benefits are covered or recoverable;
- payment for services that are eligible for payment under the provisions of an automobile insurance contract, or pursuant to any federal or state law that mandates indemnification for such service to persons suffering bodily Injury from Motor Vehicle accidents, where permitted by state law;
- charges for which Medicare or Medicaid is the primary payor;
- claims submitted after 12 months from the date the cost was incurred;
- any expenses or charges for services or supplies which are chiefly for instruction, education or training;
- any expense or charge associated with adoption or surrogate parentage;
- collection or storage of your own blood, blood products, semen or bone marrow except as otherwise provided; and
- any expenses or charges incurred in connection with injuries to the driver or operator of a Motor Vehicle whose injuries arise from operating such Motor Vehicle where the Motor Vehicle is not covered by statutorily-mandated Motor Vehicle insurance or the Motor Vehicle insurance provides no coverage for the driver or operator's medical care as required by law (for other exclusions involving the operation of a Motor Vehicle, see the "Motor Vehicle Operation Exclusions" section below).

Experimental Drugs and Procedures

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided as a "Clinical Trial"; or
- the subject of an ongoing phase I, II or III clinical trial, except as provided as a "Clinical Trial"

Experimental, investigational drugs are all non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and Experimental drugs, except as provided for in the Fund.

Motor Vehicle Operation Exclusions

Effective July 1, 2008, no coverage is provided for the injuries to the driver or operator of a Motor Vehicle whose injuries arise from operating such Motor Vehicle where the Motor Vehicle is not covered by statutorily-mandated Motor Vehicle insurance or the Motor Vehicle insurance provides no coverage for the driver or operator's medical care as required by law.

In addition, no benefits are available to you or your eligible Dependents, whether the claimant maintains Motor Vehicle insurance or not if the claimant:

- intentionally causes his or her own Injury;
- is injured as a result of operating a Motor Vehicle while in an intoxicated condition or while the ability to operate such vehicle is impaired by use of a drug;
- is committing an act that would constitute a felony, or seeking to avoid lawful apprehension or arrest by a law enforcement officer;
- is operating a Motor Vehicle in a race or speed test;
- is operating or occupying a Motor Vehicle known to be stolen; or.
- is operating a private passenger vehicle as a public or livery conveyance.

SPECIAL RULE FOR DENTAL BENEFITS

For dental benefits, please refer to the Fund's Certificate of Insurance with Dentcare and accompanying riders for information regarding exclusions, expenses not covered by the Fund, and general limitations.

COORDINATION OF BENEFITS

This section describes the circumstances when you or your covered Dependents may be entitled to medical benefits from the Fund and may also be entitled to recover all or part of your medical expenses from some other source. It also describes the rules that apply when this happens.

There are several ways in which you and/or your covered Dependents could be reimbursed for your medical and/or dental expenses not only from the Fund, but also from some other source.

This could occur if you or a covered Dependent is also covered by:

- Another group medical plan; or
- Medicare or some other government program, such as Medicaid or TRICARE, or any coverage either provided by a federal, state or local government or agency, or any coverage required by federal, state or local law, including, but not limited to, any Motor Vehicle no-fault coverage for medical expenses or loss of earnings that is required by law; or
- Workers' compensation.

Duplicate coverage of medical expenses can also occur if a third party is financially responsible for the Injury or Sickness because that third party caused the Injury or Sickness by negligent or intentionally wrongful action – *e.g.*, slip and fall accidents due to a dangerous/hazardous condition, medical mistakes, assaults, dog bites, etc.

The Fund operates under rules that prevent it from paying benefits which, together with the benefits from any other group medical plan (Medicare, workers' compensation, coverage provided by a federal, state or local government or agency, coverage under any Motor Vehicle no-fault coverage (or any other coverage) for medical expenses or loss of earnings that is required by law, or recovery you may receive from a negligent or wrongful third party) would allow you to recover more than 100% of medical expenses you incur. In many instances, you may recover less than 100% of those medical expenses from the duplicate sources of coverage or recovery. In some instances, the Fund will not provide coverage if you can recover from some other resource. In other instances, the Fund will advance its benefits, but only subject to its right to recover them if and when you or your covered Dependents actually recover some or all of your losses from a third party.

When And How Coordination Of Benefits ("COB") Applies

For purposes of this Fund, "group medical plan" means:

- a group or blanket insurance company, or
- a group hospital or medical service plan or other group medical payment coverage program.

Many families with more than one person working are covered by more than one group medical plan (or "plan"). If this is the case with your family, you must let this Fund know about all your coverage when you submit a claim.

Coordination of Benefits (or "COB") operates so that one of the plans (called the "primary plan") pays its benefits first. The other plan (called the "secondary plan") may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses. The Fund will only pay for Covered Expenses and will not pay more than the amount it would normally pay if it were primary. In other words, the Fund will not pay more than the MRC for Eligible Expenses, whichever is applicable. In order to determine whether or not this Fund is the primary plan, original bills for medical expenses must be submitted with your claim.

General Rules

The order of payment is generally determined as follows:

- If the other plan does not have a COB provision, that plan always pays first.
- If both plans have a coordination provision, the plan covering you as an employee pays your expenses first.
- If your Spouse is covered under a separate plan, the separate plan should cover your Spouse's expenses first.
- If you and your Spouse are both covered employees in this Fund, you will receive payment first as an employee and second as a Dependent.
- If you are covered by more than one plan, other than an individual plan, the plan which covered you the longest pays first.

Rules For Dependent Children

Dependent Child Covered Under More Than One Plan – The Birthday Rule

When this Fund and another plan cover the same child as the Dependent of two or more parents, the primary plan is the plan of the parent whose birthday falls earlier in the year if:

- the parents are married;
- the parents are not separated (whether or not they have ever been married);
- a court order awards joint custody without specifying which parent must provide health coverage; or
- a court awards joint custody and charges each parent with equal responsibility to provide health coverage for their Dependent children.

If both parents have the same birthday, the plan that covered either of the parents longer is the primary plan. If the other plan does not have a birthday rule, then the Fund is primary.

Dependent Child Covered Under More Than One Plan – Court Order

When this Fund and another plan cover the same child as the Dependent of two or more parents, and a court order has established responsibility for the child's health care expenses, the plan of the parent with this responsibility is primary.

Dependent Child Covered Under More Than One Plan – Custodial Parent

When this Fund and another plan cover the same child as the Dependent of two or more parents, if the parents are not married, or are separated (whether or not they ever married), or are divorced, the primary plan is:

- the plan of the custodial parent; then
- the plan of the Spouse of the custodial parent; then
- the plan of the non-custodial parent; and then
- the plan of the Spouse of the non-custodial parent.

If The Fund Is The Secondary Plan

When the Fund is the secondary plan, it will pay the same benefits that it would have paid had it paid first **minus** whatever payments were actually made by the plan (or plans) that paid first. If the primary plan pays benefits equal to or greater than what would have been paid by the Fund had it paid first, this Fund will not pay any benefits. The total payments from both the primary and secondary plans will never exceed the total allowable expenses under the Fund.

Administration Of COB

To administer COB, the Fund reserves the right to:

- exchange information with other plans involved in paying claims;
- require that you or your health care provider furnish any necessary information;
- reimburse any plan that made payments this Fund should have made; or
- recover any overpayment from your Hospital, Physician, dentist, other health care provider, other insurance company, you or your Dependent.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the medical expenses that were incurred. However, any person who claims benefits under the Fund must give all the information the Fund needs to apply COB.

Special Rule For Prescription Drugs

There is no COB provision for prescription drugs. This Fund will make no secondary payments for prescription drug claims.

Coordination With Medicare And Other Government Plans

Active Employees or Dependents of Active Employees Eligible for Medicare Due to Age

If you are covered under the Fund due to your or someone else's current employment with a Contributing Employer, and are also eligible for Medicare due to age, you may:

- Continue your coverage under the Fund (to the extent you remain eligible) and defer enrollment in Medicare; or
- Continue your coverage under the Fund and also enroll in Medicare; the Fund would be your primary medical coverage and Medicare would be your secondary medical coverage as long as your coverage under the Fund is attributable to current employment with a Contributing Employer; or
- Drop your coverage under the Fund and enroll in Medicare.

You should be aware that if you drop the Fund coverage, then your family's coverage under the Fund will also end. Medicare will be your only Hospital and medical-surgical insurance, unless there is coverage through your Spouse's employer or unless you decide to purchase private health insurance.

Covered Individuals Eligible for Medicare Due to Disability

If you, your Spouse and/or your Dependent child(ren) are covered by this Fund and by Medicare, as long as you remain actively employed, this Fund pays first and Medicare pays second. If you become eligible for Medicare by reason of disability and you cease active employment, you and your family members will no longer be covered by the Fund.

Medicare and End-Stage Renal Disease

If, while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease ("ESRD"), the Fund pays first and Medicare pays second for a limited period of time (30 months). After this 30-month period, Medicare pays first and the Fund pays second.

Here's how COB works in ESRD situations:

- Medicare generally imposes a three-month Waiting Period at the onset of ESRD before Medicare becomes effective. Therefore, the Fund would pay benefits during the Waiting Period and then continue to pay first for an additional 30 months, while Medicare pays second during this latter time period. Therefore, the Fund will pay primary for a total time period of 33 months. Beginning with the **34th month**, Medicare will pay first and the Fund will pay second.
- If the Medicare Waiting Period is waived, this Fund will pay first for the first 30 months and Medicare will pay second. Beginning with the **31st month**, Medicare will pay first and the Fund will pay second.

Medicaid

If both the Fund and Medicaid cover you, the Fund pays first and Medicaid pays second.

Coordination With Motor Vehicle Insurance

Covered Expenses incurred for the treatment of injuries arising out of the maintenance or use of a Motor Vehicle shall be eligible for coverage only to the extent that such benefits are in excess of, and not in duplication of, benefits paid or payable:

- under a plan or policy of Motor Vehicle insurance (including the mandatory part of any insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law), provided that non-duplication as contained herein is not prohibited by law; or
- through a program or other arrangement of qualified or certified self-insurance.

Not all expenses incurred in the treatment of Injury arising out of the maintenance or use of a Motor Vehicle are covered by the Fund (please see the "Motor Vehicle Operation Exclusions" section for more information). In no event will the Fund pay more than it would if it were primary.

Notwithstanding any provision to the contrary, in determining whether the Fund or another plan is the primary plan, the Fund will be secondary to coverage provided under Motor Vehicle insurance which provides for health insurance protection, including coverage provided under any personal injury protection ("PIP") or "no-fault" coverage of medical care or treatment.

When the Owner or Operator of the Motor Vehicle and the Claimant are the Same Person

The Fund will be secondary to coverage provided under Motor Vehicle insurance which covers bodily or personal injuries even if you selected coverage under the Motor Vehicle insurance as secondary for eligible medical care or treatment. Thus, if you or your Dependent decline to select health care coverage under Motor Vehicle insurance as primary, but such insurance provides health care coverage that purports to be secondary to coverage under your health care plan, the Fund will nevertheless pay benefits second, if at all. This provision is intended to avoid the possibility that the Fund will be determined to be primary to coverage that is available under Motor Vehicle or "no-fault" insurance.

Therefore, if you live in a state that requires personal injury protection ("PIP"), sometimes called no-fault coverage, such as New Jersey or New York, your Motor Vehicle insurance is the primary plan for medical expenses related to a Motor Vehicle accident. You need to buy the maximum coverage offered with PIP. The Fund is secondary to PIP, but only if you exceed the PIP maximum coverage limits.

Again, the Fund does not permit Participants to opt out of no-fault coverage as the primary plan by designating the Participant's own health insurance as a primary source of coverage in the case of Injury related to a Motor Vehicle accident. If you should make such a designation, be aware that the Fund will reimburse you as the secondary plan only, under the assumption that you have received primary reimbursement from your Motor Vehicle insurance to the maximum limit available. In other words, you will receive little or no reimbursement from the Fund unless the accident expenses exceed the PIP maximum.

SPECIAL RULE FOR DENTAL BENEFITS

For dental benefits, please refer to the Fund's Certificate of Insurance with Dentcare and accompanying riders for information regarding COB.

REIMBURSEMENT AND SUBROGATION OF BENEFITS

Third Party Recovery/Subrogation

General Principle

When you or your covered Dependent receive benefits under the Fund which are related to medical expenses that are also payable under Workers' Compensation, any disability award or order, any governmental or private right of recovery, any statute, any uninsured or underinsured motorist program, any no fault insurance program, any personal injury protection program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your covered Dependent shall reimburse the Fund for the related benefits received out of any funds or monies you or your Dependent recovers from any such third party payee.

Specific Requirements and Fund Rights

Because the Fund is entitled to reimbursement, the Fund shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your covered Dependent may have against any third party. The Fund is granted a specific and first right of reimbursement from the first dollar of any payment, amount or recovery from a third party. This right to reimbursement applies regardless of the manner in which the recovery is structured or worded, regardless of how the monies are described or what they are for, and even if you or your covered Dependent have not been paid or fully reimbursed for all of your/their damages or expenses.

The Fund's share of recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Fund agrees in writing to such reduction. The Fund retains the sole and final discretion to decide whether and in what case such consent will be granted, if requested. Further, the Fund's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, the "collateral source" rule, the "attorney's fund" doctrine, regulatory diligence or any other defenses or doctrines that may affect the Fund's right to subrogation or reimbursement.

This provision applies to any type of payment received that arises from or in connection with the Sickness, Injury, accident, occurrence, loss or condition, whether or not the payor caused or is legally responsible or liable for it. This provision applies regardless of whether such liability or responsibility is or is not denied or is in dispute.

The Fund may enforce its subrogation or reimbursement rights by requiring you or your covered Dependent to assert a claim to any of the benefits to which you or your covered Dependent may be entitled.

In addition, by participation in the Fund, you and any covered Dependent agree to irrevocably assign to the Fund all rights to recover monetary compensation from a third party, including the right to bring suit in your or your covered Dependent's name, or to intervene in any action brought by you or your covered Dependent to the extent of all benefits paid by the Fund and to give notice of this assignment directly to such third parties, their agents or insurance carriers, or to any agent or attorney who may represent you or your covered Dependent. The assignment shall entitle the Fund to reimbursement from any sums held or received by the following third parties which are due to you or your covered Dependent prior to any distribution of benefits to you or your covered Dependent, and shall provide that such parties shall hold such sums, which are subject to the constructive trust and/or equitable lien as described below, in trust as a fiduciary for the benefit of the Fund. The parties shall be bound by such assignment are:

- Any party or its insurance carriers making payments to or on behalf of you or your covered Dependent; or
- Any agent or attorney receiving payments for or on behalf of you or your covered Dependent.

If the Fund should become aware that you or your covered Dependent has received a third party payment, amount or recovery and not report such amount, the Fund, in its sole discretion, may suspend all further benefit payments related to you or any of your covered Dependents until the reimbursable portion is returned to the Fund or offset against amounts that would otherwise be paid to or on behalf of you or your covered Dependents.

The Fund may withhold or suspend payment of any or all benefits in case a claim against any third party exists, and may require that you sign a reimbursement agreement/consent to lien form guaranteeing the Fund's right to reimbursement. If you, your Dependent, attorney, representative or agent fail or refuse to cooperate with this provision and with the Fund's right by disputing the Fund's lien, failing to advise the Fund of the status of the claim against the third party, withholding necessary information, not executing the consent to lien form described above, or in any other way, the Fund will withhold, suspend and exclude payment of any benefits which would otherwise be payable under the Fund. This is a specific exclusion and limitation of the Fund, and is in addition to any other legal rights, which the Fund may have, or any other action the Fund may take to protect its rights.

The Fund has sole and final discretion to determine whether to assert its rights under this provision as a lien, through subrogation, or through reimbursement, to advance payments of benefits and require repayment, or through any combination or variation of these methods. The determination of which method(s) will be used in a particular case will be made to protect the interests of the Fund and its Participants, and is at the Fund's sole and final discretion.

No claim against any third party may be settled or resolved, and no payment may be accepted from any third party, without written consent from the Fund. Unless and until the Fund has received full reimbursement, no monies from or through a third party may be distributed to you, your Dependent, your attorney, representative or agent without the Fund's written consent. If any monies are distributed to you or your attorney, they are to be held in constructive trust, and these monies are, to the extent of benefits payable or paid by the Fund, assets of this Fund and debt owed to the Fund, and will promptly be repaid to the Fund. The Fund's decision on whether to grant, or withhold its consent is a final and binding decision, made in the sole discretion of the Fund's Trustees.

The Fund may, by written notice given to you, require that all other persons comply with this provision as well in order to secure the Fund's rights in the exercise of its sole and final discretion.

No other liens may be superior to the Fund's lien or rights under this provision. The Fund may, in its discretion and in an appropriate case, agree to a reduction of its lien for the payment of a portion of attorneys' fees and costs of a legal proceeding, if all terms of this provision have been and are being observed.

Any disputes arising under or in connection with this section, including disputes over liens, their amount, reimbursement or withholding of benefits, or reductions or compromises in the Fund's lien shall, if not resolved with the Fund Office, be settled in accordance with the procedure for "Claims and Appeals" in this booklet, including review by the Board of Trustees.

Participant Duties and Actions

By participating in the Fund, you and your covered Dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Fund exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you and your covered Dependents agree to cooperate with the Fund in reimbursing it for costs and expenses.

Once you or your covered Dependent has any reason to believe that you or they may be entitled to recovery from any third party, you or your covered Dependent must notify the Fund in writing within 30 days. Such written notice must include the name, address, telephone number of the attorney, representative or other agent handling the claim on behalf of you or your covered Dependent. The notice should also identify any such third party. You or your covered Dependent must also notify the third party and its counsel or representative in writing of the Fund's lien within 30 days of the date you assert your claim against the third party.

Upon the Fund's receipt of such written notice, the Fund will provide you with an "Agreement to Reimburse the United Teamster Fund For Amounts Recovered" (the "Reimbursement Agreement") that confirms the prior acceptance of the Fund's subrogation rights and the Fund's right to be reimbursed for expenses arising from circumstances that entitle you or your Dependent to any payment, amount or recovery from a third party. This Reimbursement Agreement must be signed by you and your covered Dependent (and you or their attorney, if applicable) and notarized. The Reimbursement Agreement confirms that you or they acknowledge, agree to and will adhere to the Fund's lien, right of subrogation and/or reimbursement and this provision of the Fund. The Fund may modify this Reimbursement Agreement at any time without further notice, in its sole and exclusive discretion, and will provide you with a copy of any new or revised Reimbursement Agreement to be executed and returned to the Fund within ten (10) days of notification. The Fund also may, in its sole and final discretion, require you, your Dependent and/or any such attorney, representative or agent to execute such other documents the Fund deems necessary, helpful or appropriate to protect the Fund's rights under this provision. You may also be required to permit the Fund to initiate or intervene in any proceeding, and you may be required to file a lien or Consent to Lien, assignment or other such forms, to protect the Fund's interests.

You and your covered Dependent consent and agree that you or they shall not assign your or their rights to settlement or recovery against a third person or party to any other party, including

their attorneys, without the Fund's consent. As such, the Fund's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Fund.

You, your Dependent, your attorney, or representative or agent must advise the Fund as to the status of any claim against any third party, including providing the Fund with information as to the third party, insurers, lawsuits or any other data related to the claim at the time the claim is initiated, every twelve (12) months thereafter, whenever a settlement is proposed, and whenever otherwise requested by the Fund.

Full cooperation with this provision is a condition to payment of any benefits under this Fund. In case of any failure of cooperation or violation of this provision no benefits will be paid and, you, your Dependent, your attorney, your representative or your agent will be liable to the Fund for full reimbursement of its lien, including costs, interest and fees. Specifically, if you or your covered Dependent fail or refuse to execute the required Reimbursement Agreement, or otherwise cooperate with this provision, the Fund may deny payment of any benefits to you and your covered Dependents until the Reimbursement Agreement is signed. Alternatively, if you or your covered Dependent fail or refuse to execute the required Reimbursement Agreement, or otherwise cooperate with this provision, and the Fund nevertheless pays benefits to or on behalf of you or your covered Dependent, you or your covered Dependent's acceptance of such benefits shall constitute agreement to the Fund's right to subrogation or reimbursement. This provision covers not only you as Participant, but your Dependents, Spouses, attorney, representatives, agents and their heirs, guardians, executors, successors and assignees.

If there is any reasonable cause to believe that the Injuries or Sicknesses sustained by you or your covered Dependent were in any way the result of the acts or omissions of one or more third parties, but you or your covered Dependent disclaims any third party involvements, the Fund shall have the right to require you or your covered Dependent to sign a declaration, under penalty of perjury, regarding such disclaimer as a pre-condition to the payment of any benefits.

Recoupment

If you or a Dependent receive any benefits from the Fund for which you are not entitled, you will be legally liable to reimburse the Fund for those benefits. The Fund may withhold or offset future benefit payments, sue to recover such amounts, or use any other lawful remedy to recoup any such amounts, including the filing of a criminal complaint with respect to any fraud or misrepresentation resulting in the improper claim and payment by the Fund.

SPECIAL RULE FOR DENTAL BENEFITS

For dental benefits insured by Dentcare, please refer to the Certificate of Insurance and riders with Dentcare for Dentcare's rules regarding claims involving reimbursement and subrogation of benefits.

CLAIMS AND APPEALS PROCEDURES

This section describes the procedures for filing claims for benefits from the Fund. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Claims Procedures

A claim is a request for benefits. A claim must be submitted, depending on the type, in accordance with the rules and procedures described below.

Types Of Claims

Urgent Care Claims
An Urgent Care claim is any claim for upcoming medical care or treatment, without which:

- could seriously jeopardize the life or health of you or your Dependent or the ability of you or your Dependent to regain maximum function; or
- in the opinion of the treating Physician with knowledge of the medical condition, would subject you or your Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

This type of claim generally includes those situations commonly treated as emergencies. The Fund will defer to the judgment of a treating Physician as to whether a claim is an Urgent Care claim.

Pre-Service Care Claims
A pre-service care claim is a claim for a benefit which requires approval (usually referred to as pre-certification) of the benefit in advance of obtaining medical care.

Post-Service Care Claims
A post-service care claim is a claim for a benefit, normally a request for payment, under the Fund which is not a pre-service claim. A claim for vision, life insurance or accidental death & dismemberment benefits is always a post-service care claim.

Concurrent Care Claims
A concurrent care claim is a claim for an extension of the duration or number of treatments provided by prior approval of the Fund. This type of claim should be filed at least twenty-four (24) hours before the expiration of any course of treatment for which an extension is being sought.

Note that simple inquiries about the Fund's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. Your interactions with Participating Providers, panel providers, pharmacists or any other health care provider will not be treated as a claim for benefits. In addition, a request for a prior approval of a benefit that does not require prior approval or an inquiry about eligibility to participate is not a claim for benefits.

Filing A Claim For Benefits

In order to file a claim for benefits, you must submit a completed claim form. A claim form may be obtained from the Fund Office by calling (718) 859-1624, (718) 842-1212 or (732) 882-1901. Benefits obtained from providers who belong to the Cigna network, do not require the submission of a claim form. The provider will complete the paperwork for you.

The following information must be completed in order for your request for benefits:

- Participant name
- Patient name
- Patient Date of Birth
- SSN of Participant
- If treatment is due to an accident, accident details

The following information will be provided by your doctor or dentists:

- Date of Service
- CPT-4 (the code for Physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association)
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Billing name and address

When Claims Must Be Filed

- An *Urgent Care claim* must be filed as soon as possible.
- A *concurrent care claim* must be filed at least twenty-four (24) hours before the expiration of any course of treatment for which the claim/extension is being sought.
- A *pre-service care claim* must be filed at least twenty-four (24) hours before the start of the service in question.
- A *post-service care claim* must be filed within 90 days following the date the charges were incurred. If it was not reasonably possible to file the claim within such time, failure to file the claim within the time required does not invalidate or reduce the claim. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than one year from the date the charges were incurred.

Where To File Claims

Claims should be filed with the appropriate Health Organization that administers claims for that type of benefit, or the Fund Office if there is no such Health Organization. A Health Organization is the organization that provides various benefits.

Health Organizations include:

- Cigna: Cigna administers medical and Hospital benefit claims. Cigna also administers certain mental health and substance abuse benefit claims.
- Fund Office: The Fund Office administers supplemental mental health and substance abuse benefit claims. The Fund Office also administers life insurance benefit claims and accidental death & dismemberment claims.
- Optum RX: Optum RX administers prescription drug benefit claims.
- Healthplex: Healthplex administers vision benefit claims.
- Dentcare Delivery Systems, Inc.: Dentcare administers dental benefit claims.

A list of each Health Organization and its address is located at the end of this Summary Plan Description. Your claim will be considered to have been filed as soon as it is received at the appropriate Health Organization or the Fund Office, as applicable.

Authorized Representatives

You may authorize someone, such as your legal Spouse, to complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A health care professional with knowledge of your medical condition may also act as an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

Determination Of Benefit Claims

The entity to whom the benefit claim was filed, that is, the appropriate Health Organization or the Fund Office, will decide whether the Fund will honor your claim for benefits. This decision is made in accordance with the guidelines established by the Health Organization or Fund Office.

These guidelines provide that all claim reviews are handled in a manner designed to ensure the independence and impartiality of the persons involved in making the decision (the "impartiality rule"). Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) are not made based upon the likelihood that the individual will support the denial of benefits.

Timeframes For Notification Of Initial Benefit Claims

The timeframe for notification depends on the type of claim being filed. For convenience, the individual who filed the claim (you or your authorized representative) is referred to below as the "Claimant," and the entity deciding the claim is referred to below as the "Reviewer."

Urgent Care Claims
In the case of an Urgent Care claim, the Reviewer will notify the Claimant of its determination on the claim (whether adverse or not) as soon as possible, taking into account the medical

exigencies, but not later than 72 hours after the Reviewer's receipt of the claim. Urgent Care determinations may be provided orally, followed within 3 days by written or electronic notification.

However, if the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Fund, the Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after the Reviewer's receipt of the claim, of the specific information necessary to complete the claim. The Claimant is afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Unless the claim is refiled properly, it will not constitute a claim. This notice may be provided orally, unless you or your representative requests written notification.

When specific information has been requested, the Reviewer will notify the Claimant of its determination as soon as possible, but in no case later than 48 hours after the earlier of: (1) the Reviewer's receipt of the specified information, or (2) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent Care Claims
When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent care claim determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, the Health Organization will notify you or your representative of the determination within 24 hours after receiving the request. If the 24 hour deadline for filing is not met by the Claimant, or if the claim does not involve Urgent Care, the Fund Administrator will make its determination on the claim, as if the claim were a pre-service care claim.

Pre-Service Care Claims
In the case of a pre-service care claim, the Reviewer will notify the Claimant of its benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Reviewer's receipt of the claim. This period may be extended one time for up to 15 days, provided that the Reviewer both determines that such an extension is necessary due to matters beyond their control 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 Reviewer 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 the Claimant's receipt of the notice to provide the specified information.

If you improperly file a pre-service care claim, the appropriate Health Organization or the Fund Office will notify you or your authorized representative as soon as possible but not later than 5 days after receipt of the claim of the proper procedures to be followed in filing a claim. This notice may be provided orally, unless you or your authorized representative requests written notification. You or your authorized representative will receive notice of an improperly filed pre-service care claim only if the claim you filed includes:

- Your or your authorized representative's name;
- your specific medical condition or symptom; and
- a specific treatment, service or product for which approval is requested.

Unless the pre-service care claim is re-filed properly, it will not constitute a claim.

If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Health Organization then has 15 days to make a decision on a pre-service care claim and notify you of the determination.

Post-Service Care Claims
In the case of a post-service care claim, the Reviewer will notify the Claimant of its benefit determination (whether or not adverse) within a reasonable period of time, but not later than 30 days after the Reviewer's receipt of the claim. This period may be extended one time for up to 15 days, provided that the Reviewer both determines that such an extension is necessary due to matters beyond their control and notifies the Claimant, prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Reviewer 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 the Claimant's receipt of the notice to provide the specified information. The determination will be suspended on the date the Health Organization sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

To file a post service care claim:

- Obtain a claim form.
- Complete the employee's portion of the claim form.
- Have your Physician complete information relevant to your claim.
- Attach all itemized Hospital bills or doctor's statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed up the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

<u>Manner And Content Of Notification Of Initial Benefit Claims</u>

If your claim for benefits has been denied by the Reviewer, in whole or in part, the Claimant will be provided with notice in writing or electronically setting forth:

- the specific reason(s) for the denial with references to the specific Fund provisions on which the denial is based;
- information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);
- the claim's treatment, diagnosis, and denial code and their corresponding meanings, and a description of the Fund's standard, if any, that was used in denying the claim;

- a description of any additional material or information necessary for the Claimant to perfect the claim (including an explanation as to why such information is necessary);
- a description of the Fund's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review and the time limit for doing so;
- a description of available external review processes, including information regarding when and how to initiate an external appeal;
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes;
- if an internal rule, guideline, protocol, or other similar criterion (an "internal rule") was relied upon in making the adverse determination, a statement that this internal rule was relied upon in making the adverse determination (and a copy of the rule is enclosed with the notice); and
- if the benefit determination is based upon a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination concerning a claim involving Urgent Care, the Claimant will also receive a description of the expedited review process applicable to the claim, and the information described above may be provided orally, provided that a written or electronic notification is furnished to the Claimant not later than 3 days after the oral notification.

The written notice from the Reviewer may be furnished through the U.S. mail or electronically.

Other Types of Claims

Dental Claims

Dentcare is responsible for evaluating all dental claims under the Fund. Dentcare will decide your claim in accordance with its claims procedures. The Certificate of Insurance and accompanying riders distributed to you by Dentcare, together with this document, will serve as the governing documents for benefits administered by Dentcare. The documents distributed by Dentcare will describe their claims procedures. Contact Dentcare at: 333 Earle Ovington Blvd., Suite 300, Uniondale, New York 11553-3608 for more information.

Life Insurance Claims, Dependent Life Insurance Claims, And Accidental Death & Dismemberment Claims

A life insurance claim is a claim made by your beneficiary on the occasion of your death. A Dependent life insurance claim is a claim made by you on the occasion of the death of your Dependent. An accidental death & dismemberment claim is a claim made by you or your beneficiary on the occasion of accidental death or serious Injury.

The following procedure applies to claims for the life insurance benefit, Dependent death benefit, and the accidental death & dismemberment benefit:

- You or your beneficiary, as applicable, must obtain a claim form from the Fund Office.

- Complete the claim form.
- Attach proof of death form (original certificate of death) or proof of serious Injury.
- Return the completed claim form and all necessary documentation to the Fund Office.

For life insurance, Dependent life Insurance and accidental death & dismemberment claims, the Fund will make a decision on the claim and notify you or your beneficiary within 90 days. If the Fund requires an extension of time due to matters beyond its control, it will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the time the Fund notifies you of the delay. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. Until you supply this additional information, the normal period for making a decision on the claim will be suspended.

Appeals Procedures

Filing The Appeal

If the claim for a benefit is denied, the Claimant may file an appeal letter, requesting a review of this denial. The appeal is to be sent to the Fund Office. The appeal must be filed within 180 days after the date of the initial claim denial.

Review Of The Appeal

The review of the appeal is conducted by the Health Organization for which the claim was filed.

The claimant may submit written comments, documents, or other information in support of the appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information. The Health Organization's review may not afford any deference to the initial claim denial.

In deciding an appeal of any adverse benefit determination which is based at least in part on a medical judgment, including a determination with regard to whether a particular treatment, drug, or other item is Experimental, investigational, or not Medically Necessary or appropriate, the Health Organization will consult with a health care professional. This professional will have appropriate training and experience in the field of medicine involved in the medical judgment. This professional will not be an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, or who is the subordinate or employee of the person who made that determination. The impartiality rule described above will apply to the review of the claim appeal.

The Health Organization will retain the identification of any medical or vocational experts whose advice was obtained to help decide the outcome of an appeal, without regard to whether the advice was relied upon in making that decision. The claimant may obtain a list of such experts upon written request.

Expedited Review Process for Urgent Care Claims

In the case of an appeal of a claim involving Urgent Care, there is an expedited review process, under which:

- a request for an expedited appeal may be submitted orally or in writing by the Claimant; and
- all necessary information, including the benefit determination on review, is transmitted between the Claimant and the Health Organization by telephone, facsimile, or other available similarly expeditious method.

New Evidence or Rationale for the Decision on the Claim

The Claimant, free of charge, will receive any new or additional evidence or rationale considered, relied upon, or generated by the Fund in connection with the claim. This evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which a notice of final adverse benefit determination is provided below, to give the Claimant a reasonable opportunity to respond prior to that date.

However, if the new or additional evidence or rationale is received, considered or relied on so late that it would be impossible to provide it to the Claimant in time for the Claimant to have a reasonable opportunity to respond, the period for providing a notice of final adverse benefit determination is tolled until such time as the Claimant has a reasonable opportunity to respond. After the Claimant responds, or has a reasonable opportunity to respond but fails to do so, the Health Organization will notify the Claimant of their benefit determination as soon as practical, taking into account the medical exigencies.

Timeframes For Notification Of Decision On Appeal

Appeals will be decided as follows:

Urgent Care Claims and Concurrent Care Claims: In the case of a claim involving urgent or concurrent care, the Claimant will be notified of a decision on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

Pre-Service Care Claims: In the case of a pre-service care claim, the Claimant will be notified of a decision on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Post-Service Care Claims: A decision on the appeal will be made no later than the date of the Trustees' meeting that immediately follows the receipt of the appeal, unless the appeal is filed within 30 days preceding the date of that meeting. In such case, the Trustees' decision on the appeal will be made by no later than the date of the second Trustees' meeting following receipt of the appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a decision on the appeal will be made not later than the third Trustees' meeting following the receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Trustees will notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the decision on the appeal will be made, prior to the commencement of the extension. The Trustees will notify the Claimant of the decision on the appeal. This notification will be made as soon as possible, but not later than 5 days after the decision on the appeal is made.

Manner And Content Of Notification Of Decision On Appeal

In the case of an adverse decision on the appeal, the notification will be made in writing and will:

- state the specific reason or reasons for the adverse decision;
- refer to the specific Fund provisions on which the benefit decision is based;
- include information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);
- include the treatment, diagnosis, denial codes and their corresponding meaning, a description of the Fund's procedures, if any, that was used in denying the claim, and a discussion of the decision;
- state 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 claim for benefits;
- describe any available external review processes, including information regarding when and how to initiate an external appeal.
- state that the Claimant has a right (within the time limit indicated below) to file suit under section 502(a) of ERISA;
- indicate the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes;
- if an internal rule, guideline, protocol, or other similar criterion (an "internal rule") was relied upon in making the adverse decision, a statement of the internal rule; and
- if the adverse benefit decision was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, state an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to the medical circumstances.

The notification of the decision on appeal may be provided through the U.S. mail or electronically.

Filing Suit

No lawsuit may be started more than 180 days after the end of the year after receipt of the Trustees decision on the appeal (or later after an external appeal has been made or 180 days after the end of the year after a decision has been made by the Independent Review Organization, as described below). Any suit must be filed in the United States District Court for the Eastern District of New York.

External Appeals Procedures

Availability Of External Appeal

A Claimant may file an external appeal of any adverse benefit determination (a decision by the Health Organization on an appeal of a denied claim (unless ERISA regulations allow external appeal of the initial claim denial)) which involves medical judgment.

Filing Request For External Review

A Claimant must file a request for an external review of an adverse benefit determination, which is eligible for external review, at the Fund Office within four months after the date of receipt of the notice of the determination.

Preliminary Review

Within five business days following the date of receipt by the Fund Office of the external review request, the Fund will complete a preliminary review of the request, to determine whether:

1. the individual in question is or was covered at the time the health care item or service was requested;
2. the adverse benefit determination does not relate to such individual's failure to meet the requirements for eligibility;
3. the Claimant has exhausted the internal appeal process (unless ERISA regulations provide an exception); and
4. the Claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Claimant will receive notification of a determination in writing. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and current contact information (including the phone number) for the United States Department of Labor, Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the Fund must allow a Claimant 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 ends later.

Referral to Independent Review Organization
If the application is complete and eligible for external review, the Fund will assign an Independent Review Organization (an "IRO") that is accredited by URAC (or by a similar nationally-recognized accrediting organization) to conduct the external review. In identifying an IRO, the following requirements apply:

1. the Fund will ensure that the IRO process is not biased and ensures independence;
2. the Fund must contract with at least three (3) IROs for assignments under the Fund and rotate claims assignments among them;
3. the IRO is not eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits; and
4. the IRO process may not impose any costs, including filing fees, on the Claimant requesting the external review.

<u>Requirements Pertaining To The IRO Review Of The External Claim</u>

A contract between the Fund and an IRO for external review must satisfy the standards set forth in Federal regulations (see 29 CFR section 2590.715-2719(d)(2)(iii)(B), copy available on request from Fund Office). In reaching a decision on the external review, the IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. The IRO must provide written notice of the final external review decision, to both the Claimant and the Fund, within 45 days after the IRO receives the request for the external review. The notice will contain information required by the Federal regulations (see 29 CFR section 2590.715-2719(d)(2)(iii)(B)(7), copy available on request from Fund Office).

The IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claimant, Fund, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Reversal Of Adverse Benefit Determination

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination at issue, the Fund must immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

Expedited External Review

Request for the Review
The Fund must allow a Claimant to make a request for an expedited external review at the time the Claimant receives an adverse benefit determination:

- which involves:
  - a medical condition,
  - the denial of a claim on initial review,
  - a timeframe for completion of an expedited internal appeal (see above) that would seriously jeopardize the patient's life or health, or that would jeopardize the patient's ability to regain maximum function, **and**
  - a request for an expedited internal appeal has already been filed;

  or

- which involves:
  - a medical condition,
  - a claim that is eligible for external claims review,
  - **and either**
    - a timeframe for completion of a standard external review that would seriously jeopardize the patient's life or health, or that would jeopardize the patient's ability to regain maximum function, or
    - an adverse benefit determination that concerns an admission, availability of care, continued stay, health care item or service for which the patient has received Emergency Services, but the patient has not been discharged from the facility.

Preliminary Review
Immediately upon receipt of the request for expedited external review, the requirements for preliminary review of a request for external appeal, set out above, will apply.

Referral to Independent Review Organization
Upon a determination that a request is eligible for expedited external review following the preliminary review, the Fund will assign an IRO pursuant to the requirements discussed above. The Fund will provide or transmit all necessary documents and information considered in making the adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the procedures discussed above. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the fund's or issuer's internal claims and appeals process.

Notice Of Final External Review Decision

The Fund's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with Federal requirements (see 29 CFR section 2590.715-2719(d)(2)(iii)(B), copy available on request from Fund Office), as expeditiously as the patients' medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claimant and the Fund.

IMPORTANT INFORMATION ABOUT THE UNITED TEAMSTER FUND

The Employee Retirement Income Security Act of 1974, as amended ("ERISA") requires that Participants receive certain administrative information about the fund and the people who administer the fund. The Fund is subject to those rules and this section will tell you more about Fund operations.

Name Of Fund

The Fund's formal name is the United Teamster Fund.

Board Of Trustees

The Board of Trustees and/or its duly authorized designee(s) have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply and interpret this SPD, the Trust Agreement and any other Fund documents, and to decide all matters arising in connection with the operation or administration of the Fund or Trust. Without limiting the generality of the foregoing, the Board of Trustees and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Fund.
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund in accordance with the terms of the Fund.
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Fund.
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Fund, including this SPD, the Trust Agreement or other Fund documents.
- Process and approve or deny benefit claims.
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) shall be final and binding upon all Participants, beneficiaries and any other individuals claiming benefits under the Fund. The Board of Trustees may delegate any other such duties or powers as it deems necessary to carry out the administration of the Fund.

The Board of Trustees consists of an equal number of employer and union representatives which reserves the right in their sole and absolute discretion to amend or terminate the Fund at any time and for any reason. Continuation of benefits is not guaranteed. Neither you, nor your beneficiaries nor any other person has or will have a vested or nonforfeitable interest in the Fund.

In the event of the Fund's termination, the monies of the Fund will be able to provide benefits or otherwise carry out the purpose of the Fund in an equitable manner until the Fund assets have been disbursed.

Sponsor And Administrator

The Board of Trustees is the Fund's Sponsor and Administrator. The Board can be contacted at:

United Teamster Fund
2137-2147 Utica Avenue
Brooklyn, NY 11234
Phone (718) 859-1624

Identification Numbers

The "employer identification number" assigned to the Fund by the Internal Revenue Service is 13-5549593. The Fund identification number is 501.

Fund Year

Records are kept May 1st to the following April 30th.

Type Of Fund

The Fund is known as a "welfare" fund under federal law. It provides medical benefits, prescription benefits, dental benefits, vision benefits, life insurance, and accidental death & dismemberment benefits.

Agent For Service Of Legal Process

Legal process may be served upon any Trustee or the Administrator at:

United Teamster Fund
2137-2147 Utica Avenue
Brooklyn, NY 11234
Phone (718) 859-1624

Collective Bargaining Agreement

The Fund was established and is maintained as a result of collective bargaining agreements between employers and unions. A copy of the collective bargaining agreement signed by your employer and union may be obtained upon written request to the Fund Office, and is available for examination during normal business hours at the Fund Office. In addition, a complete list of the Contributing Employers in the Fund may be obtained upon written request to the Fund Office and is available for examination by Participants and beneficiaries during normal business hours at the Fund Office. The Fund Office may charge a reasonable amount for copies.

Participants and beneficiaries may also receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is participating in the Fund and, if the employer or employee organization is participating, its address.

Source Of Contributions

The benefits described in this booklet are provided through employer contributions or COBRA premiums. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the applicable collective bargaining or other written agreements.

Trust Fund

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered Participants and defraying reasonable expenses of the Fund.

Identification Of Insuring Or Administering Entities

All benefits under the Fund are paid out of the Fund's assets. This means they are "self-funded" or "self-administrated." The Fund has entered administrative contracts with various entities to assist in administering the Fund. Contact information for all providers (sometimes referred to as "Health Organizations") are at the end of this booklet.

QMCSO Procedures

If a court or a state administrative agency has issued an order with respect to the provision of health care coverage for any of the Participant's children, the Administrator or its designee will determine if the court or state administrative agency order is a Qualified Medical Child Support Order ("QMCSO") as defined by federal law, and that determination will be binding on all parties. The state administrative agency order must be issued through an administrative process established by state law and must have the force and effect of state law under the applicable state law.

An order is not a QMCSO if it requires the Fund to provide any type or form of benefit or any option that the Fund does not otherwise provide, or if it requires an individual employee who is not covered by the Fund to provide coverage for a Dependent child, except as required by a state's Medicaid-related child support laws.

If an order is determined to be a QMCSO, and if the Participant is covered by the Fund, the Administrator or its designee will so notify the parents and each child, and advise them of the Fund's procedures that must be followed to provide coverage to the child. However, no coverage will be provided for any child under a QMCSO unless the applicable employee contributions for that child's coverage are paid, and all of the Fund's requirements for coverage of that child have been satisfied. The Fund Office will provide you with a copy of its procedures pertaining to QMCSO's upon written request.

Important Notice Regarding Termination Of Healthcare Coverage For Cause, Including Fraud Or Intentional Misrepresentation

The Fund reserves the right to terminate coverage for you and/or your Dependent(s) if you and/or your Dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act"), the coverage will not be rescinded (within the meaning of the Affordable Care Act) retroactively (as opposed

to prospectively), except in the circumstances permitted by law, such as the failure to pay premiums or the commission of fraud or intentional misrepresentation (for example, in enrollment materials, a claim or appeal for benefits or in response to a question from the Fund Administrator or its delegates) by you, your covered Dependent(s), or someone seeking coverage on your behalf. In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days' notice. Failure to inform the Fund Office that you or your Dependent is covered under another group health plan or knowingly providing false information to obtain coverage for an ineligible Dependent are examples of actions that constitute fraud or intentional misrepresentation.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("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"). ERISA provides that all Participants and eligible Dependents shall be entitled to:

Receive Information About Your Fund And Benefits

- Examine, without charge, at the Fund Office, all documents governing the Fund, including summary plan descriptions, collective bargaining agreements signed by the Participant's employer and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Fund, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Trustees are required by law to furnish each Participant with a copy of this summary annual report, upon written request.

Continued Group Health Plan Coverage

You may continue health coverage for yourself, Spouse 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 the rules in this summary plan description on COBRA continuation coverage rights.

Prudent Actions By 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 are called "fiduciaries." Fiduciaries have a duty to act 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit 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, 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 the Fund's documents or the latest annual report 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 that is denied or ignored, in whole or in part, you may file suit in federal court. In addition, 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 federal court. If it should happen that 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 costs and 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 Office. 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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington D.C, 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HEALTH ORGANIZATIONS AND CONTACT INFORMATION

BENEFIT	HEALTH ORGANIZATION	TYPE OF FUNDING
Medical/Hospital	Cigna P.O.Box 182223 Chattanooga, TN 37422-7223 (T) 1-800-Cigna24 (1-800-244-6224) (F) Fax number for Escalated Claims: 1-859-410-2422	Self-funded. The Fund pays the cost of benefits, which are administered by Cigna. Cigna provides pre-certification and case management services.
Prescription Drugs	OPTUMRX P.O. Box 2975 Misson, KS 66201 (T) 1-800-797-9791 www.optumrx.com	Self-funded. The Fund pays the cost of benefits, which are administered by Optum RX.
Vision	Healthplex, Inc. 333 Earle Ovington Boulevard Suite 300 Uniondale, New York 11553-3608 (T) 516-542-2200 OR 800-468-0600	Self-funded. The Fund pays the cost of benefits, which are administered by Healthplex.
Life Insurance	United Teamster Fund 2137-2147 Utica Avenue Brooklyn, New York 11234 (T) 718-859-1624	Self-funded. The Fund provides and administers benefits.
Substance Abuse	Cigna P.O.Box 182223 Chattanooga, TN 37422-7223 (T) 1-800-Cigna24 (1-800-244-6224) (F) Fax number for Escalated Claims: 1-859-410-2422 D.J. O'Grady Consultants Ltd. 90 John Street, Suite 305 New York, N.Y., 10038 (T) 212-206-7898 (F) 212-206-8798	Self-funded. The Fund pays the cost of benefits, which are administered by Cigna. Cigna provides pre-certification and case management services. Self-funded. The Fund also provides and administers supplemental substance abuse benefits.
Mental Health	Cigna P.O.Box 182223 Chattanooga, TN 37422-7223 (T) 1-800-Cigna24 (1-800-244-6224) (F) Fax number for Escalated	Self-funded. The Fund pays the cost of benefits, which are administered by Cigna. Cigna provides pre-certification and case management services.

	Claims: 1-859-410-2422 D.J. O'Grady Consultants Ltd. 90 John Street, Suite 305 New York, N.Y., 10038 (T) 212-206-7898 (F) 212-206-8798	Self-funded. The Fund also provides and administers supplemental substance abuse benefits.
Dental	Dentcare Delivery Systems, Inc. 333 Earle Ovington Boulevard Suite 300 Uniondale, New York 11553-3608 (T) 516-542-2200 OR 800-468-0600 www.dentcaredeliverysystems.org	Insured. The benefits are provided under an insurance policy between the Fund and Dentcare. Premiums for the insurance policy are paid from the Fund's trust. In return, Dentcare pays for the cost of the insured benefits.