# UNITED TEAMSTER FUND

# SUMMARY PLAN DESCRIPTION

# EFFECTIVE MAY 1, 2021

May 1, 2021

The Board of Trustees (the "Trustees") is pleased to provide you with this updated Summary Plan Description (also called the "SPD"), which summarizes the benefits available under the United Teamster Fund (referred to 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 SPD contains provisions in effect as of May 1, 2021. Please keep this SPD in a convenient place, where you will have it for future reference and can share with your family. This SPD also serves as the Plan Document.

The Fund 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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## ***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 SPD.

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 or a participation agreement with this Fund under which it is required to make contributions to this Fund on behalf of employees covered by the agreement.

Coordination of Benefits ("COB")- If you are covered by another health care arrangement, the payments for benefits will be coordinated so that no more than 100% of your actual expenses are reimbursed. Where the Fund provides secondary coverage, it will only pay for Covered Expenses and will not pay more than the amount it would normally pay if it provided primary coverage for you and your eligible Dependents.

Copayment ("Copay")- 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 are those expenses or services payable to the extent provided under the Fund's terms. They include treatment, care, services, or supplies if:

- The treatment, care, service or supply is Medically Necessary;
- Coverage is not excluded under the terms of the Fund; and
- No Fund maximums for those expenses have been reached.

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

Dependent- A Spouse or child who may be eligible for benefits coverage while you are an employee of a 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.

Emergency- A Sickness or injury that arises with symptoms of sufficient severity that a

reasonably prudent person would believe that absence of emergency medical evaluation or treatment could seriously jeopardize his/her life or health or his/her ability to regain maximum function.

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 and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

Fund- United Teamster Fund.

Fund Year- The period from May 1st through April 30th of each calendar year.

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 or 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 s/he is:

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

Injury- An accidental bodily injury.

Investigational and Experimental- A treatment, service, drug, or supply that is determined 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; or
- not approved by the U.S. Food and Drug Administration (the "FDA") or other appropriate regulatory agency to be lawfully marketed for the proposed use; or
- the subject of review or approval by an Institutional Review Board for the proposed use; or
- the subject of an ongoing phase I, II or III research trial; or
- a drug, treatment, service of supply for which reliable evidence indicates that the prevailing opinion amount experts is that further study or clinical trials are needed to compare it with standard means of treatment.

The Fund will not cover Investigational and Experimental treatments, services, drugs, or supplies.

Legally Qualified Physician, Medical Doctor or Surgeon- A legally qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.), including a hospitalist. 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 ("MRC")- Except as otherwise provided in this booklet:

(1) With respect to an In-Network provider or facility, MRC will be the lesser of (1) the fee set forth in the agreement between the provider/facility and the network or the Fund or

(2) the actual billed charge. If an In-Network health care provider or facility is under a contract which stipulates that it does not have to accept the network discount for claims involving a third party payer (such as auto insurance, workers' compensation or other individual insurance or where the Fund may be a secondary payer), MRC is the discounted fee that would have been payable by the Fund if the claim was processed as an In-Network claim.

(2) For services rendered Out-of-Network, MRC will be the lesser of (1) the actual billed charge or (2) the fee determined under an external data source adopted by the Fund's Trustees at the time the services were rendered. As of July 1, 2017, MRC for all Out-of-Network services that are listed in the National Medicare Fee Schedule (the "Schedule") equals 110% of the Schedule as adjusted for locality. For services not listed in the Schedule, the Fund will utilize a reference other than the Schedule to assist in determining the MRC. The Fund will pay a percentage of MRC for Out-of-Network services and supplies.

(3) MRC is not based on or intended to be reflective of fees that are or may be described as usual and customary, reasonable, and customary, usual, customary and reasonable, prevailing charges or any similar term.

(4) The Fund adheres to the National Correct Coding Initiative (NCCI) edits. Claims will be processed according to NCCI guidelines regardless of how a provider submits a claim. For example, when a provider bills separately for several individual services and NCCI guidelines indicate that these services should be billed under a single CPT-code, the Fund will follow the NCCI edits and pay the claim as a single, bundled claim.

(5) The Fund or its designee may negotiate with an Out-of-Network provider to reduce its billed charges. This negotiated discounted amount will become the MRC for that claim and will be subject to the Fund's cost-sharing provisions.

Medically Necessary- Medically Necessary Covered Services and Supplies are those services and supplies that are 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 most cost-effective setting that is appropriate for the delivery of the services and supplies. Where applicable, the Fund or Meritain Health may compare the cost-effectiveness of alternative services, settings, or supplies.

Motor Vehicle- As used in this SPD, 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 other fees you must pay for Eligible Covered Expenses which are not reimbursed by the Fund. For purposes of calculating the annual maximum on Out-Of-Pocket Expenses, "Eligible Covered Expenses" includes only expenses associated with Covered Services.

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 the OptumRx, 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, or a third party provider network to which Participants have access and who 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.

Review Organization- 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. For purposes other than an External Review, the Review Organization will be an affiliate of Meritain Health or another entity to which Meritain Health has delegated responsibility for performing utilization review services or D.J. O'Grady Consultants ("D.J. O'Grady") for claims involving mental health or substance abuse. For purposes of an External Review, services will be rendered in accordance with applicable law by an Independent Review Organization that is not affiliated with and does not perform utilization review services for Meritain Health or D.J. O'Grady.

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

Spouse- A person to whom you are legally married under the laws of the state in which your marriage was entered into and from whom you are not legally separated or divorced by judgment, decree or signed separation agreement.

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

Waiting Period- The period after your employment with a participating employer begins during which you are not yet eligible to participate in the Fund. The Waiting Period will end on 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, 2021

**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 which applies to some Covered Services. There is also a 20% Coinsurance for certain Covered Services and Copays for other services including 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 (the "MRC"), except that it will cover up to 100% of the MRC payable for an anesthesiologist or ambulance. You are responsible for the remaining portion 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 per year for a semi-private room.

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 Copay for generic and brand name** drugs and a $50 Copay for injectable medications. You will receive up to a 30-day supply.
- If you use the mail order service, you will be charged a $35 Copay for generic and brand name** drugs and a $50 Copay 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 Copay, for any difference in cost between the brand name and generic drug.

**Dental Benefits**

The Fund provides dental benefits through Healthplex, Inc. ("Healthplex").

**Vision Benefits**

Vision Benefits are provided through Healthplex, Inc.

The Fund will reimburse you up to:

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

Vision benefits are available once every 12 months.

**Life Insurance Benefit (Subject to The Exclusions Described Later on in This SPD)**

- $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 (applies to Ambulance, Durable Medical Equipment, Hospice and Home Health Care) | $250/Single<br>$500/Family | $3,000/Single<br>$6,000/Family |
| | | |
| Coinsurance (Percentage you pay) (only applies to certain services) | 20% | 40% |
| | | |
| Annual Maximum Out-Of-Pocket Costs (for any Fund Year, you will not pay more than this for Copayments, Coinsurance and Deductibles) | $3,000/Single<br>$6,000/Family | $13,000/Single<br>$26,000/Family |
| | | |
| Annual Maximum Paid by The Fund | No maximum | No maximum |

When you are treated by a provider, you are responsible for the Deductible, any applicable Copayment, and any applicable Coinsurance. You are also responsible for any amount above the percentage of the Maximum Reimbursable Charge ("MRC") paid by the Fund for Out-Of-Network services. 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% | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Well-Baby/Well-Child Care (Children through age 5) | Fund pays 100% | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Immunizations | Fund pays 100% | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Primary Care Office Visits | You pay $25 Copay per visit | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Specialist Office Visits | You pay $25 Copay per visit | Fund pays 60% 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% | Fund pays 60% 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 | Fund pays 60% of MRC after you have met the Deductible |
| Inpatient Facility Charges | You pay $100 Copay per day, to a maximum of $500 in Copays per Fund Year. Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required |
| Outpatient Surgical Facility Charges | You pay $100 Copay per visit. Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is Required |
| Inpatient and Outpatient Professional Services | Fund pays 100% | Fund pays 60%* of MRC after you have met the Deductible. * Inpatient/Outpatient Professional Services for Anesthesiologist: Fund pays 100% of MRC, Deductible is waived |
| | | |
| Allergy Treatment/Injections | You pay the lesser of $25 Copay or actual charge | Fund pays 60% of MRC per visit after you have met the Deductible |
| | | |
| Allergy Serum (Dispensed by the Physician in the Physician's office) | Fund pays 100% | Fund pays 60% of MRC per visit after you have met the Deductible |
| | | |
| Chiropractic Care (Max 25 visits per Fund Year) | You pay $25 Copay per visit | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Routine Foot Disorders (Max 25 visits per Fund Year) | You pay $25 Copay per visit | Fund pays 60% of MRC after you have met the Deductible |

| | | |
|---|---|---|
| **Outpatient Surgery (Prior Authorization is Required for Surgeries)** | | |
| Facility Charges | You pay $100 Copay per visit. Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required |
| Professional Services Charges For Surgeons, Radiologists, And Pathologists | Fund pays 100% | Fund pays 60% of MRC after you have met the Deductible |
| Professional Services Charges for Services Performed by Anesthesiologists | Fund pays 100% | Fund pays 100% of MRC. Deductible is waived |
| | | |
| **Laboratory Services** | | |
| At Physician's Office | You pay $25 Copay per visit | Fund pays 60% of MRC after you have met the Deductible |
| At Outpatient Hospital Facility or Independent Lab Facility | Fund pays 100% | Fund pays 60% 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 | Fund pays 60% 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 | Fund pays 60% 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% | Fund pays 60% of MRC after you have met the Deductible |
| | | |

| **Inpatient Hospital Services (Prior Authorization is Required for Surgeries)** | | |
|---|---|---|
| Facility Charges | You pay $100 Copay per day, to a maximum of $500 in Copays per Fund Year. Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required |
| Professional Services Charges for Surgeons, Radiologists, and Pathologists | Fund pays 100% | Fund pays 60% of MRC after you have met the Deductible |
| Professional Services Charges for Anesthesiologists | Fund pays 100% | Fund pays 100% of MRC. Deductible is waived |
| Inpatient Hospital Physician's Visits/Consultations | Fund pays 100% | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Ambulance | You pay 20% after you have met the Deductible. **There is no coverage if there is no emergency** | Fund pays 80% of MRC after you have met the In-Network Deductible. **There is no coverage if there is no emergency** |
| | | |
| Hospital Emergency Room | You pay $100 Copay. Copay is waived if you are admitted to the Hospital, then inpatient Hospital charges would apply. There is no coverage if there is no emergency | You pay $100 Copay. Copay is waived if you are admitted to the Hospital, then inpatient Hospital charges would apply. There is no coverage if there is no emergency |
| | | |
| 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 | Fund pays 60% of MRC after you have met the Deductible. Copay is waived if you are admitted to the Hospital, then inpatient Hospital charges would apply |
| | | |
| Surgery Performed by Physician at Physician's Office | Fund pays 100%. Prior Authorization is required | Fund pays 60% of MRC per visit after you have met the Deductible. Prior Authorization is required |
| | | |
| Inpatient Skilled Nursing Care (Max 60 days per Fund Year) | You pay $100 Copay per day to a maximum of $500 per Fund Year. Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required |
| | | |
| Hospice Care – Inpatient or Outpatient | You pay 20% after you have met the Deductible. Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required |

| | | |
|---|---|---|
| | | |
| Home Health Care (includes outpatient private duty nursing days when approved as Medically Necessary)<br>(Max 40 days per Fund Year; 16-hour max per day) | You pay 20% after you have met the Deductible. Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required |
| | | |
| Inpatient Rehabilitation<br>(Max 60 days per Fund Year) | You pay $100 Copay per day, to a maximum of $500 per Fund Year, then Fund pays 100%. Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required |
| | | |
| Short-Term Rehabilitative Therapy – Outpatient<br>Physical, Occupational, Cognitive, Speech, Pulmonary and Cardiac Therapy and Psychotherapy<br>(Max 60 days per Fund Year for all therapies combined) | You pay $25 Copay per visit. Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required |
| | | |
| Durable Medical Equipment | You pay 20% after you have met the Deductible. Prior Authorization is required for equipment costing $500 or more | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required for equipment costing $500 or more |
| | | |
| External Prosthetic Appliances ("EPA") | You pay 20%, Deductible is waived. Prior Authorization is required for prosthetic appliances costing $500 or more | Fund pays 60% of MRC after you have met the Deductible. Prior Authorization is required for prosthetic appliances costing $500 or more |
| | | |
| Inpatient Abortion | You pay $100 Copay per day, to a maximum of $500 per Fund Year. Prior Authorization is required for elective abortion procedures | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Inpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived<br>Prior Authorization is required for elective abortion procedures |

| | | |
|---|---|---|
| Outpatient Abortion | Office Visit: You pay $25 Copay per visit.<br>Surgery in Office: Fund pays 100%.<br>Outpatient Surgical Facility: $100 Copay per visit. Prior Authorization is required for elective abortion procedures | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Inpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived.<br>Prior Authorization is required for elective abortion procedures |
| | | |
| Outpatient Chemotherapy | Fund pays 100% | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Outpatient Radiation Therapy | You pay 20% after you have met the Deductible | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Dialysis | Office Visit: You pay $25 Copay per visit.<br>Outpatient Hospital: Fund pays 100% | Office Visit: Fund pays 60% of MRC after you have met the Deductible.<br>Outpatient Hospital: Fund pays 60% 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.<br>Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible.<br>Prior Authorization is required |
| | | |
| Outpatient Mental Health | You pay $25 Copay per visit | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| **Inpatient Substance Abuse** | | |
| Claims administered by D.J. O'Grady in-network and by Meritain out-of-network | Fund pays 100%.<br>Prior Authorization is required | Fund pays 60% of MRC after you have met the Deductible.<br>Prior Authorization is required |
| | | |
| **Outpatient Substance Abuse** | | |
| Claims administered by DJ O'Grady In-Network and by Meritain Out-of-Network | Fund pays 100% | Fund pays 60% of MRC after you have met the Deductible |
| | | |

| | | |
|---|---|---|
| Circumcision<br>(Out-Of-Network charges limited to $5,000 for charges other than Hospital facility fee) | Office: Fund pays 100%<br>Ambulatory Surgicenter or Outpatient Hospital. You pay $100 Copay<br>Inpatient: You pay $100 Copay per day, to a maximum of $500 per Fund Year | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Inpatient Nursery | Fund pays 100% | Fund pays 60% of MRC after you have met the Deductible |
| | | |
| Breast-Feeding Equipment & Supplies | Fund pays 100% | Not covered |
| | | |
| Diabetic Supplies | Fund pays 100% | Fund pays 60% 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.<br>Prior Authorization is required | Fund pays 60%* of MRC after you have met the Deductible.<br>Prior Authorization is required.<br>*For In-patient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived. Prior Authorization is required |
| | | |
| Outpatient TMJ (surgical and non-surgical) | Office Visit: You pay $25 Copay per visit.<br>Surgery – Office Setting: Fund pays 100% Outpatient.<br>Surgical Facility: $100 Copay per visit.<br>Prior Authorization is required | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Outpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived. Prior Authorization is required |
| | | |
| Women's Family Planning Services<br>(Inpatient and Outpatient) | Fund pays 100%.<br>Prior Authorization is required for surgical procedures. | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Inpatient and Outpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived.<br>Prior Authorization is required |

| | | |
|---|---|---|
| | | for surgical procedures |
| | | |
| Men's Inpatient Family Planning Services & Reversal of Voluntary Sterilization (The Fund will not pay for both voluntary sterilization and reversal of voluntary sterilization) | You pay $100 Copay per day, to a maximum of $500 per Fund Year.<br>Prior Authorization is required for surgical procedures | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Inpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived. Prior Authorization is required for surgical procedures |
| | | |
| Men's Outpatient Family Planning Services & Reversal of Voluntary Sterilization | Office Visit: You pay $25 Copay per visit.<br>Surgery – Office Setting: Fund pays 100%.<br>Outpatient Surgical Facility: $100 Copay per visit.<br>Prior Authorization is required for surgical procedures | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Outpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived. Prior Authorization is required for surgical procedures |
| | | |
| Inpatient Bariatric Surgery | You pay $100 Copay per day, to a maximum of $500 per Fund Year<br>Prior Authorization is required | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Inpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived. Prior Authorization is required |
| | | |
| Outpatient Bariatric Surgery | Office Visit: You pay $25 Copay per visit.<br>Outpatient Surgical Facility: $100 Copay per visit.<br>Prior Authorization is required | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Outpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived. Prior authorization is required |
| | | |
| Inpatient Organ Transplant | You pay $100 Copay per day, to a maximum of $500 per Fund Year<br>Prior Authorization is required | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Inpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is |

| | | |
|---|---|---|
| | | waived.<br>Prior Authorization is required |
| | | |
| Outpatient Organ Transplant | Office Visit: You pay $25 Copay per visit<br>Outpatient Surgical Facility: $100 Copay per visit<br>Prior Authorization is required | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Outpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived. Prior authorization is required |
| | | |
| Limited Inpatient Dental Care (Through Meritain Health) | You pay $100 Copay per day, to a maximum of $500 per Fund Year | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Inpatient Professional Services Performed by Anesthesiologist: Fund pays 100% of MRC, Deductible is waived |
| | | |
| Limited Outpatient Dental Care<br>(Through Meritain Health) | Office Visit: You pay $25 Copay per visit.<br>Surgery – Office Setting: Fund pays 100%.<br>Outpatient Surgical Facility: $100 Copay per visit | Fund pays 60%* of MRC after you have met the Deductible.<br>*For Outpatient Professional Services Performed by Anesthesiologist: Fund pays 100% 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. Your eligible Dependents will be eligible for coverage only if you are eligible to participate and your employer's contribution level is high enough for family coverage.

### **When Your Coverage Starts**

If you are eligible to participate, you must satisfy a Waiting Period. The Waiting Period will end as of the first day of the month following sixty (60) days from the date your employer starts to make contributions on your behalf. On or after the day your waiting period ends, you may enroll in the Fund, and your coverage will begin with your enrollment.

## How Long Coverage Continues

Once you have enrolled, your coverage continues on a month-to-month basis.

## Dependent Coverage

When you become eligible for coverage, the Fund Office will let you know whether your employer contribution level qualifies you for family 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 child(ren) 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; and
- Unmarried handicapped Dependent children over age 26 who 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 such as 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.

In order for someone to be considered your Spouse, you and your Spouse must have been 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, is not 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. Coverage for a Spouse will also terminate at the end of a month in which a judgment or stipulation of separation is signed. At the time of the divorce or legal separation, the former Spouse has the option of continuing coverage under COBRA. You are responsible for notifying the Fund of your divorce or legal separation if your Spouse had been covered by the Fund. If you fail to so notify the Fund, 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 a divorce or legal separation**.**

## 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 new 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 new Dependent will be delayed.

**Dependent children** include the following:

- Your natural children (including children born out of wedlock if proper evidence of paternity is submitted to the Fund Office);
- Your legal Spouse's natural children if your Spouse has legal custody of them;
- Legally adopted children or step-children;
- Foster children if no other health benefits are being provided to them by any governmental agency; and
- Children required to be recognized as your Dependents under a Qualified Medical Child Support Order.

## About Qualified Medical Child Support Orders

A Qualified Medical Child Support Order, or a "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.

If a court or a state administrative agency has issued an order with respect to the provision of health care coverage for any of a Participant's children, the Administrator will determine if the court or state administrative agency order is a 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.

The Fund will promptly notify the Participant and any affected party of the receipt of any such order. If the order is determined to be a QMCSO, the Administrator will notify the Participant, 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 the Fund's requirements for coverage of that child have been satisfied. The Fund will provide you with a copy of its procedures pertaining to QMCSOs upon written request.

## When Coverage Ends

Your coverage ends on the last day of the month in which:

- you stop working for a Contributing Employer;
- you enter active military service (except where coverage is continued under applicable law);
- the Fund discontinues group health care 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 Fund's eligibility requirements.

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;
- You or your Dependent engages in fraud or intentional misrepresentation of a material fact with regard to coverage or benefits under the Fund; or
- you die.

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

## Continuation of Coverage During Certain Absences

If you become disabled and lose your coverage because you are no longer working, your coverage will continue for each month after the coverage loss that 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 a 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 your medical coverage and other benefits offered through the Fund. You are generally eligible for FMLA leave if you:

- worked for your employer for at least 1,250 hours during the 12 months prior to the start of leave; and
- worked at a location where at least 50 employees are employed by your 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. If your coverage under the Fund 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 your 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, you should 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, if 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 for up to two years.

**Paid Family Leave (New York)**

Under the New York State Paid Family Leave Law, you may take job-protected, paid leave to care for a child, to care for a family member with a serious health condition or to help manage affairs if a family member is called to active military service. If you take Paid Family Leave, your employer must maintain health benefits for you and your Dependents during the paid leave.

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

For leaves of absence covered by the FMLA or Paid Family Leave Law and leaves of absence for qualified military service, your employer must properly grant the leave, and make the required notification and any required payments 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 COBRA that this Fund offers 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 SPD.

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, you and your Spouse 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** | **Maximum Period of COBRA Coverage (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 child | 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 coverage loss may be available to those who, by no later than the first 60 days of the period of continuation coverage, 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's 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.

*** Your entitlement to Medicare is a qualifying event for your Dependents, but not for you. But, if you become entitled to Medicare and experience termination of employment (other than for gross misconduct) or reduction of hours that constitutes a qualifying event within 18 months thereafter, you will be eligible for COBRA coverage resulting from that qualifying event. Your COBRA coverage will run for 36 months from the date on which you became entitled to Medicare.

## 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 initial loss of coverage.

**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 initial loss of coverage (due to 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, or reduction in hours of employment no later than 60 days of the loss of coverage. 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

You or your Dependent must provide the Fund Office with timely notice of divorce, legal separation, death, Medicare entitlement or a child losing Dependent status. You or the affected qualified beneficiary should notify the Fund of the following:

- The occurrence of a second qualifying event after the qualified beneficiary has become entitled to COBRA which extends the period of continuation coverage to 36 months.

This second qualifying event could include an employee's death, entitlement to Medicare, divorce or legal separation, or a child losing Dependent status; or

- 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.

The Fund Office must be notified of any of the events listed above within 60 days of the qualified event (in the case of disability, within 60 days after the Social Security Administration determination of disability is made). 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 address of your Dependent(s), if different; and
- the nature and date of the occurrence you are reporting to the Fund.

**When the Notice Must Be Sent**

You or your Dependent must provide notice to the Fund within the 60-day period discussed above (and do not forget to provide addresses for both you and the Dependent(s). **If the Fund is not notified by the end of the 60-day period, you and your Dependents may not be entitled to continuation coverage.**

**Electing COBRA Coverage**

The Fund must notify you 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 coverage 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. 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 premium amounts 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 of the initial loss of coverage;
- 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 premium 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; or
- 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).

An individual whose disability is determined by the Social Security Administration to have ended must notify the Fund Office within 30 days of this determination. 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.

## Additional COBRA Election Period and Tax Credit in Cases of Eligibility for Benefits Under the Trade Act of 1974

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your Dependents did not elect COBRA during your election period but are later certified by the DOL for Trade Act benefits, you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended.

Also, under the Trade Act eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

## Your Rights Under the Health Insurance Portability and Accountability Act of 1996

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. (Note that with Dependents, these rights only apply if you are entitled to family coverage.) These are known as "Qualifying Circumstances." Qualifying Circumstances occur when:

- You have a change in family status, such as marriage, divorce, birth, adoption, placement for adoption, or death; or
- 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 fund 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 Dependent, 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 and 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.

**Privacy Rights**

This section describes how the Fund may use and disclose your Protected Health Information ("PHI") in order to carry out Treatment, Payment and Health Care Operations and for other purposes permitted or required by law. It also describes your rights to access and control your PHI.

"Protected Health Information (PHI)" includes all individually identifiable health information related to an individual's past, present or future physical or mental health conditions, to the provision of health care or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

"Treatment" means the provision, coordination, or management of health care and related services. For example, the Fund may disclose PHI to healthcare providers to provide information about alternative treatments.

"Payment" includes, but is not limited to, actions to make coverage determinations and payment for services and items you receive. For example, the Fund may disclose to a doctor whether you are eligible for coverage or the amount that the Fund will reimburse a provider for certain services. If the Fund contracts with third parties to help us with payment operations, such as a Physician who reviews medical claims, we will also disclose information to them. These third parties are known as "Business Associates."

"Health Care Operations" are the operations of the Fund relating to such things as underwriting and quality assessment and activities relating to creating or renewing insurance contracts. They also include auditing functions, including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Fund may use PHI to audit the accuracy of claims processing.

The Fund's privacy practices are intended to comply with HIPAA at all times. If a privacy practice is materially changed, information about that change will be provided to you by mail within 60 days of its effective date.

**Uses and Disclosures of Protected Health Information**

*Disclosure of Your PHI Generally Requires Your Written Authorization*. Except as provided in this section, any use and disclosure of PHI will be made only with your written authorization. You may revoke this authorization in writing at any time, provided the Fund has not yet taken action in reliance on your authorization.

*Circumstances in Which the Fund Will Disclose Your PHI in the Absence of a Written Authorization*. Under the law, the Fund may disclose your PHI without your authorization, or without giving you the opportunity to agree or object, in the following cases:

- At Your Request. If you request it, the Fund is required to give you access to certain of your PHI in order to allow you to inspect and/or copy it. Your right to this information is detailed later in this section;
- For Treatment, Payment or Health Care Operations. The Welfare Fund and its business associates may use PHI in order to carry out Treatment, Payment or Health Care Operations.
- Disclosure to Business Associates. The Fund may also disclose your PHI to third parties that assist the Fund in its operations. For example, the Fund may share your PHI with Meritain which is responsible for paying medical claims for the Fund. Every Business Associate has the same obligation to keep your PHI confidential as the Fund does. The Fund must require each Business Associate to ensure that your PHI is protected from unauthorized use or disclosure;
- Disclosure to Trustees. The Fund may disclose PHI to the Trustees as Fund sponsor, for administrative functions. For example, the Fund may disclose information to the Trustees to allow them to decide an appeal or review a subrogation claim.

The Fund may disclose "summary health information" to the Trustees for obtaining premium bids or modifying, amending or terminating the Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by Participants and Dependents. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.

The Fund may also disclose PHI to the Trustees concerning whether an individual participates in the Fund.

In order to permit the Fund to disclose certain PHI to the Trustees, the Trustees have executed a HIPAA Plan Sponsor Privacy Certification ("Certification") that confirms that the Fund has been amended as required by the Privacy Rule, 45 C.F.R. §164.504(f).

Effective April 14, 2003, the Trustees are subject to the following limitations and requirements related to their use and disclosure of PHI received from the Fund:

- The Trustees will not use or further disclose PHI other than as permitted or required by the Fund's rules or as required by law;
- The Trustees will require that any agents, including subcontractors, to whom they provide PHI received from the Fund agree to the same restrictions and conditions that apply to the Trustees with respect to such information;
- The Trustees will not use PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Trustees;
- The Trustees will report to the Fund any improper use or disclosure of PHI of which they become aware;
- `The Trustees will make available PHI as necessary for the Fund to comply with the access requirements found at 45 C.F.R. § 164.524;
- The Trustees will make available PHI as necessary for the Fund to comply with the amendment requirements under 45 C.F.R. § 164.526, and incorporate any amendments to PHI as required by 45 C.F.R. § 164.526;
- The Trustees will document and provide a description of any disclosures of PHI and information related to such disclosures as would be required for the Fund to respond to a request for an accounting of disclosures of PHI in accordance with *45* C.F.R. § 164.528;
- The Trustees will make the internal practices, books and records relating to the use and disclosure of PHI received by the Fund available to the Secretary of the Department of Health and Human Services for compliance purposes;
- If feasible, the Trustees will return or destroy all PHI received from the Fund that the Trustees maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Trustees will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- The Trustees will notify all potentially affected Participants and Beneficiaries of a breach of unsecured PHI.

The Fund has established adequate separation between the Trustees and the Fund as required under 45 C.F.R. § 164.504(f)(2)(iii) and as follows:

- In accordance with the Fund's Privacy Rules Compliance Policy ("Policy"), access to PHI is limited to those Fund employees whose duties include the handling of PHI to perform administration functions on behalf of the Fund, or who receive PHI relating to Payment, Healthcare Operations or other matters pertaining to the Fund in the ordinary course of business; and
- Those Fund employees only use or disclose PHI in accordance with this section and the Policy to perform administration functions on behalf of the Fund. Those Fund employees only use or disclose PHI to the Trustees as permitted by this section, the Policy and the Certification.

The Trustees, acting with the Fund, will resolve issues of noncompliance with this Policy and/or the Privacy Rule by Fund employees and/or the Fund's Business Associates in a timely and effective manner. Any Fund employee who violates this Policy and/or the Privacy Rule may be subject to sanctions at the discretion of the Fund and/or the Trustees, including but not limited to, oral counseling, adjustment of job responsibilities to prevent the Fund employee from accessing PHI and/or termination.

*Disclosure to Family and Friends*. The Fund may release PHI to friends or family members that you have identified and authorized who are involved in caring for you or involved in paying for your care unless you notify the Fund's Privacy Officer in writing that you object. The Fund will disclose only PHI that is directly relevant to that person's involvement. In an emergency or if you become incapacitated, the Fund may also disclose your PHI to other family members, relatives or close friends under certain circumstances as permitted in the Fund's procedures, unless you have previously notified the Fund's Privacy Officer in writing that you do not want your information shared under those circumstances. If you want the Fund to disclose your PHI to specific persons then you must complete an authorization form designating that person as authorized to receive your PHI. Authorization forms are available from the Privacy Officer at the Fund office.

Additional Disclosures. In addition to the above permitted uses and disclosures, the Fund may also use and disclose your PHI under the following unique circumstances:

- As Required by Law. Disclosure of your PHI may be required by federal, state, or local law. For example, the Fund may disclose your PHI to assist law enforcement officials in their law enforcement duties;
- As Required by HHS. Disclosure of your PHI may be required by the U.S. Department of Health and Human Services to investigate the Fund's compliance with the privacy regulations;
- In the Event of Domestic Violence or Abuse. Your PHI may be disclosed when authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect, or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless so informing you would cause a risk of serious harm;
- Health Oversight Activities. Your PHI may be disclosed to a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor);
- Legal Proceedings. Your PHI may be disclosed when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or court ordered discovery request. In the case of subpoenas and discovery requests which are not court ordered, the Fund will disclose your PHI only if certain conditions are met;

- Law Enforcement Purposes. Your PHI may be disclosed for certain law enforcement purposes, such as identification or location of a suspect, fugitive, material witness or missing person, and reporting a crime;
- Deceased Individuals. Your PHI may be disclosed to a coroner, medical examiner, or funeral director so that those professionals can perform their duties;
- For Organ and Tissue Donation. If you are an organ donor, your PHI may be used or disclosed to an organ donor, eye, or procurement organization to facilitate an organ or tissue donation or transplantation;
- Research. Under certain circumstances, your PHI may be used or disclosed for research purposes, as long as the procedures required by law to protect the privacy of the research data are followed;
- Health or Safety Threats. Your PHI may be disclosed when, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure of PHI is necessary to prevent a serious and imminent threat to the health or safety of a person or the public. Under these circumstances, the Fund will limit the disclosure to a person reasonably able to prevent or lessen the threat, including the target of the threat;
- Government Functions. Your PHI may be disclosed in connection with certain government functions, such as military service or national security; or
- Workers' Compensation Programs. Your PHI may be disclosed to the extent necessary to comply with Workers' Compensation or other similar programs established by law.

**Your Individual Privacy Rights**

You May Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," as defined below, for as long as the Fund maintains the PHI. You or your personal representative will be required to request access to the PHI in your designated record set in writing. A reasonable fee for copying may be charged. Requests for access to PHI should be made to the Fund's Privacy Officer.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Fund is unable to comply with the deadline and provides you with notice of the reason for the delay and the expected date on which the requested information will be provided. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and HHS.

A "designated record set" includes your medical or billing records that are maintained by the Fund. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by the Fund or other information used in whole or in part by or for the Fund to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

You Have the Right to Amend Your PHI. If you feel that any PHI kept by the Fund is incorrect or incomplete, you may request that the Fund amend it subject to certain exceptions. PHI is not subject to amendment if it was not created by the Fund, is not part of the designated record set

you are permitted to inspect and copy, or if it is not kept by the Fund. The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI. You should make your request to amend PHI to the Fund's Privacy Officer, in writing.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures. At your request, the Fund will also provide you with a list of certain disclosures by the Fund of your PHI made after April 14, 2003. This accounting is not required to include disclosures related to Treatment, payment for Treatment, or Health Care Operations, or disclosures made to you or authorized by you in writing. The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. The first accounting you request in a 12-month period will be provided free of charge. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable cost-based fee for each subsequent accounting. You or your personal representative must submit your request for an accounting in writing to the Fund's Privacy Officer.

You May Request Restrictions on PHI Uses and Disclosures. You may request that the Fund restrict the uses and disclosures of your PHI to carry out Treatment, Payment or Health Care Operations. In addition, you may restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care. The Fund, however, is not required to agree to your request. You or your personal representative must submit your request for restrictions on uses and disclosures of your PHI in writing to the Fund's Privacy Officer.

You May Request Confidential Communications. You may also request to receive communications of PHI confidentially by alternative means or solely at an alternative location (for example, mailing information somewhere other than your home address) if it is feasible and reasonable. You or your personal representative will be required to request confidential communications of your PHI in writing. Make such requests to the attention of the Fund's Privacy Officer Belkis Henriquez, or her successor, at the Fund's office. Please note that the Fund is required to grant this request only if the individual states he or she would be in danger if the communications were not confidential.

You May Exercise Your Rights Through a Personal Representative. You may exercise your rights through a personal representative. Except as provided below in connection with parents of unemancipated minor children, your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without completion of an

Appointment of Personal Representative form. For example, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable state law requires otherwise. Unemancipated minors may, however, request that the Fund restrict information that goes to family members if permitted by applicable state laws. Other documentation that may substitute for the Appointment of Personal Representative form would include other official legal documentation that demonstrates that, under relevant state law, the representative is authorized to make health care decisions for you (for example, appointment as a legal guardian, or a health care power of attorney).

**The Fund's Duties**

Maintaining Your Privacy. The Fund is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices. You may obtain a copy of this notice by contacting the Privacy Officer at the address provided below.

Your Right to File a Complaint with the Fund or the Department of Health and Human Services. If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the Privacy Officer at the following address:

Privacy Officer
United Teamster Fund
2137 Utica Avenue
Brooklyn, New York 11234

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights at:

Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201
1-(877)-696-6775.

You can also contact them through https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

The Fund will not retaliate against you for filing a complaint.

**If You Need More Information**

If you have any questions regarding this section or the subjects addressed in it, you may contact the Privacy Officer at the Fund office.

**Security Rules for Electronic PHI**

The Fund is required by law to protect PHI maintained in electronic form (e-PHI) that is used for Fund administration. The Fund and its Board of Trustees have implemented administrative,

physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the e-PHI that is created, received, maintained, or transmitted on behalf of the Fund. The Fund must further:

- Identify and protect against reasonably anticipated threats to the security or integrity of e-PHI;
- Protect against reasonably anticipated impermissible uses or disclosures of e-PHI;
- Ensure compliance by the Fund's employees; and
- Ensure that any agent, including a subcontractor, to whom it provides e-PHI created, received, maintained, or transmitted on behalf of the Fund, agrees to implement reasonable and appropriate security measures to protect the e-PHI.

In addition, the Board of Trustees has agreed to the following so that it may receive and use e-PHI for administrative purposes:

- To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Fund;
- To ensure that adequate separation between the Fund and the Board of Trustees is supported by reasonable and appropriate security measures;
- To ensure that any agent, including a subcontractor, who receives e-PHI created, received, maintained, or transmitted on behalf of the Fund, agrees to implement reasonable and appropriate security measures to protect the e-PHI; and
- To notify Participants and the Federal Trade Commission of any probable disclosure of e-PHI of which the Fund, or any Business Associate of the Sponsor becomes aware, in accordance with HIPAA's health breach notification rule (16 CFR Part 318).

## ***MEDICAL BENEFITS***

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

### **Overview of Coverage**

Participants and Dependents have access to Aetna's network of hospitals and providers. Benefits provided through the Aetna network are described as "In-Network." Benefits that are not provided through the Aetna network are described as "Out-Of-Network." Your benefits may differ depending on whether you use an In-Network or Out-of-Network provider.

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.

## The Aetna Network of Providers

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

- You will have access to an extensive network of medical care providers to choose from;
- A $250 Deductible for employee-only coverage or a $500 Deductible for employee-and-family coverage applies for ambulances, durable medical equipment, hospice care and home health care;
- 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 applies;
- you will pay only a Copayment for most covered services, although, in some circumstances, you will have to pay a 20% Coinsurance amount; 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 Aetna's online directory.** To locate an In-Network doctor, Hospital or other provider in the network, log on to www.meritain.com or browse the online provider directory;
- **Contact Aetna** Customer Service at 1-800-343-3140; or
- **Contact the Fund Office.** The Fund Office can also help you find an In-Network provider.

Although you can choose an In-Network provider or an Out-Of-Network provider for your medical care, you pay less when you use an In-Network provider.

## *How Out-of-Network Care is Covered*

When you see a provider that does not participate in the 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 an annual Deductible of $3,000 for employee-only coverage or $6,000 for employee-and-family coverage before being reimbursed for Covered 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, except that service for an out-of-network anesthesiologist or ambulance are reimbursed at 100% of MRC;
- You are responsible for paying a percentage of the provider's charges (Coinsurance);
- If the provider's bill exceeds the amounts of your Coinsurance and the benefits paid by the Fund, you are responsible to pay the balance of the provider's bill;
- 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; and
- You must file a claim form. In some cases, you must pay the provider when the service is rendered, then submit a claim for reimbursement to Meritain Health.

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 sections 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 Meritain Health 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.

**Prior Authorization and Continued Stay Review**

*Prior Authorization* is required in order for certain services and benefits to be covered by the Fund., You must call Meritain Health Review Organization (for medical, surgical or hospital services and benefits) or D.J. O' Grady (for mental health or substance abuse services and benefits) and obtain approval before a scheduled admission to a hospital or other inpatient facility, or before you undergo certain treatments and services. Prior Authorization is used to certify Medical Necessity and the initial length of a Hospital or other inpatient Confinement**. If you do not call and obtain Prior Authorization for an admission, treatment or service that requires it, the Fund will not pay any benefits for that admission, treatment or service.**

Prior Authorization is required for:

- Hospitalizations (except for emergency admissions);
- surgeries, whether performed inpatient or outpatient;
- the use of an operating room and other facilities at a Hospital for a surgical procedure;
- the use of an operating room and other facilities at an ambulatory facility (outpatient surgeries);
- durable medical equipment costing $500 or more;
- prosthetics and orthotics costing $500 or more;

- injectable medications;
- private duty nursing;
- elective abortion procedures;
- Medically Necessary circumcision if not newborn (more than 30 days old);
- home health care benefits;
- hospice services (both inpatient and at home);
- hyperbaric oxygen benefits;
- bariatric treatment for obesity;
- speech, respiratory, occupational, cardiac, pulmonary, and cognitive therapy and psychotherapy;
- physical therapy and rehabilitation;
- skilled nursing facility;
- inpatient rehabilitation;
- long-term acute care facilities;
- transfers between inpatient Hospitals;
- sleep disorder benefits (testing and treatment);
- organ transplant benefits;
- genetic testing or genetic counseling;
- all residential treatment services; and
- all other services or treatments indicated in other parts of the SPD.

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 Meritain Health Review Organization by the end of the third month of pregnancy.

The Fund will not pay any benefits if you are required to, but do not obtain Prior Authorization, except in cases of Emergency Admissions to Hospitals and other medical facilities. In cases of an Emergency Admission, the Fund will pay benefits if Authorization is obtained within 48 hours after your admission.

*Continued Stay Review ("CSR")* is the process by which Meritain Health or D.J. O'Grady will determine whether a Hospital or facility to which you are confined is still the most appropriate place of service to provide the level of care you require. CSR is used to certify Medical Necessity and length of a continued Hospital Confinement when you or your Dependent are already receiving treatment in a Hospital or other inpatient or residential facility.

CSR should be requested, prior to the end of the certified length of stay, for continued Confinement in a Hospital or other inpatient or residential facility.

The Fund will not pay benefits for additional days of confinement to a Hospital or facility which were not approved through the Fund's CSR procedures.

## Case Management

Case management is a service provided through a Meritain Health 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 Meritain Health 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 assistance in obtaining needed medical resources and ongoing family support in a time of need.

## ***HOSPITAL BENEFITS***

When you are hospitalized, the Fund covers semi-private room and board (if you have a private room, the Fund still pays no more than the semi-private 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;
- use of electrocardiographic equipment;
- 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;
- use of physiotherapeutic equipment;
- plaster casts; and
- 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 or Injury, you are eligible for Hospital medical expense benefits.

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 for care at a veteran's facility 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 year Hospital Confinement. A "confinement" is a period of hospitalization that is separated from the previous and following confinement by at least 90 days.

Prior Authorization is required.

**Emergency Care**

The Fund covers diagnosis and treatment rendered in the Emergency Room of a Hospital only in cases of an Emergency. An Emergency is a Sickness or injury that arises with symptoms of sufficient severity that a reasonably prudent person would believe that absence of emergency medical evaluation or treatment could seriously jeopardize his/her life or health or his/her ability to regain maximum function.

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

**Minor Surgery**

The Fund's coverage for 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.

Prior Authorization is required.

If multiple surgeries are performed In-Network during one operating session, benefits will be paid in full for only the surgery with the largest charge. Benefits will be reduced by 50% for each of the additional surgeries. If multiple surgeries are performed Out-Of-Network during one operating session, benefits will be paid as provided for under the Fund's terms for the surgery with the largest charge. Benefits will be reduced by 50% for the surgery with the second largest charge. Benefits for all additional surgeries performed during the operating session will be reduced by 75%.

**Assistant Surgeon:** The maximum amount payable for an Assistant Surgeon will not exceed 25% of the allowable charge for the primary Surgeon. (For purposes of this limitation, allowable

charge means the amount payable to the Surgeon prior to any reductions due to Coinsurance or Deductibles.)

**Co-Surgeon:** Benefits for a Co-Surgeon are payable at 75% of the allowable charge payable for the corresponding Surgeon.

## Women's Health and Cancer Rights Act Of 1998

Under federal law, group health funds 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.

## Genetic Testing and Counseling

The Fund covers genetic testing and counseling for Participants and Dependents under the following circumstances:

- A Participant or Dependent has symptoms or signs of a genetically-linked inheritable illness;
- A Participant or Dependent has been diagnosed with a genetically-linked inherited disease;
- A Participant or Dependent is at risk for being a carrier of a genetically-linked inheritable illness; and
- When genetic testing is needed to identify a specific genetic mutation in order to determine a patient's treatment options.

Benefits will be provided for up to three diagnostic tests of genetic information and related counseling sessions per calendar year.

All genetic testing and counseling must be pre-authorized.

## Maternity Care

The Fund provides Hospital maternity benefits for Participants and 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.

Prior Authorization is required.

## 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 Prior 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.

Prior Authorization is required.

## 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 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 where the Fund is primary to Medicaid);
- care for health conditions that are required by state or local law to be treated in a public facility;
- 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 SPD);
- Hospital benefits for services of physicians or private or special nurses, or other private attendants or their board, except as otherwise provided under this SPD;
- 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 SPD);
- 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 SPD;
- membership costs or fees associated with health clubs and weight loss programs;
- genetic screening or pre-implantation genetic screening, except as otherwise provided in this SPD. In addition, the Fund will cover BRCA testing for an individual who meets the appropriate criteria;
- dental implants for any condition;
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where 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;
- cosmetic surgery or therapy, except to correct defects caused by traumatic Injury or disease, 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, is Medically Necessary and is covered elsewhere in this SPD;
- 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 SPD;
- private Hospital rooms and/or private duty nursing, except as provided elsewhere in this SPD;
- expenses incurred for medical treatment when payment is denied by the primary fund because treatment was not received from a Participating Provider of the primary fund;
- services for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit;
- 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;
- services, supplies and equipment provided in connection with elective sterilization, except as specifically provided for elsewhere in this SPD;
- tests to determine a donor match except as specifically provided for elsewhere in this SPD;
- services, supplies and equipment provided to the donor of an organ for transplant, unless both the donor and the recipient are 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;
- except as expressly provided in this SPD, non-medical 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 SPD;
- 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 this SPD.

## ***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 12-month period.

### Annual Physical Exam

The Fund covers one routine health maintenance examination per 12-month period. Coverage includes a physical examination and vital signs check, select screening lab procedures including

a chemical profile, complete blood count or any of its components, urinalysis, cholesterol testing, routine gynecological exam and PAP smear, and prostate cancer screening. The Fund will also cover chest x-rays, EKG, and pulmonary functions test if performed at and billed by the doctor's office.

**Immunizations**

The Fund covers all required immunizations. The Fund also covers the office visits for an 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**

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

Home health services are provided only if Meritain Health has determined that the home is a medically appropriate setting. If you are a minor or an adult who needs 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.

Prior Authorization 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.

Prior Authorization 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 under the Fund's terms.

**Hospice Care**

Hospice care covers services provided to 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;
- 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; and
- Bereavement counseling for the survivors.

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.

Prior Authorization 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 Meritain Health; 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.

Prior Authorization is required.

**Injection Therapy**

The Fund covers injections to the joints and the cost of drugs subject to a $50 Copay. 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.

Prior Authorization is required only for in Hospital surgery.

**Short-Term Rehabilitative Therapy Services - Outpatient Physical, Occupational, Cognitive, Speech, Pulmonary, and Cardiac Rehabilitation Therapy and Psychotherapy**

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.

Prior Authorization is required.

The Fund covers short-term therapy that is part of a habilitation or 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 therapy services provided on the same day constitute one day of service. A separate Copayment 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 due to an 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 neurological 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 Meritain Health 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.

Prior Authorization 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, wheelchairs 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, and 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, handheld showers, paraffin baths, bathmats, 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; and

- **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 transplant services. The Aetna Institute of Excellence program (IOE) offers a network of participating facilities for organ transplant services that you may use. If you use a facility in the IOE network that has been approved by Aetna for the type of transplant you require, you will only be responsible for your copayments. You may also use an Out-of-Network facility or provider for organ transplant services. If you use an Out-of-Network facility or provider, the Fund will cover a percentage of the Maximum Reimbursable Charge for the Medically Necessary services you receive after you satisfy your Deductible and you will be responsible for all co-insurance and amounts billed by the provider or facility that exceed the amount payable by the Fund.

Pre-authorization is required for all organ transplant services.

## Covered Transplant Expenses

The Fund will pay covered transplant expenses in accordance with the Fund's terms. These expenses include the following:

- Charges for activating the donor search process with national registries;
- Compatibility testing of prospective organ donors that are immediate family members. For purposes of this section an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings and children;
- Inpatient and outpatient expenses directly related to a transplant;
- Charges made by a Physician or a transplant team;
- Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent this is not covered by another plan or program; and
- Related supplies and services provided during the transplant process. These services and supplies may include physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Transplant coverage does not include charges for the following:

- Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor unless the donor and the recipient are both covered by the Fund;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs without the expectation of immediate transplant for an existing Illness;
- Cornea or cartilage transplants.

**Travel and Lodging Expenses (In-Network only)**

Travel and lodging expenses will be covered to an In-Network facility that is more than 100 miles away from the patient's primary residence. Coverage is limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companions and donor. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed per IRS guidelines.

Reimbursement of expenses incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, to a maximum of $100 per night.

Prior Authorization 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; and
- Licensed health aide from the state where service is provided.

**Outpatient/Ambulatory Facility**

For an operating room or ambulatory facility other than a Hospital, Prior Authorization 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.

The Fund has partnered with D.J. O'Grady to assist you and your Dependents with finding, and obtaining treatment from an appropriate, accredited mental health facility or provider that will be covered by the Fund as "in-network." This means that you will only have to pay your copayment. You will not be responsible for coinsurance, deductibles or "balance billing" (amounts that a provider charges that exceed your coverage and are payable by you). If you choose to work with D.J. O'Grady, they will provide guidance, education and support during and after your treatment. You can contact D.J. O'Grady by calling (212) 206-7898.

You are not required to use D.J. O'Grady's services to obtain mental health treatment. If you choose not to use D.J. O'Grady, the Fund will cover a percentage of the Maximum Reimbursable Charge for the Medically Necessary services you receive after you satisfy your Deductible and you will be responsible for all coinsurance and amounts billed by the provider or facility that exceed the amount payable by the Fund.

Prior Authorization and CSR are required for all inpatient mental health services. In order to obtain Prior Authorization or Continued Stay Review, please call DJ O'Grady at (212) 206-7898. DJ O'Grady performs Prior Authorization and Continued Stay Review for all In-Network and Out-of-Network services.

If an admission to a mental health facility is on an emergency basis, you or your Dependent do not have to obtain Prior Authorization. However, you or someone acting on your behalf (or your Dependent or someone acting on his or her behalf), must contact D.J. O'Grady and obtain authorization for the stay within 48 hours after you are admitted.

**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.

Prior Authorization is required for all inpatient 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 mental health benefit.

*Mental Health Residential Treatment Services*- Mental health residential treatment services are services provided by a Hospital or other residential facility 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 as a hospitalization.

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 or other medical professional.

**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 are provided in an individual, group or mental health intensive outpatient therapy program. Covered services include, but are not limited to, outpatient treatment of conditions such as anxiety or depression which interfere 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.

**Mental Health Exclusions**

The following exclusions apply to the Fund's coverage for mental health services:

- Any court ordered treatment or therapy 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 and which are covered under the Fund's medical provisions;
- 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; and
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

**Substance Abuse Benefits**

The Fund has partnered with D.J. O'Grady to assist you and your Dependents with finding and obtaining treatment from an appropriate, accredited substance abuse facility or provider that will be covered by the Fund as "In-Network". This means that you will only have to pay your copayment. You will not be responsible for coinsurance, deductibles or "balance billing" (amounts that a provider charges that exceed your coverage and are payable by you). If you choose to work with D.J. O'Grady, D.J. O'Grady will provide guidance, education and support during and after your treatment. You can contact D.J. O'Grady by calling (212) 206-7898.

You are not required to use D.J. O'Grady's services to obtain treatment for substance abuse. If you choose not to use D.J. O'Grady, the Fund will cover a percentage of the Maximum Reimbursable Charge for the Medically Necessary services you receive after you satisfy your Deductible and you will be responsible for all coinsurance and amounts billed by the provider or facility that exceed the amount payable by the Fund.

Prior authorization and CSR are required for all inpatient services. In order to obtain Prior Authorization or Continued Stay Review, please call DJ O'Grady at (212) 206-7898. DJ O'Grady performs Prior Authorization and Continued Stay Review for both In-Network and Out-of-Network services.

If an admission to a facility is on an emergency basis, you or your Dependent do not have to obtain Prior Authorization. However, you or someone acting on your behalf (or your Dependent or someone acting on his or her behalf), must contact D.J. O'Grady and obtain authorization for the stay within 48 hours after you are admitted.

**Inpatient Substance Abuse Services**

Inpatient substance abuse services are services provided for rehabilitation while you or your Dependent are Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient substance abuse services include partial hospitalization sessions and substance abuse residential treatment services.

Prior Authorization is required for all inpatient 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 as hospitalizations.

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 Services**

Outpatient substance abuse 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.

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.

*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.

**Substance Abuse Exclusions**

The following substance abuse services are not covered by the Fund:

- Any court ordered treatment or therapy unless Medically Necessary and otherwise covered under the Fund;
- 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; and
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

## ***PRESCRIPTION DRUG BENEFITS***

### How the Prescription Drug Benefit Works

The Fund provides coverage through OptumRx for prescription drugs purchased at a Participating Pharmacy or through the OptumRx 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 |

### What Types of Prescription Drugs Are Covered?

| **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 |

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.

### 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 Copayment.

## 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 OptumRx 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 OptumRx 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:

- non-prescription 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 item listed under "General Exclusions, Exceptions and Limitations."

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

- Vaccines, growth hormones, and some cancer treatments require a letter of Medical Necessity.

## 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 or contact lenses 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 panels, 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 panels from the Fund Office.

### How It Works

You can use any provider of your choosing. Call the Fund Office for an optical voucher if you are using a provider on the Fund's panels. If you do not use a provider from the Fund's panels, 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 Healthplex.

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 or 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 Healthplex.

The maximum dental benefit payable per person per Fund Year is $2,000. The maximum orthodontia limit payable per lifetime is $1,650 for an in-network dentist or $1,845 for an out-of-network dentist. Orthodontia is only covered for children under the age of 19.

Very limited dental coverage is provided by the Fund through the medical benefits administered by Meritain Health. 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 Meritain Health, the terms of the SPD will govern.

You must obtain Prior Authorization for Dental Benefits provided by Meritain Health.

## ***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.

### 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 and Limitations

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

- If you die and your death was not due solely to external, violent and accidental means, 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; and
- 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 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. The same rules for designating a beneficiary that apply to a life insurance benefit apply to the Accidental Death & Dismemberment Benefit. 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 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 benefit will be paid. You will receive benefits for the loss which pays the largest benefit.

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 AD&D 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; and
- 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 AD&D claim, see the section called "Claims and Appeals Procedures."

## GENERAL EXCLUSIONS, EXCEPTIONS & LIMITATIONS

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

- expenses for care that is not Medically Necessary, except as specifically provided in this SPD;
- charges that have been paid for, or should have been paid for by another insurance carrier (see the "Coordination of Benefits" section);
- expenses for services or supplies for which a third party may be liable or which arises from the negligence or other tortious or wrongful act of a 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 SPD;
- 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 SPD (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 SPD;
- charges for 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, drugs, services or supplies which, in the sole discretion of the Fund, are either Investigational and Experimental, obsolete or ineffective (see the "Glossary" section for the definition of "Investigational and Experimental");
- 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 as otherwise specifically provided for in this SPD);
- 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, except where such injuries were the result of a medical condition;
- 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; and
- collection or storage of your own blood, blood products, semen or bone marrow except as otherwise provided.

***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 Motor Vehicle is covered by insurance or not, if the injured individual:

- intentionally causes his or her own Injury, except where this is due to a medical condition;
- 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 injured while 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.

***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 fund; or
- Medicare or some other government program, such as Medicaid or TRICARE, or
- A federal, state or local government or agency, or through 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 source described above 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 source. 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 Applies**

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

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

Many families with more than one person working are covered by more than one group medical fund. 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 funds (called the "primary fund") will pays its benefits first. The other fund (called the "secondary fund") may then pay additional benefits. In no event will the combined benefits of the primary and secondary funds 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 Covered Expenses, whether it offers primary or secondary coverage. 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 fund does not have a COB provision, that fund always pays first;
- If the Fund and the other fund both have a coordination provision, then whichever covers you as an employee pays your expenses first;
- If your Spouse is covered under a separate fund, the separate fund will 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 fund, other than an individual fund, the fund which covered you the longest pays first.

**Rules for Dependent Children**

**Dependent Child Covered Under More Than One Fund – The Birthday Rule**

- When this Fund and another fund cover the same child as the Dependent of two or more parents, the primary fund is whichever of the two covers the parent whose birthday falls earlier in the year.

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

**Dependent Child Covered Under More Than One Fund – Court Order**

When this Fund and another fund 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 arrangement which covers the parent with this responsibility is primary.

**Dependent Child Covered Under More Than One Fund – Custodial Parent**

When this Fund and another fund cover the same child as the Dependent of two or more parents, if the parents are not married, or are separated, or are divorced, the primary fund is:

- the fund which covers the custodial parent; then
- the fund of the Spouse of the custodial parent; then
- the fund of the non-custodial parent; and then
- the fund of the Spouse of the non-custodial parent.

**If the Fund Is Secondary**

When the Fund is the secondary coverage, it will pay the same benefits that it would have paid had it paid first **minus** whatever payments were actually made by the coverage that paid first. If the primary fund 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 funds 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 funds involved in paying claims;
- require that you or your health care provider furnish any necessary information;
- reimburse any fund 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 with each fund 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 Provided Coverage**
**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, 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 a situation involving end-stage renal disease:

- Medicare generally imposes a three-month Waiting Period at the onset of end-stage renal disease 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. As such, the Fund will provide primary coverage 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 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 fund is primary, 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 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. 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 any other coverage you have, the Fund will

still be secondary. This 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.

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

Again, the Fund does not permit Participants to opt out of no-fault coverage as primary by designating the Participant's own health insurance as a primary source of coverage in the case of an 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 coverage 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 no fault coverage maximum.

## ***REIMBURSEMENT AND SUBROGATION OF BENEFITS***

In some situations, you or your covered Dependent may be entitled to money or benefits because of an Injury or Sickness caused by another party. The Fund does not provide benefits for an Injury or Sickness to the extent that you or your covered Dependent is entitled to any money from, or on behalf of the party that was responsible for the Injury or Sickness. As a courtesy, the Fund will advance benefits for you or your Dependent on the condition that you or your covered Dependent reimburse it from any money that you or your covered Dependent receive from, or on behalf of the third party that was responsible for the Injury or Sickness, whether it is received as a result of a settlement, judgment or otherwise.

### The Fund's Right of Subrogation

The Fund's has the right to pursue your or your covered Dependent's claims against another party or parties to the extent that they cover expenses paid by the Fund. It may also intervene in a legal action brought by you or your covered Dependent against a third party to protect its rights.

### The Fund's Rights of Recovery and Reimbursement

The Fund must be reimbursed from any payments recovered by, or on behalf of you or your covered Dependent, regardless of how the recovery is structured or worded, how the payment is described, what the payment is for or whether the payor caused or is legally responsible for the Injury or Sickness. The Fund must be reimbursed before any money is paid to you, your covered Dependent, your lawyer or anyone else. Reimbursement must be made, even if you or your covered Dependent has not been paid or fully reimbursed for all the damages or expenses incurred. The Fund can, but does not have to, agree in writing to accept less that the whole amount due to it.

The Fund's right to 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. The Fund's right to reimbursement is not subject to reduction for attorneys' fees and expenses for which you or your covered Dependent might be responsible.

Any amounts which are held on your or your covered Dependent's behalf by any party, but which are owed to the Fund under these provisions, are subject to a constructive trust and/or equitable lien on the Fund's behalf. This means the monies must be held in trust for the benefit of the Fund. If a party that is holding money owed to the Fund does not agree to hold the money in trust, the Fund can take appropriate legal action to protect its rights.

By participating in the Fund, you and your covered Dependents agree to irrevocably assign to the Fund all rights to recover money from a third party (including the right to bring suit in your or your covered Dependent's name or intervene in any action brought by you or your covered Dependent to recover for the Sickness or Injury), and to give notice of this assignment directly to such third parties, their agents or insurance carriers, and/or to any agent or attorney who may represent you or your covered Dependent. You and your covered Dependent cannot assign your or their rights to settlement or recovery against a third party to any other party, including your or his/her attorney(s), without the Fund's consent.

The Fund has sole and final discretion to determine whether to advance payment of benefits and require repayment and whether to assert its rights under this provision as a lien, through subrogation, through reimbursement, or through any combination or variation of these methods. The decision on whether to advance payment and 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 Trustees' sole and final discretion.

Any disputes arising under, or in connection with the Fund's reimbursement and subrogation rights, 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 SPD, including review by the Board of Trustees.

**Participant Duties and Actions**

If you or your covered Dependent believes that you or (s)he may be entitled to recovery from a third party for an Injury or Sickness, you or your covered Dependent must notify the Fund in writing within 30 days of the incurrence of the Injury or Sickness. Your notice must include the name, address and telephone number of the attorney, representative or other agent handling the claim on behalf of you or your covered Dependent, if any. The notice should also identify the third party responsible for the Injury or Sickness. After making any claim against a third party, you or your covered Dependent must immediately notify the third party and its counsel or representative in writing of the Fund's subrogation and reimbursement rights.

Upon receipt of the written notice, the Fund will provide you or your covered Dependent with an "Agreement to Reimburse the United Teamster Fund for Amounts Recovered" (the "Reimbursement Agreement"). This Reimbursement Agreement confirms your acceptance of

the Fund's subrogation and lien rights and the Fund's right to be reimbursed for expenses arising from circumstances that entitle you or your covered Dependent to any payment or recovery from a third party. This Reimbursement Agreement must be signed by you and your covered Dependent (and your or his/her attorney, if applicable) and notarized. 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 as the Fund deems necessary to protect the Fund's rights. 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.

If you or your covered Dependent fails or refuses to execute the required Reimbursement Agreement or otherwise cooperate with these provisions, the Fund may deny payment of any benefits to you and your covered Dependents. Alternatively, if the Fund 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, Spouse, attorney, representatives, agents and their heirs, guardians, executors, successors and assignees.

You, your Dependent, your attorney, or representative or agent must keep the Fund up to date on the status of any claim against any third party. The Fund must be provided 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. You, your covered Dependent and anyone acting on your or his/her behalf may not settle or resolve any claim against any third party or accept any payment from any third party without written consent from the Fund.

If you or your covered Dependent receives any payment or recovery, you must immediately report it to the Fund and must use it to repay the Fund.

Full cooperation with these provisions is a condition to payment of any benefits from the 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 any money paid by the Fund and the costs of enforcing the Fund's lien and right of recovery, including interest and fees. The Fund may, also, at its discretion, offset future benefits payments to you or your covered Dependents against the amounts that you or your Covered Dependent owe to the Fund.

If the Fund reasonably believes that an Injury or Sickness was 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 involvement, the Fund can require you or your covered Dependent to sign a declaration, under penalty of perjury, stating that the Injury or Sickness was not related to any act or omission by a third party. The Fund need not pay benefits for the Injury or Sickness until the signed declaration is provided to it.

## ***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. You should save all claims forms and other documents that you submit to, or receive from, the Fund.

## 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:

- the life or health of you or your Dependent or the ability of you or your Dependent to regain maximum function could be seriously jeopardized; or
- in the opinion of the treating physician with knowledge of the medical condition, you or your Dependent would suffer severe pain that cannot be otherwise adequately managed. 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 Prior Authorization) 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, 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 Prior Authorization of a benefit that does not require Prior Authorization 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 or your provider must submit a claim to the appropriate Health Organization (see below).

**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 fifteen (15) days before the start of the service in question; and
- 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 Health Organization that administers claims for that type of benefit, or the Fund Office if there is no such Health Organization.

Health Organizations include:

- Meritain Health: Meritain Health administers medical and Hospital benefit claims and claims for Out-of-Network mental health and substance abuse services;
- Fund Office: The Fund Office administers mental health and substance abuse benefit claims for services provided through D.J. O'Grady. The Fund Office also administers life insurance benefit claims and Accidental Death & Dismemberment claims;
- OPtumRx: OPtumRx administers prescription drug benefit claims;
- Healthplex: Healthplex administers vision benefit claims; and
- Healthplex, Inc.: Healthplex administers dental benefit claims.

A list of each Health Organization and its address can be found 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 as authorized representative 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 claim for benefits is payable and the amount covered by the Fund. This decision is made in accordance with the guidelines established by the Health Organization and applicable Fund terms.

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 (except as otherwise provided herein)

The timeframe for notification depends on the type of claim being filed. For convenience, the words "you" or "your" below refer to the individual who filed the claim (either you or your authorized representative), 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 you 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.

If your fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Fund, the Reviewer will notify you 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. You are 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 request written notification.

When specific information has been requested, the Reviewer will notify you 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 to you to provide the specified additional information.

**Concurrent Care Claims**

When an ongoing course of treatment or confinement has been approved for you for a particular period of time or number of treatments and you wish to extend the period of confinement or number of approved treatments, you must request a required Concurrent Care Claim determination at least 24 hours prior to the expiration of the previously approved period of time or number of treatments. When you request such a determination, the Reviewer will notify you of the determination within 24 hours after receiving the request. If the 24 hour deadline for filing is not met by you, or if the claim does not involve Urgent Care, the Reviewer 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 you of its benefit determination (whether adverse or not) within a reasonable period 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 its control and notifies you, 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 your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from your receipt of the notice to provide the specified information.

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 Reviewer then has 15 days to decide your Pre-Service Care Claim and notify you of the decision.

If you improperly file a Pre-Service Care Claim, the appropriate Health Organization or the Fund Office will notify you as soon as possible, but not later than 5 days after receipt of the claim (24 hours in the case of a failure to file a claim involving urgent care), of the proper procedures to be followed in filing the claim. This notice may be provided orally unless you request written notification. You 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.

**Post-Service Care Claims**

In the case of a Post-Service Care Claim, the Reviewer will notify you 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 its control and notifies you, 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 your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from your receipt of the notice to provide the specified information. The determination will be suspended on the date the Reviewer sends such a notice of missing information and resume on the date you respond 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; and
- 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.

**Manner and Content of Notification of Initial Benefit Claims**

If the claim for benefits has been denied by the Reviewer, in whole or in part, you 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 and a copy of the plan language supporting the denial;
- a description of any additional material or information necessary for you 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 your right to bring a civil action 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 the Public Health Safety Act 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 either copy of the rule or a statement that a copy of the rule will be provided without charge upon request); and
- if the benefit determination is based upon 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, you 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 you not later than three (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**

**Vision Claims**

Healthplex administers vision claims under the Fund and will decide your claim in accordance with the Fund's claims procedures. For more information on vision claims, contact Healthplex at 333 Earle Ovington Blvd., Suite 300, Uniondale, New York 11553-3608, or call them at (516) 542-2200 or (800)466-0600. You may also contact the Fund office for information.

**Dental Claims**

Healthplex administers dental claims under the Fund and will decide your claim in accordance with the Fund's claims procedures. For more information on dental claims, contact Healtplex at 333 Earle Ovington Blvd., Suite 300, Uniondale, New York 11553-3608, or call them at (516) 542-2200 or (800)466-0600. You may also contact the Fund office for information.

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

A Life Insurance claim is a claim made by your beneficiary after of your death. A Dependent life insurance claim is a claim made by you after the death of your Dependent. An Accidental Death & Dismemberment claim is a claim made by you or your beneficiary after an accidental death or serious Injury.

The following procedure applies to claims for the Life Insurance benefit, Dependent life insurance 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; and
- Return the completed claim form and all necessary documentation to the Fund Office.

The Fund will decide 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 required 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 deciding the claim will be suspended.

## Appeals Procedures

### Filing the Appeal

If your claim for a benefit is denied, you 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.** Your appeal will be reviewed and determined by the Fund's Board of Trustees or a Health Organization authorized by the Board of Trustees (the "Reviewer").

You 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 consider all new information. The Reviewer 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 Investigational and Experimental or not Medically Necessary or appropriate, the Reviewer may 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 employer, subordinate or employee of the person who made the initial adverse determination. The impartiality rule described above will apply to the review of the claim appeal.

The Fund will provide the names 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 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 you; and

- all necessary information, including the benefit determination on review, is transmitted between you and the Reviewer by telephone, facsimile, or other available similarly expeditious method.

**New Evidence or Rationale for the Decision on the Claim or Appeal**

You will receive, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Fund or authorized Health Organization in connection with your claim or appeal. 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 you 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 you in time for you to have a reasonable opportunity to respond, the period for providing a notice of final adverse benefit determination is tolled until such time as you have a reasonable opportunity to respond. After you respond or have a reasonable opportunity to respond but fail to do so, the Trustees or authorized Health Organization will notify you of the 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, you will be notified of a decision on your appeal 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, you will be notified of a decision on your appeal 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 you 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 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;
- state that you are 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 you have a right (within the time limit indicated below) to file suit;
- indicate the availability of, and contact information for, any office of health insurance consumer assistance or ombudsman established by the Public Health Safety Act 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, state that the internal rule was so relied on and include either a copy of the internal rule or state that you may obtain a copy of the rule without charge upon request; 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.

**External Review Procedures**

**Availability of External Review**

If your appeal is denied by the Trustees or an authorized Health Organization and the denied appeal involved medical judgment or the rescission of your coverage, you or your authorized representative may request External Review. The External Review will be determined by an Independent Review Organizations, which is not related to the Health Organization and the Fund. The Fund will pay the costs of the External Review.

**Filing Request for External Review**

You must file your request for external review with the Fund Office within four months after the date you received an adverse determination on your appeal.

**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:

- the individual in question is or was covered at the time the health care item or service was requested;
- the adverse benefit determination does not relate to such individual's failure to meet the requirements for eligibility;
- you have exhausted the internal appeal process (unless an exception applies); and
- you have provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, you will receive notification of the Fund's determination in writing. If your request is complete but not eligible for external review, the notification will 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 your request is not complete, the notification will describe the information or materials needed to make the request complete and the Fund will allow you 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 your request is complete and eligible for external review, the Fund will assign an Independent Review Organization (or "IRO") that is accredited by a nationally recognized accrediting organization to conduct the External Review. The IRO will be Independent and will not be eligible for any financial incentives based on its decision. There is no cost to you for requesting an external review.

**Requirements Pertaining to the IRO Review**

The Fund will provide the IRO with all information and documents considered in making its decision on your claim. In reaching a decision on the external review, the IRO will 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 you and the Fund, within 45 days after the IRO receives the request for the external review. The notice will contain the following information:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the denial);

- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the IRO's determination is binding except to the extent that other remedies may be available under State or Federal law the Fund or to the patient, or to the extent the Fund voluntarily makes payment on the claim or otherwise provides benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Safety Act.

The IRO will 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 you, the Fund, or the 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 will immediately provide coverage or payment (including immediately authorizing care or immediately paying benefits) for the claim.

**Expedited External Review**

**Request for the Review**

You may request an expedited External Review of:

- An adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the claimant's life or health or his/her ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
- A final adverse benefit determination that involves a medical condition for which the timeframe for completion of a standard External Review would seriously jeopardize the claimant's life or health or his/her ability to regain maximum function; or
- A final adverse benefit determination that concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency services but has not been discharged from the facility.

**Preliminary Review**

Immediately upon receiving your request for expedited External Review, the Fund will complete a preliminary review of your request to determine whether the request is eligible for External Review. The Fund will immediately notify you of its decision.

**Referral to Independent Review Organization**

Once it determines that your request is eligible for expedited External Review, the Fund will assign an IRO. 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 IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the same procedures as a Standard External Review. In reaching a decision, the IRO is not bound by any decisions or conclusions reached during the Fund's internal claims and appeals process.

In accordance with applicable law, the Fund has retained the following accredited IROs to handle External Reviews for Fund Participants:

- Alicare Medical Management
- IMEDECS
- Medical Care Management Company (MCMC)

**Notice of Final External Review Decision**

The IRO will provide notice of the final external review decision 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, the IRO will provide written confirmation of the decision to you and the Fund within 48 hours.

**Filing Suit**

No lawsuit may be started more than 180 days after the end of the year in which you received the Trustees' decision on your appeal (or, in cases where External Review occurs, more than 180 days after the end of the year in which the IRO issued its decision). Any suit must be filed in the United States District Court for the Eastern District of New York.

## ***IMPORTANT INFORMATION ABOUT THE UNITED TEAMSTER FUND***

### Name of Fund

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

### Board of Trustees

The Board of Trustees or its duly authorized designee have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply and interpret this SPD, the Trust Agreement, any collective bargaining agreement and any other documents, and to decide all matters arising in connection with the operation and administration of the Fund or Trust. Without limiting the generality of the foregoing, the Board of Trustees or its duly authorized designee 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; and
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Board of Trustees or its duly authorized designee shall be final and binding upon all Participants, Dependents, beneficiaries, any labor organization, contributing employer 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.

### Amendment and Termination

The Trustees expect to continue this Fund indefinitely. They have the right, however, to amend, modify, or discontinue all or part of this Fund whenever, in their judgment, conditions so warrant. The Trustees may also terminate the Fund if the obligation of all employers to contribute to the Fund ceases.

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. You and your Dependents have no right to any benefits from the Fund following its termination.

## Source of Information

This SPD and the personnel at the Fund Office are authorized sources of Fund information for you. The Trustees of the Fund have not empowered anyone else to speak for them with regard to the Fund. No employer, local union official, business agent, or shop steward is in a position to discuss your rights under the Fund with authority.

## Participation is Not a Contract of Employment

Participation in the Fund is not intended or meant to be construed as a contract of employment between you and your employer. Your employer retains the right to address employment issues, including dismissal or other termination of employment, in accordance with applicable collective bargaining agreements and separate from the participation of its employees and their Dependents in the Fund. The Fund provides specific guidance with regard to a Participant's rights to Fund benefits following termination of employment.

## 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

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, Hospital 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 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 SPD 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 Administering Entities

The Fund has entered into administrative contracts with various Health Organizations to assist in administering the Fund. Contact information for the Health Organizations is found at the end of this Summary Plan Description.

## Important Notice Regarding Termination of Healthcare Coverage for Cause, Including Fraud or Intentional Misrepresentation

The Fund reserves the right to terminate coverage for you or any of your Dependents if you or any of your Dependents 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 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 has other coverage 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***

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 Fund Administrator, copies of documents governing the operation of the Fund, including the trust agreement for the Fund, collective bargaining agreements, financial reports, copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Fund Administrator may make a reasonable charge for the copies; and
- 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 Coverage***

You may continue health coverage for yourself, Spouse and/or other 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 frames.

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, 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 | Meritain Health, Inc.<br>P.O. Box 853921<br>Richardson, TX 75085<br>(T) (800) 925-2272 | Self-funded. The Fund pays the cost of benefits. Meritain Health administers benefits and provides Prior Authorization and Case Management services. |
| Prescription Drugs | OptumRx<br>P.O. Box 2975<br>Mission, KS 66201<br>(T) 1-800-797-9791<br>www.optumrx.com | Self-funded. The Fund pays the cost of benefits, which are administered by OptumRx. |
| Vision | Healthplex, Inc.<br>333 Earle Ovington Boulevard<br>Suite 300<br>Uniondale, New York 11553-3608<br>(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<br>2137-2147 Utica Avenue<br>Brooklyn, New York 11234<br>(T) 718-859-1624 | Self-funded. The Fund provides and administers benefits. |
| Mental Health and Substance Abuse | D.J. O'Grady Consultants Ltd.<br>3219 East Tremont Avenue<br>Bronx, New York 10461<br>(T) 212-206-7898<br>(F) 212-206-8798<br><br>Meritain Health, Inc.<br>P.O. Box 853921<br>Richardson, TX 75085<br>(T) (800) 925-2272 | Self-funded. The Fund pays the cost of benefits, which are administered by D.J. O'Grady Consultants and Meritain Health |
| Dental | Healthplex, Inc.<br>333 Earle Ovington Boulevard<br>Suite 300<br>Uniondale, New York 11553-3608<br>(T) 516-542-2200 or 800-468-0600 | Self-funded. The Fund pays the cost of benefits, which are administered by Healthplex. |