

CENTRAL PENNSYLVANIA TEAMSTERS

HEALTH AND WELFARE FUND

PLAN 16

SUMMARY PLAN DESCRIPTION

Effective: April 1, 2007

1055 SPRING STREET WYOMISSING, PA 19610

IN PENNSYLVANIA:

610-320-5500 OR TOLL FREE: 1-800-422-8330

TOLL FREE IN USA: 1-800-331-0420

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PREFACE

This SPD summarizes the benefits, rights and obligations that you, as a participant, have under the Central Pennsylvania Teamsters Health and Welfare Fund, Plan 16 (the "Plan"). The Trustees of the Fund hope that you will find this SPD helpful. You should review and discuss this SPD with your family. If you have any questions after reading this SPD or if you would like to discuss any of the provisions of the Plan, write or call the Fund Office. The Fund will be glad to help you.

*The street/UPS Delivery Address for the Fund Office is:
1055 Spring Street, Wyomissing, PA 19610.*

*The mailing address of the Fund Office is:
P.O. Box 15224, Reading, PA 19612-5224.*

The telephone numbers of the Fund Office are:

610/320-5500

In Pennsylvania: 1-800-422-8330 - toll free

Outside Pennsylvania: 1-800-331-0420 - toll free

INTRODUCTION

Central Pennsylvania Teamsters Health & Welfare Fund Plan 16 covers only employees of governmental employers. Participating employers can include state or local governments, or subdivisions, or agencies thereof. Because the Plan's terms are complex, it is important that you take the time to acquaint yourself with its provisions. This booklet is a summary of the Plan Document, and is called the Summary Plan Document or "SPD". It cannot present full details of the Plan. Nothing in this summary is meant to interpret, extend or change in any way the rules and regulations expressed in the Plan's governing documents. The Plan's governing documents, including the Plan Document, Plan Rules and Regulations, Plan procedures and policies, and underlying contracts with Network providers are incorporated by reference into this SPD. If any information in this booklet is in conflict with any provisions in the Plan Document and Trust Agreement, the provisions of the Plan Document, Plan Rules and Regulations, Plan procedures and policies, underlying contracts with Network providers, and the Trust Agreement shall control. Therefore, if you have a question, you should review the Plan Document and Trust Agreement and other listed documents which are available at the Fund Office.

Only the entire Board of Trustees is authorized to interpret the Plan's governing documents. No employer or union, nor any representative of any employer or union, acting in that capacity, is authorized to interpret the Plan's governing documents. No

employer or union, nor any representative of any employer or union, acting in that capacity, can act as an agent for the Board of Trustees. Accordingly, WE RECOMMEND THAT YOU DIRECT ALL QUESTIONS ABOUT THE PLAN AND THIS SPD TO THE FUND OFFICE. Please note that you may be able to find the information you need on the Fund's website, at www.centralpateamsters.com, where you will find FAQ's, forms, information about recent plan changes and other important information.

This SPD summarizes the provisions of the Plan in effect as of April 1, 2007. You and your family should read this entire SPD. The Plan may be amended in the future by the Trustees and the Trustees have the right to modify or eliminate benefits. Notice of amendments to the Plan will be provided to you. If you have any questions about amendments to the Plan made by the Board of Trustees after the publication of this SPD, write or call the Fund Office.

ARTICLE I: GENERAL INFORMATION

Q. *What is the name of the Plan?*

A. Your health and welfare plan is formally known as the Central Pennsylvania Teamsters Health and Welfare Fund, Plan 16. Throughout the rest of this SPD, it will be referred to as the "Plan".

Q. *Who is the Plan Administrator?*

A. The Plan Administrator is the Board of Trustees. It is the Trustees' responsibility to administer the Plan exclusively for the benefit of all participants and dependents.

The Trustees have established a Fund Office, and have retained Administrator Joseph J. Samolewicz and a staff to conduct the day-to-day operations of the Plan. You may contact the Trustees at the Fund Office as follows:

**Central Pennsylvania Teamsters Health and Welfare Fund, Plan 16
c/o Joseph J, Samolewicz, Administrator**

**Street/UPS Delivery Address:
1055 Spring Street
Wyomissing, PA 19610**

**Mailing Address:
P.O. Box 15224
Reading, PA 19612-5224**

Q. Who are the individuals who serve as Trustees?

A. The Board of Trustees is made up of ten individuals. There are five Trustees selected by Teamsters Local Union No. 429, and five Trustees selected by the Transport Employers Association. They are:

Union Trustees:

William M. Shappell, President
Teamsters Local Union No. 429
1055 Spring Street
Wyomissing, PA 19610

Keith Noll, Secretary-Treasurer
Teamsters Local Union No. 429
1055 Spring Street
Wyomissing, PA 19610

Kevin M. Cicak, Recording Secretary
Teamsters Local 776
2552 Jefferson Street
Harrisburg, PA 17110

Howard Rhinier, Secretary-Treasurer
Teamsters Local 771
1025 North Duke Street
Lancaster, PA 17602

Michael Rys, Business Agent
Teamsters Local 429
1055 Spring Street
Wyomissing, PA 19610

Employer Trustees:

Tom J. Ventura, Trustee
Yellow Freight System, Inc.
c/o Central Pennsylvania Teamsters
Health & Welfare Fund
1055 Spring Street
Wyomissing, PA 19610

Peter Hassler, Trustee
Roadway Express, Inc.
c/o Central Pennsylvania Teamsters
Health & Welfare Fund
1055 Spring Street
Wyomissing, PA 19610

Michael Jones, Trustee
United Parcel Service
c/o Central Pennsylvania Teamsters
Health & Welfare Fund
1055 Spring Street
Wyomissing, PA 19610

Tomm Forrest, Trustee
ABF Freight System
c/o Central Pennsylvania Teamsters
Health & Welfare Fund
1055 Spring Street
Wyomissing, PA 19610

Daniel Schmidt, Trustee
New Penn Motor Express
c/o Central Pennsylvania Teamsters
Health & Welfare Fund
1055 Spring Street
Wyomissing, PA 19610

Q. What is the Plan Year?

A. The Plan Year is the calendar year ending on December 31.

Q. Is the Plan Year different than the Benefit Year?

A. No. The Plan Year is the same as the benefit year (January 1 to December 31).

Q. What type of benefit plan is Plan 16, and how does it work?

A. Plan 16 is a multiemployer self-insured health and welfare plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). Depending on which optional benefits have been selected, Plan 16 pays benefits in certain circumstances for the following: hospitalization services, physician visits, physical therapy, immunizations and injections, surgical services, diagnostic services, hearing and vision services, dental services, prescription drugs, transplants, mental health and substance abuse services, and short-term disability. In addition, if the option has been selected, the Plan will purchase insurance from Aetna to provide death benefits and accidental death and dismemberment benefits (for active employees) for you.

Q. What are "core" benefits and what are "optional" benefits?

A. Core benefits are those benefits that are available to all participants. They include:

- hospital benefits
- inpatient benefits
- physical therapy benefits
- surgical benefits
- outpatient diagnostic benefits
- transplant benefits
- immunization and injection benefits
- Major Medical benefits

Optional benefits are those benefits which are available only if your Employer and Union have selected the benefits in collective bargaining or pursuant to a participation agreement and your Employer's contribution has been adjusted to include the option. The optional benefits that your Employer and Union may choose among include:

- death and accidental death and dismemberment benefits
- dental/orthodontic benefits
- hearing/vision benefits

- prescription benefits
- mental illness/substance abuse benefits
- physician office visits
- short-term disability benefits

You are eligible for optional benefits ONLY IF your Employer and Union selected the benefit in collective bargaining or pursuant to a participation agreement and your Employer's contribution rate reflects that option. If you are not covered by a particular optional benefit, then you will not be eligible for any part of that benefit. For example, if you are not covered by the optional hearing and vision benefits described below in this SPD, you will not be eligible for any hearing or vision benefits.

Q. What are the Plan's identification numbers?

A. The Plan's Employer Identification Number assigned by the Internal Revenue Service is 236263170. The Plan Number is 501.

Q. Who is the agent for service of process?

A. Legal process may be served on the Plan or any member of the Board of Trustees at the Fund Office located at 1055 Spring Street, Wyomissing, PA 19610.

ARTICLE II: ELIGIBILITY

Q. When am I eligible to receive benefits from the Plan?

A. Generally, you are eligible to receive benefits from the Plan if you are working for a contributing employer in a position for which contributions are due and paid to the Plan. Eligible employees are called participants. Contributions are made on your behalf pursuant to a collective bargaining agreement negotiated by your union and employer or by a participation agreement between your employer and the Fund. Under these agreements, you may be required to pay a portion of the contribution. Contact your union representative or your employer and determine whether you must make such a contribution and if so, how much. For retirees, contributions to the Fund are made on your behalf by your employer pursuant to a participation agreement that provides for contributions to provide benefits.

Special rules apply for eligible retirees. Please see the discussion below for when retirees are eligible for benefits after their retirement.

Contributions made in the "Contribution Period" purchase coverage in the "Benefit Period" as described below:

Contributions made for hours worked in November	Benefits available for the period January 1 to January 31
Contributions made for hours worked in December	Benefits available for the period February 1 to February 28
Contributions made for hours worked in January	Benefits available for the period March 1 to March 31
Contributions made for hours worked in February	Benefits available for the period April 1 to April 30
Contributions made for hours worked in March	Benefits available for the period May 1 to May 31
Contributions made for hours worked in April	Benefits available for the period June 1 to June 30
Contributions made for hours worked in May	Benefits available for the period July 1 to July 31
Contributions made for hours worked in June	Benefits available for the period August 1 to August 31
Contributions made for hours worked in July	Benefits available for the period September 1 to September 30
Contributions made for hours worked in August	Benefits available for the period October 1 to October 31
Contributions made for hours worked in September	Benefits available for the period November 1 to November 30
Contributions made for hours worked in October	Benefits available for the period December 1 to December 31

Q. *I am eligible for retiree benefits under Plan 16. After I retire (and am no longer working “hours”), when will my employer make contributions on my behalf?*

A. Your employer will be required to make contributions for retired employees on the same schedule as for active employees. (Note: If you are eligible for retiree benefits, the employer must contribute on the schedule set forth in the participation agreement between the employer and the Fund. But, if you are not eligible for retiree coverage, the employer does not need to make any contributions.)

- Q. Our collective bargaining agreement requires that I make a biweekly payment for my benefits. Who is responsible for forwarding my contributions to the Fund?**
- A. Your employer is responsible for forwarding its portion of the monthly contribution as well as your portion of the monthly contribution to the Fund.
- Q. I am retired but must make partial payment for my benefits. Who is responsible for forwarding my contributions to the Fund?**
- A. Your former employer is responsible for forwarding its part of the monthly contribution and your part of the monthly contribution to the Fund.
- Q. Am I eligible for benefits from Plan 16 after I retire?**
- A. If your employer has certified to the Fund that you have met the employer's criteria for entitlement to retiree benefits **and** your employer remains obligated to make contributions to the Fund on your behalf and has executed a participation agreement with the Fund, you may continue to receive benefits from the Fund. Your benefits from the Fund, consistent with Fund rules, will continue until the earliest of the following: (1) your death; (2) the termination date established pursuant to the statute, rules, or regulations of your pre-retirement employer; or (3) the date on which your employer certifies to the Fund that you are no longer eligible for benefits from the Fund. In addition, if your former employer ceases to be obligated to make contributions to the Fund on your behalf or you cease to make the required payments to continue your coverage, your benefits will be terminated.
- Q. Can I continue to cover my family after I retire?**
- A. If you are entitled to dependent coverage after your retirement under the rules established by your former employer, you may continue to cover your dependents after you retire. The Trustees have elected to treat the first eighteen (18) months following your retirement as your continuation coverage under COBRA triggered by your retirement, even if your employer covers all or part of the cost during this period. If your former employer does not provide post-retirement coverage for your dependents, the Fund will offer the dependents "COBRA" coverage when you retire. Note that if you terminate your benefits after you retire (for example, by failing to pay your portion of the monthly contribution) and your benefits are terminated, neither you nor your dependents will be offered "COBRA" coverage unless your dependent can be deemed to have experienced a "qualifying event" as that term is set forth in the "COBRA" statute.
- Q. There is a period of time between my date of hire and the date my coverage begins. Can I purchase coverage from the Plan to cover this period?**
- A. Yes. Contact the Fund Office for more information on this option.

Q. *If I cease to meet the eligibility requirements of this Plan, are there any special instances in which I still would have partial or total coverage under the Plan after my eligibility otherwise ends?*

A. Yes. A number of illustrative examples are set forth below. Please note this coverage does not extend to a new claim for short term disability benefits filed after your retirement because these benefits are only available to participants who are actively employed by an employer obligated to make contributions to the Fund and who are eligible for benefits on the date that the disability began.

- (1) Disability and Medical benefits for Non-Job-Related Disability May Continue For a Maximum Period of 26 Weeks. For example, John Smith stopped working for XYZ Municipality, a contributing employer, on November 28, 2005 due to a non-job-related disability. He remained eligible for benefits from Plan 16 until January 31, 2006. On December 1, 2005, he began receiving non-job-related disability benefits. His disability ended on July 14, 2006. In this case, the Plan will continue to pay disability benefits (if the participant is covered by the optional short-term disability benefit), and medical benefits for the specific disabling injury or illness, until May 31, 2006, even though benefit coverage ended January 31, 2006.
- (2) Up to Three Months of Contribution Credit If an Employer Becomes Insolvent. For example, John Smith and Bill Jones worked for GHI Borough, a contributing employer. The Borough made its last contribution to the Plan in December, 2006, for hours worked in November, 2006. After making this payment, the Borough became a “distressed municipality” under state law, and stopped making contributions to the Plan. However, Mr. Smith continued working there until January 31, 2007, and Mr. Jones continued working there until February 28, 2007. In this case, Mr. Smith will receive 2 months of contribution credit and Mr. Jones will receive the maximum 3 months of contribution credit.
- (3) Continued Eligibility for Death and Accidental Death benefits If Death Occurs Within 30 Days of End of Eligibility. For example, John Smith stopped working for LL County, a contributing employer, on November 28, 2006. He remained eligible for benefits from Plan 16 until January 31, 2007. Mr. Smith died in a car accident on February 28, 2007. If Mr. Smith was covered by the death and accidental death and dismemberment benefit option, the Plan will pay death benefits and accidental death benefits to Mr. Smith's dependent.
- (4) Hospitalization Charges If Date of Admission Is During a Period of Eligibility. For example, John Smith stopped working for LMN Township, a contributing employer, on November 28, 2006. He remained eligible for benefits from Plan 16 until January 31, 2007. Mr. Smith was admitted to the hospital from January 20 to February 10, 2007. The Plan will pay hospitalization benefits for Mr. Smith through February 10, 2007.

- (5) The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under this federal law, you may be able to purchase continuation coverage from the Plan after the date your coverage would otherwise end. Your COBRA rights are described in Article XXI.

Q. *I have health benefits under my wife's plan. Do I have to accept coverage under this Fund?*

- A. No. However, if you initially decline coverage under this Fund, you cannot enroll for benefits under this Fund until the Annual Open Enrollment Period unless you are eligible for "Special Enrollment," as described below.

NOTE: If you wish to waive coverage under this Plan, you must execute the "Waiver of Coverage" form demonstrating that you have other coverage. The form will be provided by the Fund.

Q. *Whom may I enroll in the Plan?*

- A. You may enroll yourself if you are eligible for enrollment. In addition, you may generally enroll your spouse and any unemancipated children in the Plan. Your children may include your natural children, your adopted children, and stepchildren who live with you and who are claimed as dependents when you file your federal income taxes. You can cover a grandchild after his first birthday if he lives with you and is claimed by you as a dependent on your federal income tax return.

Your spouse and children properly enrolled in the Plan are called eligible dependents. If you have court-ordered legal custody of a child (who is not a child or grandchild described above) and claim that child on your federal income tax return, he can be enrolled as of the date of custody.

However, if you initially decline coverage for your dependents, you cannot enroll them for benefits under this Fund until the Annual Open Enrollment Period, unless they are eligible for "Special Enrollment", as described below.

In order for your eligible dependents to be covered by the Plan, your employer must pay the appropriate contribution for them, as well as for you. You must also provide appropriate documentation to the Fund Office.

Q. *My spouse and I are divorced. Should I take my ex-spouse off this coverage?*

- A. Yes. To do so, you must provide the Plan with a divorce decree entered by a court of competent jurisdiction. You must notify the Fund of the divorce because your spouse is entitled to elect COBRA continuation coverage under the Plan for up to 36 months, provided that timely notice is given to the Fund. COBRA is summarized in Article XXI.

Please notify the Fund Office as soon as you are divorced. Once a divorce occurs, your ex-spouse is no longer eligible for benefits under your coverage -

your ex-spouse is only entitled to elect COBRA continuation coverage. If the Fund Office is not properly notified of a divorce, you will be responsible to reimburse the Plan for all benefits paid on behalf of your ex-spouse after the divorce became final. The Trustees reserve the right to take all action to recover benefits that were paid on behalf of your ex-spouse, including off-setting benefits against benefits payable on behalf of any other family member and taking any appropriate legal action.

Q. *I have a common-law spouse. Can I enroll my spouse in the Plan?*

- A. You can enroll your common-law spouse in the Plan only if you submit all of the required documentation to the Fund Office and the Fund determines that you and your spouse entered into a valid common law marriage on or before January 1, 2005.

You should note, however, that if you assert and the Fund determines that you and your spouse are parties to a valid common law marriage, you are legally married for all purposes, not just for Plan coverage. You will not be able to remove your common-law spouse from coverage unless you obtain a divorce decree from a court of competent jurisdiction.

Q. *I live in Pennsylvania. For a couple of years, I lived with someone, and I listed her as my common-law spouse under the Plan. Now, we do not live together anymore. Can I take her off of coverage?*

- A. Yes, but only if you provide the Plan with a divorce decree from a court of competent jurisdiction.

In addition, if the Trustees determine that you did not have a valid common law marriage, the Fund reserves the right to offset future benefits to recover any overpaid benefits, or to sue you directly for the benefits the Fund paid on behalf of the individual you listed as a spouse.

Q. *How long are my children eligible for benefits under the Plan?*

- A. Your unemancipated children are eligible so long as they are unmarried and are under age 19, or under age 23 if they are full-time students (you must submit documentation to the Fund on a yearly basis to verify full-time student status). An emancipated child is not eligible for benefits, regardless of age.

Q. *What if my child is disabled?*

- A. If your child has been declared totally and permanently disabled by the U.S. Social Security Administration, is dependent upon you for care, and is unmarried, he will be covered by the Plan beyond age 19 so long as these circumstances continue, and required documentation is provided to the Fund on a yearly basis.

Q. *Do I have to enroll my dependents in the Plan?*

- A. No. You can decide which of your dependents you wish to cover under the Plan. However, you cannot cover any dependents under the Plan if you do not have coverage for yourself under the Plan. In order for your dependent to have

coverage, the Employer must make or be obligated to make the appropriate contribution and you must make any copayment required for the dependent coverage and you must submit all required documentation.

In addition to the Open Enrollment and "Special Enrollment" Rules, in limited circumstances you may have your dependent child excluded from coverage under the Plan. In order to do so, you must: (1) send a request in writing to the Plan to exclude your dependent child from coverage; (2) explain in that written request specifically why you seek to exclude your dependent child from coverage; and (3) the Trustees, in their sole discretion must conclude that the exclusion serves the child's best interests.

Once you have excluded a dependent child from coverage, you can restore benefit coverage by making a written request if you seek to restore coverage outside the Fund's Annual Open Enrollment Period. Unless the dependent child is eligible under the "Special Enrollment" Rules, coverage will not be restored until the first day of the sixth month following the Plan's receipt of your written request to restore coverage. Keep in mind that you can re-enroll an eligible dependent under the Fund's Annual Open Enrollment Period.

Q. *My spouse works at a job with health insurance, but I want to enroll her in this Plan. Can I?*

A. Yes, However, if your spouse elects coverage at her employment, that insurance will be primary for her under the Fund's coordination of benefit rules (see Article XIX). That means that your spouse's insurance will be responsible for payment of the spouse's medical claims before the Fund will make payment on her claims. Your spouse must follow the rules imposed by that health insurance.

Q. *Are there any exclusions for pre-existing conditions in the Plan?*

A. Yes, but only to the extent permitted by a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you received medical advice or treatment for a condition in the 90 days before your date of hire, or, in the case of a new employer entering the Fund for the first time, the date with respect to which the obligation to make contributions begins, that condition is a pre-existing condition under the Plan. Generally, the Plan will not pay benefits for that condition for a period of 12 months from your date of hire or, in the case of a new employer entering the Fund for the first time, the date from which the obligation to make contributions on your behalf begins.

However, if you had other prior health coverage before your date of hire, or, in the case of a new employer entering the Fund for the first time, the date from which the obligation to make contributions on your behalf begins, that period of prior coverage may offset part or all of the 12-month exclusion on a day-for-day basis. In order to enjoy the benefit of that offset, you will need to provide a "certificate of creditable coverage" from your other insurance(s) to the Fund Office. Any period of prior coverage before a break in coverage of more than 63

days will not be counted to offset the 12-month exclusion.

Example: John Smith was employed by XYZ Municipality from January 1, 2006, to December 31, 2006. During this time, he had health insurance under XYZ Municipality's plan. On January 10, 2007, Mr. Smith was diagnosed by his doctor with hypertension. This condition requires prescription drugs and regular office visits. On March 1, 2007, Mr. Smith begins working for ABC County, an employer participating in Plan 16. Although Mr. Smith's hypertension is a preexisting condition under the Plan, the 12-month exclusion of benefits for this condition will not apply. This is because he had 12 months of prior health benefits coverage with XYZ Municipality, and more than 63 days did not pass between his last day of coverage in the XYZ plan and his date of hire by a Plan 16 employer.

Please contact the Fund Office if you have any questions on these rules.

Q. Does the Fund impose a period of exclusion for pre-existing conditions if I leave Fund coverage but then return to an employer with coverage from the Fund?

A. The Fund will not impose a new period of pre-existing exclusion of coverage if an employee does not have a break in Fund coverage of greater than twenty four (24) months.

Q. When can I enroll in the Plan?

A. You can enroll yourself and your eligible dependents (1) when your employer initially becomes a Contributing Employer to the Plan; (2) on the date set forth in the collective bargaining agreement between the Union and your employer or a participation agreement between your employer and the Fund; (3) during the Fund's "Annual Open Enrollment" Period (this is explained in more detail below); or (4) upon becoming a "special enrollee" or "late enrollee" as described in more detail below.

Q. What information do I have to provide in order to enroll myself and my dependents?

A. You must complete all required enrollment materials and provide all applicable documentation. This material can include a marriage certificate, birth certificate, adoption and custody documentation. The forms and documentation must be submitted to the Fund Office.

Q. What happens if I don't get all of the information in by the time I'm eligible for benefits?

A. If a participant is eligible for benefits but fails to provide the required information, the Fund will provide benefit coverage for the participant from the date that he would have been eligible for benefits had the required information been timely submitted after all required information is received by the Fund. However, the Fund will only provide coverage for dependents from the date that all required information was received by the Fund.

Q. What is the Annual Open Enrollment Period and when does it occur?

- A. If you or a dependent were eligible to enroll when Fund coverage was first offered but declined to enroll at that time and you are not eligible to enroll at any time as a “special enrollee” as described below, you may enroll yourself or your dependents only during the Fund’s Annual Open Enrollment Period.

The Annual Open Enrollment Period will be held each year during November and December for the following Plan Year, which starts on January 1. The Fund will provide notice in advance of the Open Enrollment Period. During that time, you will be permitted to enroll yourself and any eligible dependents whom you have not previously enrolled in the Plan. (Keep in mind that you may not enroll any dependents unless you are also enrolled for coverage under this Plan.) Like all other participants and dependents, participants and dependents enrolled during the Annual Open Enrollment Period will be subject to the Eligibility and Pre-existing Condition Exclusion provisions set forth in the Plan Document as well as to the Fund’s Rules and Regulations.

Q. My family didn’t enroll in Plan 16 when it was first offered because we had coverage through my wife’s job. If we lose our health coverage under her Plan in the middle of the year, may I enroll myself or my dependents for coverage even though it’s not the Annual Enrollment Period?

- A. You can enroll yourself and your dependents outside the Annual Open Enrollment Period if you and your dependents are “special enrollees” – that is, individuals entitled to enroll in coverage without waiting until the Fund’s next Open Enrollment Period.

A participant or dependent may be considered a “special enrollee” if he has previously declined coverage under the Fund and if he has lost other health benefits coverage. If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted. In addition, a new dependent may be a “special enrollee” if he has newly become eligible for benefits under the Fund’s rules, through marriage, birth, adoption or placement for adoption.

NOTE: individuals must notify the Fund of their request for special enrollment within 30 days after losing their other coverage or within 30 days of having (or becoming) a new dependent. If the participant or dependent can be deemed a “special enrollee,” coverage will be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

Caution: A “special enrollee” is subject to the same pre-existing condition exclusion rules as an individual who has initially become eligible for benefits. However, a newborn, adopted child or child placed for adoption cannot be subject to a preexisting condition exclusion period if the child is enrolled within 30 days of birth,

adoption or placement for adoption and has no subsequent significant break in coverage. A twelve (12) month exclusion period, reduced by Creditable Coverage, applies.

Q. *Who sets the rates for Plan 16 benefits? Do the Trustees determine how much of the rate I have to pay monthly?*

A. The Trustees set the rates for Plan 16 benefits annually, after consultation with the Fund's Actuary. The contribution rates for all benefits (except for death and accidental death and dismemberment benefits) are calculated by the Fund's actuary to support coverage for both active and Retired Participants. The contribution rates for death and accidental death and dismemberment benefits are annually determined separately for active and retired Participants by the Fund's insurance carrier and reviewed by the Fund's actuary.

The Trustees do not determine how much of the rate you have to pay monthly. The monthly amount you need to pay for health benefits is determined in collective bargaining by your Union and your employer. If you are a retired employee, this rate is determined by your employer pursuant to the applicable local laws, ordinances, rules or regulations of your former employer. Regardless of the portion of the premium for which you are responsible, your employer or former employer is responsible for forwarding the full premium to the Fund.

ARTICLE III: MANAGED CARE PROGRAM

Q. *What is the Plan's Managed Care Program?*

A. The Plan's Managed Care Program has four key features. First, the Plan has enrolled itself in a Network of providers to serve you. These Network providers perform their services at an advantageous cost to you and the Plan. You may also hear Network providers called "PPO" or "Par" providers. PPO means Preferred Provider Organization, and is simply another way to say a provider that participates in the Plan's Network. "Par" is also just another way to say "participating" provider in the Plan's Network.

Second, the Plan limits the benefits it pays for treatment by non-Network providers. While you are free to obtain medical treatment from these providers, you will be responsible for any balance on charges not paid by the Plan.

Third, the Plan limits or may deny the benefits for treatment in certain circumstances regardless of whether you treat with a Network or non-Network provider. For example, the Fund will not pay any benefits for treatment that is not "medically necessary" or is "experimental or investigational" as those terms are defined in the Plan. In these circumstances, you will be responsible for any charges not covered by the Plan.

Fourth and finally, the Plan has a utilization review program under which the services and treatment you receive are reviewed under the standards

established by the Plan.

Each of these features is described in greater detail below.

Q, *How does the Plan's Network operate?*

- A. Generally, if you treat with a Network provider for considered services, the Plan will pay benefits in full.

The Networks currently offered by the Plan may change, and, if so, you will be informed. In central Pennsylvania, the primary Network for medical benefits is the Health Assurance Network. Other central Pennsylvania subnetworks include Berkshire Health Plan and Intergroup.

The Plan has also contracted with various networks of health care providers for your medical needs. The Devon Network serves Pennsylvania, Delaware and New Jersey. The OneNet PPO, LLC Network serves West Virginia, Virginia, Maryland, North Carolina and the District of Columbia. The Beech Street sub-Network serves all remaining states. (These subnetworks are available only to Participants and Dependents who live in the subnetwork's service area.) The Plan also has contracts with Multiplan to provide discounts to the Plan for hospitalization and related services on a nationwide basis.

Davis Vision is the Network for vision benefits.

General Prescription Programs, Inc. (GPP) is the Network for prescription drugs.

United Behavioral Health (UBH) is the Network for mental health and substance abuse services.

Provider lists are furnished automatically, without charge, as a separate document. From time to time, you will receive directories from the Fund Office listing which providers are in a specific Network. Please remember that in some areas, not every individual provider within a group listed in the directory is in the Network. It is important that you make sure that the provider you are seeing is a Network provider. For the most up to date information, contact the Fund Office.

Q. *What if I am treated by a non-Network provider?*

- A. The Plan limits the benefits it pays for treatment by non-Network providers. Typically the Plan will pay only the Usual, Customary and Reasonable rate (UCR) for a service performed by a non-Network provider, less any applicable deductibles or copayments

The UCR is a percentile of a database. The Trustees select the percentile and the database. Unless otherwise indicated in this SPD, the percentile is 85%. The database is obtained from organizations that compile data on the fees that are paid for specific medical services throughout the country.

If there is no UCR for the particular service rendered, the Plan will pay benefits to non-Network providers equal to a percentage of billed charges. However, in general, the Plan will not pay benefits for billed charges from non-Network providers which exceed the rate payable by Medicare for such services.

Example: John Smith treats with a non-Network physical therapist. The bill for these services is \$100.00. The UCR for these services is \$65.00. The Plan will pay \$40.00 (UCR less \$25.00 copay) to the provider and Mr. Smith will have to pay the provider the remaining \$60.00.

We will discuss non-Network limits in the pages that follow. After you have read this SPD, please contact the Fund Office if you need to determine in a specific situation what benefits the Plan will pay for services provided by a non-Network provider.

Q. *What are other limits that are placed on some benefits?*

- A. Depending on the service that you receive, one or more of the following limits on benefits may apply:
- (1) Limits on a per-condition basis. For example, if you are disabled and if your optional benefits include short-term disability benefit coverage, you typically receive no more than 26 weeks of temporary disability benefits for that disability. However, if your optional benefits include short-term disability benefit coverage, Option A or B, you may be entitled to an additional 10 weeks of short-term disability benefits at a reduced rate, provided you meet the Fund's requirements summarized in Article XVI.
 - (2) Limits on a per patient basis. For example, each participant or eligible dependent can receive up to \$300,000 per transplant.
 - (3) Limits on a per-benefit year basis. For example, each participant or eligible dependent whose optional benefits include dental benefits, Option A, can receive up to \$1,000.00 per benefit year in dental benefits.
 - (4) Limits on a per-family family basis. For example, each benefit year, each family in the Plan whose optional benefits include hearing benefits may receive up to \$1,000 in hearing benefits.
 - (5) Limits on a per lifetime-in-the-Fund basis. For example, each participant or eligible dependent in this Plan may receive up to \$1,000,000 in Major Medical benefits while he participates in this Plan or another plan sponsored by the Fund.

This SPD will discuss these limits in the pages that follow where they apply. After you have read this SPD, please contact the Fund Office if you need to determine in a specific situation what benefits the Plan will pay consistent with these limits.

Q. What is utilization review?

A. Utilization review is a process through which the Trustees, in reliance upon the Plan's medical advisors, determine whether proposed treatment is medically necessary, as that term is defined in the Plan. A determination under utilization review that a procedure is medically necessary is NOT a guarantee of payment. HealthAmerica performs the utilization review for the Plan's medical benefits. United Behavioral Health (UBH) performs the utilization review for the Plan's mental health/substance abuse benefits.

Q. What is medically necessary care?

A. Medically necessary care is care that the Trustees, in reliance upon the Plan's medical advisors, determine is appropriate to treat your injury or illness. In determining whether care is medically necessary, the medical professionals advising the Trustees consider the standards of medical practice applicable to the particular treatment rendered.

Q. Does medically necessary care include experimental or investigational treatments?

A. No. If the Trustees, in reliance upon the Plan's medical advisors, determine that a treatment is "experimental or investigational" as defined in the Plan, no benefits shall be paid for that treatment.

In determining whether a treatment is experimental or investigational under the Plan, the Plan's medical advisors will use the following process:

Step 1: The Plan's medical advisors will examine if the treatment has been formally studied and reported in the literature recognized as authoritative by the medical profession. If the answer is no, the Plan's medical advisors will conclude that the treatment is experimental or investigational, and the Plan will deny benefits. If the answer is yes, the Plan's medical advisors will move to Step 2.

Step 2: The Plan's medical advisors will examine if the treatment has undergone government review by the National Institutes of Health or Medicare. If the answer is yes, the Plan's medical advisors will follow the conclusion of these agencies on the usefulness of the treatment. If the answer is no, the Plan's medical advisors will move to Step 3.

Step 3: The Plan's medical advisors will examine if the treatment is under a National Institutes of Health formal medical protocol, and if it has been cleared by an institutional review board as an experiment. If the answer is no, the Plan's medical advisors will conclude that the treatment is experimental or investigational, and the Plan will deny benefits. If the answer is yes, the Plan's medical advisors will move to Step 4.

Step 4: The Plan's medical advisors will examine how an expert in the field evaluates this treatment as compared to more traditional treatments. If the expert

selected by the Plan's medical advisors believes that the treatment is more effective than traditional treatments, the Plan's medical advisors will conclude that the treatment is not experimental or investigational, and the Plan will pay benefits for the treatment. If the expert believes the treatment is not more effective than traditional treatments, the Plan's medical advisors will move to Step 5.

Step 5: The Plan's medical advisors will examine whether the treatment is experimental or investigational in their opinion. If, after reviewing all the Steps set forth above and any other relevant considerations, the Plan's medical advisors determine that the treatment is experimental or investigational, the Plan will deny benefits.

Q. Does the Plan's Managed Care Program require that I get pre-certification for the care I receive?

A. In some cases, yes. For example, all non-emergency hospitalization and surgery must be pre-certified at least 14 days in advance. If you are using a Network provider, it is the provider's responsibility to contact the Fund Office and follow its instructions to obtain pre-certification. If you use a non-Network provider, it is your responsibility to contact the Fund Office and follow its instructions to obtain pre-certification. If you have emergency surgery, you or your provider must notify the Fund Office within 2 business days after treatment/hospitalization. Other benefits are also subject to pre-certification as set forth in this SPD.

Q. If my pre-certification request is approved, does that automatically mean that I am entitled to benefits?

A. The purpose of pre-certification is to determine whether the treatment or service is "medically necessary" as that term is defined by the Plan. However, it is possible that the treatment may not be covered if, on review, the Fund determines, for example, that the individual was not eligible for benefits at the time the treatment is provided or that the treatment is subject to a Plan exclusion.

Example: Jane Smith's doctor asked for and received pre-certification for removal of Ms. Smith's appendix and related surgical procedures. When Mrs. Smith's doctor submits her claim, the Trustees discover that the "related procedures" included a "tummy tuck" unrelated to the appendectomy. Although the Fund would pay for the medically necessary appendectomy, it will not pay for those services that were not medically necessary and instead were cosmetic plastic surgery.

Example: John Jackson's doctor receives pre-certification for medically necessary surgery on June 1. Mr. Jackson's coverage lapses on July 1. The surgery is not performed until July 15. Even though the surgery was pre-certified as medically necessary, the Fund will not pay benefits for the surgery because Mr. Jackson was not eligible for benefits at the time of the surgery.

Q. Does the Plan require me to get a second or even a third opinion?

A. If the Plan's medical advisors recommend a second or third opinion, you will have to get one or both. The Plan will pay benefits for these additional opinions.

Q. What if my provider or I refuse or fail to cooperate with the Plan's Managed Care Program?

A. In simplest terms, the Plan will not pay any benefits for your treatment from that provider.

ARTICLE IV: HOSPITAL BENEFITS - CORE BENEFIT

Q. What benefits does the Plan pay if I am hospitalized?

A. Subject to the Plan's Managed Care Program, the Plan pays for medically necessary hospitalizations at a level that depends primarily on whether you are in a Network or non-Network hospital. As noted in this SPD, it is to your advantage to use a Network hospital in order to limit your out-of-pocket costs for medical care.

The following Q&As address how and in what amount the Plan pays hospital benefits.

Q. What benefits does the Plan pay for room and board?

A.

(1) Network Hospital. For medically necessary stays at a Network hospital, you will receive benefits equal to payment in full for room and board. Private rooms are not covered by the Plan unless they are determined to be medically necessary.

(2) Non-Network Hospital. For medically necessary stays at a non-Network hospital, the Plan will pay benefits in accordance with the Plan's Major Medical Provisions. Private rooms are not covered by the Plan unless they are determined to be medically necessary (if approved, they are paid at the same rate as a semi-private room).

If room and board benefits for a Non-Network hospitalization are denied by the Plan as not medically necessary and you are retained in the hospital by your physician, you will be responsible for any non-Network hospital room and board services and for any services by that same physician if he is a non-Network provider. No Major Medical benefits will be available.

Q. What benefits does the Plan pay for miscellaneous hospital services?

A. Miscellaneous hospital services include things like inpatient diagnostic services (X-rays, lab tests, etc.), and outpatient treatments like chemotherapy. The following limits apply to these services:

- (1) Network Hospital. For medically necessary miscellaneous inpatient or outpatient hospitalization services, the Plan will pay benefits in full if you use a Network hospital.
- (2) Non-Network Hospital. If you use a non-Network hospital, the Plan will pay benefits for medically necessary miscellaneous inpatient or outpatient hospitalization services in accordance with the Plan's Major Medical Provisions.

Q. *What benefits does the Plan pay for anesthesia services?*

A.

- (1) Network provider. For medically necessary anesthesia services from a Network provider, the Plan will pay benefits in full.
- (2) Non-Network provider. For medically necessary anesthesia services from a non-Network provider in a Network hospital, the Plan will pay benefits in full.
 - (a) If you use a non-Network provider in a non-Network hospital, the Plan will pay benefits in accordance with the Plan's Major Medical Provisions.

Q. *Do I have to pay a copayment if I go to the emergency room for treatment?*

A. Yes. For Emergency Room visits on or after July 1, 2007, you will be required to pay a \$50 copayment for emergency room services. This fee will be waived if you are admitted to the hospital immediately following emergency room treatment.

Q. *What benefits does the Plan pay for emergency room services when I have an injury?*

A. If you suffer an accidental injury that requires emergency care and you use a Network hospital emergency room within 48 hours of the injury, the Plan will pay benefits for medically necessary emergency room services, less any required copayment. These services include physician services and prescription drugs.

Q. *Does the Plan pay benefits for things like splints, casts, and immobilizers after I have had treatment in an emergency room for an injury?*

A. Yes. Subject to the Network or non-Network limits noted above, the Plan will pay benefits for medically necessary splints, casts or immobilizers. In order to receive these additional benefits, you must receive such items within 7 days of the initial emergency treatment for an accident. You also must have received treatment for the initial emergency within 48 hours of the injury. If these requirements are not met, the coverage for these services is only provided under Major Medical benefits, which may not cover the full cost of these items.

Q. What benefits does the Plan pay for emergency room services when I have an illness?

A. If you suffer from an illness requiring medically necessary emergency care and you use a Network hospital emergency room, the Plan will pay benefits in full, less any required copayment.

Q. What does the Plan mean by the term "emergency?"

A. The term "emergency" under the Plan means an unforeseeable condition or complaint of pain which causes a reasonable person to fear serious injury, illness or death. You should think of emergencies as things like heart attacks, strokes, accidental injuries, etc. Things like colds and the flu are not emergencies under the Plan. If you use an emergency room for a non-emergency, the Plan will not pay any benefits at all.

Q. What benefits does the Plan pay for ambulance services?

A.

- (1) Network Ambulance to Network Hospital. The Plan will pay benefits in full for medically necessary ambulance services if you use a Network ambulance or if you use a non-Network ambulance but are transported to a Network hospital.
- (2) Non-Network Ambulance to a Non-Network Hospital for an Accident or Admission of at Least 1 Day. The Plan will pay benefits in accordance with the Plan's Major Medical provisions for medically necessary ambulance services if you use a non-Network ambulance and are transported to a non-Network hospital for an accident or for an admission of at least 1 day.
- (3) Non-Network Ambulance to a Non-Network Hospital - Emergency illness. The Plan will pay benefits in accordance with the Plan's Major Medical provisions for medically necessary ambulance services if you use a non-Network ambulance and are transported to a non-Network hospital for an emergency illness.

If a participant or dependent is compelled by an emergency to seek treatment from a Non-Network provider, the Trustees have sole discretion to pay benefits as if the treatment had been administered by a Network provider.

Q. What benefits does the Plan pay for life flights?

A. If it is medically necessary that you be transported by air, the Plan will pay benefits in full if a Network provider is used, or up to the UCR if a Non-Network provider is used, for such flights. If the treatment is required as the result of an emergency, the Plan will pay benefits in full even if a Non-Network provider is used for the life flight.

Q. I was released from the hospital. A week later, I had to go back because my health got worse. Do benefits paid for my first stay count against benefits I can receive for my second stay?

A. No.

Q. *If my wife has just delivered a child, how long can she stay in the hospital?*

A. Under federal law, group health plans like Plan 16 and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider (e.g., your physician, nurse midwife, or physician assistant), after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Although a plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours) to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact the Fund Office.

ARTICLE V: PHYSICIAN BENEFITS - CORE AND OPTIONAL BENEFITS

Q. *When I need to see a doctor in his office, what benefit will the Plan pay?*

A. Subject to the Plan's Managed Care Program, *and if your optional benefits include physician office visits*, the Plan will pay benefits for medically necessary office visits to a doctor. The level of benefits paid will depend on whether you use a Network or a non-Network provider.

- (1) Network provider. For office visits to a Network provider, you will have to pay a \$15 copayment per visit to a Network Non-Specialist and \$25 per visit to a Network Specialist. The Plan will pay benefits to cover the rest of the costs of the visit. There is no limit on the number of medically necessary office visits you can have with a Network provider. Chiropractic benefits are paid on a different basis than other physician visits. Please see subparagraph (5) below.
- (2) Non-Network provider. For office visits to a non-Network Non-Specialist, the Plan will pay benefits equal to the lesser of UCR or billed charges, less a \$25 co-payment that you will have to pay per visit. For office visits to a Non-Network Specialist, the Plan will pay benefits equal to the lesser of UCR or billed charges, less a \$50 copayment that you will have to pay per visit. Chiropractic benefits are paid on a different basis than other physician visits. Please see subparagraph (5) below.
- (3) Non-Specialist means a general practitioner, an obstetrician/gynecologist, an internist, a pediatrician, or a general doctor of osteopathy.

- (4) Specialist means every physician other than a Non-Specialist or a Chiropractor.
- (5) Chiropractor - if your optional benefits include coverage for physician office visits, then for office visits to a Chiropractor, the Plan will pay benefits of \$25 per visit, up to 20 visits per eligible family member per Benefit Year.

Q. *What if I need to see a doctor while I am hospitalized?*

A. Subject to the Plan's Managed Care Program, the Plan will pay benefits for medically necessary inpatient visits by a doctor as a core benefit. The amount of benefits paid will depend on whether you use a Network or non-Network provider.

- (1) Network provider. For medically necessary inpatient visits from a Network provider, the Plan will pay benefits in full.
- (2) Non-Network provider. For medically necessary inpatient visits from a non-Network provider, the Plan will pay benefits in accordance with the Plan's Major Medical provisions.

ARTICLE VI: PHYSICAL THERAPY BENEFITS - CORE BENEFIT

Q. *What are the Plan's physical therapy benefits?*

A. Subject to the Plan's Managed Care Program, the Plan pays benefits for medically necessary physical therapy, including speech therapy, occupational therapy, and work hardening. For each injury or illness, the Plan will pay benefits for up to 24 outpatient visits in a 2 month period per participant or eligible dependent. If you need physical therapy that requires more than 24 visits or 2 months, whichever comes sooner, such additional visits must be pre-certified under the Plan's Managed Care Program.

Q. *What is the amount of physical therapy benefits for each of the physical therapy visits described above?*

A.

- (1) Network provider. If you use a Network provider, the Plan pays benefits in full for up to 3 modalities (that is, types) of treatment per day, less a co-payment by you of \$15 per visit. Examples of modalities would be whirlpools, massages, and various strength-building and agility-building exercises.
- (2) Non-Network provider. If you use a non-Network provider, the Plan pays the UCR for up to 3 modalities of treatment, less a co-payment by you of \$25 per visit. You will be responsible for any balance charged by a non-Network provider. No Major Medical benefits will be available.

ARTICLE VII: IMMUNIZATION AND INJECTION BENEFITS - CORE BENEFIT

Q. Does the Fund provide benefits for immunizations for my dependent children?

A. If you use a Network provider, the Fund provides full coverage for immunizations recommended by the Centers for Disease Control and Prevention (“CDC”) for children and adolescents through age 23. If you use a non-Network provider, the Plan pays the UCR. You will be responsible for any balance charged by the Non-Network provider. No Major Medical benefits will be available.

Q. Are immunizations not included on the list recommended by the CDC for dependents as well as other injections for participants and dependents of any age covered under the Plan?

A. (1) Network Provider. Subject to the Plan's Managed Care Program, if you or a dependent require a medically necessary immunization that is not one of those recommended by the Centers for Disease Control and Prevention (“CDC”) or if you or a dependent of any age require another injection and the Network provider charges separately for an office visit, immunization or injection, the Plan will pay for the office visit in accordance with the contracted Network rate, less a \$15 co-payment, if the office visit payment made by the Fund is less than \$25, the Plan will pay the difference up to the \$25 benefit towards the immunization or injection service. If the Network provider does not charge for an office visit, the Plan will pay up to \$25 towards the immunization or injection services.

For example, John Smith goes to a Network provider for an office visit. At the office visit, he receives a medically necessary injection. The Network provider submits a claim for \$40 for the office visit, and \$25 for the injection. HealthAssurance reprices the office visit to \$30, and it reprices the injection to \$20. The Plan pays benefits of \$15 for the office visit, and Mr. Smith is responsible for a \$15 co-payment. The Plan benefits of \$10 for the injection, and Mr. Smith is responsible for the \$10 balance.

(2) Non-Network Provider. Subject to the Plan's Managed Care Program, if you or a dependent require a medically necessary immunization not one of those recommended by the CDC or if you or a dependent of any age require another injection and the Non-Network provider charges separately for an office visit, immunization or injection, the plan will pay benefits for the services as an office visit to a Non-Network Provider. If the office visit charge made by the provider is less than \$25, the Plan will pay the difference up to the \$25 benefit towards the immunization or injection service. If the Non-Network provider does not charge for an office visit, the Plan will pay up to \$25 towards the immunization or injection service.

For example, John Smith goes to a Non-Network Non-Specialist for an office visit. At the office visit, he receives an injection. The Non-Network provider submits a claim for \$40 for the office visit, and \$25 for the injection. The fund will pay benefits of \$40 (or up to the UCR, if the UCR is less than \$40) for the office visit, less a \$25 co-payment by Mr. Smith. The Plan pays benefits of \$10 for the injection and Mr. Smith is responsible for the \$15 balance.

Q. Does the Fund provide benefits for “flu shots” and pneumonia vaccines for individuals after age 18?

A. If you use a Network provider, the Fund provides full coverage for flu shots and pneumonia vaccines, regardless of the patient’s age. If you use a non-Network provider, the Plan pays the UCR. You will be responsible for any balance charged by the Non-Network provider. No Major Medical benefits will be available.

ARTICLE VIII: SURGICAL BENEFITS -- CORE BENEFIT

Q. What benefits does the Plan pay if I need surgery?

A. Subject to the Plan's Managed Care Program, the Plan will pay benefits for medically necessary inpatient or outpatient surgery as follows:

- (1) Network provider. If you use a Network provider, the Plan will pay benefits in full.
- (2) Non-Network provider. If you use a non-Network provider, the Plan will pay benefits in accordance with the Plan's Major Medical provisions.

Q. I had a mastectomy. Will the Plan cover reconstructive surgery, prostheses, and treatment for any complications?

A. The Plan will pay surgical benefits for reconstruction of the breast on which the mastectomy has been performed, and for the reconstruction of the other breast to produce a symmetrical appearance. The Plan also will pay benefits for prostheses for mastectomies under its Major Medical provisions summarized in Article X. Finally, the Plan also will pay benefits for any complications arising from a mastectomy (including lymphedemas) under the relevant Plan provision (hospital benefits, physician visits, surgical benefits, etc.). The Plan will not deny a patient eligibility, or continued eligibility, to avoid paying these benefits. The Plan also will not penalize or otherwise reduce or limit the reimbursement of an attending provider to avoid paying these benefits, or induce such a provider to provide care to a patient in a manner to avoid paying these benefits. Nevertheless, the hospitalization and medical benefits are subject to the regular Plan provisions covering the use of Network and non-Network providers described above.

ARTICLE IX: OUTPATIENT DIAGNOSTIC BENEFITS - CORE BENEFIT

Q. *What benefits does the Plan pay if I need X-rays, lab tests or some other kind of outpatient diagnostic treatment?*

- A. Subject to the Plan's Managed Care Program, the Plan will pay benefits for medically necessary outpatient diagnostic services as follows:
- (1) Network provider. If you use a Network provider, the Plan will pay benefits in full.
 - (2) Non-Network provider. If you use a non-Network provider, the Plan will pay benefits up to the lesser of 90% of UCR or 90% of billed charges. No Major Medical benefits will be available.

Q. *Do any other Plan provisions cover outpatient diagnostic services?*

- A. The Plan will pay for hospital pre-admission testing under the hospital benefit provisions of the Plan. Eye exams and dental X-rays are payable under the vision and dental benefit provisions of the Plan, respectively. Therefore, if your Union and Employer did not elect vision and dental benefits as a plan option, these services will not be covered by the Fund. Contact the Fund Office with any questions you have on when other provisions of the Plan cover outpatient diagnostic services.

ARTICLE X: MAJOR MEDICAL BENEFITS – CORE BENEFIT

Q. *When does Major Medical apply?*

- A. Subject to the Plan's Managed Care Program and assuming that the services are medical necessary, Major Medical benefits are generally payable, if you have a diagnosed condition, for Hospital Services for Non-Network Patients, Inpatient Services for Non-Network Patients, and transplants from Non-Network providers (which are subject to the \$300,000 per transplant cap summarized in Article XI). Major Medical benefits are also available for the following medically necessary special items:
- (1) Non-inpatient nurse (RN or LPN) services up to 240 hours per benefit year;
 - (2) Non-inpatient nurse (RN or LPN) services after 240 hours per benefit year, payable at 50%;
 - (3) Oxygen and its administration;
 - (4) Blood and blood plasma, except whole blood products;
 - (5) The rental or purchase and repair of durable medical equipment, including a wheelchair, hospital beds, crutches, and respirators;
 - (6) The purchase or repair of orthopedic braces for individuals who have reached their maximum growth. The Plan will pay benefits for the subsequent repair of, but not the replacement of, the initial brace. For individuals who have not reached their maximum growth, the Plan will pay

benefits for subsequent brace repairs, and for the replacement of the initial brace once every two benefit years;

- (7) The purchase, replacement or repair of artificial eyes, artificial larynx, and prostheses for arms, hands and legs once every 2 benefit years;
- (8) The purchase of mastectomy bras (2 per benefit year) and bra inserts (2 per breast per benefit year); and
- (9) Pre-certified orthotics, but only if the Plan's Medical Advisor certifies that the foot orthotics are medically necessary to treat the patient for diabetes or peripheral vascular disease.

Q. Are there any deductibles for Major Medical benefits?

- A. Yes. There is a \$200 per-patient deductible each benefit year. No more than 3 such deductibles (\$600) shall be payable by a family in any single benefit year. In addition, the participant is responsible for 10% of the lesser of UCR or billed charges (or the Network rate for Network claims) up to \$2,500 (limited to \$5,000 per family in any given benefit year), as well as any amounts in excess of the UCR. Once the deductible and co-payments have been paid by you, the Fund will pay the lesser of the UCR or the billed charges until the end of the benefit year, at which time the deductible and co-payment obligation will begin again.

Example: John Smith and his wife Mary are enrolled in Plan 16. John had a heart attack on January 15, 2007, and went to a non-Network hospital. His non-Network hospital bill was \$10,000 (which, in this example, is less than the UCR). Under the Major Medical provisions of the Plan Mr. Smith will have to pay \$1,180 out-of-pocket based on a \$200 deductible, and 10% of the balance (\$10,000 less \$200 equals \$9,800. 10% of that amount is \$980. Together with the deductible of \$200, Mr. Smith will pay, in total, \$1,180).

Q. Is there a maximum Major Medical benefit payable?

- A. Yes. Each participant or eligible dependent has a \$1,000,000 lifetime Major Medical limit (except for Transplant benefits which are subject to the \$300,000 cap described in Article XI).

ARTICLE XI: TRANSPLANT BENEFITS - CORE BENEFIT

Q. What benefits does the Plan pay if I have an organ transplant?

- A. Subject to the Plan's Managed Care Program, the Plan will pay benefits for medically necessary organ transplants of human heart, kidney, liver, lung, pancreas, and bone marrow and related services as follows:
- (1) Network provider: up to \$300,000 per patient per transplant for transplant related claims incurred from the date of the transplant and through the six week period immediately following the transplant. Thereafter, the patient's claims will be payable under the Plan's hospital, physician, surgical and other medical provisions.

- (2) Non-Network provider: the plan will pay benefits according to the Plan's Major Medical provisions, up to a cap of \$300,000 per patient per transplant for transplant related claims from the date of the transplant and through the six week period immediately following the transplant. Thereafter, the patient's claims will be payable under the Plan's hospital, physician, surgical and other medical provisions.

Transplant costs include treatments for the organ donor if he has no other insurance.

This \$300,000 benefit will continue even if you move into another plan sponsored by the Central Pennsylvania Teamsters Health and Welfare Fund with no transplant benefit or a less generous transplant benefit. For the benefit to follow you to another plan, the transplant must have occurred while you were enrolled in this Plan.

ARTICLE XII: HEARING AND VISION BENEFITS - OPTIONAL BENEFIT

Q. *Are there any limits on hearing benefits payable by the Plan?*

- A. Yes. Each benefit year the Plan will pay benefits *for those covered by the optional hearing benefit* up to a maximum of \$1,000 per family for medically necessary hearing services. The Fund will provide vision benefits as set forth below.

Q. *What hearing benefits does the Plan pay?*

- A. The Plan pays benefits up to the UCR for the purchase or repair of medically necessary hearing aids. You are responsible, however, to purchase batteries and other supplies for hearing aids. No Major Medical benefits will be available.

Q. *What Network vision benefits does the Plan pay?*

- A. The Plan will pay benefits for medically necessary vision services if you use a Network (Davis Vision) provider as follows:

- (1) If you or your dependent are age 19 or over, every 2 benefit years you will receive benefits in full for 1 eye examination and 1 complete pair of eyeglasses (lenses and Davis collection frame) or soft daily wear contact lenses.
- (2) If you or your dependent are under age 19, every benefit year you will receive benefits in full for 1 eye examination and 1 complete pair of eyeglasses (lenses and Davis collection frame) or soft daily wear contact lenses.
- (3) You will have a wide variety of choice and features for eyeglasses and soft daily wear contact lenses at no extra charge from Davis Vision. However, copayments apply if you select certain features, which currently are:
Reflection Free (TM) coating
Hi-index lenses

- Polaroid lenses
- Transition (TM) lenses
- Certain disposable contact lenses
- Certain soft daily wear contact lenses
- Certain Frames not included in the Davis collection

Contact the Fund Office for more information about these copayments.

Note: Gas Permeable (hard) contact lenses are not covered under the Davis Vision program. They are, however, covered under the non-Network benefits discussed in the next section.

- (4) A pair of eyeglasses is any eyeglasses that have new frames, lenses, or both.

For example, Thomas Jones, Jr., the 16 year old son of Thomas Jones, Sr., a participant, is entitled to one pair of eyeglasses during 2007. In January, 2007, Tom, Jr. obtains through the Fund new lenses on the frame he used in 2006. Because of the new lenses, Tom, Jr.'s eyeglasses will be considered to be new eyeglasses and Tom, Jr. will have no further allowance for eyeglasses until the 2008 benefit year.

Q. *If my wife has other vision insurance that is primary, what does the plan pay?*

- A. If this Plan is secondary under COB rules, this Plan will pay up to the lesser of the Non-network rate or the balance remaining after the primary insurance has made their payment. The Coordination of Benefits or COB rules can be found in Article XIX of this SPD.

Q. *What if I go outside the Davis Vision Network?*

- A. In that case, the Plan will pay reduced benefits in the form of a reimbursement to you upon your submission of proper bills to the Plan. The benefits payable are as follows:
 - (1) If you or your dependent are age 19 or over, every 2 benefit years you will receive up to \$45 in benefits for 1 eye examination, and up to \$75 in benefits for 1 complete pair of eyeglasses or contact lenses. These allowances are not transferable to other benefit years.
 - (2) If you or your dependent are under age 19, every benefit year you will receive up to \$45 in benefits for 1 eye examination and \$75 in benefits for 1 complete pair of eyeglasses or contact lenses. These allowances are not transferable to other benefit years.

Q. *What if I have a condition that requires me to wear medically necessary contact lenses?*

A. If you suffer from a medical condition that requires contact lenses as opposed to eyeglasses (for example, keratoconus, anisometropia, aphakia), the maximum benefit that the Plan will pay for such medically necessary special contact lenses is \$350 per benefit year if the patient is under age 19, and \$350 once every 2 benefit years if the patient is age 19 or older. Davis Vision reviews each such request to determine medical necessity.

**ARTICLE XIII: DENTAL, ORTHOGNATHIC SURGERY AND
ORTHODONTIC BENEFITS - OPTIONAL BENEFIT**

Q. *Does the Plan have a Network for dental services?*

A. Yes. The Fund provides dental benefits under an insured arrangement with Delta Dental. Although the annual dollar maximum for benefits is the same whether you use a Network or non-Network provider, your dental benefit dollars will generally purchase more dental services if you use a Network provider. In addition, if you use a Delta Dental provider, the provider will submit claims for you directly to Delta Dental. If you use a non-Network provider, you may have to pay your dentist for services and submit the claims to Delta Dental for adjudication and reimbursement.

Q. *What are my dental benefits under the Plan?*

A. Your benefits are paid based on the option your union and your employer selected. Subject to the Fund's Managed Care Program, your benefits are determined by looking at (1) an annual dollar maximum and (2) the percentage of each claim that the Fund will pay under the option that was selected during collective bargaining or pursuant to a participation agreement. If your union and employer (or your employer, pursuant to a participation agreement) selected Dental Benefit Option, A, B, or C, each covered individual in your family is eligible for dental benefits up to the following annual maximum, subject to the percentage of Delta's charge or the "usual, customary and reasonable" ("UCR") charge for that service. The Fund determines the fee schedule on which the UCR is based.

Dental Benefit Option A - \$1,000 (100% UCR)

Dental Benefit Option B - \$800 (80% UCR)

Dental Benefit Option C - \$600 (60% UCR)

Option A: Network Provider

If your union and employer (or your employer, pursuant to a participation agreement) selected Option A and you use a Network provider, then Delta Dental will pay 100% of your claims up to the annual benefit of \$1,000 annually. Thereafter, you will be required to pay for services but you will receive these services at the Delta Dental Network discounted rate.

Option A: Non-Network Provider.

If you use a non-Network dental provider, Delta will pay dental claims at the lesser of 100% of the UCR or 100% of billed charges until you reach the annual maximum of \$1,000. These claims will be paid at the rate established by the Fund. Thereafter, you will be required to pay for services at the charge established by the dentist. Note that if you receive services from a non-Network provider, you may be required to pay for treatment at the time of service and submit your claims to Delta Dental for reimbursement.

Option B: Network Provider

If your union and employer selected Option B and you use a Network provider, then Delta Dental will pay your claims at a reimbursement level of 80% of Delta's contracted rate up to the annual benefit of \$800 annually. Thereafter, you will be required to pay for services but you will receive these services at the Delta Dental Network discounted rate.

Option B: Non-Network Provider.

If you use a non-Network dental provider, Delta will pay dental claims at a reimbursement level of the lesser of 80% of the UCR or 80% of billed charges until you reach the annual maximum of \$800. These claims will be paid at the rate established by the Fund. Thereafter, you will be required to pay for services at the charge established by the dentist. Note that if you receive services from a non-Network provider, you may be required to pay for treatment at the time of service and submit your claims to Delta Dental for reimbursement.

Option C: Network Provider

If your union and employer selected Option C and you use a Network provider, then Delta Dental will pay your claims at a reimbursement level of 60% of Delta's contracted rate up to the annual benefit of \$600 annually. Thereafter, you will be required to pay for services but you will receive these services at the Delta Dental Network discounted rate.

Option C: Non-Network Provider.

If you use a non-Network dental provider, Delta will pay dental claims at a reimbursement level of the lesser of 60% of the UCR or 60% of billed charges until you reach the annual maximum of \$600. These claims will be paid at the rate established by the Fund. Thereafter, you will be required to pay for services at the charge established by the dentist. Note that if you receive services from a non-Network provider, you will be required to pay for treatment at the time of service and submit your claims to Delta Dental for reimbursement.

Q. *If I don't use my entire annual benefit maximum, may I apply it to another family member whose claims exceed his balance?*

A. No. No part of your balance can be applied to the claims of another family member.

Q. I didn't use much of last year's dental benefit maximum. Can I apply some of the amount I didn't use to a procedure this year that will exceed my annual benefit maximum?

A. No. No part of one benefit year's maximum can be transferred forward or backward to another benefit year's claims.

Q. I was eligible for benefits in November of 2006 but the work couldn't be finished until January 2007, after I lost coverage. Is the service I received in January 2007 covered?

A. No. Coverage is based upon the date of service and the date of service must fall within a month in which the patient is eligible for benefits from the Fund.

Q. If I exhaust my dental benefits, can I use Major Medical benefits to cover dental claims?

A. No. Major Medical benefits are not available to pay dental claims.

Q. What are the benefits available for routine cleaning?

A. The benefits for routine cleaning are the same for Network and non-Network providers. In general, the Fund will pay for a maximum of two cleanings per benefit year.

Q. My son's teeth are discolored because of antibiotic therapy he received for a serious illness. Is teeth bleaching covered by the Fund?

A. Before the Fund will be able to provide any benefits for this service, the Delta Dental professional advisor must determine that the treatment is dentally necessary. If so, and if the individual has dental benefit available under his annual allowance, the Fund will provide benefits for this service. If you use a Network provider, the Fund will pay up to the Delta rate, in the percentage allowed under your plan. If you use a non-Network provider, the Fund will pay the lesser of the UCR rate or billed charges, in the percentage allowed under your plan.

Q. I have been treated for gum disease. Are periodontal cleanings covered?

A. If you use a Network provider, you will be eligible for periodontal cleaning as provided under the Delta Dental plan of benefits. Contact the Fund office or your provider to learn what benefits are available. If you use a non-Network provider, the Fund will pay for a maximum of two periodontal cleanings per benefit year. These cleanings are in addition to the routine dental cleanings provided for above. In addition, even if you have not exhausted your per benefit year allowance, the Plan will not pay benefits for more than 2 regular and 2 periodontal cleanings per patient per benefit year. If you submit information demonstrating that more than 2 such cleanings are medically necessary, the Plan will pay benefits for these additional cleanings subject to the per benefit year limit.

Q. Does the per benefit year maximum for dental benefits include surgery to remove impacted teeth, orthognathic surgery, or dental care arising from an accident?

A. No. If you have medically necessary surgery to remove impacted teeth or orthognathic surgery (for TMJ), the surgical benefit provisions of the Plan will apply. If you have an accidental injury to your teeth, the Plan will pay benefits up to \$1,000 per accident per lifetime. This additional accidental dental benefit is available only if you seek initial treatment within 48 hours of the accident, and the dental services are medically necessary.

Q. What about orthodontia?

A. If you are covered by the optional orthodontic benefit, then for each child 18 years of age and under, the Plan will pay a lifetime benefit for medically necessary orthodontia up to \$3000 if you use a Network provider (for braces first placed on the teeth on or after April 1, 2007) and up to \$2000 if you use a non-Network provider. In order to receive this benefit, the child must have had his braces first applied while covered under this Plan.

Q. What about dental services covered by the medical provisions of the Plan?

A. For dental services covered by the medical provisions of the Plan, there are oral maxillofacial surgeons listed as Network providers. These oral maxillofacial surgeons, however, are only contracted for certain surgical procedures. An oral maxillofacial surgeon is one specially trained in both medicine and dentistry who performs the removal of cysts and tumors from the jaws and mouth, repair of cleft palates, and reconstructive surgery of the mouth following an accident or illness. To confirm a PPO procedure, you should contact the Fund Office.

ARTICLE XIV: PRESCRIPTION DRUG BENEFITS - OPTIONAL BENEFIT

Q. What benefits does the Plan pay for prescription drugs?

A. If you are covered by one of the prescription drug benefit options, and subject to the Managed Care Program, the Plan pays benefits for medically necessary prescription drugs as follows:

(1) Network Pharmacy. The Network provider for prescription drugs is General Prescription Programs, Inc. (GPP). If you fill your prescription at a GPP - participating pharmacy, for each thirty-four (34) day supply of the prescription, you will pay the following per-prescription copayment upon presenting your GPP card.

(a) Generic Drugs - a co-payment of \$5 under Option A, \$10 under Option B, and \$10 under Option C. Unless your doctor has indicated on the prescription that a brand name drug is medically necessary, your prescription may be filled with a generic drug if a generic version of a Brand Name Drug is available.

- (b) Brand Name Drugs - for Brand Name Drugs, other than those on the Negative Formulary List, a co-payment of \$15 under Option A, \$20 under Option B, and \$30 under Option C.
 - (c) Negative Formulary - for prescription drugs on the Negative Formulary List, a copayment of \$30 under Option A, \$40 under Option B, and \$50 under Option C. The Negative Formulary List is furnished automatically, without charge, as a separate document. From time to time, you will receive notices and newsletters from the Fund Office listing any revisions to the Negative Formulary. However, if you are not certain whether a particular prescription drug is on the Negative Formulary, contact the Fund Office.
- (2) Non-Network Pharmacy. If you fill your prescription at a non-GPP pharmacy, you will initially pay the full cost of the prescription charged by the pharmacy. You may then file a claim with GPP to receive reimbursement. Contact the Fund Office to request the required form. The reimbursement will be equal to the GPP wholesale price of the drug, less one of the following per-prescription co-payments:
- (a) Generic Drugs - a co-payment of \$5 under Option A, \$10 under Option B, and \$10 under Option C.
 - (b) Brand Name Drugs - for Brand Name Drugs, other than those on the Negative Formulary, a co-payment of \$15 under Option A, \$20 under Option B, and \$30 under Option C.
 - (c) Negative Formulary - if a patient fills his prescription with a drug on the Negative Formulary, a co-payment of \$30 under Option A, \$40 under Option B, and \$50 under Option C. As stated above, the Negative Formulary is furnished automatically, without charge, as a separate document.

Q. Does the Plan have a mail order prescription drug program?

A. Yes. You can purchase medically necessary maintenance prescription drugs (for example, high blood pressure medication) through GPP's mail order program:

Option A: Copayment for up to a ninety (90) day supply: \$15 for generic drug; \$30 for brand drug (not on Negative Formulary); and of a generic drug and \$60 for a brand drug on the Negative Formulary;

Option B: Copayment for up to a ninety (90) day supply: \$30 for generic drug; \$40 for brand drug (not on Negative Formulary); and of a generic drug and \$80 for a brand drug on the Negative Formulary;

Option C: Copayment for up to a ninety (90) day supply: \$30 for generic drug; \$60 for brand drug (not on Negative Formulary); and of a generic drug and \$100 for a brand drug on the Negative Formulary.

Call the Fund Office for mail order forms.

Q. Under what circumstances are new drugs covered?

A. New drugs are covered if they are found to be medically necessary under the Plan's rules. The Trustees, acting upon the advice of the Fund's medical advisors, determine whether new drugs are medically necessary. Medically necessary drugs do not include those that are experimental or investigational in nature. If you have been prescribed a new drug and are not certain if it is covered, contact the Fund Office.

**ARTICLE XV: MENTAL ILLNESS/SUBSTANCE ABUSE
BENEFITS - OPTIONAL BENEFIT**

Q. What benefits does the Plan pay if I suffer from a mental illness or have a substance abuse problem?

A. If you are covered by the optional mental illness/substance abuse benefit, and subject to the Plan's Managed Care Program, the Plan will pay benefits for medically necessary mental illness or substance abuse treatments for you as follows:

- (1) Inpatient Treatment. The Plan will pay inpatient benefits for up to 30 days per benefit year and 90 days per lifetime for mental illness, and for up to 30 days per benefit year and 90 days per lifetime for substance abuse, as follows:
 - (a) Network Hospital. If you use a Network mental/substance abuse hospital, you will receive benefits equal to payment in full less copayments and deductibles.
 - (b) Non-Network Hospital. If you use a non-Network mental/substance abuse hospital, you will receive benefits equal to 85% of billed charges. You will be responsible for any remaining balance. No Major Medical benefits will be available.
 - (c) Exchange of In-Patient Treatment for Outpatient Treatment. The Plan will pay benefits for medically necessary services provided under "partial hospitalization" and "intensive outpatient" programs. Each day of partial hospitalization will be treated as one-half day of inpatient hospitalization. Each day of intensive outpatient therapy will be considered to be one-fourth of a day of inpatient hospitalization.
- (2) Outpatient Treatment. The Plan will pay outpatient benefits for up to 30 visits per benefit year and 90 visits per lifetime for mental illness, and for up to 30 visits per benefit year and 90 visits per lifetime for substance abuse, as follows:
 - (a) Network provider. If you use a Network provider, you will receive benefits equal to payment in full. You will have a \$15 co-payment for each visit.

- (b) Non-Network provider. If you use a non-Network provider, you will receive benefits equal to the lesser of UCR or the billed charges. You will have a \$25 copayment for each visit. You will be responsible for any remaining balance. No Major Medical benefits will be available.

Q. *Can I use any other Plan benefits to get more mental health/substance abuse treatment?*

- A. No. For mental illness and substance abuse conditions, the benefits listed above are the only benefits which are payable by the Plan.

ARTICLE XVI: SHORT TERM DISABILITY BENEFITS - OPTIONAL BENEFIT

Q. *If I become temporarily disabled, does the Plan help me replace part of my lost wages?*

- A. If you are covered by the optional short term disability benefit, the answer is yes, so long as certain conditions are met. NOTE: You must be eligible for short term disability benefits on the date your disabling injury occurred or your disabling illness began. If you became eligible for benefits after your injury or after your illness began, you are not eligible for short term disability benefits from the Fund.

For job-related disabilities for which you are off less than 14 days, you are entitled to a maximum of 7 days of short-term disability benefits, calculated on a per day basis at the rate of \$275.00 per week (7 days) under Option A, \$175.00 per week under Option B, and \$100 per week under Option C. No job-related short-term disability benefits will be paid for any day for which you receive workers compensation benefits.

For non-job-related disabilities, you are entitled to a maximum of 26 weeks of short-term disability benefits at the weekly rate set forth above for Option A, B or C. If you continue to be disabled beyond the 26-week period, and if you are covered by Option A or B, you can receive an additional 10 weeks of short-term disability benefits at \$100 per week. In order to receive the additional 10 weeks of benefits, you must request them from the Fund Office in writing and submit a written certification by your doctor that your disability is temporary and not permanent in nature.

Every 4 weeks, you must submit to the Fund Office proof that you remain disabled in order to continue receiving short-term disability benefits. Benefits are payable beginning with the first day of missed work if on account of an injury, as long as your employer certifies that you stopped working within 1 day of your injury, and beginning with the fourth day of missed work if on account of an illness.

Q. *When am I considered disabled under the Plan?*

- A. Generally, you are treated as disabled under the Plan if:

- (1) You miss work as a result of an injury or illness; and
- (2) Your physician certifies on a form available from the Fund Office that as of the date of your injury or illness for which you seek disability benefits, you were completely unable to perform any gainful employment - at your regular job or any other job you have; and
- (3) Your physician certifies that you sought treatment for your injury or illness within 3 days of its onset. If you do not seek treatment for your disability within 3 days of its onset, you are eligible for disability benefits only from the day you do seek treatment.

Q. *What are the situations in which the Plan will not pay short-term disability benefits, even if I meet the general rules for eligibility?*

A. The Plan will not pay short-term disability benefits in the following circumstances, even if you otherwise meet the Plan's definition of disabled:

- (1) You are receiving workers compensation payments and are off more than 14 days; or
- (2) Your injury was caused by, or is the result of an accident while you were operating, or otherwise riding, a motorcycle, motorized land vehicle (other than an automobile, a farm tractor, a lawn mower, or golf cart, all of which are covered only if in regular use), a motorized or non-motorized air vehicle (such as an airplane not operated by a commercial airline, a helicopter, a hang glider, a parachute, or a balloon) or a personal watercraft (such as a jet ski).
- (3) Your injury or illness was the result of a condition for which benefits are generally excluded (for example, you are recovering from a drunk driving accident);
- (4) You are on strike, layoff, or leave of absence (unless your disability began prior to the strike, layoff, or leave); or
- (5) You are enrolled in the Plan under COBRA continuation coverage;
- (6) Your injury was caused by, or is the result of a motor vehicle accident.

If you live in a state in which you can purchase wage loss protection from your motor vehicle insurance carrier, the Fund will pay short-term disability benefits for the first five (5) days of missed work caused by the motor vehicle accident disability. If you live in a state in which you cannot purchase wage loss protection from your motor vehicle insurance carrier, the Fund will pay short-term disability benefits so long as you provide documentation required by the Fund to prove that you cannot purchase such protection in your state.

- (7) You are self-employed and have not obtained liability insurance to provide the coverage that an employee would receive from worker's compensation coverage for the same disability.

Q. *I am retired from my job with the county but have a part-time job as a parking lot attendant. If I become disabled from my post-retirement job, am I still eligible for short-term disability benefits from the Fund?*

A. No. You are only eligible for short-term disability benefits while you are actively employed with a Contributing Employer on the date that you were disabled.

**ARTICLE XVII: DEATH AND ACCIDENTAL DEATH AND
DISMEMBERMENT BENEFITS - OPTIONAL BENEFIT**

Q. *What death benefits are available?*

A. If you are an active employee and covered by the optional death benefit, then the Plan will purchase on your behalf a life insurance policy from an insurer selected by the Trustees to provide death benefits for your eligible dependents and you. Subject to the terms of that policy, if you die, the Plan will pay death benefits to your designated beneficiary in the amount agreed upon by your Union and your employer. (Note that if your insurance coverage exceeds the federally permitted amounts for tax-free premium payments, your employer will be responsible for withholding and remitting any required taxes.) Under all Options, if your spouse dies, you will receive a death benefit of \$2,000, and if your child dies, you will receive a death benefit of \$2,000. If you are a retired employee and covered by the optional death benefit, the Fund will provide the benefit offered under the Fund's insured policy and purchased by your employer. The amount of death benefits for retirees may be lower than the death benefits offered to active employees. In addition, the dependents of retired employees may not be eligible for death benefits.

Q. *What if my death was the result of an accident?*

A. The Plan has purchased an insurance policy from Aetna to provide accidental death and dismemberment benefits for active participants. Subject to the terms of that policy, if you die as a result of an accident, the Plan will pay your designated beneficiary an accidental death benefit selected by your Employer and the Union, in amounts equal to the value of the life insurance policy that provides your death benefits. This is in addition to any regular death benefit described in the preceding Q&A that may be payable to your designated beneficiary. (Retired employees may not be eligible for accidental death and dismemberment benefits.)

Q. *What if I become dismembered as a result of an accident?*

A. If you are an active employee and become dismembered as a result of an accident, subject to the terms of the Aetna accidental death and dismemberment policy, you will receive the full or partial dismemberment benefits as provided under the insurance policy purchased by the Fund on your behalf as described in the table below.

Dismemberment	Percentage of Principal Sum Payable
Loss of both hands, both feet or both eyes	100%
Loss of both hearing and speech	100%
Quadriplegia	100%
Third degree burns covering 75% or more of the body	100%
Loss of either hearing or speech	50%
Loss of one hand, one foot or one eye	50%
Paraplegia or hemiplegia	50%
Third degree burns covering 50% to 74% of the body	50%
Loss of thumb and index finger of the same hand	25%
Uniplegia	25%

Q. *Are accidental death and dismemberment benefits payable if I die or am dismembered because of an illness?*

A. No.

Q. *Do I have to designate a beneficiary for death or accidental death benefits?*

A. Yes, if you fail to designate a beneficiary, benefits will be paid to the following individual(s) in the following order:

- (1) To your widow or widower;
- (2) Equally to any surviving natural or adopted children;
- (3) To your surviving parents;
- (4) Equally to any surviving brothers and sisters; and
- (5) To your estate.

To ensure that your death and accidental death benefits are distributed as you wish, you must keep an up-to-date dependent designation form on file at the Fund Office.

ARTICLE XVIII: EXCLUSIONS

Q. *Are there any services for which the Plan will not pay benefits in any circumstances?*

A. Yes. They are as follows:

- (1) Medical Necessity. The service is not medically necessary as determined by the Trustees in reliance upon the Plan's professional medical advisors.

- (2) Lack of Eligibility. The service was rendered at a time when you were not eligible for benefits as summarized in Article II.
- (3) Certain Actions by the participant or eligible dependent.
- (a) The service is rendered coincident to your driving with a blood alcohol limit at or in excess of the applicable lawful limit; as a coincident with your ingesting an illegal substance abuse (except for substance abuse benefits summarized in Article XV); or coincident with your participation in an illegal activity, regardless of whether the activity can be characterized as a misdemeanor or felony.
 - (b) The service is rendered as a result of your submission to a provider of incorrect, false or misleading information, or is paid for as a result of your submission (or your provider's submission) to the Plan of incorrect, false or misleading information.
 - (c) The service is rendered when you (or your provider) failed to comply with the Plan's Managed Care Program or other administrative and informational requirements of the Plan.
 - (d) The service is rendered as a result of injury or illness arising from any non-covered employment for wage or profit. For purposes of this paragraph, covered employment means employment for which contributions are made to the Plan.
 - (e) The service is rendered as a result of injury incurred from your participation in racing of any sort, other than bicycle racing.
 - (f) The service is rendered as a result of injury incurred from your participation in a competition offering a prize worth \$100 or more, unless that competition is sponsored by a local union affiliated with the Fund.
 - (g) The service is rendered and you attempt to make this Plan primary by failing to comply with the requirements of other primary insurance. Please see the coordination of benefit rules summarized in Article XIX.
- (4) Certain Item Condition or Service Exclusions.
- (a) The service is for personal comfort items (for example, air conditioners and dehumidifiers) or is for home or motor vehicle alterations or improvements.
 - (b) The service is for the pregnancy of an eligible dependent child.
 - (c) The service relates to the diagnosis and treatment of sexual dysfunction, impotency or infertility.
 - (d) The service is for cosmetic purposes. A service is for cosmetic purposes if its purpose is to enhance appearance, rather than to

correct a physical deformity caused by a congenital defect, accident, trauma, or disfiguring disease.

- (e) The service relates to a program or regimen, such as diet, exercise, rest, and obesity programs and regimens, even if it is medically necessary, unless specifically authorized by the Trustees as a bona fide wellness program adopted as a Plan Benefit.
- (f) The service is visual or orthoptic therapy.

(5) Other Coverage.

- (a) The service is compensable under workers compensation or similar law.

Note: A person who is self-employed and otherwise eligible for coverage under the Plan must obtain liability insurance to provide the coverage that an employee would obtain through worker's compensation insurance. In no event shall the Fund be liable to cover a self-employed person for any service that arises from an illness or injury incurred in the scope of self-employment.

- (b) The service is payable by other insurance, including government-sponsored insurance.

(6) Miscellaneous.

- (a) The service is performed by a provider that is unqualified, uncertified, or not licensed from the appropriate authority to perform the service.
- (b) The participant or eligible dependent does not have a legal responsibility to pay for the service rendered.
- (c) The service is rendered as a result of injury from military service or an act of war.
- (d) The Trustees, in their sole discretion and in consultation with the Plan's professional advisors, determine that the payment of benefits is inconsistent with the Plan's governing documents or with the best interests of the Plan, its participants and dependents.

Q. Are there special additional Major Medical exclusions?

A. Yes. The Major Medical provisions of the Plan, summarized in Article X, do not provide for payment of Major Medical benefits for the following:

- (1) If the service is described in Article VI (Physical Therapy); Article IX (Outpatient Diagnostics); Article XII (Hearing and Vision), Article XIII (Dental/Orthognathic [unless services are received from a non-Network provider]/Orthodontic), Article XIV (Prescription Drugs); and Article XV (Mental Illness/Substance Abuse).

- (2) If the service relates to non-surgical treatment for foot conditions, other than orthotics. (Note: benefits are available under other Plan provisions for pre-certified orthotics, but only if the Plan's Medical Advisor certifies that the foot orthotics are medically necessary to treat the patient for diabetes or peripheral vascular disease).
- (3) If the service is rendered by a chiropractor. (Please note that if your optional benefits include coverage for physician office visits, then for office visits to a Chiropractor, the Plan will pay benefits of \$25 per visit, up to a 20 visits per eligible family member per Benefit Year under the Physician Office Visit provisions of the Plan.)
- (4) If the service relates to immunizations, or to health checkups, routine physical examinations, and injections where no diagnosis is made. (These may be payable under other provisions of the Plan.)
- (5) If the service is one for hospital room and board or physician services by a physician who keeps you in the hospital on a day when room and board benefits have been denied.

Q, *Are there special additional exclusions for death and accidental death and dismemberment benefits?*

- A. Yes. The exclusions which appear in the death and accidental death and dismemberment insurance policies summarized in Article XVII apply to those benefits. Call the Fund Office if you would like to review or receive a copy of these insurance policies.

ARTICLE XIX: SUBROGATION/REIMBURSEMENT AND COORDINATION OF BENEFITS

Q. *What if I become ill or injured as a result of a third party's actions?*

- A. In this case, the Plan is given the broadest rights to recover any medical expenses paid on your behalf, including, but not limited to reimbursement, subrogation, constructive trust and any other federal or state causes of action that may provide legal and/or equitable relief to the Plan. Generally, the Plan treats the third party as primarily liable for your medical expenses. However, the Plan will pay benefits to you with the understanding that payment of these benefits is expressly and automatically conditioned on the Plan being reimbursed for these benefits if there is any recovery from that third party (including any recovery from your automobile or other insurance carrier). You and your attorney are required, as a condition of the Fund providing any benefits for you under this Plan, that you hold all money you receive in constructive trust for the Fund, regardless of whether you execute a subrogation agreement. This means that you must treat all dollars you receive from the third party as if you are holding them to repay the Fund before you pay anyone else. At the Plan's discretion, it may choose to be subrogated to your rights against the third party, or to proceed with an action for reimbursement. If the Plan chooses to be subrogated, that means that it will take over your rights against the third party. If the Plan chooses

to proceed with an action for reimbursement, that means it looks to the third party for repayment of expenses it paid on your behalf. The Plan also can proceed with an action against you if you receive money from the third party and do not reimburse the Plan. The Fund's subrogation rights extend to any excess coverage that the Participant or Dependents may have purchased on his own.

In addition to the above, the Plan may sue you, your attorney, or any other recipient of money from a third-party for imposition of a constructive trust or other legal and/or equitable remedy if you do not reimburse the Plan.

Any reimbursement amounts which the Plan receives from a third party shall not be reduced by any attorney fees greater than 20%, unless the Plan has consented to a higher attorney fee in writing.

Q. *What must I do to protect the Plan's right to reimbursement?*

A. You must not do anything that could interfere with the Plan's right to reimbursement from the third party. The Plan may ask you to assign to it your rights against that third party, or your recovery from that third party, to the extent of benefits paid by the Plan. The Plan may also ask you not to settle the case without the prior written consent of the Plan, or to authorize the Plan to sue on your behalf. In addition, as noted above, you and your attorney are required, as a condition of the Fund providing any benefits for you under this Plan that you hold all money you receive in constructive trust for the Fund, regardless of whether you sign a subrogation agreement.

Q. *What can the Plan do to protect its right to reimbursement?*

A. The Plan can and will deny benefits to any participant or eligible dependent who acts against the Plan's right to reimbursement from the third party. The Plan also can sue you, your attorney or any other person to recover the reimbursement owed to it if you or such person receives money from the third party and do not reimburse the Plan. Finally, the Plan can offset the amount that should have been reimbursed to it against other benefits.

Q. *What about future medical expenses for the same injury or illness?*

A. The Plan's right to reimbursement is an ongoing one. If you have future medical expenses which were the result of the third party's actions, the Plan's right to reimbursement continues. The following example explains how this works.

Example: John Smith was enrolled in Plan 16 and was injured in an automobile accident in Pennsylvania. The Plan paid benefits of \$5,000 for medical expenses related to this accident after Mr. Smith's auto insurance paid the first \$5,000 in claims. Mr. Smith sues the driver of the other car. He recovers \$45,000 for the accident. Of this, his attorney receives one-third, or \$15,000. The Plan receives \$4,000 (\$5,000 less \$1,000, which is the 20% attorney recovery fee allowed by the Fund). Mr. Smith receives the balance: \$26,000. The Plan will not pay any benefits for future medical expenses related to the same illness or injury and may

off-set benefits paid against any other future benefits until the expenses exceed \$26,000.

Q. *I was injured on the job, and my employer wants me to sign a workers compensation lump sum commutation. Should I sign?*

A. You should contact your own attorney to help you answer this question. If you do sign a lump sum commutation, however, it should be limited to wages only, not medical care for your work-related injury. If you do waive your right to future medical care payments as part of a lump sum commutation, the Plan will not pay any benefits for your work-related injury until your medical expenses exceed your lump sum commutation [for all expenses, not just for work-related injury expenses].

Q. *What if one of my eligible dependents or I has other insurance coverage; does the Plan coordinate coverage with that other insurance?*

A. Yes. The Plan follows Coordination of Benefits ("COB") rules established by the Fund. The following is a summary of the Plan's rules.

As an initial matter, if the other insurance has no provision for the coordination or non-duplication of benefits, that other insurance is the primary plan. That means that the other insurance will pay benefits for your medical expenses first. Plan 16 will be secondary. That means that it will pay benefits only after the other insurance has paid its full benefits.

If the other insurance does have a COB provision, the following rules apply:

Except in the case of automobile accidents, this Plan is primary for you as long as you are an employee/participant. If you enjoy benefits from the Plan as a former employee and you have gotten another job with a non-contributing employer which provides health insurance for the same coverage period, your new employer's insurance will be primary.

For your spouse, if he/she has other insurance as an employee, that other insurance will be primary for his/her, medical expenses. Otherwise, this Plan is primary for his/her medical expenses.

For your children, a number of special rules apply. First, if your child is born in Pennsylvania and your spouse has other insurance in the form of single coverage, that other insurance will cover your child for the first 30 days of your child's life. The primary insurance carrier will be determined in accordance with the Coordination of Benefits provisions of each plan.

Second, if you, your spouse, and your children live together as a family, and your spouse has other coverage that also covers your children, the plan of the parent with the first birthday in the calendar year is the primary plan for your children. If you and your spouse have the same birthday, or if the other insurance does not follow this "first birthday" rule, Plan 16 will

follow the coordination rule of the other insurance.

If you and your spouse are living apart or are divorced, and your spouse has other coverage, the Plan will follow any "qualified medical child support order," or QMCSO, issued by a court and approved by the Plan designating you or your spouse as the one who is responsible for the child's medical care. If there is no QMCSO, the plan of the parent (or stepparent if the parent does not have any other insurance) with custody of the child will be the primary plan. If none of the above rules apply, the plan of the parent (or step-parent) whose birthday is earlier in the year will be considered the primary plan.

Q. *What if I or one of my eligible dependents is eligible for Medicare or other insurance under any government program?*

A. If you are a retired Employee who receives benefits under this Plan and you are over age 65 and eligible for Medicare Part B benefits, you must elect Medicare Part B coverage. Medicare will be primary for you and this Fund will provide coordinated secondary coverage. If you or your spouse is eligible for Medicare Part B coverage but do not elect this coverage, the Fund will only pay benefits as if you or your spouse had elected Medicare Part B coverage. For example, if you are eligible to elect Medicare Part B coverage but did not do so and incurred a \$1,000 bill for which Medicare would have paid \$800 and the Fund would have paid \$200, the Fund will only pay \$200. You will be responsible for paying the \$800 that would have been paid by Medicare.

If, however, you have coverage under this Plan on account of your active employment, the Plan is primary to Medicare. In general, if you receive Medicaid or Medical Assistance, the coverage provided by the Plan (including prescription drug coverage) is also primary. You may be required to reimburse one of these agencies for benefits they have paid if you do not use this Plan as the primary carrier.

Q. *Can I waive coverage under the Plan for myself when I am covered by my spouse's plan?*

A. Yes, if you elect not to enroll under this Plan. Please see the rules above relating to the Annual Open Enrollment Period and Special Enrollment.

Q. *What if I am in an automobile accident?*

A. In this case, this Plan is secondary to any automobile insurance.

Q. *What if I purchase my own supplemental health insurance policy for cancer, or for motorcycle accidents?*

A. In this case, this Plan is primary, and your supplemental insurance can be used to pay for medical or other expenses not covered by this Plan.

Q. *The primary plan denied my claim as not medically necessary. Will Plan 16, as a secondary plan, also deny my claim as not medically necessary?*

A. You first must exhaust the appeals procedures of the primary plan. Once you have done that, you can forward the record of your claim to the Fund Office. The Fund Office will evaluate your claim with the Plan's medical advisors under Plan 16's medical necessity criteria.

ARTICLE XX: PLAN ADMINISTRATION

Q. *What are the rules for claims submission to the Plan?*

A. Network claims will be submitted for you by the provider. Non-Network claims should be submitted directly to the Fund Office. Claim forms are available at the Fund Office, and also should be available at your employer's worksite or local union office. All claims for payment of benefits from the Plan must be submitted within 1 year from the date the service was rendered, or the onset of disability, or they will not be processed.

Q. *I have a complex health condition and need my wife or personal representative to help me work through the claims. Can the Plan accommodate this?*

A. Yes. You may designate an "authorized representative" to act on your behalf with respect to processing claims or appealing the denial of a claim. Please contact the Fund Office for the appropriate form designating your authorized representative. After you have properly designated an "authorized representative, the Fund will communicate directly with your authorized representative unless you tell the Fund on your authorization form that you would like the Fund to continue to communicate directly with you. (If you have an "urgent care claim," the health professional with knowledge of your medical condition may act as your authorized representative without an executed authorization form from you.)

Q. *How long will it be before I know whether the Fund will cover my claims for medical treatment?*

A. The Fund has different time limits established by law and followed by the Plan depending of the type of claim you (or your provider) submit when you first receive treatment or service, either you or your provider will submit claims for processing. The time limits for processing your claim will be determined by the type of claim you have. If you have already received the service or treatment, the claim is a "post-service" claim. Post-service claims will likely be the majority of claims that you or your providers submit. For certain treatment or services, the Fund may limit the number of visits (for example, for physical therapy) or days of hospitalization based on medical necessity. Or, once you begin a course of treatment, your health professional may determine that you need additional services or treatment. Claims for extended visits or care are called "**concurrent claims.**" Also, certain services and procedures require pre-authorization or pre-certification. These claims are called "**pre-service claims.**" Finally, you may

have an “**urgent care claim.**” The different types of claims, and the time limits for processing these claims, are described below.

Q. What is an “urgent care” claim and how long does the Fund have to respond? Are there special rules that apply?

A. Urgent Care Claims: An urgent care claim is a claim for treatment that the treating physician believes must be provided immediately or the patient’s health or life could be jeopardized or the patient will suffer severe pain that cannot otherwise be managed. Your claim must be certified as an “urgent care” claim by a physician. If your claim includes all of the information the Fund needs to process your claim, you will receive a response as soon as possible but no later than 72 hours after your request for review is received. If your claim does not include all of the information needed, you will be contacted within 24 hours and told what information you need to submit to support your claim. You will have up to 48 hours to submit the requested information. You will receive a response, including the reason for the decision, as possible but no later than 48 hours after you submit the required information or the expiration of the period you were given to provide additional information. The Fund may initially provide response orally, including by telephone, if the situation so warrants.

Q. What is a “concurrent care” claim and how long does the Fund have to respond? Are there special rules that apply?

A. Concurrent Care Claim: A concurrent care claim arises when the Fund has approved an ongoing course of treatment to be provided over a period of time or a number of treatments. For example, a concurrent care claim is one for additional visits to the physical therapist or for additional hospital days for an already hospitalized patient. If the Fund determines that the course of treatment, the number of treatments or the amount of service is going to be reduced or terminated, it must notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefits are reduced or terminated. If your concurrent care claim is for “urgent care” and you notify the Fund, at least 24 hours before the expiration of the period or number of treatments, the Fund will notify you within 24 hours of the receipt of your claim. If the request is made less than 24 hours prior to the end of the course of treatment, the Fund will notify you of its decision within 72 hours of receipt of the claim. If the concurrent care claim is not an urgent care claim, the Fund will treat it as a pre-service claim or post-service claim and will process it according to the applicable deadlines described below.

Q. What is a “pre-service” claim and how long does the Fund have to respond? Are there special rules that apply?

A. A pre-service claim must be submitted when the Fund requires advance approval or certification prior to receiving medical treatment or services. In many instances, pre-service claims may be submitted directly by the medical provider. The Fund will provide a response not later than fifteen (15) days after it receives your request, unless it cannot respond because you (or your provider) have not submitted all of the information it needs to process the claim or for other reasons

beyond its control. If the delay is caused by circumstances beyond its control, the Fund, the Fund shall notify you in advance of the expiration of the first 15 day period that an additional fifteen (15) days are required. If you (or your provider) have not submitted the information needed to process your claim, the Fund will inform you of the specific information needed to process your claim. At that point, consideration of your claim will be suspended. You will have forty five (45) days to submit this information. After you submit the required information, your claim will be processed during the balance of time remaining before consideration of your claim was suspended.

Q. *What is a “post-service” claim and how long does the Fund have to respond? Are there special rules that apply?*

A. Post-Service Care Claim: A post-service claim is a claim for benefits for treatment or services that you have already received. In many instances, post-service claims may be submitted directly by the medical provider to the Fund. The Fund will provide a response not later than thirty (30) days after it receives your request, unless it cannot because you (or your provider) have not submitted all of the information it needs to process the claim or for other reasons beyond its control. If the delay is caused by circumstances beyond the control of the Fund you will be notified in advance of the expiration of the first thirty (30) day period that an additional fifteen (15) days are required. If you (or your provider) have not submitted the information needed to process your claim, the Fund will inform you of the specific information needed to process your claim. At that point, consideration of your claim will be suspended. You will have forty five (45) days to submit this information. After you submit the required information, consideration of your claim will resume and it will be processed within the balance of time remaining before consideration of your claim was suspended.

Q. *Where do I submit my claim for processing?*

A. If you use a Network provider, the claim will be submitted by the provider directly to the Fund. If you use a non-Network provider and need to submit your claim to the Fund, forward it to the Fund Office. You or your authorized representative (including your health care provider) may file a claim for you by US Mail, by fax, or by commercial delivery service (e.g. UPS). If your claim is for “urgent care,” you may provide information about your claim by telephone, if you follow your telephone call with documentation to support your claim.

Q. *What information will the Fund provide if my claim is denied?*

A. If your claim is denied, you will receive a written notice that will include the following information, regardless of whether your claim is processed and denied by the Fund. In the case of an urgent claim, the information may initially be provided orally but will be followed with written confirmation no later than three days after the original decision is rendered. The information will include:

- (1) The specific reasons for the denial (for example, you were not eligible for benefits at the time you applied for benefits);
- (2) The specific plan provisions under which your claim was denied;

- (3) If an internal rule, guideline or protocol was relied upon to make the decision, you will be provided with the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;
- (4) If the decision turned on medical necessity or whether a treatment was experimental, you will be provided with either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or a statement that it will be provided to you free of charge upon request;
- (5) A description and explanation of the information you must submit in order to perfect your claim;
- (6) A description of the procedures you must follow to appeal the denial of your claim to the Board of Trustees.

Q. *What can I do if I disagree with the Fund's decision on a claim?*

- A. **Appeal of the Denial of Your Claim.** If you are dissatisfied with the denial of your claim, or of a portion of your claim, you may appeal to the Board of Trustees. You must submit your written request for review to the Board of Trustees no later than 180 days after the denial or partial denial of your claim. Your request for review must include the reasons for your request for review. If you fail to appeal your claim, you waive your right to dispute the Fund's determination on this claim.

NOTE: Appeal of the denial of an urgent care claim may initially be submitted by telephone.

Your request should be submitted to the Board of Trustees.

Q. *What are my rights on appeal?*

- A. Your rights when you request a review of the denial of a claim:
- (1) Your claim will be considered by the Board of Trustees. The Board of Trustees does not participate in the processing and denial of claims at the initial stage. The Board of Trustees will not defer to the original decision of the Fund staff who originally denied your claim. You have the right to appeal in person or by telephone and at least one Trustee will participate in the hearing on appeal.
 - (2) In support of your request for review, you are permitted to submit written comments, documents, records and other information relevant to your request for review. The Board of Trustees will review this information in making a determination about your request for review.
 - (3) At your request and free of charge, you will be provided reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
 - (4) If consideration of your request for review requires that the Board make a medical judgment (for example, if the Trustees must consider whether the

prescription drug was medically appropriate or experimental), the Trustees shall consult with an appropriate health care professional. If the Trustees consult medical experts with respect to your request for review, they will provide for the identification of these experts. The medical expert consulted by the Board of Trustees on appeal shall be different from any medical professional consulted with respect to the original claim for benefits.

Q. *If the Trustees deny my claim, what information will the Fund provide to me?*

A. If the Board of Trustees denies your appeal of the denial of a claim, you will be provided with the following information:

- (1) The specific reasons for their determination;
- (2) The plan provisions on which the Trustees based their determination;
- (3) A statement 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 your claim for benefits;
- (4) If an internal rule, guideline or protocol was relied upon to make the decision, the Board of Trustees will provide either the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;
- (5) If the decision turned on medical necessity or whether a treatment was experimental, the Board of Trustees will provide either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or will provide the explanation to you free of charge upon request;
- (6) You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State regulatory agency.
- (7) You have the right to bring an action against the Fund under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, after you have exhausted all levels of appeal required under this claim procedure.

Q. *When Will the Board of Trustees Provide a Decision on Appeal?*

A. It depends on the type of claim:

- (1) **Urgent Care Claims:** The Board of Trustees will provide a response no later than seventy two (72) hours after the Fund receives your appeal of the denial of a claim.

- (2) **Pre-service Claims:** The Board of Trustees will provide a response no later than thirty (30) days after the Fund receives your appeal of the denial of a claim.
- (3) **Post-Service Claims:** The Board of Trustees will generally provide a response to an appeal after the regular meeting of the Board of Trustees that follows the submission of your request for appeal. If your request for appeal was filed less than thirty (30) days before the meeting, the Trustees may defer consideration of the appeal until the next regular meeting. If, due to special circumstances (for example that the Board believes that a hearing would be appropriate), the Board of Trustees will provide a response no later than following the third meeting after your request for appeal was submitted. If the Board of Trustees requires an extension due to special circumstances, the Board will provide you with a description of the special circumstances and the date on which a determination will be made before the extension of time begins. The Board of Trustees will provide you with a response no later than five (5) days after the decision is made.

NOTE: If you (or your provider) have not submitted the information needed for the Board to consider your appeal, you will be informed of the specific information needed to process your claim. At that point, the Fund's consideration of your claim will be suspended. After you submit the required information, the Board of Trustees will resume consideration of your appeal within the balance of time remaining before consideration of your appeal was suspended. During the period that the Trustees are awaiting the requested information, the deadlines for rendering a decision will be suspended.

Q. *What happens if the Board of Trustees fails to make a decision within the time deadlines for my type of claim?*

A. If the Board of Trustees fail to act within the time lines set forth above or fails to provide you with the information described above, your request for review is deemed denied.

Q. *Who has final authority to interpret the Plan's provisions, terms, rules, regulations, policies and procedures?*

A. The Board of Trustees has final authority to make all determinations regarding the Plan's provisions, terms, rules, regulations, policies and procedures. The Board of Trustees has full authority and discretion to make factual findings regarding a claim or request for review and to interpret the terms of the Plan as they apply to the claim or request for review. The Board of Trustees will provide only those benefits to which you are entitled under the terms of the Plan.

Q. *Does the Fund have special rules for claims for short term disability?*

A. Yes. **Initial Claim for benefits:** The Fund provides short term disability benefits. The Fund will provide a response not later than forty five (45) days after

it receives your application for short term disability benefits, unless it cannot because you (or your provider) have not submitted all of the information it needs to process the claim or for other reasons beyond its control. If the delay is caused by circumstances beyond the control of the Fund, the Fund will notify you in advance of the expiration of the initial forty five (45) day period that an additional thirty (30) days are required. If the Fund determines that an additional thirty (30) day period is required due to circumstances beyond the control of the Fund, the Fund will notify you in advance of the expiration of the first extension. The Fund will include in the notice of any extension an explanation of the standards used to determine if you are entitled to the benefit and a description of both the unresolved issues that prevent a decision on the issues and the information that you can provide that will resolve these issues. You will have at least forty five (45) days to present any required information. The Fund's consideration of your claim will be suspended when it informs you that additional information is required. After you submit the required information, Fund will process your claim within the balance of time remaining before consideration of your claim was suspended.

Q. *What information will I receive if my claim for short term disability is denied?*

A. You will receive the following information:

- (1) The specific reasons for the denial (for example, you were not eligible for benefits at the time you applied for benefits);
- (2) The specific plan provisions under which your claim was denied;
- (3) If an internal rule, guideline or protocol was relied upon to make the decision, the Fund will provide either the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;
- (4) If the decision turned on medical necessity or whether a treatment was experimental, the Fund will provide an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or will provide the explanation to you free of charge upon request;
- (5) A description and explanation of the information you must submit in order to perfect your claim;
- (6) A description of the procedures you must follow to appeal the denial of your claim to the Board of Trustees.

Q. *When will the Board of Trustees respond to my appeal for Short Term Disability benefits?*

A. The Board of Trustees will generally provide a response to an appeal of an adverse decision on a short term disability claim after the regular meeting of the Board of Trustees that follows the submission of your request for appeal. If your request for appeal was filed less than thirty (30) days before the meeting, the Trustees may defer consideration of the appeal until the next regular meeting. If,

due to special circumstances (for example that the Board believes that a hearing would be appropriate), the Board of Trustees will provide a response no later than following the third meeting after your request for appeal was submitted. If the Board of Trustees requires an extension due to special circumstances, the Board will provide you with a description of the special circumstances and the date on which a determination will be made before the extension of time begins. The Board of Trustees will provide you with a response no later than five (5) days after the decision is made.

Q. *What information will the Board of Trustees provide if my claim is denied?*

- A. If your request for review is denied the Board of Trustees' written notice will include the following information (In the case of an urgent claim, the following information may initially be provided orally but will be followed with written confirmation no later than three days after the original decision is rendered):
- (1) the specific reasons for the denial;
 - (2) The specific plan provisions under which your claim was denied;
 - (3) A description of the relevant documents and information to which the Board of Trustees referred in making its decision, as well as the assurance that you will be provided with access to these documents;
 - (4) If an internal rule, guideline or protocol was relied upon to make the decision, the Board of Trustees will provide either the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;
 - (5) If the decision turned on medical necessity or whether a treatment was experimental, the Board of Trustees will provide either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or will provide a statement that the explanation to you free of charge upon request;
 - (6) A statement that you may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State regulatory agency;
 - (7) and a statement that you have the right to bring an action against the Fund under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, after you have exhausted all levels of appeal required under this claim procedure.

Q. *If the Fund overpaid benefits for my eligible dependents or me, am I responsible to reimburse the Fund?*

- A. Yes. To protect itself in this instance, the Fund reserves the right to offset future benefits to recover overpaid benefits, or to sue you directly for the overpayments.

Q. Can the Plan be changed?

A. Yes. The Board of Trustees has the right to amend this Plan at any time, including the right to modify or eliminate benefits. Any such amendment shall be adopted by formal action of the Board, and you will receive notice of amendments as required by law.

Q. Do the Trustees have the power to terminate the Plan, or terminate my benefits under the Plan?

A. Yes. In any event, it will be in accordance with applicable law. In the case of a Plan-wide termination, it will be handled in accordance with applicable law. The Trustees also reserve the right to deny you and your family benefits if you fail to meet the eligibility requirements summarized in Article II, including the requirement that your employer pay contributions for you in a timely manner.

The Trustees further reserve the right to terminate an employer's participation in the Plan for any reason. No such termination will take place until (1) the Trustees have passed a resolution; (2) this resolution has been communicated to the employer; and (3) the Benefit Period ends (at least 4 months after the date of the resolution).

Q. Who has the power to interpret the Plan and to determine eligibility for benefits?

A. To the fullest extent allowed by law, the Trustees have the absolute power and discretion to:

- (1) Determine a participant or eligible dependent's rights and benefits, as well as obligations, under the Plan;
- (2) Interpret the terms and provisions of the Plan, including ambiguous provisions; and
- (3) Determine the relevant facts, and apply the facts to the law and to the terms of the Plan. The Trustees' determinations shall be binding on all parties.

Q. What basic guidelines must the Trustees follow in the performance of their duties?

A. In accordance with the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), the Board of Trustees as fiduciaries must act solely in the interest of the participants and dependents of the Plan and for the exclusive purpose of providing benefits to participants and dependents and defraying the reasonable expenses of administering the Plan. The Trustees actions pursuant to their fiduciary obligations should be taken with care, skill, prudence and diligence in accordance with the provisions in the Plan.

In order to assist them in the execution of their duties, the Trustees, as Plan Administrator, are permitted to retain professional advisors including: independent certified public accountants, attorneys, consultants and actuaries,

investment consultants, investment managers, and professional medical advisors. A list of the professional advisors who serve the Plan may be obtained, upon request, from the Fund Office.

Q. *Who manages the investment of the Plan's assets?*

- A. The Trustees have retained professional investment managers who are responsible for investing the Plan's assets in accordance with the Plan's investment guidelines and objectives established by the Trustees.

The Trustees also have retained an investment consultant whose primary function is to assist the Trustees to develop an investment policy, to monitor the investment managers comply with that investment policy, and to evaluate each investment manager.

Q. *How are the assets in the Plan managed?*

- A. All Plan assets are invested in accordance with the Statement of Investment Policies and Objectives that has been developed by the Trustees in conjunction with the investment consultant. These guidelines and objectives are reviewed and changed, as appropriate, on a periodic basis to reflect changing capital markets, Plan characteristics, and Trustees' expectations. As a result, the Plan's assets are invested in a diversified, conservative portfolio of cash, stocks and bonds.

ARTICLE XXI: COBRA CONTINUATION COVERAGE RIGHTS AND QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Q. *What is COBRA continuation coverage?*

- A. Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan must offer participants and their eligible dependents the opportunity to continue coverage under this Plan in certain circumstances and at a certain cost. You and your spouse should read the following Q&As carefully because they explain, in a summary form, your rights to COBRA continuation coverage,

Q. *Who can elect COBRA continuation coverage?*

- A. A person who is a "qualified beneficiary" can elect COBRA continuation coverage. A qualified beneficiary is an employee/participant, that employee/participant's spouse, and that employee/participant's eligible dependent children, who were covered under this Plan the day before a "qualifying event." Qualifying events are described in the next Q&A. Qualified beneficiaries also include children born or placed for adoption with an employee/participant during the period of COBRA continuation coverage.

Q. *Under what circumstances can a Qualified Beneficiary elect COBRA continuation coverage?*

- A. A qualified beneficiary can elect COBRA continuation coverage when certain occurrences, called "qualifying events," happen. Below is a list of qualifying

events for employee/participants, spouses of employee/participants, and eligible dependent children of employee/participants.

- (1) Employee/participant: If a person is eligible for benefits from the Plan because of his/her employment, he/she can choose COBRA continuation coverage if he/she loses coverage on account of:
 - (a) The termination of his/her employment (by reason of a voluntary quit, discharge or retirement) NOTE: If you continue with this coverage under Plan 16 after your retirement, the Fund will treat your first eighteen months of post-retirement coverage as the continuation coverage under COBRA to which you are entitled on account of your retirement (even though you may not have to pay for this coverage). When you later cease coverage under the Fund, no additional COBRA coverage will be offered to you on account of your retirement; or
 - (b) The reduction in his/her hours of work.
- (2) Spouses: If a person is eligible for benefits from the Plan because he/she is the spouse of an employee/participant, he/she can choose COBRA continuation coverage if he/she loses coverage on account of:
 - (a) The death of his/her employee-spouse;
 - (b) The termination of his/her employee-spouse's employment (by reason of a voluntary quit, discharge or retirement);
 - (c) The reduction in the employee-spouse's hours of work;
 - (d) His/her divorce from the employee-spouse; or
 - (e) The employee-spouse becoming covered by Medicare after he or she became a qualified beneficiary
- (3) Dependent Children (including Children Born or Adopted While the Employee/Parent Was Under COBRA): If a person is eligible for benefits from the Plan because he is the dependent child of an employee, he/she can choose COBRA continuation coverage if he loses coverage on account of:
 - (a) The death of the employee-parent;
 - (b) The termination of the employee-parent's employment (by reason of a voluntary quit, discharge or retirement);
 - (c) The reduction in the employee-parent's hours of work such that eligibility for benefits from the Plan stops;
 - (d) The parents' divorce;
 - (e) The dependent child's eligibility for coverage ends because he stops being an eligible dependent child under the Plan; or
 - (f) The employee-parent becoming covered by Medicare. After the employee-parent became a qualified beneficiary.

Q. What type of coverage does COBRA provide?

A. If you are an employee/participant, you can choose:

- (1) Not to elect COBRA coverage;
- (2) To elect all Plan 16 benefits previously available to you, except short-term disability benefits; or
- (3) To elect all Plan 16 benefits previously available to you, except short-term disability, death, and accidental death and dismemberment benefits.

If you are the spouse or child of an employee/participant, you can choose:

- (4) Not to elect COBRA coverage; or
- (5) To elect all Plan 16 benefits previously available to you, except short-term disability, death, and accidental death and dismemberment benefits.

You should note, however, that a qualified beneficiary's benefits will change if the Plan's benefits change.

Q. What are the notification requirements for COBRA continuation coverage?

A. A qualified beneficiary must notify the Plan:

- (1) If he/she divorces;
- (2) If he/she or his/her spouse becomes covered by Medicare or is covered by another group health plan; or
- (3) If a dependent child ceases to qualify as a dependent child under this Plan.

Such notification must be given to the Plan as soon as possible, and in no circumstances later than 60 days after the event. If a qualified beneficiary fails to notify the Fund of one of these events in a timely manner, the Fund will not offer COBRA coverage to the qualified beneficiary. Also, if a qualified beneficiary or participant fails to notify the Fund of one of these events and the Fund continues to provide coverage on account of the failure to provide the Fund with the appropriate information, the Fund may deduct the cost of all benefits paid on behalf of the qualified beneficiary from benefits payable to any other family member or take any such other legal action as the Trustees deem necessary to protect the Fund. If you fail to provide the required notification, the Fund will not be able to offer COBRA continuation coverage to the affected individual.

The Plan will notify a qualified beneficiary of his/her right to elect COBRA continuation coverage after the contributing employer advises the Plan that an employee has lost coverage due to a termination of employment for any reason (including death) or due to a reduction in hours.

Q. *How can I elect COBRA continuation coverage?*

A. The Plan will provide you with a COBRA election form. You must complete and return this form to the Plan. A qualified beneficiary will have at least 60 days to elect COBRA. This period will end on the later of:

- (1) 60 days from the date of your loss of coverage; or
- (2) 60 days from the date the Plan mails the qualified beneficiary a notice of his/her right to elect COBRA continuation coverage and a COBRA election form,

If a qualified beneficiary incurs covered expenses during the election period before that person has submitted the election form, claims will not be processed until the Plan receives the election form and the required contribution.

Q. *How long does COBRA continuation coverage last?*

A. An employee may elect to continue coverage up to a maximum of 18 months from the date of the first qualifying event. Under certain circumstances, the employee's spouse or dependent children may elect to continue coverage up to a maximum of 36 months from the date of the first qualifying event.

If, within the first 60 days of COBRA coverage you or your spouse or dependent children became disabled under Title II of XVI of the Social Security Act, the disabled person may elect up to 29 months of COBRA continuation coverage from the date of the first qualifying event, so long as notice of the Social Security Disability certification is given to the Fund within the first 18 months of COBRA coverage.

Q. *When does COBRA continuation coverage stop?*

A. COBRA continuation Coverage ends when one of the following occurs:

- (1) The period of maximum continuation coverage ends for your particular qualifying event.
- (2) The qualified beneficiary fails to pay the premium for COBRA continuation coverage when it is due. There is a 30-day grace period for payment of the premium (but not for coverage) before the Plan will cut off the COBRA continuation coverage for failing to pay the premium.
- (3) The date, after the qualified beneficiary's COBRA election, that he/she first becomes covered under another group health plan (unless that plan contains a pre-existing condition exclusion which applies to a condition suffered by the qualified beneficiary), or he/she becomes covered by Medicare. You must notify the Plan immediately of such other coverage – or the Fund may seek repayment of all Benefits paid on your behalf, etc.

Q. *What is the cost of COBRA continuation coverage?*

A. You must self-pay for COBRA continuation coverage. The cost for the coverage is equal to the Plan's cost of providing the coverage option you select, plus 2%. The 2% covers a portion of the Plan's costs to provide this coverage. You will be

notified of the costs upon notice to the Plan of your qualifying event. Upon your election you will have a period of 45 days in which to remit the premium(s) for all periods of coverage from the date coverage was lost up to the current coverage period.

Q. *What if I lose eligibility in the Plan because of military service?*

A. Under a federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you will be able to purchase Plan continuation coverage for you and your eligible dependents at the COBRA rate(s) for up to 36 months. If your period of military service is 30 days or less, your last contributing employer, or the Plan, will pay for the continuation coverage. If you are reinstated to employment with a contributing employer at the end of your military service, your coverage under the Plan will resume without any waiting period or preexisting condition exclusion. However, the Plan will not pay benefits for any injury or illness which the federal government determines was caused or aggravated by your military service. If you need more information about USERRA, you may wish to visit the U.S. Department of Labor website on the topic at <http://www.dol.gov/vets/programs/userra/userra>.

Q. *What happens at the end of maximum period of COBRA continuation coverage?*

A. Once the maximum period of COBRA continuation coverage ends, the person's coverage under this Plan terminates.

Q. *What is a "qualified medical child support order (QMCSO)?"*

A. A medical child support order (MCSO) is an order typically entered by a state family court as part of a divorce. A MCSO calls for the continued enrollment of a child in the non-custodial parent's group health plan.

A MCSO will be "qualified," or honored by the Fund, if it includes the following information:

- (1) The name and last known mailing address of the Plan participant and of the child to be covered (known as the "alternate recipient");
- (2) A reasonable description of the type of coverage to be provided to the alternate recipient (not to include any coverage generally unavailable to Plan participants); and
- (3) The period of the time the coverage is to be provided.

Q. *What are the procedures that the Plan follows in determining whether a medical child support order is "qualified?"*

A. Because the Plan pays benefits for your eligible dependent child even if he/she does not live with you, the Plan requires you to submit a medical child support order only if the court orders that the alternate recipient's benefits are to be made payable to the custodial, non-participant parent.

The Plan has adopted procedures for determining whether a medical child

support order is "qualified." These procedures are available upon request free of charge. Upon receipt of a medical child support order, the Plan shall notify the participant and each alternate recipient of the receipt of the order. It shall also forward a copy of the Plan's QMCSO procedures to the participant and alternate recipient. Within a reasonable period after receipt of the order, the Plan shall determine whether the order is QMCSO pursuant to these procedures. It will notify the participant and each alternate recipient of its determination in writing.

Please be advised that the Plan cannot provide benefits under a QMCSO unless the Fund Office receives a copy of the QMCSO.

ARTICLE XXII: THE U.S. DEPARTMENT OF LABOR, STATEMENT OF YOUR RIGHTS UNDER ERISA

Q. *What does the U.S. Department of Labor say are my rights under the law?*

A. The U.S. Department of Labor requires that the following notice be provided to you.

As a participant in Plan 16, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- (1) Receive Information About Your Plan and benefits
 - (a) Examine, without charge, at the Fund Office and at other specified locations, such as worksites and your local union office, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
 - (b) Obtain, upon written request to the Trustees, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The Trustees may impose a reasonable charge for the copies.
 - (c) Receive a summary of the Fund's annual financial report. The Board of Trustees is required by law to furnish each participant with a copy of the summary annual report.
- (2) Continue Group Health Plan Coverage
 - (a) Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- (b) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under this Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from this Plan (a) when you lose coverage under the Plan, (b) when you become entitled to elect COBRA continuation coverage, (c) when your COBRA continuation coverage ceases, (d) if you request it before losing coverage, or (e) if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
- (3) Prudent Actions by Plan Fiduciaries.
 - (a) In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and solely in the interest of you and the other Plan participants and dependents. 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 health and welfare benefit or exercising your rights under ERISA.
- (4) Enforce Your Rights.
 - (a) If your claim for a health and welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
 - (b) Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Board of Trustees to provide the materials and pay you up to \$110 a day (indexed for inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Board. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you

are successful the court may order the person you have sued to pay these 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 this Plan, you should contact the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Board of Trustees, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W, Washington, 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.

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