

CENTRAL PENNSYLVANIA TEAMSTERS
HEALTH AND WELFARE FUND
RETIREE PLAN R-5
SUMMARY PLAN DESCRIPTION

Issued: June, 2010

DIRECTIONS

From Lancaster, PA and York, PA

Take Rt. 222N to Reading until you come to the junction of Rt. 222 and Rt. 422W (head towards Lebanon). Take Rt. 422W until you come to the N. Wyomissing Blvd. Exit. Take this exit and turn left onto North Wyomissing Blvd. Continue until you come to a "T" in the road, which is Spring Street and turn right. The Fund Office is the first building on your left (a one story, white brick building).

From Harrisburg, PA

Take Pa Turnpike (I-76) to Exit 286 to Rt. 222N to Reading, PA. until you come to the junction of Rt. 222 and Rt. 422W (head towards Lebanon). Take 422W to the North Wyomissing Blvd Exit. At the first light, proceed straight and continue until the stop sign. Continue straight and when you come to a "T", turn right onto Spring Street. The Fund office is the first building on your left (a one story, white brick building).

From Philadelphia, PA

Take I-76 to Rt. 202S to Rt. 422W. Take 422W to Reading, PA. Take North Wyomissing Blvd. Exit. At the first light, proceed straight and continue until the stop sign. Continue straight and when you come to a "T", turn right onto Spring Street. The Fund office is the first building on your left (a one story, white brick building).

From Allentown, PA

Take Rt. 222S to Reading/Lancaster. Take North Wyomissing Blvd Exit. At the first light, proceed straight and continue until the stop sign. Continue straight and when you come to a "T", turn right onto Spring Street. The Fund office is the first building on your left (a one story, white brick building).

From Scranton, PA

Take Rt. 81S to Rt. 61S through the towns of Pottsville, Schuylkill Haven, and Leesport until you come to the junction of Rt. 222S. Proceed to Rt. 422E until you come to the N. Wyomissing Blvd. Exit. Take this exit onto North Wyomissing Blvd. Continue until you come to a "T" in the road, which is Spring Street and turn right. The Fund Office is the first building on your left (a one story, white brick building).

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

HOURS

Monday through Friday – 7:00 A.M. to 4:00 P.M.

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PREFACE

This booklet summarizes the benefits, rights and obligations that you, as a Participant, have under the Central Pennsylvania Teamsters Health and Welfare Fund, Plan R-5 (the "Plan"). The Trustees of the Fund hope that you will find this booklet helpful. You should review and discuss this booklet with your family. If you have any questions after reading this booklet 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:

*In Pennsylvania: 1-800-422-8330 - toll free
1-610-320-5500*

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

INTRODUCTION

Because this booklet is a summary of the Plan Document, 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. 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 and the Trust Agreement shall control. Therefore, if you have a question, you should review the Plan Document and Trust Agreement which are available at the Fund Office. Please make sure to read carefully the Summaries of Material Modification ("SMM's") that you periodically receive. These SMM's describe changes to the Plan since the SPD was issued.

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 BOOKLET TO THE FUND OFFICE.

This booklet summarizes the provisions of the Plan in effect as of January 1, 2010. You and your family should read this entire booklet. 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 booklet, write or call the Fund Office.

SECTION 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 R-5. Throughout the rest of this booklet, 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 Beneficiaries.

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 R-5
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:

Employer Trustees	Union Trustees
<p align="center">Tom J. Ventura Secretary and Trustee YRC Worldwide, Inc. c/o Central Pennsylvania Teamsters Health and Welfare Fund 1055 Spring Street Wyomissing, PA 19610</p>	<p align="center">William M. Shappell Chairman and Trustee Teamsters Local 429 1055 Spring Street Wyomissing, PA 19610</p>
<p align="center">Tomm Forrest, Trustee ABF Freight System, Inc. c/o Central Pennsylvania Teamsters Health and Welfare Fund 1055 Spring Street Wyomissing, PA 19610</p>	<p align="center">Kevin M. Cicak, Trustee Teamsters Local 776 2552 Jefferson Street Harrisburg, PA 17110</p>
<p align="center">Ken Ross, Trustee United Parcel Service c/o Central Pennsylvania Teamsters Health and Welfare Fund 1055 Spring Street Wyomissing, PA 19610</p>	<p align="center">Keith L. Noll, Trustee Teamsters Local 429 1055 Spring Street Wyomissing, PA 19610</p>
	<p align="center">Howard W. Rhinier, Trustee Teamster Local 771 1025 N. Duke Street Lancaster, PA 17602</p>

Employer Trustees	Union Trustees
<p>Daniel W. Schmidt, Trustee New Penn Motor Express c/o Central Pennsylvania Teamsters Health and Welfare Fund 1055 Spring Street Wyomissing, PA 19610</p> <p>J. Christopher Michael, Trustee Associated Wholesalers, Inc c/o Central Pennsylvania Teamsters Health and Welfare Fund 1055 Spring Street Wyomissing, PA 19610</p>	<p>Michael P. Rys, Trustee Teamster Local 429 1055 Spring Street Wyomissing, PA 19610</p>

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?

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

Q. What type of benefit plan is Plan R-5, and how does it work?

A. Plan R-5 is a Retiree welfare plan offered by the Central Pennsylvania Teamsters Health & Welfare Fund, which is a multiemployer self-insured health and welfare plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). Plan R-5 pays Benefits for Hospitalization Services, Physician visits, Physical Therapy, Immunizations and Injections, Surgical Services, Diagnostic Services, Prescription Drugs, and limited Transplant-related Services. In general, the Fund self-insures and directly administers the Benefits listed above. However, the Fund self-insures Prescription Benefits but administers the Prescription Benefits through General Prescription Programs, Inc. (GPP), 222 Lafayette Street, Newark, New Jersey 07105. This booklet outlines both the Services for which the Fund provides Benefits (see Parts IV through XII) as well as those services for which the Fund does not provide benefits. Items and Services that are not covered are also described in detail throughout this SPD.

Q. What are the Fund's federal identification numbers?

A. The Employer Identification Number assigned by the Internal Revenue Service is 23-6263170. 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.

SECTION 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 a Retired Employee and you satisfy the following requirements:

(1) You must have been a participant covered through your former employer in Plan 13, 13Y or 14 (with optional retiree coverage under Plan 14) for at least ten (10) years prior to your retirement. To satisfy the 10 year requirement, you must have two (2) years of continuous coverage immediately prior to your retirement and you must have had coverage for at least eight (8) of the prior thirteen (13) years. For purposes of meeting the eight (8) year requirement, participation for a twelve (12) month period will be considered participation for a year even if the months are not consecutive;

(2) You must timely pay the monthly Contribution that a Retired Employee is required to pay for Benefits under this Plan. Monthly Contributions must be received by the 25th day of the month preceding the month for which you are Eligible. The Fund will inform you directly of the amount of the premium.

For example, to be Eligible for Benefits in April 2009, the required monthly payment must be received by March 25, 2009.

(3) If you or your Spouse are eligible to enroll in Medicare Part B, then such enrollment is required and eligibility in Medicare Part B must be maintained;

(4) You must be at least 55 years of age, or, if you are under age 55, you must be receiving a disability pension benefit from the Central Pennsylvania Teamsters Pension Fund.

(5) If you are at least age 57, you are eligible to purchase a maximum of eight (8) years of coverage under the Plan if you meet all of the following requirements ("Rule of 82-85"):

(a) You must be eligible to receive a pension benefit from the Central Pennsylvania Teamsters Pension Fund under the "Rule of 82-85;" and

(b) At the time of your retirement (that is, when you begin to receive pension benefits under the Rule of 82-85 from the Central Pennsylvania Teamsters Pension Fund), you must have been a Participant covered through your former Employer in Plan 13, 13Y or Plan 14 (with optional retiree coverage under Plan 14) for at least ten (10) years prior to retirement. Of these ten (10) years of coverage, you must have two (2) years of continuous coverage immediately prior to your retirement and you must have had coverage for at least eight (8) of the prior thirteen (13) years. For purposes of meeting the eight (8) year requirement, participation for a twelve (12) month period will be considered participation for a year even if the months are not consecutive. In addition, you and your Dependents will have to meet certain Plan Eligibility requirements.

For example: Joe is eligible for pension benefits under the Rule of 82-85. For the last 18 years, he has worked as a driver for PDQ Express. He has been a Participant in the Plan 13 for the entire period. Joe meets the Plan Eligibility rules.

Marty is eligible for pension benefits under the Rule of 82-85. Marty worked for LMN Trucking, which provides health benefits under LMN's own company health plan. Marty does **not** meet the Plan Eligibility rules.

Finally, Mack works for ABC Hauling. Mack is eligible for pension benefits under the Rule of 82-85. The contract between ABC Hauling and the union provides for health benefits under Plan 14 but the employer and the union did **not** include the option of retiree coverage in the contract. Mack does **not** meet the Plan eligibility rules; and

- (c) You must have maintained "Comparable Health Coverage" during the time you started receiving pension benefits under the Rule of 82-85 and the time you wish to elect Plan coverage. "Comparable Health Coverage" means coverage of an individual under a group health plan, health insurance coverage, and coverage under certain federal and state programs (as more fully defined in the Fund's Plan Document).

You must have "Comparable Health Coverage" for yourself (and any Dependents you intend to cover) for at least Eighty Five (85%) of the "Interim Period" and One Hundred Percent (100%) of the "Final Period". The "Final Period" is the two year period immediately before you commence benefits. The "Interim Period" is any other period between the time you start receiving Pension Benefits under the Rule of 82-85 and the Final Period. If, during the Final Period, an individual loses his group health coverage and COBRA is not available to him, the individual may elect Plan coverage if he has coverage during at least Eighty Five (85%) of the Final Period. A retiree may not cover any Dependent under the Plan unless the Dependent meets the requirements for maintenance of Comparable Health Coverage described above. The requirements relating to maintenance of Comparable Health Coverage for any Dependent of the Retiree shall apply only on and after the date on which such individual becomes the Retiree's Dependent.

Q. Before I Retired and became Eligible for the Plan, my former Employer contributed to the Plan for me, but I did not work enough hours for these Contributions to provide me with coverage under Plan 13, 13Y or 14. Can I make up the difference?

A. You can only make up the difference for the Contribution Period immediately prior to your retirement.

Q. My residence is distant from the Plan's Primary Network of Providers. What do I do?

A. Contact the Fund Office for more information about the Fund's secondary networks and the benefits to which you will be entitled. The Plan has contracted with Devon to provide Networks of health care Providers for your medical needs. The Devon Network serves Pennsylvania, Delaware and New Jersey. The OneNet sub-Network serves West Virginia, Virginia, Maryland, North Carolina and the District of Columbia. The Beech Street sub-Network serves all remaining states. The Plan also has contracts with MultiPlan to provide discounts to the Plan for hospitalization and related services across the country.

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 Dependent 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. In order to provide Benefit Coverage for a stepchild, you must be married to the parent of the stepchild and the stepchild must reside with you. You must submit a signed copy of pages 1 & 2 of the federal tax return showing that you claim the stepchild as a tax Dependent on or before April 30 each year or Benefit Coverage for the stepchild will be terminated.

If you are required by a Medical Child Support Order (MCSO) to provide health Benefit Coverage for a Child who does not reside with you, the Fund will provide coverage if the order can be qualified as a Qualified Medical Child Support Order ("QMCSO"). (Please see below for a detailed discussion of QMCSO's.)

You can cover your grandchildren less than one year of age, if you have legal custody or permanent legal guardianship of the Child. You must submit a certified copy of the court order granting custody or permanent legal guardianship before the Plan can provide coverage. You can cover a grandchild over one year of age even if you do not have legal custody or permanent legal guardianship, provided that (i) the Child resides with you and (ii) the a Child is claimed as a Dependent on your annual federal income tax return. You must submit a signed copy of pages 1 & 2 of your federal tax return showing that you claim the grandchild as a Dependent on or before April 30 each year or Benefit Coverage for the grandchild will be terminated.

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, the Child can be enrolled as of the date of custody.

In order for your Eligible Dependents to be covered by the Plan, you must pay the appropriate premium. You must also provide appropriate documentation to the Fund Office.

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

- A. Yes. Your Spouse is not Eligible for Benefits as of the date your divorce becomes final. 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 Section XVI.

Please notify the Fund Office as soon as you are divorced. Once a divorce occurs, your ex-Spouse is no longer is not Eligible for Benefits under your coverage after the end of the month in which the divorce occurred. Your ex-Spouse is only entitled to elect COBRA continuation coverage. If the Fund Office is not properly notified of a divorce and you continue to cover your Spouse as a Dependent, you will be responsible to reimburse the Plan for all Benefits paid on behalf or for 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 Common-Law 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 before January 2, 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. This may mean, for example, that your Common-Law Spouse could claim part of your pension. Therefore, you should only claim common law marriage status if you understand that you may be considered married for all purposes.

Q. *I live in Pennsylvania. For a couple of years, I lived with someone, and I listed him/her as my Common-Law Spouse under the Plan. Now, we do not live together anymore. Can I take him/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 Benefits paid on the Spouse's behalf, 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 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). Note: if your Child has been declared an "emancipated minor," the 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/she will be covered by the Plan after age 19 so long as the conditions above are met and you annually submit the required documentation, including your annual federal income tax form, showing that you claim the Child as a Dependent.

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

- A. 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 only restore benefit coverage by making a written request. The 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.

Q. *What if my Spouse's Employer offers health insurance?*

- A. Your Spouse must enroll in the health insurance at his/her job. Your Spouse's coverage from his/her job will be primary for him/her. That means that it will pay for your Spouse's medical care first. Your Spouse must follow the rules imposed by his/her employment-based health insurance. Your Spouse does not have to enroll in health insurance at his/her job in order to enjoy coverage under this Plan if he/she would have to pay 100% of the premium for the Other 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 your Eligible Dependent received medical advice or treatment for a condition in the 90 days before becoming Eligible for Benefits under this Plan, 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 the date of Eligibility for Benefits under the Plan.

However, if the individual had other prior coverage before becoming Eligible for Benefits from the Fund, 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 the 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, a Dependent of Participant Jane Smith, was employed by XYZ Company from January 1, 2009, to December 31, 2009. During this time, he had health insurance under XYZ Company Plan. On January 10, 2010, Mr. Smith was diagnosed by his doctor with hypertension. This condition requires prescription drugs and regular office visits. On February 18, 2010, Mr. Smith began coverage as an Eligible Dependent under the Plan and presents the Fund with a Certificate of Creditable Coverage showing that he had health coverage under XYZ Company Plan from January 1, 2009 to December 31, 2009. Although Mr. Smith's hypertension is a pre-existing 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 benefit coverage with XYZ Company, and more than 63 days did not pass between his last day of coverage in the XYZ Company Plan and his date of enrollment in the Plan.

Q. *When Can I Enroll in the Plan?*

- A. You can enroll yourself and your Eligible Dependents after retirement and when you meet the Eligibility rules described above for the Plan.

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/she 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 is received by the Fund.

Q. Who sets the rates for the Plan?

A. The Trustees set the rates for the Plan Benefits annually, after consultation with the Fund's Actuary.

Q. I am having trouble paying the premium for the Plan. May I change my coverage to Plan R-7?

A. Yes. You may make a one-time election for your self and your Eligible Dependents to move from the Plan to Plan R-7 coverage. However, you may not elect to move back to the Plan after you have moved to Plan R-7 coverage. Please note that the Plan R-7 does not provide the same level of benefits as the Plan.

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

SECTION 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 contracted with Networks of Providers to serve you. These Network Providers perform their Services at an advantageous cost to you and the Plan and generally do not bill you the balance between the amount the Plan pays and the amount the Provider charges. 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 that a Provider is "participating" 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, the Fund will not pay more than the Network Rate for the Services or treatment and you will be responsible for any balance on charges not paid by the Plan.

Third, the Plan limits or may deny the Benefits it pays 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 by 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 Fund's Medical Advisor and HealthAmerica review the Services and treatment you receive to make sure that they are provided consistent with 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, less any required Copayments, Out-Of-Pocket Payments or Deductible.

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 HealthAmerica Network. Other central Pennsylvania sub-Networks 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. The Plan also has contracts with MultiPlan to provide discounts to the Plan for Hospitalization and related Services on a nationwide basis. (These sub-Networks are available only to participants who live in the sub-Network's service area.)

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

Provider lists are furnished automatically, without charge, as a separate document. From time to time, you will receive Provider lists from the Fund Office listing which Providers are in a specific Network. Please remember that in some areas, not every Provider within a group listed in the Provider list 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 the applicable Deductibles, Out-Of-Pocket Payments or Copayments.

The UCR is set at a percentile of a database, carefully selected by the Trustees. 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. 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. The UCR for these services is \$65. The Plan will pay \$40 (UCR less \$25 copayment) to the Provider and Mr. Smith will have to pay the Provider the remaining \$60.

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. Are there other limits placed on Plan Benefits?

A. Yes. Some examples of these are described below. This is not an exhaustive list of limits on Benefits:

- (1) Limits on a per Patient basis. For example, each Participant or Eligible Dependent is subject to a \$200 deductible each Benefit Year for major medical services.
- (2) Limits on per-condition basis. For example, the Plan limits physical therapy Benefits to 24 visits per condition.
- (3) Limits on a per-Benefit Year basis. For example, the Plan provides that a Participant or Eligible Dependent can receive Benefits for up to 17 visits to a chiropractor per Benefit Year.
- (4) Limits on a per-family basis. For example, each family in the Plan has a maximum family deductible of \$600 under major medical.
- (5) Limits on a per Lifetime-in-the-Fund basis. For example, each Participant or Eligible Dependent in this Plan may receive up to \$175,000 in Major Medical Benefits while he/she participates in this Plan.

These limits will be discussed in the pages that follow where they apply. If you have any questions about these limits, please contact the Fund office.

Q. What is utilization review?

A. Utilization review is a process through which the Trustees, in reliance upon the Plan's medical advisors, determines whether treatment is Medically Necessary, as that term is defined in the Plan. A determination under the 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.

For example, Mr. Jones is brought into the Emergency Room for treatment of serious injuries following a car Accident. Because Mr. Jones needs immediate treatment, the admission would initially be deemed "Medically Necessary" under the terms of the Plan. However, that does not mean that the Fund will make payment for the claims. If the Fund later learns that the Accident was caused by the fact that Mr. Jones was highly intoxicated, with a blood alcohol level in excess of the state's legal limit, the Fund would deny payment for the charges because the Plan includes a specific exclusion for claims arising from an Accident related to a Participant's driving while unlawfully intoxicated.

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 the 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 my Hospital stays and Surgical Procedures be pre-certified?

A. Yes. All non-Emergency Hospitalization and surgery (both inpatient and outpatient) must be pre-certified at least 14 days in advance. If you are using a HealthAmerica Provider, it is the Provider's responsibility to contact the Fund Office and follow its instructions to obtain pre-certification. If you are using the Devon, OneNet, Beech Street, or MultiPlan Providers, YOU are responsible for pre-certifying your Hospital with the Fund Office.

If you have Emergency surgery, you or your Provider must notify the Fund Office within two (2) business days after treatment/Hospitalization. Certain other Services must also be pre-certified. Please contact the Fund Office if you have any questions about whether a procedure or Service must be pre-certified.

If you fail to pre-certify your Hospital or Service, the Fund may limit or deny Benefits for the claims incurred.

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

A. No. The purpose of pre-certification is to make a preliminary determination about 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 Ms. 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.

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 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 the second or third opinion. 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. If you or your Provider do not cooperate with the Plan’s Managed Care Program, the Plan will not pay any Benefits for your treatment from that Provider.

SECTION IV: HOSPITAL BENEFITS

Q. *What Benefits does the Plan pay if I am Hospitalized?*

A. The Plan pays for Medically Necessary Hospitalizations (subject to the Plan’s Managed Care Program). The level the Plan will pay depends primarily on whether you are using a Network or Non-Network Hospital. Using a Network Hospital will limit your out-of-pocket costs for medical care.

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

A. The Plan pays a different level of Benefits for Hospital room and Services depending on whether you use a Network or Non-Network Provider.

(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. There is no limit on the number of days of your stay.

(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. (See Section XII Major Medical Benefits). 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).

- (3) **IMPORTANT:** If the Plan denies your room and board Benefits for a Non-Network Hospitalization because they are not Medically Necessary (as defined by the Plan) 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/she 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. The Plan pays a different level of Benefits for anesthesia Services depending on whether you use a Network or Non-Network Provider.

- (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.

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. 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. *Does the Plan pay differently for Emergency Room Services for injuries and for illness?*

A. Yes. Please review the following Q & A's for a full description of these differences.

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 in full for Medically Necessary Emergency Room Services. These Services include Physician

visits and prescription drugs. If you use a Non-Network Hospital, the Plan will pay Benefits in accordance with the Plan's Major Medical provisions.

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 seven (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 are 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 Co-payment.

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 or 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 One 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 one (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. *If my wife just delivered a Child, how long can she stay in the Hospital?*

- A. Under federal law, group health plans like the Plan 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., her 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.

The Plan does not and under federal law, may not 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) or that you use a particular Provider or facility. However, the Plan's general pre-certification rules do apply. Keep in mind that if you use a Non-Network Physician or Non-Network facility, you are responsible for ensuring that your stay is pre-certified. Also, please remember that you can reduce your out-of-pocket costs by using a Network Physician and a Network facility. For information on pre-certification, contact the Fund Office.

SECTION V: PHYSICIAN BENEFITS

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

- A. The Plan will pay Benefits for Medically Necessary office visits to a doctor (subject to the Plan's Managed Care Program). The level of Benefits the Plan will pay depends 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. Note: A Chiropractor is not covered as a Non-Specialist. Please see below for discussion of Chiropractor Benefits.
 - (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 Copayment 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. Note: A Chiropractor is not covered as a Non-Specialist. Please see below for discussion of Chiropractor Benefits.

- (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.** The Plan will pay for office visits to a Chiropractor up to \$15 per visit, up to 17 visits per Eligible Family Member per Benefit Year.

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

A. The Plan will pay Benefits for Medically Necessary inpatient visits by a doctor while you are Hospitalized (subject to the Plan's Managed Care Program). 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.

SECTION VI: PHYSICAL THERAPY BENEFITS

Q. *What are the Plan's Physical Therapy Benefits?*

A. The Plan pays Benefits for Medically Necessary Physical Therapy, including speech therapy, occupational therapy, and work hardening (subject to the Plan's Managed Care Program). For each injury or illness, the Plan will pay Benefits for up to 24 outpatient visits in a two (2) month period starting with the first visit to the Physical Therapist, per Participant or Eligible Dependent. If you need Physical Therapy that requires more than 24 visits or two (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. The Plan will pay Benefits for Medically Necessary Physical Therapy (subject to the Plan's Managed Care Program). The level of Benefits the Plan will pay depends on whether you use a Network or Non-Network Provider.

- (1) **Network Provider.** If you use a Network Provider, the Plan pays Benefits in full for up to three (3) modalities and/or therapeutic procedures (that is, types) of treatment per day, less a Copayment 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 three (3) modalities and/or therapeutic procedures of treatment, less a Copayment 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.

SECTION VII: IMMUNIZATION AND INJECTION BENEFITS

Q. Does the Fund provide Benefits for immunizations for my Dependent Children?

A. Yes. 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. Immunization and Injection Benefits are not subject to the Major Medical Deductible and Out-Of-Pocket Maximum provision of the Plan. Also, no Major Medical Benefits will be available for Immunizations and Injection Services.

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.

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 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 Copayment. If the office visit payment made by the Fund is less than \$15, the Plan will pay the difference up to the \$15 Benefit towards the immunization or injection Service. If the Network Provider does not charge for an office visit, the Plan will pay up to \$15 towards the immunization or injection Services.

For example, John Smith goes to his family doctor, a Network Non-Specialist 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. HealthAmerica reprints the office visit to \$30, and it reprints the injection to \$20. The Plan pays Benefits of \$15 for the office visit, and Mr. Smith is responsible for a \$15 Copayment. The Plan pays no additional Benefits than the \$15, so that Mr. Smith is responsible for the cost of the injection.

(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 payment made to the Provider is less than \$15, the Plan will pay the difference up to the \$15 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 \$15 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 \$15 (or up to the UCR, if the UCR is less than \$15) for the office visit, and Mr. Smith will be responsible for the \$25 balance. The Plan pays no additional Benefits beyond the \$15, so Mr. Smith is responsible for the \$25 balance for the injection.

SECTION VIII: SURGICAL BENEFITS

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

A. The Plan will pay Benefits for Medically Necessary inpatient or outpatient surgery (subject to the Plan's Managed Care Program). The level of Benefits will depend on whether you use a Network or Non-Network Provider:

- (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 Section XII. 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.

SECTION IX: OUTPATIENT DIAGNOSTIC BENEFITS

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

A. The Plan will pay Benefits for Medically Necessary outpatient diagnostic Services (subject to the Plan's Managed Care Program). The level of Benefits the Plan will pay depends on whether you are treated by a Network or Non-Network Provider:

- (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. Contact the Fund Office with any questions you have on when other provisions of the Plan cover outpatient diagnostic Services.

SECTION X: PRESCRIPTION DRUG BENEFITS

Q. *What Benefits does the Plan pay for prescription drugs?*

A. The Plan pays Benefits for Medically Necessary prescription drugs (subject to the Plan's Managed Care Program):

(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 Copayment of \$5. 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 Copayment of \$15.

(c) **Negative Formulary List** - for prescription drugs on the Negative Formulary List, a Copayment of \$30. 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 List. However, if you are not certain whether a particular prescription drug is on the Negative Formulary List, 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 Copayments:

(a) **Generic Drugs** - a Copayment of \$5.

(b) **Brand Name Drugs** - for Brand Name Drugs, other than those on the Negative Formulary List, a Copayment of \$15.

(c) **Negative Formulary List** - if a Patient fills his/her prescription with a drug on the Negative Formulary List, a Copayment of \$30. As stated above, the Negative Formulary List 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:

Copayment for up to a ninety (90) day supply: \$15 for a generic drug ; \$30 for a Brand Name Drug (not on the Negative Formulary List); and \$60 for a Brand Name Drug on the Negative Formulary List.

Call the Fund Office for mail order forms.

Q. Do I have to take any special steps if my doctor prescribes a very expensive medication?

A. Yes. If your prescription medication costs \$500 or more, the pharmacist must call GPP to get pre-authorization for the drug. The phone number for GPP is on the back of your prescription card.

Q. Do I have to try a generic “proton pump inhibitor” before the Fund will pay for a prescription “proton pump inhibitor” like Nexium, Protonix, Aciphex and Prevacid?

A. If your Physician first prescribes a “proton pump inhibitor” (“PPI”) for you, tell him to write a prescription for an over-the-counter (OTC) PPI (Prilosec) or a generic OTC PPI (omeprazole). Take this prescription to your pharmacy and you will receive up to a thirty-four (34) day supply for the Copayment you regularly pay under the Plan.

If the Prilosec OTC or the OTC omeprazole is effective, your refills will be covered under the Prescription Plan. If the medication is not effective, ask your doctor to write a letter to the Fund describing why it was not effective and stating that a prescription drug is Medically Necessary. At that time, the Fund will provide the prescription drug upon payment of your Copayment.

Q. May I use this “step therapy” program even if I am currently using a prescription PPI so that I can save money on my Copayments?

A. Ask your Physician whether OTC Prilosec or generic OTC omeprazole is appropriate for you. If so, ask him to write a prescription for OTC Prilosec or generic OTC omeprazole and present the prescription and your Copayment to the pharmacist.

Q. May I get my OTC Prilosec or the generic OTC omeprazole through the Fund’s mail order program?

A. Yes. Once you and your Physician have determined that the OTC Prilosec or the generic OTC omeprazole is effective, you may receive this medication through the mail order program.

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.

SECTION XI: TRANSPLANT-RELATED BENEFITS

Q. What Benefits does the Plan pay if I have an organ Transplant?

A. The Plan does not generally provide Transplant Benefits. Transplant related benefits will be paid only if the Transplant occurred when the Patient was Eligible for Transplant Benefits under Plans 13, 13Y or 14. If the Patient qualifies under this rule, and subject to the Plan’s Managed Care Program, the Plan will pay Benefits for Transplant related services as follows:

- (1) **Network Provider.** The Plan will pay the balance remaining on the \$300,000 Lifetime per Patient per Transplant cap under Plan 13, 13Y or 14 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 up to the lesser of the remaining Major Medical balance or the balance remaining on the \$300,000 Lifetime per Patient per Transplant cap under Plan 13, 13Y or 14 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.

SECTION XII: MAJOR MEDICAL BENEFITS

Q. When do the Major Medical provisions apply?

A. Major Medical Benefits are available for the following Medically Necessary special items and Services listed below:

- (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 prosthesis for arms, hands and legs once every two Benefit Years;
- (8) The purchase of mastectomy bras (two per Benefit Year) and bra inserts (two 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.

In addition, the Plan pays Major Medical Benefits for Services or treatment for a diagnosed condition for Medically Necessary Hospital Services for Non-Network Patients, inpatient Services (including surgical charges) for Non-Network Patients, and Transplant-related services from Non-Network Providers (which are subject to the Transplant provisions summarized in Section XI).

Q. Are there any Deductibles for Major Medical Benefits?

- A. Yes. There is a \$200 per-Patient Deductible each Benefit Year. No more than three 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 Copayments 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 Copayment obligation will begin again.

Example: John Smith and his wife Mary are enrolled in the Plan. John had a heart attack on January 15, 2010, and went to a Non-Network Hospital. His Non-Network Hospital bill was \$10,000 (which, in this example, is less than the UCR). Mr. Smith will have to pay \$1,180 out-of-pocket. This amount is made up of the \$200 Deductible plus 10% of the charges (\$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 \$175,000 Lifetime Major Medical limit (including Transplant-related Benefits as described in Section XI).

SECTION XIII: EXCLUSIONS

Q. Are there any Services for which the Plan will not pay Benefits in any circumstances?

- A. Yes. The Plan will not pay Benefits if one of the following exclusions apply:
- (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 Section II of this SPD.
 - (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 coincident with your ingesting an illegal substance; 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.

- (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 Section XIV.

(4) Certain Item, Condition or Service Exclusions.

- (a) The Service is for personal comfort items or is for home or motor vehicle improvements or alterations. A Service is for Personal Comfort if the Trustees, acting in reliance upon the Plan's medical advisors, find that the Service does not materially advance medical treatment of the Patient's condition when compared to other Services, but is primarily prescribed or sought for the Patient's comfort or convenience (examples of Personal Comfort Services include, without limitation, air conditioners, dehumidifiers, and electronic controlled thermal therapy).
- (b) The Service is for the pregnancy of an Eligible Dependent child or for any expenses related to a surrogate pregnancy.
- (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.
- (g) The Service relates to the diagnosis and treatment of mental nervous or substance abuse diagnosis and treatment.
- (h) The Service relates to a routine eye examination and refraction, eyewear, and contact lenses.
- (i) The Service relates to dental services, except for Medically Necessary removal of impacted teeth, or orthognathic surgery.

(5) Other Coverage.

- (a) The Service is compensable under workers compensation or similar law.
- (b) 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 the 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 Section XII, do not provide for payment of Major Medical Benefits for the following:

(1) If the Service is described in Section VI (Physical Therapy); Section IX (Outpatient Diagnostics); or Section X (Prescription Drugs).

(2) If the Service relates to non-surgical treatment for foot conditions, other than orthotics.

(3) If the Service is rendered by a chiropractor.

(4) If the Service relates to immunizations, or to health checkups, routine physical examinations, and injections where no diagnosis is made.

(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.

SECTION XIV: 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 agree and are required, as a condition of the Fund providing any Benefits for you under the Plan, to hold all money you receive in a 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. Your attorney must place these funds in a restricted account and make payment first to the Fund before taking fees himself or providing payment to you.

At the Plan's discretion, the Plan 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 that 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/her 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. You must also contact the Plan before you settle the case without the prior written consent of the Plan. The Plan may request that you authorize the Plan to sue on your behalf. In addition, as noted above, you and your attorney agree and are required, as a condition of the Fund providing any Benefits for you under the Plan, to 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, a Plan Participant, 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 former 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 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.

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. The Plan will be secondary, paying Benefits only after the Other Insurance has paid its full benefits.

If the Other Insurance does have a COB provision, the following rules apply:

- (1) Except in the case of automobile Accidents, this Plan is primary for you so long as you are a Participant.
- (2) 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.
- (3) 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.
- (4) 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, the Plan will follow the coordination rule of the Other Insurance.
- (5) 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 stepparent) whose birthday is earlier in the year will be considered the primary plan.

Q. Do I have to pay Copayments to my Provider even if this Fund pays secondary under the Coordination of Benefits rules?

A. Yes. Copayments apply regardless of whether the Fund pays primary or secondary under the Coordination of Benefits rules.

Q. What if I or one of my Eligible Dependents is eligible for Medicare or Other Insurance under any government program?

A. Because you are only Eligible for Benefits under the Plan if you are Retired, Medicare will be primary to the Plan once you are Eligible for Medicare. However, in general, if you receive Medicaid or Medical Assistance, the coverage provided by the Plan (including prescription drug coverage) is primary. You may be required to reimburse one of these agencies for Benefits they have paid if you do not use the Plan as the primary carrier.

Q. Can my Spouse make the Plan primary by waiving other coverage?

A. No, *unless* your Spouse would have to pay 100% of the cost of his/her Other Insurance.

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 the Plan.

Q. The primary plan denied my claim as not medically necessary. Will the Plan, 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 the Plan's criteria for whether the treatment was Medically Necessary.

SECTION XV: 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. Claims forms are available at the Fund Office 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 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 on the type of claim you (or your Provider) submit when you first receive treatment or Services. Either you or your Provider will submit claims for processing. The time limit for processing your claim will be determined by the type of claim you have. If you have already received the Services or treatment, the claim is a “post-Service” claim. Post-Service claims will likely be the majority of claims that you or your Provider submit. For certain treatments 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. A claim 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 discussed 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 Claim.** 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 soon 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 an oral response, 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 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 Services 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. **Pre-Service Claim.** 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 to the Fund 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 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 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 care” 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; and
- (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 you claim or 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 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 a statement that such an explanation will be provided 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 happened 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 fails 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 the 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 Fund'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. *If the Fund overpaid Benefits for me or my Eligible Dependents, 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 to amend or terminate my Benefits under the Plan?

A. Yes. In any event it will be handled 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 Section II, including the requirement that you make timely premium payments.

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 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: I am very concerned about the privacy of my medical information. Does the Fund take any steps to ensure that my information will remain confidential?

A. The Plan believes that all Participants and their Family Members should be assured that the Plan will treat their medical information with a high degree of professionalism and sensitivity. In addition, the Plan has adopted policies and procedures in order to implement HIPAA's Privacy Rule (45 CFR 160 and 164). The Plan will provide you with a description of these policies and procedures when you first become covered under the Fund and will regularly notify you of the availability of this Notice. The Notice is available on the Plan's website, at www.centralpateamsters.com.

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 to ensure that they 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.

**SECTION XVI: COBRA CONTINUATION COVERAGE RIGHTS;
OTHER FEDERAL LAWS: AND QUALIFIED MEDICAL CHILD SUPPORT ORDER**

The Information in this Section is current as of the date this SPD was published. Please contact the Fund Office if you have any questions about your rights under COBRA. You can also review the Department of Labor's website at www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), each Participant and his/her Spouse and Dependents covered under the Fund have a legal right to continue coverage under the Fund in certain instances where coverage otherwise would end. This Section is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. Both you and your Spouse should take the time to read this section carefully. For additional information about your rights and obligations under the Plan and under COBRA, you should contact the Fund Office.

Q: *What is COBRA continuation coverage?*

- A. COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed later in this Section. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Q. *What is a Qualifying Event?*

- A. Your right to continuation coverage applies if you, your Spouse and/or your Dependents otherwise would lose coverage because of one of the following events:

Events that Apply to You:

- You are no longer employed by an Employer that participates in the Fund for any reason other than gross misconduct; or
- Your working hours are reduced so that you no longer meet the Eligibility requirements for coverage.

Events that Apply to Your Spouse:

- Your Spouse ceases to be employed by an Employer that participates in the Fund for any reason other than gross misconduct, or your Spouse's hours are reduced causing a loss of coverage;
- Your Spouse dies, or becomes covered by Medicare; or
- You are divorced.

Events that Apply to Dependents:

- The parent-Employee ceases to be employed by an Employer that participates in the Fund for any reason other than gross misconduct, or the parent-Employee's hours are reduced causing a loss of coverage;
- The parent-Employee dies;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parent is divorced from the parent who is employed by an Employer that participates in the Fund; or
- The individual ceases to be a "Dependent" under the terms of the Plan because of age or marital status or because he/she has ceased to be a Full Time Student or to qualify for coverage pursuant to "Michelle's Law" (see below for further explanation).

Q. *When is COBRA coverage available?*

- A. The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Fund office has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Fund Office of the Qualifying Event.

For other Qualifying Events (divorce or a Dependent Child's losing Eligibility for coverage as a Dependent Child), you must notify the Fund office within 60 days after the Qualifying Event occurs and provide any documentation required by the Fund.

Q. *How is COBRA continuation coverage provided?*

- A. Once the Fund Office receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of

their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

A Qualified Beneficiary can elect to receive the same type of medical, prescription, and other Benefits (except death Benefits) that he/she had under the Fund immediately prior to the Qualifying Event. A Qualified Beneficiary's Benefits will change if the Plan's Benefits change.

Q. *What is the maximum COBRA coverage period?*

- A. COBRA continuation coverage is a temporary continuation of coverage. You, your Spouse and/or your Dependents may elect to continue coverage for up to the following periods:
- Up to thirty-six (36) months in the event of the death of the Employee, divorce, or a Dependent Child's losing eligibility as a Dependent Child. When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).
 - Up to eighteen (18) months in the event of your termination of employment or a reduction in your hours.

Q. *Can the 18-month period of COBRA continuation coverage be extended?*

- A. Yes. There are two ways in which an 18-month period of COBRA continuation coverage can be extended.

Disability Extension. If any Qualified Beneficiary covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and he/she notifies the Plan Administrator in a timely fashion, all Qualified Beneficiaries in the Family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Also, in order to extend COBRA coverage for the additional 11 months, the Qualified Beneficiary is required to provide notice of this determination to the Fund Office within sixty (60) days after the date of the determination and before the end of the initial 18-month coverage period described above.

Second Qualifying Event. If a Qualified Beneficiary who was the Employee experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Children may get up to 19 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to the Spouse and any Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both) or gets divorced, or if the Dependent Child stops being Eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

Q. Can a new Dependent be added after COBRA continuation coverage is elected?

A. Yes. If, while a Qualified Beneficiary is receiving continuation coverage, he/she has a Child born or placed with him/her for adoption, he/she may immediately enroll the Child. Once the newborn or adopted Child is enrolled for COBRA coverage, he/she will be treated like all other COBRA Qualified Beneficiaries. If, while receiving COBRA coverage, a Qualified Beneficiary gets married, the new Spouse may be enrolled; however, the new Spouse will not be a COBRA Qualified Beneficiary and will not have the rights of a COBRA Qualified Beneficiary. For example, the new Spouse will not have the right to a second Qualifying Event extension of an additional 18 months of continuation coverage. It is your obligation to notify the Fund Office if you need to enroll a new Dependent.

Q. Who pays for COBRA continuation coverage?

A. You must pay for COBRA continuation coverage. The charge for the coverage is equal to the total cost of the coverage plus two percent, which is determined annually by the Fund's actuary. The two percent charge covers the administrative expenses of providing you this coverage. Disabled Participants who continue coverage after eighteen (18) months (up to twenty-nine (29) months) will be charged 150% of the total cost for the extra coverage period. The Fund sets COBRA premiums once every twelve (12) months.

The Fund will provide prompt notification of any increases that occur during a Qualified Beneficiary's COBRA continuation coverage period.

Q. When must I notify the Fund of a Qualifying Event?

A. If you become divorced or legally separated, or you or your Spouse becomes covered by Medicare, or one of your Children ceases to qualify as a Dependent under the Plan, you must notify the Fund Office as soon as possible, but no later than sixty (60) days after the event.

Within fourteen (14) days of the date of notification, or of the date your Employer advises the Fund of your termination of employment for any reason (including death) or of your reduction in hours, the Fund Office will notify you and your Dependents of your and their rights to continue coverage under the Plan.

Your failure to notify the Fund of any of the events described above within sixty (60) days after the event may result in the waiver of the right to continuation coverage for you and your Dependents.

Q. How long do I have to elect COBRA continuation coverage?

A. You and your Spouse and Dependents will have at least sixty (60) days in which to elect continuation coverage. This election period will end on the later of (1) sixty (60) days from the date you otherwise would lose coverage (except for making a COBRA election) or (2) sixty (60) days from the date the Fund mails the individual notice of continuation coverage and provides an election form.

If you qualify for trade adjustment assistance ("TAA"), you may qualify for additional time to make a COBRA election, and for advantageous tax treatment of the payment of COBRA premiums.

If you or your Dependents incur covered expenses during the election period before you have elected continuation coverage, your claims will not be processed until the Fund receives your properly executed forms.

Q. *When does COBRA continuation coverage stop?*

A. Continuation coverage will end on the first date on which any of the following occurs:

- The end of the maximum coverage period (18, 29 or 36 months) for the Qualifying Event as described above.
- The Qualified Beneficiary fails to pay the premium for the continuation coverage when it is due. The payment is due on the first day of the month for that month's coverage. A 45-day grace period after election is provided for the first payment, and a 30-day grace period is provided for subsequent payments. However, if the payment is not paid when due, the Fund will terminate coverage subject to retroactive reinstatement if and when payment is made.
- The date the Qualified Beneficiary becomes covered under another group health plan, unless the new plan contains a pre-existing condition exclusion or limitation which applies to any pre-existing condition suffered by the Qualified Beneficiary (or your Spouse or Dependent).
- The date you (or your Spouse) becomes covered by Medicare after your COBRA election.

Q. *What happens if I am on a leave of absence?*

A. If there is a qualifying event but the Employer provides coverage without charge to you (regardless of whether it is pursuant to a collective bargaining or other agreement or pursuant to the Family and Medical Leave Act of 1993), or Michelle's Law, then COBRA continuation coverage does not begin until the date you lose coverage because the FMLA coverage ceases. You will have at least sixty (60) days to make an election to accept or reject COBRA coverage beginning with the later of the date you otherwise would lose coverage after FMLA leave or the date the Fund provides you with notice of your COBRA rights and an election form.

Q. *Are there other important Federal laws which effect Benefit coverage?*

A. Yes. The following laws may effect your Benefit coverage:

Michelle's Law. Under a federal law, called "Michelle's Law," the Fund will extend coverage for Dependents who would otherwise be Full-Time Students, but are unable to maintain Full-Time Student status because they have a serious illness or injury that necessitates a "medically necessary leave of absence." Eligibility for such coverage is available only to an individual who is a "Dependent" (as defined by the Fund) and is enrolled in post-secondary education immediately before the medically necessary leave of absence.

A "medically necessary leave of absence" is a leave of absence from (or any other change in enrollment at) a post-secondary educational institution (including a college or a university), that also:

- is medically necessary
- begins while the Dependent is suffering from a serious illness or injury, and
- causes the Dependent to lose his/her status as a Full Time Student for purposes of coverage under the Plan.

During a medically necessary leave of absence, the Fund can not terminate coverage before the earlier of: (1) one year from the first day of the medically necessary leave of absence, or (2) the date on which your coverage would otherwise terminate under the Plan (for example, if the Dependent reaches age 23 or the Employee terminates employment).

In order to qualify for extended coverage under Michelle’s Law, the Dependent must provide the Fund with written certification from a treating physician.

Children’s Health Insurance Program Reauthorization Act of 2009. If you are eligible for coverage under the Plan, but are unable to afford the premiums, your State may have a premium assistance program that can provide financial assistance for the coverage. States with a premium assistance program use funds from their Medicaid or CHIP program to help people who are eligible for health coverage, but need assistance in paying their premiums.

If you or your Dependents are already enrolled in Medicaid or CHIP, and you live in a state listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might qualify for these programs, you can contact your State Medicaid or CHIP office or call 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

Pennsylvania	
Medicaid Website:	http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm
Medicaid Phone:	1-800-644-7730
New Jersey	
Medicaid Website:	http://www.state.nj.us/humanservisec/dmahs/clients/medicaid/
Medicaid Phone:	1-800-356-1561
CHIP Website:	http://www.njfamilycare.org/index.html
CHIP Phone:	1-800-701-0710

If the applicable State determines that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, the Fund is required to permit you or your dependents to enroll in group health benefits provided under the Fund, provided that you or your Dependents are Eligible for coverage under the Fund, but not already enrolled in the benefits. This is called a “special enrollment opportunity”, and you must request coverage within 60 days of being determined eligible for premium assistance.

Health Insurance Portability and Accountability Act. Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), you have certain protections against pre-existing condition exclusions imposed by this Plan or by future group health plans under which you might be covered. HIPAA is a federal law under which a health plan may be required to reduce any period during which a Participant’s claims would not be covered (because of the new plan’s pre-existing condition exclusion) by the time the Participant was covered under a former plan.

If you cease coverage under this Plan and become covered under another group health plan, you will be eligible to receive a "Certificate of Creditable Coverage" to present to your new group health plan. Your new health plan may have to reduce any period during which a pre-existing condition is not covered by the length of time you were covered under this Plan. Note, however, that any period of prior coverage before a break in coverage of sixty-three (63) days or more will not be counted to offset the exclusion

period of the new plan. To see if your new plan's pre-existing condition exclusion period can be reduced, you should present this Certificate to your new plan.

Newborns' and Mothers' Health Protection Act: If you are eligible for medical coverage under the Plan, then as required under federal law (the Newborns' and Mothers' Health Protection Act of 1996) and state law, the Plan generally may not restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, these requirements generally do not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier. In any case, the Plan may not require that a Provider obtain authorization from the Plan for prescribing a length of stay within the above time periods.

Women's Health and Cancer Rights Act: If you are eligible for medical and surgical coverage under the Plan, then in accordance with federal law (the Women's Health and Cancer Rights Act of 1998), the Plan must provide Benefits for mastectomy-related services including reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of a mastectomy, including lymphedemas. This coverage will be provided in a manner determined in consultation with the attending physician and the Patient. This coverage also shall be subject to the general provisions under the applicable medical coverage – for example, rules regarding pre-certification, limitations, annual deductibles, co-payments, etc. If you have any questions about mastectomies and reconstructive surgery under your medical coverage, please contact the Fund Office.

Military Service Continuation Coverage: The Fund will determine coverage, benefits and credited hours with respect to qualified military service by Participants in accordance with federal law (the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")). In general, during qualified military service, Participants may purchase continuation coverage from the Fund at their own expense in accordance with rules similar to COBRA. Participants who return to covered employment after qualified military service within the time period prescribed by law will be able to resume participation in this Fund as if their military leave did not occur.

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.

Keep the Fund Informed of Address Changes. In order to protect your Family's rights, you should keep the Fund informed of any changes in the addresses of your Family members. You should keep a copy, for your records, of any notices you send to the Fund.

**SECTION XVII: THE U.S. DEPARTMENT OF LABOR'S
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 R-5, 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:

Receive Information About Your Plan and Benefits

- (1) Examine, without charge, at the Fund Office and at other specified locations, such as work-sites 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 Benefits Security Administration.
- (2) 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.
- (3) 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.

Continue Group Health Plan Coverage

- (1) Continue health care coverage for your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan for the rules governing your COBRA continuation coverage rights.
- (2) 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.

Prudent Actions by Plan Fiduciaries

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 Beneficiaries. No one, including your employer, your union, or any other person, may discriminate against you in any way to prevent you from obtaining a health and welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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.

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 Employees Benefits Security Administration.

GLOSSARY

A. Definitions. The following words and phrases shall have the following meanings when used in this Summary Plan Description ("SPD"), unless their context clearly indicates otherwise. These words are capitalized throughout the text of the SPD.

Accident (Accidental). An event which is external, sudden, violent, by chance, and unexpected, and which causes injury.

Ambulatory Surgical Center. A facility that provides surgical Services to individuals not requiring inpatient Hospitalization. The Plan only provides Benefits for Services received at an Ambulatory Surgical Center if it is properly licensed by the state in which it is located and complies with the appropriate national standards, where applicable.

Benefits. The dollar amounts that the Fund will pay under the terms of the Plan. The Trustees establish the level of Benefits in their sole discretion.

Benefit Coverage. Coverage provided under the Plan for Eligible Participants or Dependents.

Benefit Period. A time period established by the Fund during which a Participant or his/her Dependent may be Eligible for Benefits under the Plan.

Benefit Year. A year-long period established by the Fund for tracking the payment of Benefits. The Benefit Year begins on January 1 and ends on December 31.

Child. For the purposes of this Plan, a "Child" is defined as follows:

(a) A natural or adopted child of a Participant;

(b) A stepchild, or a grandchild (after the first year of the grandchild's life) of a Participant even if not adopted by the Participant; provided, however, that the Participant provides to the Fund documentation required by the Trustees, including information demonstrating that the Participant is legally responsible for the stepchild's or grandchild's medical coverage. The Trustees may, in their sole discretion, rely on documentary evidence to determine for purposes of this Plan that the Participant is legally responsible for the stepchild's or grandchild's medical care, including evidence that the Participant claims the stepchild or a grandchild as a dependent for federal income tax purposes.

(c) A child placed in the custody or guardianship of a Participant by court order, regardless of whether that order requires the provision of health benefits; provided, however, that such custody or guardianship shall be of a permanent nature and not subject, in written form or otherwise, to any condition or agreement which would allow a natural parent or other person to acquire or reacquire custody or guardianship in his discretion, even by court order. The Trustees may rely, in their sole discretion, on documentary evidence to determine for purposes of this Plan that the Participant has custody of, guardianship of, or is otherwise legally responsible for, the child, including evidence that the Participant claims the child as a dependent for federal income tax purposes.

(d) A child who has been placed with the Participant for adoption. The term "placed for adoption," means the assumption and retention of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation. The Participant must provide the Fund with written updates about the progress of the adoption process at least once every six (6) months.

(e) Subject to the provisions of applicable law and the provisions above, a child shall include only children who reside with the Participant on a full-time basis, excluding times the child spends away from home for vacation, illness, schooling, or other temporary absences. This restriction does not apply to the Participant's natural children.

(f) For purposes of this Plan, and subject to Michelle's Law, a Full-Time Student is a Child who is enrolled in and is attending a full-time accredited or licensed course of study or training at an institution such as a high school, vocational school, college, university, licensed private school, licensed technical school, nurses' training school, beautician school, automotive school, or other such institution as determined by the Trustees in their sole discretion. By September 30th of each year, a Full-Time Student must submit written certification from his school evidencing full-time enrollment in a licensed or accredited course of study. The definition of Full-Time Student also includes individuals during the interim period (not to exceed three (3) months) between high school graduation and enrollment in a full-time course of study.

(i) Michelle's Law: Special Definition of "Full-Time Student" where the student is a "dependent child on a medically necessary leave of absence" as defined below:

(A) A "dependent child on a medically necessary leave of absence" shall include a Dependent Child (1) who is eligible for coverage under the plan on account of being a Full-Time Student at a postsecondary educational institution; and (2) who was enrolled in the plan, on the basis of being a student at a postsecondary educational institution immediately before the first day of a "medically necessary leave of absence," as that term is described below.

(B) A "postsecondary educational institution" includes an institution of higher education as defined in section 102 of the Higher Education Act of 1965.

(C) The leave commences while such child is suffering from a serious illness or injury; and

(D) The leave is "medically necessary" for the purpose of this subsection as certified in writing by the student's treating physician, documenting that the child is suffering from a serious illness or injury; and

(E) The leave is necessitated by a serious injury or illness that causes the child to lose full-time student status.

(F) The dependent child on a medically necessary leave of absence shall be entitled to the same coverage to which he would have been entitled as if he or she was not on a medically necessary leave of absence. If the plan coverage changes for all similarly situated individuals, the coverage for the dependent child on a medically necessary leave of absence shall also change.

(G) Dependents meeting all criteria set forth above shall be entitled to coverage under this Fund's plan of benefits for a period of up to one year after the first day of a "medically necessary leave of absence" (defined above), provided that such coverage would not otherwise terminate during that time.

Collective Bargaining Agreement. An agreement between an Employer and the International Brotherhood of Teamsters or a Local Union representing Employees, which agreement governs the terms and conditions of employment, including Contributions to the Fund for Employees covered by the agreement.

Common Law Spouse. An individual who is validly a Participant's Spouse pursuant to common law and not pursuant to ceremonial marriage in accordance with the laws of the state in which the Participant and Spouse reside; provided that both the Participant and the Common Law Spouse have executed properly an affidavit of common law marriage required by the Fund. NOTE: The Fund will not recognize any common law marriage entered into in Pennsylvania after January 1, 2005.

Contribution or Premium. A payment made or required to be made by an Employer to the Fund pursuant to the terms of a Collective Bargaining Agreement or other written document as provided under the Fund's policies and procedures. Where, as in this Plan, monthly Contributions are paid by a Retiree, the Contribution may be referred to as a "Premium."

Contribution Period. A time period determined by the Fund for which Contributions are due to the Fund to establish a Participant or Dependent's Eligibility for Benefits during a subsequent Benefit Period.

Copayment. A charge for Services for which a Participant or Dependent is responsible and which is collected by the Provider. For example, a Patient must pay \$15 to his Family Physician as an office visit Copayment.

Deductible. A charge for Services for which a Participant or Dependent is responsible, and which is deducted from Benefits paid by the Fund after the Services have been rendered. For example, before the Plan will pay Major Medical Benefits, the Patient must pay a Deductible of \$200 under the Plan per Patient Deductible each Benefit Year (limited to three Deductibles per Family per Benefit Year). See also, Out-of-Pocket Maximum, below.

Dependent. A "Dependent" may include:

(a) The Spouse of the Participant. For purposes of this Plan, a Spouse is a Participant's lawful husband or wife, including a Common Law Spouse.

(b) An unmarried, Dependent Child of the Participant who is under age 19; an unmarried, Dependent Child who is a Full-Time Student under the age of 23 and who has not graduated; or an unmarried, Dependent Child who is a Disabled Child.

Durable Medical Equipment. Medically Necessary equipment that can withstand repeated use, is not generally useful to the Participant or Dependent in the absence of an injury or illness, and is approved for use in the home. Examples of Durable Medical Equipment are wheelchairs, canes and walkers.

Eligible (Eligibility). An Employee or his/her Dependent is "Eligible" to receive Benefits from the Fund when the Employee has made a Contribution as required by the Collective Bargaining Agreement and the Employee has met the requirements set forth in the Fund's Plan Documents. These requirements are set forth in Section I-Section 2 above.

Emergency. "Emergency" means an unforeseeable condition or complaint of pain which causes a reasonable person to fear serious injury, illness or death. Emergencies include heart attacks, strokes, and gashes requiring treatment to stop or control bleeding and broken limbs. Conditions like colds and the flu are not considered "Emergencies" under the Plan.

Employee. An Employee includes any of the following individuals:

(a) A common law Employee who is performing bargaining unit work as a member of the bargaining unit with respect to which unit an Employer is required to make a Contribution to the Fund pursuant to a Collective Bargaining Agreement with the Union, regardless of whether

the individual is a full-time, part-time or casual Employee (unless the applicable Collective Bargaining Agreement explicitly excludes certain classes of Employees).

(b) A common law Employee who is engaged by or who is an Employee of the Union or any Local Union which Union or Local Union is required to make Contributions to the Fund pursuant to a participation or other appropriate written agreement.

(c) A common law Employee who is engaged by or who is an Employee of the Fund and/or the Trust or the Central Pennsylvania Teamsters Pension Fund which Fund or Trust is required to make Contributions to the Fund pursuant to participation or other appropriate written agreement.

(d) A common law Employee of an Employer who is not performing bargaining unit work but who is a Participant by virtue of the Employer's execution of an appropriate participation or other appropriate written agreement where the Employer has made the appropriate Contribution and the individual meets the requirements set forth in the Fund's Plan Documents.

(e) A common law Employee who had been employed pursuant to one of the Subparagraphs set forth next-above and who is now making self-payments under rules established by the Trustees and who meets the requirements set forth in the Fund's Plan Documents.

Employer. "Employer" includes any of the following entities:

(a) An entity, like a corporation, that is represented in collective bargaining by the Transport Employers Association ("TEA") that is party to a Collective Bargaining Agreement with a Local Union that requires Contributions to the Fund. By making Contributions to the Fund, an Employer agrees to make Contributions as required by the Fund's Plan Documents.

(b) An entity, like a corporation, not represented in collective bargaining by the Association, but which has entered into a Collective Bargaining Agreement with a Local Union, which requires Contributions to the Fund. By making Contributions to the Fund, an Employer agrees to make Contributions as required by the Fund's Plan Documents.

(c) An entity that has been accepted by the Fund as a contributing Employer and is or was obligated to make Contributions to the Fund. By making Contributions to the Fund, an Employer agrees to make Contributions as required by the Fund's Plan Documents.

(d) A Local Union which has entered into an agreement with the Fund whereby it is required to make Contributions for its Employees to the Fund.

(e) The Trust, Fund and/or the Central Pennsylvania Teamsters Pension Fund which, for purposes related to its engagement or employment of Employees who are Participants in the Fund, has entered into an agreement with the Fund whereby it is required to make Contributions to the Fund.

Experimental, Investigational. In determining whether a treatment is Experimental or Investigational under the Plan, the Fund's medical advisors will use the following process:

Step 1: The Fund'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 Fund's medical advisors will conclude that the treatment is Experimental or Investigational, and the Fund will deny Benefits. If the answer is yes, the Fund's medical advisors will move to Step 2.

Step 2: The Fund'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 Fund's medical advisors will follow the conclusion of these agencies on the usefulness of the treatment. If the answer is no, the Fund's medical advisors will move to Step 3.

Step 3: The Fund'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 Fund's medical advisors will conclude that the treatment is Experimental or Investigational, and the Fund will deny Benefits. If the answer is yes, the Fund's medical advisors will move to Step 4.

Step 4: The Fund'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 Fund's medical advisors believes that the treatment is more effective than traditional treatments, the Fund's medical advisors will conclude that the treatment is not Experimental or Investigational. If the expert believes the treatment is not more effective than traditional treatments, the Fund's medical advisors will move to Step 5.

Step 5: The Fund'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 Fund's medical advisors determine that the treatment is Experimental or Investigational, the Fund will deny Benefits.

Family (Family Members). A Participant and all of his/her Eligible Dependents.

Hospital. A facility that provides medical and diagnostic care for injured or ill persons on an inpatient basis; is supervised by a staff of Physicians and provides 24-hour-per-day nursing care under the supervision of registered nurses (R.N.'s); provides diagnosis and treatment of surgical, medical, or mental (including substance abuse) conditions, and which is approved by the Joint Commission on Accreditation of Hospitals, or other appropriate accreditation body, or licensed to operate in the state in which it is located. The term Hospital may include Ambulatory Surgical Centers.

NOTE: The term Hospital does not include residential or nonresidential treatment facilities; nursing homes; skilled nursing facilities or facilities that primarily provide custodial, domiciliary, or convalescent care, or that provide residential diet or exercise Services or care, except sub-acute or hospice care that has been pre-certified by the Fund's Medical Advisor and/or is provided in a manner consistent with the Fund's policies, rules and regulations.

Lifetime. A Participant or Dependent's Lifetime in this Plan.

Local Union. A Local Union affiliated with the International Brotherhood of Teamsters, that represents individuals Eligible for Benefits under this Plan, or a Joint Council or Conference of the International Union with which such a Local Union is affiliated. This term will include Teamsters Local No. 429, also known as Local No. 429, when not acting in its capacity as a settlor of the Fund.

Medically Necessary. Services that meet the criteria listed below:

(a) The Service is rendered in accordance with medical and surgical practices and standards prevailing in the community where the Service is provided at the time the Service is provided; and

(b) The Service is commonly and customarily recognized throughout the Physician's specialty as appropriate in the treatment of the diagnosed disease, injury or illness; and

- (c) The Service is furnished to the Participant or Dependent at an appropriate level of care; and
- (d) The Service is not Experimental or Investigational or custodial in nature; and
- (e) The Service is not mainly for the purpose of medical or other research; and
- (f) The Service must not be provided for the convenience of the Physician, Hospital or any other Provider or individual; and
- (g) The Service is determined, in the sole discretion of the Trustees acting upon the advice of the Fund's medical advisors, to be Medically Necessary.

Network. The individuals, organization, or organizations with which the Fund contracts to provide Services to Participants and Dependents at advantageous rates.

Network Providers. The Physicians, Hospitals and other Providers of health Services to Participants and Dependents who are affiliated with the Network.

Network Rate. The amount of Benefits for a Service negotiated with a Network Provider, which amount the Network Provider will accept as payment in full for the Service.

Non-Network Providers. The Physicians, Hospitals and other Providers of health Services to Participants and Beneficiaries who are not affiliated with the Network.

Other Insurance. "Other Insurance" includes any of the following types of coverage:

- (a) Any group insurance coverage, including any Plan covering individuals as Employees of an Employer or as members of any other group which provides Hospital or medical care Benefits or Services on an insured or a prepayment basis;
- (b) Any coverage under a labor-management Trustee Plan or other welfare Plan, Employer Plan, Employer organization Plan, or other arrangement for Benefits for individuals or a group, whether insured, partially insured, self-insured, non-insured, or otherwise;
- (c) Any coverage under any governmental program, including, but not limited to, worker's compensation, occupational disease, or similar programs; provided, however, that such coverage shall not be deemed Other Insurance for purposes of this Plan if applicable law mandates that the Plan provide Primary coverage;
- (d) Any Other Insurance, private or otherwise, carried by the Participant or an Eligible Dependent of a Participant, including, but not limited to, motor vehicle coverage (including fault, no-fault, financial responsibility, catastrophic, liability, collision or other coverage).

Out-of-Pocket Maximum. In addition to the Deductible (defined above), the Participant is responsible for the "Out-of-Pocket" Maximum, which is 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.

Participant. An Employee who may be Eligible for Benefits for himself and his/her Dependents under the terms of the Plan.

Patient. A Participant or Eligible Dependent receiving medical care.

Physician. A practitioner of the healing arts who is appropriately qualified, properly licensed, and accredited or certified to practice such profession in accordance with the laws of the state governing his/her licensure and in accordance with all other applicable laws. The term Physician includes, for example, a Physician, surgeon, dentist, psychologist, nurse midwife, optometrist, or podiatrist.

Plan. The Central Pennsylvania Teamsters Health and Welfare Fund, Plan R-5, as it may be amended from time to time. The Fund is a multiemployer self-insured health and welfare plan governed by ERISA.

Provider. A person or organization that provides health care Services.

Qualified Beneficiary. An individual who was covered by the Plan on the day before a Qualifying Event occurred and who is either an Employee, the Employee's Spouse or former Spouse, or the Employee's Dependent Child.

Qualifying Event. Events that cause an individual to lose Coverage under the Plan and may trigger an individual's right to elect Coverage under COBRA.

Qualified Medical Child Support Order (QMCSO). A court or administrative order requiring the Fund to provide Benefit Coverage for a Dependent, which order the Trustees have determined complies with ERISA § 609(a).

Retired / Retiree. A Participant is "Retired" if he/she is at least 55 years of age, or, if under age 55, must be receiving a disability pension benefit from the Central Pennsylvania Teamsters Pension Fund or have terminated Covered Employment with an Employer.

Service(s). Any medical care, treatment, Hospitalization, or item provided to a Participant or Eligible Dependent.

Trustees. Those ten (10) persons, including five (5) Employer Trustees and five (5) Employee Trustees appointed by the Teamsters Local 429 and the Transport Employers Association, respectively, to administer the Fund.

Usual, Customary and Reasonable Rate (UCR). The rate which the Trustees of the Fund may determine, in their sole discretion, is the appropriate compensation for various Services provided under the Plan. The UCR will be set with reference to an external database; in accordance with a fee schedule adopted by the Trustees; or in accordance with some other objective standard selected by the Trustees.

B. Construction.

1. The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender, unless the context clearly indicates otherwise.

2. The singular shall be deemed to include the plural, and the plural the singular, as the context may require.

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**CENTRAL PENNSYLVANIA TEAMSTERS
HEALTH & WELFARE FUND**

TRUSTEE UPDATE AS OF JUNE 17, 2010

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