CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND

ACTIVE PLAN DOCUMENT for Plan 13Y

September 2018

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CENTRAL PENNSYLVANIA TEAMSTERS HEALTH & WELFARE FUND

PLAN APD-13Y

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

INTRODUCTION

The Trustees of the Central Pennsylvania Teamsters Health & Welfare Fund are pleased to offer you this combined Plan Document and Summary Plan Description for Plan 13Y, called the "Active Plan Document-13Y" ("APD-13Y"). Because Plan 13Y's terms are complex, it is important that you take the time to acquaint yourself with its provisions. Plan 13Y's governing documents, including this APD-13Y, Rules and Regulations, procedures and policies, and those portions of the Fund's contracts with insurers and administrators that describe the Benefits provided to you, are incorporated by reference into this APD-13Y.

The Fund Administrator shall make copies of the latest APD-13Y, annual report, collective bargaining agreements, Trust Agreement, or other instruments under which Plan 13Y was established or is operated available for examination by any Participant or Beneficiary in the Fund Office at the address above.

Only the entire Board of Trustees is authorized to interpret Plan 13Y's governing documents. No Employer or Union, nor any representative of any Employer or Union, acting in that capacity, is authorized to interpret Plan 13Y'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 APD-13Y TO THE FUND OFFICE.***

You may be able to find a variety of helpful information on the Fund's website, at www.centralpateamsters.com, where you will find Frequently Asked Questions ("FAQs"), forms, information about recent Plan changes, plan summaries, updated lists of Network Providers, links to wellness information and important documents.

This APD-13Y sets forth the provisions of Plan 13Y in effect as of January 1, 2016. You and your Family should read this entire APD-13Y. The Plan may be amended in the future by the Trustees. Under the Fund's governing documents, the Trustees have the right to modify or eliminate any Benefits provided under this Plan. Notice of amendments to Plan 13Y 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 APD-13Y, write or call the Fund Office.

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

Many words and terms are capitalized in this text, indicating that they have special meanings when used in this APD-13Y. These terms are defined in detail in the "Glossary" section of this APD-13Y.

SECTION 1
GENERAL INFORMATION

WHAT INFORMATION IS IN THIS SECTION? This Section includes general information about the Plan, who administers it, and where it is located.

1. **Name of the Plan:** Your health and welfare plan is formally known as the Central Pennsylvania Teamsters Health and Welfare Fund - Plan 13Y. Throughout the rest of this APD-13Y, it will be referred to as the "Plan" or the "Fund".

2. **Plan Administrator:** The Plan Administrator is the Board of Trustees. It is the Trustees' responsibility to administer the Plan exclusively for the benefit of all Participants and Dependents. The Trustees have established a Fund Office, and have retained Joseph J. Samolewicz, Administrator and a staff to conduct the day-to-day operations of the Plan.

3. **Contacting the Fund:** You may contact the Trustees at the Fund Office as follows:

   Central Pennsylvania Teamsters Health and Welfare Fund
   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

   Fund Trustees: 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. As of August 1, 2015, the Trustees are:

UNION TRUSTEES:

William M. Shappell, President
Teamsters Local 429
1055 Spring Street
Wyomissing, PA 19610

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

Kevin Bolig, Secretary- Treasurer
Teamsters Local 429
1055 Spring Street
Wyomissing, PA 19610

Charles Shafer, Secretary-Treasurer
Teamsters Local 773
3614 Lehigh St, Suite A
Whitehall, PA 18052

Jeff Strause, Vice-President and Business Agent
Teamsters Local 429
1055 Spring Street
Wyomissing, PA19610

EMPLOYER TRUSTEES:

Tom J. Ventura
YRC Worldwide, Inc.
c/o Central Pennsylvania Teamsters
Health & Welfare Fund
1055 Spring Street
Wyomissing, PA 19610

Eric W. Bucheit
ABF Freight System, Inc.
c/o Central Pennsylvania Teamsters
Health & Welfare Fund
1055 Spring Street
Wyomissing, PA 19610

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

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

[One Employer Trustee position was vacant at the time this document was printed]

4. **Plan Year:** The Plan Year is the calendar year beginning on January 1 and ending on December 31. The Plan Year is the time period the Fund uses for financial and accounting purposes, as well as for government reporting purposes.

5. **Benefit Year:** The Benefit Year, which is also the calendar year beginning on January 1 and ending on December 31, is the time-period the Fund uses for measuring annual Benefit limits.

   For example, the annual adult dental Benefits are limited to $600 per Benefit Year. This means that from January 1 through December 31 of each year an adult individual may receive a maximum of $600 in dental Benefits. No balance of Benefits remaining in one Benefit Year will be carried over to the next Benefit Year.

6. **Type of Plan; Available Benefits; Self-Insured Benefits; Self-Insured Externally Administered Benefits:** The Plan is a multiemployer self-insured health and welfare

plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The Plan provides for Hospitalization Services, Physician visits, physical therapy, immunizations and injections, surgical Services, diagnostic Services, hearing Services, dental Services, prescription drugs, transplants, mental health and substance abuse Services..

In general, the Fund administers the Benefits listed immediately above. However, while the Plan self-insures the prescription Benefits, it administers the prescription Benefits through an agreement with General Prescription Programs, Inc. (GPP), 222 Lafayette Street, Newark, NJ 07105. Similarly, the Plan self-insures the dental Benefits but administers these Benefits through an agreement with Delta Dental, 1 Delta Drive, Mechanicsburg, PA 17055. Finally, the Plan self-insures the vision Benefits, which are administered through an agreement with Davis Vision, HVHC Inc., 175 E. Houston Street, San Antonio, Texas 78205.

7. **Insured Benefits:** The Plan has purchased insured coverage for Death and Accidental Death and Dismemberment Benefits through The Hartford. The address of its U.S. main office is: 1 Hartford Plaza, Hartford, CT 06115.

8. **Plan Identification Numbers for this Plan:** The Plan's Employer Identification Number assigned by the Internal Revenue Service is 23-6263170. The Plan Number is 501.

9. **Agent for Service of Process:** 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 2
CREATION AND PURPOSE OF THE FUND

The Central Pennsylvania Teamsters Health and Welfare Fund and this Plan were created and are maintained for the exclusive purpose of providing such health and welfare benefits to Participants and Eligible Dependents as are set forth in this Plan, as it may be amended from time to time by the Trustees and as may be required by applicable law. Fund assets may be used to provide such Benefits to Participants and their Eligible Dependents and to defray the reasonable expense of administering the Fund and the Plan. It is intended that the Fund shall be a "welfare plan" within the meaning of ERISA § 3(l) and a "multiemployer" plan within the meaning of ERISA § 3(37).

SECTION 3
ELIGIBILITY

WHAT INFORMATION IS IN THIS SECTION? This Section describes the rules that the Fund uses to determine if you and your Dependents may receive Benefits from the Fund. By law and by the terms of this Plan, the Fund may only pay Benefits for individuals who meet the Eligibility requirements set forth in this Section.

1. *Eligibility Rules for You and Your Eligible Dependents*
2. *Contributions*
3. *Contribution Periods and Benefit Periods*
4. *Special Instances of Continued Eligibility Applicable to Hourly Employees*
5. *Enrolling Yourself and Eligible Dependents in the Plan*

1. **Eligibility Rules for You and Your Eligible Dependents:** Generally, you are Eligible to receive Benefits from the Plan if you are working for a contributing Employer in a position for which Contributions are due and the required Contributions are actually paid to the Plan. If Contributions are made on your behalf during a **"Contribution Period,"** you and your Dependents will generally be Eligible to receive Benefits in the immediately following **"Benefit Period."** A description of **Contribution Periods** and **Benefit Periods** is found below.

   Set forth below are the Fund's rules under which an Employee or Dependent may be Eligible for Benefits. Individuals who are NOT Eligible Employees or Dependents may not receive any Benefits from the Fund.

   IMPORTANT NOTE: NO RETIREE BENEFITS THROUGH THIS PLAN: The Plan Does Not Provide Retiree Benefits: *You are not Eligible for Coverage under this Plan after retirement unless you elect COBRA continuation coverage, as described in more detail below. However, you may be eligible for benefits under the Fund's Retiree Plan. Contact the Fund Office to discuss the eligibility requirements for the Retiree Plan.*

2. **Contributions:** Contributions are generally made by a Contributing Employer with respect to a Collective Bargaining Agreement or a Participation Agreement. The Trustees are responsible for setting the required hourly Contributions.

   IMPORTANT NOTE: *If the terms of a Collective Bargaining Agreement are inconsistent with the terms of this Plan and the Fund's other rules and regulations (including the Fund's document control program), then this APD-13Y and such rules and regulations shall govern.*

   a. **Contributions:** Employers contribute to the Plan using ***composite*** rates. A ***composite*** rate is a fixed rate that is paid per Participant regardless of Participant's family status.

***IMPORTANT NOTE**: You should update your list of Eligible Dependents on the Fund's Application and Beneficiary Form. These forms are available from the Fund Office or on the Fund's website: www.centralpateamsters.com. The Fund will mail a copy of the form to you upon your request. These forms must be signed and returned to the Fund Office in order for your Eligible Dependents to be covered and for your beneficiary designations to be effective.*

b. Contributions: Employer's Failure to Make Required Contributions to the Fund. The Fund's rules require that Contributions are due on the 15th day of the month following the month worked. The Trustees may determine annually the Contribution Periods and Benefit Periods set forth in the next Section.

If your Employer does not make the required Contributions to the Fund, your Benefits Coverage will be terminated effective as of the beginning of the first Benefit Period following the Contribution Period in which there was a Contribution deficiency. If this occurs, you will have the opportunity to purchase continuation coverage for certain Benefits (as described in the "Important Federal Laws Applicable to this Plan" section). You should speak to your Union Business Representative about other remedies that may be provided by the terms of the Collective Bargaining Agreement.

3. Contribution Periods and Benefit Periods: You and your Eligible Dependents will receive Benefits from the Fund as of the first day of the Benefit Period immediately following a Contribution Period in which your Employer contributed the required hourly rate multiplied by at least **420 hours**.

The terms Contribution Period and Benefit Period are defined as follows:

Contributions made for at least 420 hours credited in September, October and November	Benefits available for period January 1 to March 31
Contributions made for at least 420 hours credited in December, January and February	Benefits available for the period April 1 to June 30
Contributions made for at least 420 hours credited in March, April and May	Benefits available for the period July 1 to September 30
Contributions made for at least 420 hours credited in June, July and August	Benefits available for the period October 1 to December 31

a. Contributions: Employee Purchase of Coverage for the first 90 days of employment. You have the option of purchasing Coverage from the Plan within 90 days from your first date of employment if you were not Eligible for Benefits between the first day of your employment and the effective date of your Benefit Coverage. You will need to pay the hourly Contribution rate multiplied by 420. Contact the Fund Office for more information on this option.

b. Contributions: Employee "Buy-Up" Coverage if Employer Contributions Insufficient to Provide Coverage. If your Employer has made Contributions in a Contribution Period equal to at least one hour on your behalf, you may purchase Benefit Coverage during the Benefit Period by paying the difference between the actual hourly Contributions submitted by the Employer and the required Contributions within 30 days of the Fund notifying you of the shortage. If your Employer makes no Contributions to the Fund, you will be entitled to elect Continuation Coverage as described in the "Important Federal Laws Applicable to this Plan" section).

4. Special Instances of Continued Eligibility:

a. Company Insolvency: If your company becomes insolvent while you are otherwise Eligible for Benefits, you will be Eligible for up to three months of Contribution Credit from the Fund, provided that you continue to work under the Collective Bargaining Agreement. "Insolvency" shall mean that the Employer has (1) ceased to conduct business; (2) is a debtor under any provision of the United States Bankruptcy Code; (3) has become, in the opinion of the Fund's legal counsel, insolvent under any state or federal law; or (4) is experiencing dissolution.

> **For example**, John Jackson and Bill Jones worked for GHI Company, a contributing Employer. Because the Company became insolvent, the Company made its last Contribution to the Plan in December 2013, for hours worked in November 2013. After making this payment, the Company stopped making Contributions to the Plan. However, Mr. Jackson continued working there until January 31, 2014, and Mr. Jones continued working there until February 28, 2014. In this case, Mr. Jackson will receive two months of Contribution credit and Mr. Jones will receive the maximum three months of Contribution credit.

b. ADD Benefits if You Die within 30 days of end of Eligibility: If you die within 30 days of the end of your Eligibility for Benefits, you will remain Eligible for Death and Accidental Death Benefits.

> **For example**, John Williams stopped working for LL Corporation, a contributing Employer, on November 28, 2013. He remained Eligible for Benefits from the Plan until March 31, 2014. Mr. Williams died in a car accident on April 28, 2014. The Plan will pay death Benefits and accidental death Benefits to Mr. William's Beneficiary.

c. Hospitalization Benefits if Eligibility Lost during Hospitalization: If you enter the Hospital while you are Eligible for Benefits but lose Eligibility while you are in the Hospital, the Fund will continue to pay Benefits for the duration of your stay in the Hospital.

For example, Jane Thomas stopped working for LMN Stores, a contributing Employer, on November 28, 2014. She remained Eligible for Benefits from the Plan until March 31, 2015. Ms. Thomas was admitted to the Hospital from March 20 to April 10, 2015. The Plan will pay Hospitalization Benefits for Ms. Thomas through April 10, 2015.

d. COBRA: Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), a federal law, you may be able to purchase continuation coverage from the Plan after the date your coverage would otherwise end. Your COBRA rights are described in the "Important Federal Laws Applicable to this Plan" section of this APD-13Y.

5. Enrolling Yourself and Eligible Dependents in the Plan:

a. Individuals Eligible for Enrollment: **Employee, Spouse and Child/Children.** You may enroll yourself if you are Eligible for enrollment. In addition, you may generally enroll your Spouse and your Children up to age 26 in the Plan. Your Children may include your natural Children, your adopted Children, stepchildren (that is, the children of your current spouse for whom you are not the natural parent), and Children for whom you have legal custody pursuant to a court order; provided, however, that the order provides for permanent custody or guardianship not subject to a condition or agreement under which the natural parent or other person may acquire or reacquire custody or guardianship in his or her discretion, even by court order. (See the definition of Child/Children in the Glossary for a more detailed description of these important terms.)

i. Court-Ordered Legal Custody of a Child: If you have court-ordered permanent legal and physical custody of an individual who is not your natural, adopted, or stepchild and that child has not reached 26 years of age and, for children under the age of 19, you claim that child on your federal income tax return, he or she can be enrolled as of the date of custody. You must provide copies of the court order, including any changes or amendments that may be made to it as well as the federal tax returns (until child reaches age 19) annually demonstrating that you claim the child as your dependent for income tax purposes.

ii. Disabled Child: 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 or she will be covered by the Plan after reaching age 26 so long as all of the conditions above are met and you annually submit the required documentation, including your annual federal income tax return, showing that you claim the Child as a Dependent.

b. Enrollment in the Fund:

i. Effective Dates: You may enroll yourself and your Eligible Dependents (1) when your Employer initially becomes a Contributing Employer to the

Plan; (2) on the date set forth in the Collective Bargaining Agreement between the Union and your Employer; or (3) as permitted under the Special Enrollment rules described below.

ii. Required Information: In order to enroll yourself and your Eligible Dependents, you must complete all required enrollment materials and provide all applicable documentation, **for example**, a marriage certificate, birth certificate, adoption or custody documentation. The forms and documentation must be submitted to the Fund Office.

A. Failure to Submit Required Information Timely: If you (the Participant) are Eligible for Benefits but fail to provide the required information, the Fund will provide Benefit Coverage for you after you submit all required information starting from the date that you would have been Eligible for Benefits had the required information been timely submitted to the Fund. However, the Fund will only provide coverage for your Dependents from the date that all required information was received by the Fund.

c. Coverage for Spouses:

i. Spouse Must Generally Enroll in His or Her Employer's Coverage: If your Spouse works full-time and is eligible for coverage at his or her job, your Spouse must enroll in that coverage in order to be eligible to enroll in coverage under the Fund. Your Spouse's employer's coverage will be primary and this Plan will provide secondary Coverage for your Spouse, pursuant to the Fund's Coordination of Benefits rules, more fully described in the "Coordination of Benefits and Subrogation" section.

There are three situations where your Spouse does not have to enroll in health insurance at his or her job in order to obtain coverage under this Plan. They are:

(1) If your Spouse would have to pay 100% of the premium for the Other Insurance; or

(2) If your Spouse is working for the same contributing Employer as you do, but in a position for which Contributions are not owed to this Plan; or

(3) If your Spouse is covered by a Collective Bargaining Agreement that permits "Dependent Opt-Out" coverage under one of the Fund's other Plans.

ii. Spouses Working For Different Contributing Employers: Where (a) an Employee and a Spouse work for different Contributing Employers; and (b) where under the terms of a Collective Bargaining Agreement and the applicable Plan, the Employee may be covered under

the Spouse's
Plan. In such event, the otherwise applicable requirements that (i) each Spouse must enroll in coverage under his or her own employer's plan and (ii) the Employee's Employer make Contributions to the Fund shall not apply.

iii. Spouses Participating in Health Savings Accounts: If your Spouse (or an Eligible Dependent) is covered under a high-deductible health plan with a "health savings account" ("HSA"), this Spouse or Dependent may not be covered under this Plan.

> ***IMPORTANT NOTE****: You should be aware that the Code provides that in order to be eligible to contribute to an HSA, an individual may NOT have coverage that is not a high-deductible health plan. The Plan does not meet the requirements to be a high -deductible health plan.*

iv. Spouses Working for a Contributing Employer: If you and your Spouse both work for a contributing Employer in positions for which Contributions are due under a Collective Bargaining Agreement, Contributions must be paid for both you and your Spouse.

v. Divorced Spouses: You can only provide coverage under the Fund for your lawful Spouse, which includes only a husband or wife to whom you are currently married. **Your former husband or wife is not Eligible for Benefits as of the last day of the month in which your divorce becomes final.**

IMPORTANT NOTE: *You must notify the Fund Office as soon as you are divorced. Once a divorce occurs, your ex-Spouse 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 (see "Important Federal Laws Applicable to this Plan" below for the rules governing this 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 of your ex-Spouse after the divorce became final.*** *The Fund reserves the right to take all action to recover Benefits that were paid on behalf of your ex-Spouse, including offsetting those Benefits against Benefits payable on behalf of any other Family member and taking any appropriate legal action.*

vi. Common Law Spouses: 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 in accordance with applicable state law. The Fund will not recognize any common law marriage entered into in Pennsylvania after January 1, 2005.

***IMPORTANT NOTE**: 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 should only claim common law marriage status if you understand that you may be considered married for all purposes.*

SECTION 4
MANAGED CARE PROGRAM
CLINICAL TRIAL COVERAGE
PREVENTIVE CARE COVERAGE

WHAT INFORMATION IS IN THIS SECTION? This Section describes the different tools the Fund's Trustees use to provide appropriate care for you and your Family at a reasonable cost.

1. **Managed Care Program:** The Trustees of the Fund design and administer the Plan in order to provide excellent benefits in a cost-effective manner. In order to protect the Fund's Participants and their Families, the Fund provides Benefits only for Medically Necessary Treatment and Services, as provided for under the terms of the Plan, and monitored through the Fund's Managed Care Program. In order to assure that Benefits are provided in a cost-effective manner, the Fund's Trustees have entered into contracts not only with a Managed Care Provider but also with Networks of Hospitals, Physicians and other health care Providers. The terms of the Fund's Managed Care Program are described below.

   ***IMPORTANT NOTE**: If the patient or his or her Provider does not cooperate with the Plan's Managed Care Program, the Plan may decline to pay any Benefits for your treatment from that Provider.*

2. **Elements of the Fund's Managed Care Program:** The Plan's Managed Care Program has four key elements, which are described below.

   a. **Network Providers:** The Fund has contracted with Networks of Providers to serve you and your Family. These Network Providers perform their Services at an advantageous cost to you and to the Plan and will generally not bill you the balance between the amount the Plan pays and the amount the Provider charges. Network Providers may also be referred to as "Participating Providers." "PPO" means Preferred Provider Organization, and is simply another way to describe a Provider that participates in the Plan's Network.

   b. **Limited Payment for Non-Network Providers:** 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 UCR rate, or percentage of billed charges as appropriate, for the Services or treatment

and you will be responsible for any balance on charges not paid by the Plan (except for emergency services for a *bona fide* emergency). Of course, the Fund will only provide Benefits for Medically Necessary Services, regardless of whether the Services are from a Network or a Non-Network Provider.

c. Limits on Treatment that is not "Medically Necessary," not consistent with the terms of the Plan or is "Experimental or Investigational": The Plan limits or may deny the Benefits for treatment in certain circumstances regardless of whether you treat with a Network or Non-Network Provider. **For example**, the Fund will not pay any Benefits for treatment that is not "Medically Necessary" or is "Experimental or Investigational" as those terms are defined in the Plan. In these circumstances, you will be responsible for any charges not covered by the Plan.

d. Utilization Review: The Plan has a utilization review program under which the Fund's Medical Advisor and Meritain Medical Management review the Services and treatment you receive to make sure that they are consistent with the standards established by the Plan. **A determination under utilization review that a procedure is Medically Necessary is NOT a guarantee of payment.**

3. Network Providers: The Trustees have sole discretion to establish or contract with one or more Networks of Providers to provide Services to you and your Dependents. Generally, if you receive Services from a Network Provider, the Plan will pay Benefits in full, less any required Copayments or Deductibles.

Providers join or leave Networks frequently. Therefore, the most current information is to be found on the electronic Provider Lists available on the Fund's website. In order to find a Provider on-line, see the "Health & Welfare Fund" tab on the Fund's website: www.centralpateamsters.com. Click the link entitled "Providers" to be directed to a page showing the lists of Participating Providers. The Networks currently offered by the Plan may change, and, if so, you will be informed. **It is the Fund's intention to post only current listings, but you should contact the Fund Office to verify if a particular Provider is currently a Network Provider or call Meritain Health at 800-343-3140.**

IMPORTANT NOTE: *In some areas, not every Provider within a practice or physician group listed in the Provider list is in the Network. It is important that you make sure that the specific Provider or Physician you are seeing, and not just the practice or group, is a Network Provider. For the most up-to-date information, contact the Fund Office, or call Meritain Health at 800-343-3140.*

For example, Janice resides in South Carolina and needs to see a dermatologist for a persistent rash. Although the practice group, XYZ Associates of Charleston, is listed as a Participating Provider, the doctor Janice is seeing, Dr. Smith, is NOT a Participating Provider. Therefore, even though the group is a Network Provider, the Fund would pay Benefits for Dr. Smith only as a Non-Network Provider.

a. **Available Networks in Central Pennsylvania:** In central Pennsylvania, the primary Network for medical Benefits is the Aetna Network. Other sub-Networks include the First Health Network.

b. **Vision Network Provider:** Davis Vision ("Davis") provides the Network for vision Benefits.

c. **Prescription Network Provider:** General Prescription Programs, Inc. ("GPP") provides the Network for prescription drugs.

d. **Dental Network Provider:** Delta Dental ("Delta") provides the Network for dental Benefits.

4. **Non-Network Providers**: The Plan limits the Benefits it pays for treatment by Non-Network Providers. Typically, the Plan will pay only the Usual, Customary and Reasonable rate (UCR) for a Service performed by a Non-Network Provider, less any applicable Deductibles or Copayments. The UCR rate is a percentile of a database of costs for treatments and procedures that has been carefully selected by the Trustees. Unless otherwise indicated in this Plan, 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. As of the effective date of this Plan, the Fund uses a database compiled by Fair Health.

   a. If there is no UCR for the particular Service rendered, the Plan will pay Benefits to Non-Network Providers using a percentage of billed charges.

      For example: John Smith treats with a Non-Network Non-Specialist Physician. The bill for these Services is $100.00. Assume that the UCR for these Services is $65.00. The Plan will pay $35.00 (UCR less $30.00 Copayment) to the Provider and Mr. Smith will be responsible to the provider for the balance of $65.00 (the $30.00 Copayment and additional $35.00, the difference between the UCR and the Physician's charge).

      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.

   b. **Change-of-Operations: Non-Network Providers May Be Treated as Network Providers.** If you are relocated pursuant to a change-of-operations under the National Master Freight Agreement, one of its supplements, or related agreements, the Trustees have the discretion to treat the Services you received from a Non-Network Provider as if received from a Network Provider.

5. **Plan Limits on Benefits Other than Use of Network or Non-Network Providers:** Some examples of these limits are described below. This is not an exhaustive list of limits on Benefits:

a. **Limits on a per-Benefit Year basis: For example**, each Participant or Eligible Dependent, can receive up to $600 per Benefit Year in dental Benefits, except that no annual or lifetime Benefit cap will be imposed on children under age 19 for Medically Necessary pediatric dental services, as determined by the Fund and Delta Dental.

b. **Limits on a per-Family basis: For example**, each Benefit Year, each Family in the Plan may receive up to $1,000 in hearing Benefits except that no annual or lifetime Benefit cap will be imposed on children under age 19 for Medically Necessary pediatric hearing services, as determined by the Fund.

c. **Additional limits are described below:** If you need to determine whether there are Plan limits that apply to your particular situation, call the Fund office.

6. **Fund Provides Benefits Only for "Medically Necessary" Services, Treatments and Items:**

a. **What is Medically Necessary care?** Medically Necessary care is care that the Trustees, in reliance upon the Plan's Medical Advisors, determine is appropriate to treat your injury or illness. In determining whether care is Medically Necessary, the medical professionals advising the Trustees consider the standards of medical practice applicable to the particular treatment rendered.

b. **Medically Necessary Care Does Not Include Experimental or Investigational Treatments:** 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.

c. **Method for Determining Whether a Treatment is Experimental or Investigational under the Plan**. In making this determination, the Fund's Medical Advisors will use the following process:

Step 1: The Plan's Medical Advisors will examine whether 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 whether 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 this 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 whether 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.

7. **Utilization Review:** Utilization review is a process through which the Trustees, in reliance upon the Plan's Medical Advisors, determine 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.** Meritain Medical Management performs the utilization review for the Plan's 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 determination does **not** ensure 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.

   a. **Pre-Certification (Hospitalization and Surgery). All non-Emergency Hospitalization and surgery (both inpatient and outpatient, and both medical and mental health/substance abuse) must be pre-certified at least 14 days in advance:** If you are using a Network Provider, it is the Provider's responsibility to contact the Fund Office and follow its instructions to obtain pre-certification. If you are using a Non-Network Provider, **YOU** are responsible for pre-certifying your Hospital stay with the Fund.

If you have emergency surgery or an emergency admission, you or your Provider must notify the Fund Office within two business days after treatment/ Hospitalization. Certain other Services must also be pre-certified. 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 stay or Service, the Fund may limit or deny Benefits for the claims incurred, unless the Pre-Certification cannot be required pursuant to the Affordable Care Act or other applicable federal law or regulation.

b. Pre-Certification: (Number of Days for Hospitalization). Upon a patient's admission to the Hospital, the Fund's Managed Care Organization ("MCO") will inform the Fund of the number of days of admission for which the Fund should pay and either the Fund or the MCO will so inform the Provider. The Fund will not pay Benefits for additional Hospital days unless approved under the Managed Care Program.

c. Pre-Certification does not Guarantee Payment of Benefits: The purpose of pre-certification is to determine whether the treatment or Service is "Medically Necessary" as that term is defined by the Plan. However, it is possible that the treatment may not be covered if, on review, the Fund determines, **for example**, that the individual was not Eligible for Benefits at the time the treatment is provided or that the treatment is subject to Plan exclusion.

> **For 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 surgery.
>
> **For example**, John Jackson's doctor receives pre-certification for Medically Necessary surgery on June 1. Mr. Jackson's coverage lapses on July 1. The surgery is not performed until July 15. Even though the surgery was pre-certified as Medically Necessary, the Fund will not pay Benefits for the surgery because Mr. Jackson was not Eligible for Benefits at the time of the surgery.

d. Second or Third Opinion May Be Required: 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 in full for these additional opinions. If you elect to seek a second or third opinion on your own, the standard Deductible, Copayments and coinsurance will apply.

8. **Coverage for Clinical Trials**

   a. Effective January 1, 2014, the Affordable Care Act requires that the Plan provide Coverage for Services related to an "Approved Clinical Trial" for a "Qualified Individual." These related services include, **for example**, Hospitalization or monitoring in connection with the Approved Clinical Trial. The Plan is **not** required to cover treatments that fall outside the designated class of Approved Clinical Trials.

      i. A "Qualified Individual" is a Plan Participant or Dependent who is eligible to participate in an "Approved Clinical Trial" because either the individual's doctor has concluded that patient is appropriate for the Approved Clinical Trial or the patient provides medical and scientific information establishing that his or her participation in the Approved Clinical Trial is appropriate.

      ii. An "Approved Clinical Trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

      iii. Routine Patient Costs for the purpose of this subsection include all Items and Services consistent with the Coverage provided in the Plan that is typically covered for a Qualified Individual who is not enrolled in an Approved Clinical Trial. Routine patient costs do **not** include (1) the investigational item, device or service itself; (2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

      iv. If a Network Provider is participating in an Approved Clinical Trial, the Plan may require the individual to participate in the trial through that Network Provider if the Network Provider will accept the individual as a participant in the trial.

9. **Preventive Care Benefits:** Under the Affordable Care Act, the Fund is required to provide certain "preventive care" services without imposing any cost sharing requirements, meaning that no Deductibles, Copayments or cost-sharing with respect to the required preventive care services will be imposed. While the Fund may not impose cost-sharing with respect to services provided by Network Providers, it is permitted to and may impose them with respect to Non-Network providers.

A listing of covered Preventive Care Services can be found on the U.S. Preventive Services Task Force website. A link to this website is: http://www.healthcare.gov/law/resources/regulations/prevention/taskforce.html. For a more detailed description of how these protections relate to the physician office visit, outpatient diagnostic, and immunization Benefits provided by the Fund, see the "Preventive Care Services" Section of this Plan document below.

SECTION 5
PHYSICIAN BENEFITS
PHYSICAL THERAPY BENEFITS
IMMUNIZATION AND INJECTIONS BENEFITS
PREVENTIVE CARE SERVICES PROVIDED BY YOUR PHYSICIAN

WHAT INFORMATION IS IN THIS SECTION? In this Section, you will find information about the Benefits available for Network and Non-Network Physician Office Visits and Physician Visits if you are Hospitalized. In addition, you will find information about which preventive care services are required by Patient Protection and Affordable Care Act ("PPACA") which will be provided to you with no Copayment or coinsurance costs.

1. *Physician Benefits*
2. *Physical Therapy Benefits*
3. *Immunization and Injections Benefits*
4. *Preventive Care Services*

1. Physician Services

a. Physician Office Visits: 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.

i. Physician Office Visits: Network Provider. For office visits to a Network Provider, you will have to pay a $20 Copayment per visit to a Network Non-Specialist and $30 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.

***IMPORTANT NOTE**: Chiropractors are not covered as a Non-Specialist Physician. See below for information about chiropractic Benefits.*

ii. Physician Office Visits: 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 $30 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 $55 Copayment that you will have to pay per visit.

A. **Non-Specialist** means a general practitioner, an obstetrician/gynecologist, an internist, a pediatrician, or a general doctor of osteopathy.

B. **Specialist** means every Physician other than a Non-Specialist or a Chiropractor.

C. Chiropractor - The Plan will pay for office visits to a Chiropractor up to $25 per visit, up to 20 visits per Eligible Family Member per Benefit Year.

b. Physician Visits: Visits while Hospitalized. 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.

i. Physician Visits While Hospitalized: Network Provider. For Medically Necessary inpatient visits from a Network Provider, the Plan will pay Benefits in full.

ii. Physician Visits While Hospitalized: 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.

2. Physical Therapy:

The Fund 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, 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, such additional visits must be pre-certified under the Plan's Managed Care Program. The Plan's Benefits differ depending on whether you receive Services from a Network or Non-Network Provider. As used below, "modality" means Medically Necessary physical therapy modalities and therapeutic procedures (**for example**, physical actions, applications, maneuvers and manipulation used to achieve a therapeutic goal).

a. Network Provider: If you use a Network Provider, the Plan pays Benefits in full for up to 3 modalities (that is, types) of treatment per day, less a co-payment by you of $20 per visit. Examples of modalities would be whirlpools, massages, and various strength-building and agility-building exercises.

b. Non-Network Provider: If you use a Non-Network Provider, the Plan pays up to the UCR for up to 3 modalities of treatment, less a co-payment by you of $30 per visit. You will be responsible for any balance charged by a non-Network Provider. No Major Medical Benefits will be available.

3. **Immunization and Injections:**

   a. **Immunization and Injections** (ACA Preventive Care): Immunizations and injections required under the "Preventive Care" provisions of the ACA (see below) will be covered at no cost to the patient using a Network Provider, HOWEVER, you may still be charged for an Office Visit.

   b. **Immunization and Injections** (Non-ACA Preventive Care): In addition to the Benefits that the Fund provides for immunization and injections from a Network Provider with no Copayment required as Preventive Care under the ACA (see below), the Fund provides Benefits for Medically Necessary Immunizations and Injections (subject to the Plan's Managed Care Program). Benefits differ depending on whether you receive Services from a Network or Non-Network Provider.

   c. **Network Provider.** If you receive a Medically Necessary immunization or injection that is not "Preventive Care" under the ACA and the Network Provider charges separately for an office visit and the immunization or injection, the Fund will pay Benefits for the Services as an office visit at the Network Rate, less the office visit Copayment. If the Network Provider does not charge for an office visit, the Fund will pay up to $25 towards the immunization or injection.

   d. **Non-Network Provider.** If you receive a Medically Necessary immunization that is not "Preventive Care" under the ACA and the Non-Network Provider charges separately for an office visit and the immunization, the Fund will pay Benefits for the Services as an office visit. If the office visit charge made by the Non-Network Provider is less than $25, the Fund will pay the difference up to the UCR or the $25 Benefit towards the immunization. If the non-Network Provider does not charge for an office visit, the Fund will pay up to the UCR or $25 towards the immunization.

4. **Preventive Care Services:** The Affordable Care Act requires that the Fund provide benefits for certain preventive care Services without requiring a Copayment from the patient.

   IMPORTANT NOTE*: The guidelines provide that these Services are to be rendered without a Copayment only for certain individuals with identified risk factors.*

   a. **Representative Preventive Services Required by the PPACA:** These Services could, but do not necessarily, include tests and screenings like the following:

      Blood pressure, diabetes, and cholesterol tests;
      Many cancer screenings;
      Counseling on such topics as quitting smoking, losing weight, eating better, treating depression, and reducing alcohol use;
      Routine vaccines for diseases such as measles, polio, or meningitis;

Flu and pneumonia shots;
Counseling, screening and vaccines for healthy pregnancies;
Regular well-baby and well-child visits, from birth to age 21; and
Well-woman visits and services.

b. Copayments and Coinsurance for Services Related to Preventive Services: Although no Copayments or Coinsurance are imposed for required "Preventive Care" Services, Copayments are imposed for certain preventive care services, as described below:

- First, if a recommended preventive Service is billed separately (or is tracked as individual encounter data separately) from an office visit, then the Plan or issuer will impose cost-sharing requirements with respect to the office visit.

- Second, if a recommended preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then the Plan or issuer will not impose cost-sharing requirements with respect to the office visit.

- Finally, if a recommended preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then the Plan or issuer will impose cost-sharing requirements with respect to the office visit.

SECTION 6
HOSPITAL BENEFITS

WHAT INFORMATION IS IN THIS SECTION? In this Section, you will find information about the Benefits available for Network and Non-Network Hospitalizations, as well as information about the Benefits available for "Emergencies," and for ambulance and life flight transportation.

1. Hospitalization Benefits
2. Hospital Miscellaneous Benefits
3. Hospital Anesthesia Services
4. Emergency Room Services
5. Emergency / Hospital Transportation

1. Hospitalization Benefits: The Plan pays for Medically Necessary Hospitalizations (subject to the Plan's Managed Care Program). The level of Benefits the Plan will pay depends 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. (See the "Mental/Nervous/Substance Abuse Benefits" section below for a fuller description of in-patient Benefits for mental health/substance abuse Hospital admissions.) Private rooms are not covered by the Plan unless they are determined to be Medically Necessary.

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

i. Network Hospital: For Medically Necessary stays at a Network Hospital, the Plan will provide Benefits equal to payment in full for room and board after you have paid a $100 Copayment for each Hospital stay.

ii. 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 after you have paid a $100 Copayment and met the required annual Deductible. The Fund will pay a Non-Network Hospital the lesser of the UCR or the billed charges. You may be responsible to the Non-Network Provider for outstanding balances beyond the Plan's payment of Benefits

IMPORTANT NOTE: *If the Plan denies your room and board Benefits for a Non-Network Hospitalization because they are not Medically Necessary (as defined in this 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 or she is a Non-Network Provider. No Major Medical Benefits will be available.*

b. Private Rooms: Private Rooms Not Covered If Not Medically **Necessary**. Regardless of whether you use a Network or Non-Network Hospital, 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).

c. Benefits for Birth Required Under Federal Law: Under federal law, group health plans like the Plan and health insurers 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 insurer 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 a Non-Network facility, YOU are responsible for ensuring that your stay is pre-certified. Also, 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.

2. Hospital Miscellaneous Benefits: Network and Non-Network Miscellaneous Hospital Services include things like inpatient diagnostic Services (X-rays, lab tests, etc.), and outpatient treatments like chemotherapy.

a. Network Hospital: For Medically Necessary miscellaneous inpatient or outpatient Hospitalization Services, the Plan will pay Benefits in full if you use a Network Hospital.

b. Non-Network Hospital: If you use a Non-Network Hospital, the Plan will pay Benefits for Medically Necessary miscellaneous inpatient or outpatient Hospitalization Services after you have paid the required Deductible and Coinsurance.

3. Hospital Anesthesia Services: Network and Non-Network Benefits.

a. Network Provider: For Medically Necessary anesthesia Services from a Network Provider, the Plan will pay Benefits in full.

b. Non-Network Provider: For Medically Necessary anesthesia Services from a Non-Network Provider in a Network Hospital, the Plan will pay Benefits in full.

c. Non-Network Provider in a Non-Network Hospital: If you use a Non-Network Provider in a Non-Network Hospital, the Plan will pay Benefits up to the lesser of the UCR or billed charges. You may be responsible for any balance billing from the Non-Network Provider.

4. Emergency Room Services:

a. Definition of "Emergency": The term "Emergency" under the Plan means an unforeseeable condition or complaint of pain that 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.

b. Emergency Room Copayment: For Emergency Room visits, you will be required to pay a $100 Copayment. You will not responsible for a second $100 Copayment if you are admitted to the Hospital immediately following Emergency Room treatment. This applies to both Network and Non-Network Emergency Room visits.

c. Emergency Room – Injury: If you suffer an Accidental injury that requires Emergency care, the Plan will pay Benefits for Medically Necessary Emergency Room Services, less a Copayment of $100. These Services include Physician Services and prescription drugs.

> ***IMPORTANT NOTE:*** *If the condition for which you seek treatment from a Non-Network facility Emergency Department is* ***not*** *an "Emergency" as defined in the Plan, the Plan will not pay any Benefits at all.*

d. Emergency Room: Benefits for Splints, Casts, and Immobilizers. Subject to the 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 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.

e. Emergency Room – Illness: If you suffer from an illness requiring Medically Necessary Emergency care, the Plan will pay Benefits in full, less a $100 Copayment.

> ***IMPORTANT NOTE:*** *The Trustees reserve the right to only pay for true medical Emergencies as defined above in full minus the Copayment.*

5. Emergency / Hospital Transportation:

a. Ambulance: The Fund provides Benefits for Medically Necessary ambulance services.

i. Network: After you have paid a $100 Copayment, the Plan will pay Benefits in full for Medically Necessary ambulance Services.

ii. Non-Network: After you have paid a $100 Copayment, and subject to the Deductible and coinsurance, the Plan will pay Benefits up to the UCR.

***IMPORTANT NOTE**: The Fund will not provide Benefits for the ambulance Services described above if the patient does not meet the short term care criteria required for Coverage under the Plan.*

b. Life Flights: The Fund provides Benefits for Medically Necessary air transportation.

i. Network: After you have paid a $100 Copayment, the Plan will pay Benefits in full for Medically Necessary air transportation.

ii. Non-Network: After you have paid a $100 Copayment, and subject to the Deductible and coinsurance, the Plan will pay Benefits up to the UCR. If the treatment is required as a result of an Emergency, the Plan will pay Benefits in full, after your $100 Copayment, even if a Non-Network Provider is used for the life flight.

SECTION 7
SURGICAL BENEFITS

WHAT INFORMATION IS IN THIS SECTION? This Section includes information about what surgical Benefits are provided by the Fund and the required Copayments for such services.

1. Inpatient Surgical Benefits
2. Outpatient Surgical Benefits
3. Preventive Care Surgical Procedures
4. Mastectomy Benefits

1. **Inpatient Surgical Benefits:** The Plan will pay Benefits for Medically Necessary inpatient 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:

    a. **Network Provider:** If you use a Network Provider, the Plan will pay Surgical Benefits in full.

        IMPORTANT NOTE: *You will be required to make a $100 Copayment for your hospital stay.*

    b. **Non-Network Provider:** If you use a Non-Network Provider, the Plan will pay Benefits up to the lesser of the UCR or billed charges after you have met your Deductible and Coinsurance.

        IMPORTANT NOTE: *You will be required to make a $100 Copayment for your hospital stay.*

2. **Outpatient Surgical Benefits.**

    a. **Network Provider:** If you use a Network Provider, the Plan will pay Surgical Benefits in full after an outpatient surgery Copayment of $100.

    b. **Non-Network Provider:** If you use a Non-Network Provider, after your outpatient surgery Copayment of $100, the Plan will pay Benefits up to the lesser of UCR or billed charges after payment of your Deductible and Coinsurance.

3. **Preventive Care Surgical Procedures:** The Fund provides Benefits for certain procedures deemed "preventive care" by the U.S. Preventive Services Task Force. These Services include, **for example**, a screening colonoscopy for adults between the ages of 50 and 75. (Preventive Services do NOT include diagnostic Services. Therefore, if your doctor orders a colonoscopy as a diagnostic tool, **for example**, to determine the extent of your diverticulitis, the procedure is diagnostic and not preventive and a Copayment will be charged.) The required Copayments differ depending on whether you use a Network or a Non-Network Provider.

    a. **Network Provider:** If you use a Network Provider, the Plan will pay benefits in full with no Copayment required from you.

b. Non-Network Provider: If you use a Non-Network Provider, after your outpatient surgery Copayment of $100 and the applicable Deductible and Coinsurance, the Plan will pay Benefits up to the lesser of the UCR or billed charges.

4. Mastectomy Benefits: 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 the "Major Medical Benefits" section. 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 8
OUTPATIENT DIAGNOSTIC BENEFITS

WHAT INFORMATION IS IN THIS SECTION? This Section includes information about the Benefits that the Fund provides for outpatient diagnostic Services (including those required by the U.S. Preventive Services Task Force) as well as the required Copayments.

1. Outpatient Diagnostic Services
2. Outpatient Diagnostic Services Provided Under Other Plan Sections

IMPORTANT NOTE: *PRECERTIFICATION MAY BE REQUIRED!*

1. **Outpatient Diagnostic Services.** 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.

    a. **Network Provider:** If you use a Network Provider, the Plan will pay Benefits in full. This applies to all Services under this Section, including those recommended by the U.S. Preventive Services Task Force.

    b. **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 after you have paid any required Deductible and Coinsurance. No Major Medical Benefits will be available.

    IMPORTANT NOTE: *PRECERTIFICATION MAY BE REQUIRED! Regardless of whether you use a Network or Non-Network provider, certain outpatient diagnostic Services (including, but not limited to, capsule endoscopies) require precertification. The Fund's benefits will be decreased or may not be available at all if you or your Provider do not precertify these procedures.*

2. **Outpatient Diagnostic Services Provided Under Other Plan Sections:** The Plan will pay for Hospital pre-admission testing under the Hospital Benefit provisions of the Plan. Eye exams and dental X-rays are payable under the vision and dental Benefit provisions of the Plan (see the "Hearing and Vision Benefits" and "Dental, Orthodontic and Orthognathic Surgery Benefits" sections). Contact the Fund Office with any questions you have on when other provisions of the Plan cover outpatient diagnostic Services.

    IMPORTANT NOTE: *Certain preventive diagnostic procedures may be provided with no patient cost-sharing. See the "Physician, Physical Therapy, and Immunization Benefits and Benefits for Preventive Care Services Provided by Your Physician" section for more information on preventive care benefits.*

SECTION 9
DENTAL AND ORTHODONTIC BENEFITS

WHAT INFORMATION IS IN THIS SECTION? This Section provides details about the dental Benefits the Fund provides, including annual maximum Benefits, orthodontic benefits and surgery for TMJ (orthognathic surgery).

1. Dental Benefits.
2. Dental Benefits: Special Rules
3. Dental Benefits: Services and Treatment
4. Orthodontic Benefits.
5. Orthognathic Surgery Benefits

1. Dental Benefits: Each covered individual in your Family is Eligible for dental Benefits up to one of the levels described below, and, within that limit, 100% of the "usual, customary and reasonable" ("UCR") charge for that Service. The Plan determines the fee schedule on which the UCR is based.

> ***IMPORTANT NOTE:*** *No annual or lifetime Benefit cap will be imposed on children under age 19 for Medically Necessary dental Services, as determined by the Fund and Delta Dental.*

a. Dental Benefits: Network Providers. The Fund provides dental Benefits that are administered by its Network Provider, Delta Dental. If you use a Network Provider, it is likely that your dental Benefit dollars will purchase more dental Services. In addition, if you use a Delta Dental Provider, the Provider will submit claims for you directly to Delta Dental. You will be responsible for any charges over the annual benefit maximum. However, you will be charged for those Services at the Network rate.

b. Dental Benefits: Non-Network Providers. The Fund will provide the same annual dollar maximum for Benefits regardless of whether you use a Network or a Non-Network Provider. If you use a Non-Network Provider, you may have to pay your dentist for Services and submit the claims to Delta Dental for adjudication and reimbursement. You will be responsible for any charges over the UCR. A Non-Network Provider sets its own rates and is not required to charge you at the Fund's Network or UCR rate.

c. Benefit Limits (See below for additional restrictions and limitations)

i. Routine

A. Network: 60% of contracted rate up to $600.00 per person per year;

B. Non-Network: up to 60% of UCR, up to $600.00 per person per year.

ii. Accidental: $600.00/per person/per injury.

2. **Dental Benefits: Special Rules:**

   a. **Dental Benefits can be applied only to the individual:** If you or another Family member do not use your entire annual Benefit maximum, the balance may not be applied to the balances of other Family members.

   b. **Dental Benefits can only be applied in a single Benefit Year:** No part of one Benefit Year's maximum can be transferred forward or backward to another Benefit Year's claims.

   c. **No Extended Eligibility for Dental Benefits:** Coverage is based upon the date of Service and the date of Service must fall within a month in which the Patient is Eligible for Benefits from the Fund.

      For example, Jeannie was Eligible for Benefits in November 2013 but the procedure couldn't be finished until January 2014, after she lost coverage. The Service received in January 2014 is not covered.

   d. **Major Medical Benefits May Not be Used for Dental Benefits:** Major Medical Benefits are not available to pay dental claims, even if you have exhausted your dental Benefits. However, an exception to this rule exists for dental implants as described below.

   e. **Special Rules for Dental Implants:** Special Rule for Dental Implants. If the Fund's dental advisor determines that an implant is necessary to maintain a Patient's dental health and function the Plan will pay the cost of the implant under the Medical Provisions of the Plan. Services related to implants, including but not limited to extractions and abutments, will remain subject to the rules for Dental Benefits.

      ***IMPORTANT NOTE**: A Provider, Participant, or Patient should submit a claim for implants to the Plan's dental advisor for determination of eligibility before installation of the implants. Failure to do so could leave the Provider and Patient with no source of payment of the implants if the plan's dental advisor subsequently determines that the implants do not qualify for coverage as a Medical Benefit.*

      Please note that Delta Dental will administer the payment of the dental implants as a medical claim and pay the claim outside of the annual maximum in order to utilize the Delta Dental network discounts.

3. **Dental Benefits: Services and Treatment**

   a. **Routine Cleaning:** In general, the Fund will pay for a maximum of two cleanings per Benefit Year, regardless of whether you use a Network or a Non-Network Provider.

i. **Cleaning During Pregnancy:** Participants or their Spouses who are Pregnant are entitled to one additional cleaning during the pregnancy.

b. Bleaching Following Antibiotic Therapy: The Fund will provide Benefits for bleaching following antibiotic therapy, subject to the Plan's annual limit and to a confirmation from the Delta Dental professional advisor that the treatment is dentally necessary. If you use a Network Provider, the Plan will pay up to the network rate. If you use a Non-Network Provider, the Fund will pay the lesser of the UCR rate or billed charges.

c. Periodontal Cleanings: If you use a Network Provider, you will be Eligible for periodontal cleaning as provided under the Delta Dental Plan of Benefits. The Plan provides for two routine cleanings and two Medically Necessary periodontal cleanings per Benefit Year. Contact the Fund office if you have further questions about available Benefits. If you use a Non-Network Provider, the Fund will pay for a maximum of two periodontal cleanings per Benefit Year.

Generally, even if you have not exhausted your per Benefit Year allowance, the Plan will not pay Benefits for more than two routine and two periodontal cleanings per Patient per Benefit Year. However, if you submit information demonstrating that additional cleanings are Medically Necessary, the Plan will pay Benefits for these additional cleanings subject to the Benefit Year limit.

d. Surgical Benefits Available for Surgical Extraction of Impacted Teeth, Orthognathic (TMJ) or Dental Surgery for Accidental Injury: If you have Medically Necessary surgery to remove impacted teeth or orthognathic surgery (for TMJ), the surgical Benefit provisions of the Plan will apply.

However, if you have an Accidental injury to your teeth, the Plan will pay Benefits up to $600 per Accident. This dollar limit will not apply to Medically Necessary pediatric dental care following an Accident. This additional Accidental dental Benefit is available only if you seek initial treatment within 48 hours of the Accident, and the dental Services are Medically Necessary.

e. Other "medical" procedures for "dental" problems: The Plan may pay Benefits for certain "dental" procedures following an Accident or illness under the medical or surgical provisions of the Plan. These procedures are not performed by dentists but instead may be performed by oral maxillofacial surgeons. Before you undergo a procedure by an oral maxillofacial surgeon, you may wish to contact the Fund office to find a Network oral maxillofacial surgeon and to confirm that the Plan will provide Benefits for this procedure.

f. Oral Surgery as Surgical and Not Dental Service: The Fund will pay Benefits for certain oral surgery under the surgical provisions of this Plan (**for example**, orthognathic surgery, removal of impacted teeth, Medically Necessary dental implants, etc.) The Trustees retain the discretion to determine whether the Fund will pay Benefits for certain Services under the provisions of this Section or under the Surgical provisions of this Plan.

4. **Orthodontic Benefits:** For each Child 18 years of age and under, the Plan will pay a Lifetime Benefit for Medically Necessary orthodontia up to $3,000 if you use a **Network Provider** and up to $2,000 if you use a **Non-Network Provider**. In order to receive this Benefit, the Child must have had his or her braces first applied while covered under this Plan, unless Creditable Coverage has been established. Dental Benefits cannot be applied to orthodontic services and treatment. These limits do not apply to medically necessary pediatric orthodontia.

5. **Orthognathic Surgery Benefits:** The Fund will pay Benefits for Medically Necessary orthognathic surgery, including all treatment for temporomandibular joint conditions ("TMJ"), surgical or non-surgical, but only if all of the Fund's requirements are met, including submission of x-rays, a treatment plan, and other documentation. All Orthognathic surgery, and any treatment for any condition likely to require Orthognathic surgery, including all TMJ conditions, will be subject to the Fund's Managed Care Program. If the treatment provided is a medical or surgical benefit, as identified by the procedure code (including certain dental codes designated by the Fund for required surgical treatment), the Fund will treat the claim as a Medical or Surgical Benefit.

SECTION 10
HEARING AND VISION BENEFITS

WHAT INFORMATION IS IN THIS SECTION? This Section provides information about the annual Benefits the Fund provides for hearing as well as detailing the vision Benefits the Fund provides, including the Benefits payable to Network and Non-Network Providers, as well as the examination, frame and lens allowances.

1. *Hearing Benefits*
2. *Vision Benefits*
3. *Vision Benefits: Medically Necessary Contact Lenses*
4. *Vision Benefits: Coordination of Benefits*

1. **Hearing Benefits:** Each Benefit Year the Plan will pay Benefits up to a maximum of $1,000 per Family for Medically Necessary hearing Services.

    a. **Hearing Benefits: Benefits Available.** The Plan pays Benefits up to the UCR for the purchase or repair of Medically Necessary hearing aids. The Plan does not provide any Benefits for batteries and other supplies for hearing aids. No Major Medical Benefits are available for hearing aids or related supplies.

2. **Vision Benefits:** The Fund provides Benefits for Medically Necessary vision Services whether you use a Network Provider or a Non-Network Provider. You will likely receive greater value if you use a Network Provider. The Trustees have selected DAVIS VISION as the Network Provider.

    IMPORTANT NOTE: *Consistent with the provisions of the Affordable Care Act and notwithstanding any specific provision set forth below, the Fund will not impose annual or lifetime dollar limits on Medically Necessary pediatric vision care for patients up to age 19.* [1]

    a. **Network Vision Benefits:** The Plan will pay Benefits for Medically Necessary vision Services if you use a Network (Davis Vision) provider as follows:

        i. **<u>Age 19 years or older:</u>** If you or your Dependent are age 19 or over, every two Benefit Years, you are Eligible for an eye exam. You may also choose any Fashion, Designer or Premier level frame from Davis Vision's Frame Collection, which would be covered in full. Or, if you select another frame in the Network Provider's office, a $90 credit will be applied. This credit would also apply at a retail location that does not

[1] Medically Necessary pediatric vision care includes the following:

- Comprehensive vision and eye health examination, by an optometrist, or ophthalmologist, during first year of life and continuing annually through age 18.
- The diagnosis and treatment of diseases, refractive errors, binocular disorders and injuries of the eye, adnexa and visual system.
- Treatment shall include but not be limited to the use of corrective devices and/or other therapeutic procedures to maximize vision and eye health.

carry the Davis Frame Collection. Patients are responsible for the amount over $90 (less the applicable discount). In the alternative, you may receive Benefits in full for soft contact lenses from a Network provider.

ii. **Under 19 years old:** If you or your Dependent are under age 19, every Benefit Year, you are Eligible for an eye exam. You may choose any Fashion, Designer or Premier level frame from Davis Vision's Frame Collection, covered in full. Or, if you select another frame in the Network Provider's office, a $90 credit will be applied. This credit would also apply at a retail location that does not carry the Davis Frame Collection. Patients are responsible for the amount over $90 (less the applicable discount). In the alternative, you may receive Benefits in full for soft contact lenses from a Network provider.

For example, Thomas Jones, Jr., the 13 year old son of Thomas Jones, Sr., a Participant, is entitled to one pair of eyeglasses during 2015. In January, 2015, Tom, Jr. obtains through the Fund new lenses for the frames he used in 2014. Because of the new lenses, Tom, Jr.'s eyeglasses will be considered to be new eyeglasses and Tom, Jr. will have no further allowance for eyeglasses until the 2016 Benefit Year.

iii. **Features for eyeglasses and soft daily wear contact lenses provided at no extra charge from Davis Vision**:

- Lenses and coatings provided at no additional charge include plastic or glass single vision, bifocal, or trifocal lenses, in any prescription range;
- glass grey #3 prescription lenses;
- oversize lenses; post-cataract lenses;
- polycarbonate lenses;
- scratch-resistant coating;
- tinting of plastic lenses
- intermediate vision lenses;
- glass photochromic lenses;
- ultraviolet (UV) coating;
- blended invisible bifocals;
- standard and premium brands of progressive addition multifocal lenses;
- standard ARC (anti-reflective coating).

This list is subject to change.

A. **Lenses and Coatings available for an additional charge from a Network Provider (Davis Vision):** Contact the Fund Office for more information about these Copayments:

- premium and ultra ARC (anti-reflective coating);

- polarized lenses;
- plastic photosensitive lenses;
- high-index lenses;
- certain disposable contact lenses;
- certain soft daily wear contact lenses;
- certain Frames not included in the Davis collection.

This list is subject to change.

IMPORTANT NOTE: *Gas Permeable (hard) contact lenses are* ***not covered*** *under the Davis Vision program. They are, however, covered under the Non-Network Benefits discussed in the next Section.*

b. Non-Network Vision Benefits: If an individual receives Services, lenses or frames from a Non-Network Provider, the Plan will pay reduced Benefits in the form of a reimbursement to you upon your submission of proper bills to the Plan. The Benefits payable are as follows:

i. If you or your Dependent are age 19 or over, every two Benefit Years you may receive up to $45 in Benefits for 1 eye examination, and up to $75 retail credit in Benefits for 1 complete pair of eyeglasses or contact lenses. These allowances are not transferable to other Benefit Years.

ii. If you or your Dependent are under age 19, every Benefit Year you may receive up to $45 in Benefits for 1 eye examination and $75 retail credit in Benefits for 1 complete pair of eyeglasses or contact lenses. These allowances are not transferable to other Benefit Years.

3. Vision Benefits: Medically Necessary Contact Lenses. If you suffer from a medical condition that requires contact lenses as opposed to eyeglasses, the Plan will pay for Medically Necessary special contact lenses. Davis Vision reviews each such request to determine Medical Necessity. These conditions include keratoconus, aphakia, anisometripia, aniseikonia, progressive/pathological myopia, aniridia, corneal disorder, post-traumatic corneal disorder, and irregular astigmatism. To be eligible for Benefits for Medically Necessary contact lenses, you must submit supporting documentation from your medical professional, which will be evaluated by the Fund's visual benefits provider or Medical Advisor.

4. Vision Benefits: Coordination of Benefits. If this Plan is secondary under this Plan's coordination of benefits rules, the Plan will pay up to the lesser of the Non-Network rate or the balance remaining after the primary insurance has made their payment. The Coordination of Benefits rules can be found in the "Coordination of Benefits and Subrogation" section of this APD-13Y.

SECTION 11
TRANSPLANT BENEFITS

WHAT INFORMATION IS IN THIS SECTION? This Section describes the Benefits payable by the Fund for Medically Necessary organ transplants.

1. Transplant Benefits
2. Benefits Payable if Transplant Fails
3. Benefits for Uninsured Organ Donor
4. Benefits after Transfer to Other Fund Plans

1. **Transplant Benefits**: The Plan will pay Benefits for Medically Necessary organ transplants of human heart, kidney, liver, lung, pancreas, and bone marrow and related Services, subject to the Plan's Managed Care Program. The level of Benefits paid by the Plan will depend on whether you are treated by a Network or Non-Network Provider:

    a. **Network Provider**: After you have paid a $100 Copayment, the Fund will provide Benefits 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. Treatment must be provided by a facility that has been designated as an Institute of Excellence, otherwise the claim will be paid as a Non-Network benefit.

    b. **Non-Network Provider**: After you have paid a $100 Copayment, the Fund will pay Benefits according to the Plan's Major Medical provisions 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.

2. **Benefits Payable if Transplant Fails**. If you receive an organ transplant and that organ later fails and you require a subsequent organ transplant, the Plan will provide additional Benefits. The level of Benefits will depend on whether the transplant is performed at a Network or Non-Network Provider.

3. **Benefits for Uninsured Organ Donor**: Transplant Benefits include treatments for the organ donor if he or she has no Other Insurance.

4. **Benefits after Transfer to Other Fund Plans**: The transplant Benefit will continue even if you move into another Plan sponsored by the Fund (**for example**, Plan 14 or the Retiree Plan) with no transplant benefit or a less generous transplant benefit. For the Benefit to follow you to another Plan, the transplant must have occurred while you were enrolled in this Plan.

SECTION 12
MENTAL NERVOUS/SUBSTANCE ABUSE BENEFITS

WHAT INFORMATION IS IN THIS SECTION? This Section provides information about the Benefits available for Mental Illness and Substance Abuse Benefits for both inpatient and outpatient treatment.

1. **Mental Health Benefits:** The Plan will pay Benefits for Medically Necessary mental illness or substance abuse treatments, subject to the Plan's Managed Care Program. The level of Benefits depends on whether you receive treatment from a Network or Non-Network Provider and whether the treatment is counseling or screening recommended by the U.S. Preventive Care Task Force (see below for additional information):

    a. **Inpatient Treatment.** The Plan will pay Benefits for Medically Necessary inpatient Benefits mental illness and substance abuse treatment, as follows.

        IMPORTANT NOTE*: Like all inpatient admissions, admissions for mental health and substance abuse treatment are subject to the Fund's Managed Care Program. If you have an Emergency admission for mental health or substance abuse issues, you or your Provider must notify the Fund Office within two business days after treatment/Hospitalization. If you fail to pre-certify your Hospital stay or treatment, the Fund may limit or deny Benefits for the claims incurred.*

        i. **Network Hospital.** If you receive treatment at a Network Hospital for mental / substance abuse, following your payment of a $100 Copayment, you will receive Benefits equal to payment in full.

        ii. **Non-Network Hospital.** For Medically Necessary stays at a Non-Network Hospital for mental/ substance abuse, the Plan will pay Benefits in accordance with the Plan's Major Medical Provisions after you have paid a $100 Copayment and met the annual Deductible ($150 individual/$450 Family) and coinsurance requirements (10% of the remaining charges until you have paid an annual total of $2,000 (Individual)/$4,000 (Family) in out-of-pocket charges).

        IMPORTANT NOTE: *If the Plan denies your room and board Benefits for a Non-Network Hospitalization because they are not Medically Necessary (as defined in this 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 or she is a Non-Network Provider. No Major Medical Benefits will be available.*

    b. **Exchange of In-Patient Treatment for Outpatient Treatment.** The Plan will pay Benefits for Medically Necessary Services provided under "partial Hospitalization" and "intensive outpatient" programs. In exchange for In-Patient Hospital Benefits, the Fund will provide Benefits for "partial Hospitalization"

treatment at a rate of 2:1 and for "intensive outpatient" treatment at a rate of 4:1 (that is, two "partial Hospitalization" treatments in exchange for one day of inpatient Hospitalization and four "intensive outpatient" treatments in exchange for one day of inpatient Hospitalization).

c. Outpatient Treatment. The Plan will pay outpatient Benefits for Medically Necessary visits for mental illness and substance abuse, as follows:

i. Network Provider. If you use a Network Provider, you will receive Benefits equal to payment in full. You will have a $20 Copayment for each visit.

ii. Non-Network Provider: For office visits to a Non-Network Provider, the Plan will pay Benefits equal to the lesser of UCR or billed charges, less a $30 Copayment that you will have to pay per visit.

iii. Preventive Care Services Provided Under this Section. In accordance with the terms of the Affordable Care Act, the Fund will provide Benefits for screening and counseling for the "A" or "B" recommendations of the U.S. Preventive Services Task Force with no Copayment to you. If, however, the counseling or screening is provided in conjunction with other mental health or substance abuse Services or Treatment, you will be responsible for the Copayments for the additional Services or Treatment. Representative counseling and screening recommended by the U.S. Preventive Services Task Force include screening and counseling for alcohol misuse, and depression. The recommendations are tailored to certain groups and only at-risk patients as identified in the Guidelines are Eligible for Treatment with no Copayment. If you want to learn about the recommended screening and counseling, you can find more information from the Task Force's website at: http://www.healthcare.gov/center/regulations/prevention/taskforce.html

If you wish to verify whether the treatment or counseling you receive will be subject to a Copayment, call the Fund Office.

SECTION 13
PRESCRIPTION DRUG BENEFITS

WHAT INFORMATION IS IN THIS SECTION? This Section provides information about the brand name and generic prescription drug Benefits that the Fund provides, the mail order feature, Copayments for the different types of prescription drugs, Step therapy requirements, and the Fund's rules regarding vitamins.

1. **Prescription Drug Benefits:** The Plan pays Benefits for Medically Necessary prescription drugs (subject to the Plan's Managed Care Program). **However, the Fund provides no Benefits for "Compound" drugs (a mixture of two or more drugs prepared by a pharmacist).** The Benefits available for prescription drugs depends on several factors, including:

   - whether you use a Network or Non-Network Pharmacy;
   - whether your drug is a generic drug, a "preferred" brand name drug, that is, one that appears on the Fund's Formulary; or a "non-preferred" brand name drug;
   - whether you purchase prescriptions at a retail pharmacy or through mail order;
   - whether your drug is a "specialty" drug;
   - whether your drug is subject to one of the limitations described below.

2. **Copayments:** If Benefits are available for your drug, you will be responsible for the following copayments, subject to the additional limitations set forth below:

   a. **Network Pharmacy**: The Fund's Network Provider for prescription drugs is General Prescription Programs, Inc. (GPP). If you fill your prescription at a GPP – participating pharmacy, you will receive a 34-day supply of the prescription, if you present your Fund GPP card and make the required Copayment:

      i. **Generic Drugs:** A Copayment of $10. Unless your doctor has indicated on the prescription that a brand name drug is Medically Necessary, your prescription may be filled with a generic version of a brand name drug if available.

      ii. **Preferred Brand Name Drugs:** A Copayment of $30 for a brand name drug that is listed on the Fund's Formulary.

iii. **Non-Preferred Brand Name Drugs:** A Copayment of $50 for a non-preferred brand name drug that is **NOT** listed on the Fund's Formulary.

IMPORTANT NOTE: *about the Fund's Formulary: The Formulary may change in the future without advance notice to you upon the advice of the Fund's pharmacy benefit manager. The Fund's Formulary is furnished automatically, without charge, as a separate document and can also be found on the Fund's website at www.centralpateamsters.com. In addition, the Formulary is published regularly in the Fund's newsletter. From time to time, you will receive notices and newsletters from the Fund Office listing any revisions to the Formulary. However, if you are not certain whether a particular prescription drug is on the Formulary, contact the Fund Office.*

b. 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 to receive reimbursement. You must ask the pharmacy for an itemized receipt listing the patient's name, dispensing date, name of the drug, and the amount paid. The Fund will forward the documentation to GPP on your behalf. The reimbursement will be equal to the GPP wholesale price of the drug, less the per-prescription Copayment listed above under "Network Pharmacy."

c. Mail Order Prescription Drug Program: You can purchase Medically Necessary maintenance prescription drugs (**for example**, high blood pressure medication) through GPP's mail order program. Call the Fund Office (610-320-5500; Toll-free in PA: 800-422-8330; Toll-free in USA 1-800-331-0420) to request a prescription order form. In addition, you can register to place your mail order refills on line by following the instructions found on the Fund's website at www.centralpateamsters.com.The Copayments for Mail Order Prescription Drugs are:

i. **Generic:** $30 for generic drugs for up to a 90-day supply;

ii. **Preferred Brand Name Drugs:** $60 for "preferred" brand name drugs for up to a 90-day supply;

iii. **Non-Preferred Brand Name Drugs:** $100 for a "non-preferred" brand name drug that is **NOT** listed on the Fund's Formulary for up to a 90-day supply.

d. Special copayment for Zohydro: The copayment for all Zohydro prescriptions will be **$150** per script (for a 15-day supply).

3. **High Cost Drugs:**

    a. **Prescription Drugs Over $500:** If your prescription medication costs $500 or more, the pharmacist must **call GPP to get pre-authorization for the medication**. The phone number for GPP is on the back of your prescription card.

    b. **Specialty Drugs: "**Specialty Drugs" are defined as ***any*** medication that costs more than $3,000 per month. The Copayment for all Specialty Drugs is $150 at retail and $300 through Mail Order, if available.

4. **Step Therapy:** Step Therapy is a process under which a patient who is beginning a drug therapy starts with the most cost-effective and safest medication (Step I) and progresses to other more costly or risky therapy (Step II), and then only if "medically necessary." The Fund will ***not*** pay benefits for certain brand name medications until you have first tried but failed on a medication listed in Step I. The Fund will ***ONLY*** provide benefits for medications listed in Step II if you tried a Step I medication and your physician provides documentation showing that you failed on the Step I medication and that the Step II medication is "medically necessary."

Before beginning a new medication,
it is essential that you inform your doctor
about the Fund's Step Therapy policy.

IMPORTANT NOTE: *When you review the list of drugs subject to Step Therapy, please look carefully to see if your medication is "grandfathered." While effective January 1, 2016, the Fund requires that you try and fail on a Step I medication before providing benefits for a Step II medication, the Fund will provide benefits for certain categories of Step II medications, such as ADD & ADHD, Anti-Migraine, Anti-Convulsants, Proton Pump Inhibitors and Ulcerative Colitis, if your physician can provide documentation that at some point in the past, you tried and failed on a Step I medication.*

The medications in each category are subject to change. Please make sure to check with the Fund (Phone: Toll Free in PA: 1-800-422-8330; Toll Free in USA: 1-800-331-0420) or on the Fund's website (www.centralpateamsters.com) for updates to this chart before beginning a course of medication.

    a. **Step Therapy Categories NOT Subject to Grandfathering:** Effective January 1, 2016, the Fund will **NOT** provide benefits for medications in Step II unless you have documented that you have tried and failed on a Step I medication and your physician has submitted documentation demonstrating that the Step II medications are "medically necessary" under the Fund's criteria.

CATEGORY	STEP I	STEP II
ALZHEIMER'S DISEASE	DONEPEZIL GALANTAMINE RIVASTIGMINE	ARICEPT EXELON NAMENDA RAZADYNE
ANGIOTENSIN RECEPTOR BLOCKERS (ANTIHYPERTENSIVES)	CANDESARTAN EPROSARTAN IRBESARTAN LOSARTAN TELMISARTAN VALSARTAN	ATACAND AVAPRO BENICAR COZAAR DIOVAN EDARBI MICARDIS TEVETEN
ANTI-DEPRESSANTS	BUPROPION HCL DESVENLAFAXINE DULOXETINE ESCITALOPRAM FLUOXETINE NEFAZODONE SERTRALINE TRAZODONE VENLAFAXINE	APLENZIN BRINTELLIX CYMBALTA EFFEXOR FETZIMA FORFIVO XL KHEDEZLA LEXAPRO OLEPTRO PRISTIQ PROZAC VllBRYD WELLBUTRIN ZOLOFT
ANTI-GLAUCOMA EYE PREPARATIONS	APRACLONIDINE HCL BETAXOLOL BRIMONIDINE CARTEOLOL DORZOLAMIDE LATANOPROST LEVOBUNOLOL METIPRANOLOL PILOCARPINE TIMOLOL TRAVOPROST	ALPHAGAN AZOPT BETIMOL BETOPTIC COMBIGAN COSOPT IOPIDINE ISTALOL LUMIGAN PHOSPHOLINE RESCULA SIMBRINZA TIMOPTIC TRAVATAN TRUSOPT XALATAN ZIOPTAN
ANTIPSYCHOTICS	CLOZAPINE OLANZAPINE QUETIAPINE RISPERIDONE ZIPRASIDONE	ABILIFY - Evidence of "medical necessity" must include documentation of failure of all other therapies, including non-drug intervention
BETA-ADRENERGIC BLOCKERS (ANTIHYPERTENSIVES)	ACEBUTOLOL ATENOLOL BETAXOLOL BISOPROLOL METOPROLOL NADOLOL PINDOLOL PROPRANONOL SOTALOL TIMOLOL	BYSTOLIC

CALCIUM CHANNEL BLOCKERS (ANTIHYPERTENSIVES)	AMLODIPINE ATORVASTATIN AMLODIPINE BESYLATE AMLODIPINE VALSARTAN DILTIAZEM FELODIPINE ISRADIPINE NICARDIPINE NIFEDIPINE NISOLDIPINE VERPAMIL	ADALAT CADUET CALAN CARDENE CARDIZEM CARTIA XT EFIDITAB EXFORGE NORVASC PROCARDIA XL SULAR TIAZAC ER VERELAN
CONTRACEPTIVES **IMPORTANT NOTE: ALL BRAND CONTRACEPTIVES ARE CONSIDERED STEP II MEDICATIONS AND ARE NOT SUBJECT TO GRANDFATHERING**	All Generic Contraceptives	All Brand Contraceptives
DIABETES	ACARBOSE GLIMEPIRIDE GLIPIZIDE GLYBURIDE JANUMET JANUVIA METFORMIN PIOGLITAZONE REPAGLINIDE	INVOKANA JARDIANCE JENTADUETO KAZANO TRADJENTA
NARCOTIC ANALGESICS **IMPORTANT NOTE: BENEFITS WILL BE PROVIDED ONLY FOR NARCOTIC ANALGESICS PRESCRIBED AT THE MANUFACTURERS RECOMMENDED SCRIPT LEVEL.**	ACETAMINOPHEN-CODEINE HYDROCODONE-ACETAMINOPHEN HYDROMORPHONE MEPERIDINE METHADONE MORPHINE SULFATE OXYCODONE OXYCODONE-ACETAMINOPHEN OXYCODONE-ASPIRIN OXYMORPHONE TRAMADOL	DEMEROL DOLOPHINE LORTAB NORCO NUCYNTA OPANA OXYCONTIN PERCOCET PERCODAN TYLENOL WITH CODEINE ULTRACET ULTRAM VICODIN VICOPROFEN
OSTEOPOROSIS	ALENDRONATE CALCITONIN-SALMON IBANDRONATE RALOXIFENE RISEDRONATE	ACTONEL ATELVIA BINOSTO BONIVA EVISTA FORTICAL FOSAMAX MIACALCIN PROLIA
RHEUMATOID ARTHRITIS	**EFFECTIVE 3/8/16, THE FOLLOWING GENERIC DRUGS ARE NOW ADDED TO THE STEP 1 RHEUMATOID ARTHRTIS STEP THERAPY:** HIGH DOSE IBUPROFEN AND NAPROXEN (PRESCRIPTION STRENGTH) CELECOXIB NABUMETONE PIROXICAM	ACTEMRA CIMZIA ENBREL HUMIRA KINERET ORENCIA SIMPONI STELARA

	DICLOFENAC DIFLUNISAL INDOMETHACIN KETOPROFEN ETODOLAC PREDNISONE CYCLOPHOSPHAMIDE CYCLOSPORINE AZATHIOPRINE METHOTREXATE XELJANZ	
URINARY AGENTS	TOVIAZ FLAVOXATE OXYBUTYNIN TOLTERODINE TROSPIUM	ENABLEX GELNIQUE MYRBETRIQ OXYTROL VESICARE

b. Grandfathered Drugs: Effective January 1, 2016, any NEW prescriptions for the medications in the chart below are subject to the Step Therapy requirements set forth above. If, however, you are currently taking a medication in one of these categories, the Fund will continue to provide benefits for your medication.

CATEGORY	**STEP I**	**STEP II**
ADD & ADHD	AMPHETAMINE SALTS D-AMPHETAMINE ER DEXMETHYLPHENIDATE DEXTROAMPHETAMINE METHAMPHETAMINE METHYLPHENIDATE	ADDERALL CONCERTA DAYTRANA DESOXYN DEXEDRINE EVEKEO FOCALIN METADATE METHYLIN PROCENTRA QUILLIVANT RITALIN VYVANSE ZENZEDI
ANTI-MIGRAINE	DIHYDROERGOTAMINE ERGOTAMINE-CAFFEINE TABLET ISOMETHEPT-CAFF-APAP ISOMETHEPT-DICHLORALP-APAP NARATRIPTAN RIZATRIPTAN SUMATRIPTAN ZOLMITRIPTAN	ALSUMA AMERGE AXERT CAFERGOT D.H.E.45 ERGOMAR FROVA IMITREX MAXALT MIGERGOT MIGRANAL RELPAX SUMAVEL TREXIMET ZOMIG
ANTI-CONVULSANTS	CARBAMAZEPINE CLONAZEPAM DIVALPROEX ETHOSUXIMIDE FELBAMATE FOSPHENYTOIN GABAPENTIN LAMOTRIGINE	APTIOM BANZEL CARBATROL CELONTIN CEREBYX DEPACON DEPAKENE DEPAKOTE

CATEGORY	STEP I	STEP II
	LEVETIRACETAM OXCARBAZEPINE PHENYTOIN PRIMIDONE TIAGABINE TOPIRAMATE VALPROATE VALPROIC ACID ZONISAMIDE	DILANTIN FANATREX FELBATOL FYCOMPA GABITRIL KEPPRA KLONOPIN LAMICTAL MYSOLINE NEURONTIN ONFI OXTELLAR PEGANONE PHENYTEK POTIGA QUDEXY TEGRETOL TOPAMAX TRILEPTAL TROKENDI VIMPAT ZARONTIN ZONEGRAN
PROTON PUMP INHIBITORS	OVER THE COUNTER ("OTC"): LANSOPRAZOLE DR OTC NEXIUM OTC OMEPRAZOLE OTC OMEPRAZOLE-BICARB OTC PREVACID OTC PRILOSEC OTC ZEGERID OTC	ACIPHEX DEXILANT ESOMEPRAZOLE LANSOPRAZOLE OMEPRAZOLE LANSOPRAZOLE NEXIUM OMEPRAZOLE OMEPRAZOLE-BICARB PANTOPRAZOLE PREVACID PRILOSEC PROTONIX ZEGERID
ULCERATIVE COLITIS	AZULFIDINE BALSALAZIDE SULFASALAZINE SULFAZINE	APRISO ASACOL COLAZAL DELZICOL DIPENTUM GIAZO LIALDA PENTASA

c. Special Step Therapy Rules: Proton Pump Inhibitors ("PPI"):

i. **Patients Must First Use an OTC PPI:** For initial prescriptions, the Fund will provide Benefits only for an over-the-counter (OTC) PPI. In order to obtain this medication, you must ask your physician to provide a script for the OTC PPI. You must then present this prescription at the pharmacy. You will then receive up to a 34-day supply after paying your Copayment. If the OTC PPI proves effective, you may obtain refills at your local pharmacy or through the Fund's Mail Order Program.

ii. **Benefits for PPI's if OTC Medication Not Effective:** If the medication is not effective, the Fund will pay Benefits for a non-OTC PPI after your physician provides sufficient documentation to the Fund demonstrating that the non-OTC PPI is Medically Necessary. The physician must provide information specific to your condition, showing why the non-OTC PPI is Medically Necessary. It is **not** sufficient for the physician to check the "Brand Necessary" box on the prescription form or to provide a generalized discussion without describing why the prescribed medication is Medically Necessary for the patient.

5. **Pre-Authorization:** Pre-authorization review is a cost-savings feature that the Fund uses to ensure the appropriate use of selected prescription medications. This program is designed to prevent improper prescribing, use of certain medications that may not be the best choice for a health condition, or use of medications that may not be "medically necessary" as that term is defined by the Plan. Please contact the Fund Office to learn if the medication your physician has prescribed is subject to a pre-authorization review. The Fund will not provide benefits for these medications unless all of the pre-authorization criteria are met.

   a. **Examples: Many medications are subject to the Fund's pre-authorization rules.** A few examples of medications subject to pre-authorization:

      i. **Zohydro:** The Fund will provide no benefits for Zohydro unless a request has been submitted to GPP and approved pursuant to the Fund's pre- authorization criteria. The pre-authorization criteria include trying certain other medications listed in Step I under Narcotic Analgesics in the attached "Step Therapy" protocol. In addition, the copayment for all Zohydro prescriptions will be $150 per script for a 15-day script.

      ii. **PCSK9:** The Fund will ***ONLY*** provide benefits for a PCSK9 medication where that medication has been pre-authorized under the Fund's criteria. The medications will be considered for patients with diagnosed and documented homozygous familial hypercholesterolemia (HoFH), who have no labeled contraindications to this therapy, where the therapy is prescribed by or in consultation with a cardiologist or lipid specialist, and who submit required documentation

      iii. **Hepatitis C drugs**: the Fund will ***ONLY*** provide benefits where the medication has been pre-authorized under the Fund's criteria, which include the patient's Metavir score, as well as documentation of patient specific information related to their condition provided by the patient's physician.

6. Limits on Specific Medications:

a. Insulin Drugs. For new prescriptions, the Fund will ***only*** provide Benefits for Insulins on the Preferred Brand Name Drug List under the Hyperglycemic category, and not for any other insulin medication. This list can be found on the Fund's website at www.centralpateamsters.com under Health and Welfare, Prescription Drug Benefits.

> ***IMPORTANT NOTE:*** *If you are currently taking another insulin medication, you will be "grandfathered," that is, the Fund will continue to provide benefits for this medication.*

b. No Coverage for Advair or Breo. Effective January 1, 2016, the Fund ***will not provide any benefits for ADVAIR or BREO***. The Fund will provide benefits for the Asthma medications listed on the attached Formulary or other medically necessary asthma medications to which Fund restrictions or prohibitions do not apply. Copayments will vary depending on the medication. No patients will be "grandfathered" for these medications.

c. Limits on FDA "CLASS II" Pain Medications: Effective January 1, 2016, the Fund will provide benefits for **a maximum of fifteen days (15) per script** for medications classified as CLASS II pain medications by the U.S. Food and Drug Administration.

d. No Benefits for "Reformulated" Medications: Effective January 1, 2016, the Fund ***will not provide any benefits for the medications in Column A***. The Fund will provide benefits for the medications in Column B. This list is subject to modification.

COLUMN A	**COLUMN B**
ATIVAN 0.5 MG TABLET	LORAZEPAM 0.5 MG TABLET
ATIVAN 1 MG TABLET	LORAZEPAM 1 MG TABLET
ATIVAN 2 MG TABLET	LORAZEPAM 2 MG TABLET
COLAZAL 750 MG CAPSULE	BALSALAZIDE DISODIUM 750 MG CAPSULE
DEXPAK 10 DAY 1.5 MG TABLET	DEXAMETHASONE 1.5 MG TABLET
FORTAMET ER 1,000 MG TABLET	METFORMIN ER 1,000 MG TABLET
GLUMETZA ER 1,000 MG TABLET	METFORMIN ER 1,000 MG TABLET
NORITATE 1% CREAM	METRONIZADOLE 1% GEL
VASOTEC 2.5 MG TABLET	ENALAPRIL MALEATE 2.5 MG TABLET
VASOTEC 5 MG TABLET	ENALAPRIL MALEATE 5 MG TABLET
VASOTEC 10 MG TABLET	ENALAPRIL MALEATE 10 MG TABLET
VASOTEC 20 MG TABLET	ENALAPRIL MALEATE 20 MG

7. **Coverage for prescription drugs newly released to the market:** Effective January 1, 2016, the Fund will provide no benefits for new brand-name prescription medications for the first six months after their initial public release. After the initial six-month period, these medications will be subject to any applicable plan rule (**for example**, medical necessity, copayment, pre-authorization, quantity limits, etc.). (This limitation does not apply to FDA approved contraceptive medications that must be provided under the Affordable Care Act.)

8. **Preventive Services Covered Under This Section**

   a. **Vitamins and Supplements Covered as "Preventive Services" under the Affordable Care Act.** The Fund provides Benefits for certain vitamins and supplements at no Copayment under the Affordable Care Act. However, Benefits are only available for those vitamins and supplements specifically recommended, and rated "A" or "B" by the United States Preventive Services Task Force.

      For example, folic acid is one of the supplements recommended by the Task Force for women who are of child-bearing age. Emma, 23, is Eligible to receive folic acid with no Copayment. However, Philip, 53, is not Eligible to receive this supplement with no Copayment.

      The website listing these items and services can be found at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. The recommended vitamins and supplements include, but are not limited to, aspirin to prevent cardiovascular disease, folic acid for women of childbearing age, and iron supplements, for at-risk patients indicated in the Task Force Guidelines. Contact the Fund Office if you'd like to confirm if a particular vitamin or supplement is covered.

   b. **No Copayment Required for Certain "Preventive Care" Vitamins and Supplements.** The Fund will provide Benefits for those non-prescription vitamins and supplements recommended by the United States Preventive Care Task Force at no cost to the patient when they are for preventive care and are provided by a Network Provider.

      IMPORTANT NOTE: *In order to purchase the recommended vitamins or supplements at no Copayment, you must obtain a prescription from your doctor for these products and submit your prescription benefit card at the pharmacy counter*.

SECTION 14
MAJOR MEDICAL BENEFITS

WHAT INFORMATION IS IN THIS SECTION? This Section describes the "Major Medical" Benefits payable from the Fund. Major Medical Benefits include the Services and Items described below that are not covered under the specific Benefits provided in other Sections of this Plan.

1. Major Medical Benefits
2. Major Medical Deductible and Co-insurance
3. Limits on and Coordination of Benefits for "Out of Pocket" Costs

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

a. Benefits for Non-Network Providers: The Plan pays Major Medical Benefits for Services or treatment for a diagnosed condition for Medically Necessary Hospital Services, inpatient Services (including surgical charges), and transplants from Non-Network Providers.

i. The Plan limits the Benefits it pays for treatment by Non-Network Providers. Typically, the Plan will pay only up to the Usual, Customary and Reasonable rate (UCR) for a Service performed by a Non-Network Provider, less any applicable Deductibles or Copayments. The UCR is a percentile of a database that has been carefully selected by the Trustees. Unless otherwise indicated in this APD-13Y, 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. As of the effective date of this APD-13Y, the Fund uses a database compiled by Fair Health.

ii. If there is no UCR for the particular Service rendered, the Plan will pay Benefits to Non-Network Providers using a percentage of billed charges.

b. Additional Major Medical Benefits: In addition, Major Medical Benefits are provided for the following:

i. Non-inpatient nurse (RN or LPN) Services up to 240 hours per Benefit Year;

ii. Non-inpatient nurse (RN or LPN) Services after 240 hours per Benefit Year, payable at 50%;

iii. Oxygen and its administration;

iv. Blood and blood plasma, except whole blood products;

v. The rental, purchase or repair of Durable Medical Equipment, including wheelchairs, Hospital beds, crutches, and respirators;

vi. 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 Medically Necessary replacements of the initial brace once every two Benefit Years;

vii. The purchase, replacement or repair of Medically Necessary artificial eyes, an artificial larynx, and prostheses for arms, hands and legs;

viii. The purchase of mastectomy bras (2 per Benefit Year) and bra inserts (2 per breast per Benefit Year); and

ix. 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.

2. **Major Medical Deductible and Co-insurance:** Once the Deductible and Coinsurance 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 Coinsurance obligation will renew.

    a. **Deductibles:** There is a $150 per-Patient Deductible each Benefit Year. No more than three such Deductibles ($450) shall be payable by a Family in any single Benefit Year.

    b. **Coinsurance**: 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 $2,000 (limited to $4,000 per Family in any given Benefit Year), as well as any amounts in excess of the UCR.

        For example, John and his wife Mary are enrolled in the Plan. John had elective surgery and went to a Non-Network Hospital. His Non-Network Hospital bill was $10,000 (which, in this example, is less than the UCR). John will have to pay $1,225 out-of-pocket. This amount is made up of the $100 inpatient Copayment, $150 Deductible plus 10% of the balance of the charges ($10,000 minus $250 equals $9,750. 10% of that amount is $975. Together with the copayment of $100.00, the Deductible of $150 and the coinsurance amount of $975.00, John will pay, in total, $1,225.00).

3. **Limits on and Coordination of Benefits for "Out of Pocket" Costs:** The Fund limits out of pocket costs to the statutory maximum. Effective January 2015, this amount is equal to the Deductible permissible under the Internal Revenue Code for "high-deductible health plans." The Fund will coordinate the "out of pocket" maximum

expenditures with Other Coverage. The Fund will remit to the individual a refund of the amount that exceeds the out-of-pocket maximum only if he or she is actually left with an unpaid balance after the benefits are coordinated with available Other Coverage.

SECTION 15
SHORT TERM DISABILITY

The Plan does not provide Short Term Disability Benefits

SECTION 16
DEATH BENEFITS

WHAT INFORMATION IS IN THIS SECTION? This Section describes the Death Benefits provided by the Plan and the terms under which these Benefits are payable. Also described in this Section are Accidental Death and Dismemberment Benefits.

1. **In General.** The Plan will purchase on your behalf a life insurance policy from The Hartford to provide Benefits for your Eligible Dependents in the event of your death. Subject to the terms of that policy, if you die, the Plan will pay death Benefits of $5,000 to your Designated Beneficiary. If your Spouse dies, you will receive a death Benefit of $1,000, and if your Child older than 14 days dies, you will receive a death Benefit of $1,000.

2. **The Hartford.** The Fund provides these benefits in accordance with the terms and conditions of the insurance policy that it has purchased. The Fund's Death and Accidental and Death Benefits are provided under a contract with The Hartford. A copy of this policy is incorporated in this Plan by reference, and is available from the Fund Office upon request.

3. **Beneficiary Designation.** You may designate a Beneficiary of your Death Benefit. Unless otherwise specified, if more than one Beneficiary survives the Participant, all surviving named Beneficiaries will share equally. If no Beneficiary is alive on the date of the Participant's death, payment will be made to the Participant's estate. If no Beneficiary is named, the benefit will be paid to the Participant's estate.

4. **Payment to the Guardian of Minor Child**: Under Pennsylvania law, if you die without a Spouse but leave a Child under age 18, a guardian must be named to manage the insurance money for the minor child. The Child's parents have the right to designate this guardian as part of the life insurance beneficiary designation or as part of their wills but if they fail to do so, the Fund will not remit payment until the court has appointed a guardian. Upon receipt of the appropriate documentation, the Fund will pay the benefit to the duly appointed guardian, absent a determination by the Trustees that the benefit may be released without the appointment of a guardian.

5. **Death Within 31 Days.** If you die within the 31-day period following the termination of your Fund coverage, during which you would have been entitled to convert your Fund coverage to individual coverage, your Beneficiary will receive a Benefit under this section upon Notice and Proof of Claim, regardless of whether you have made an application for the individual policy or whether payment of the first premium has been made. The benefit is the amount of Life Insurance you would have been eligible to convert.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

1. **In General.** The Plan will purchase on your behalf an accidental death and dismemberment insurance policy from The Hartford to provide Benefits to you or your Eligible Dependents in the event of your accidental death or dismemberment. Subject to the terms of that policy, if you die or are dismembered as the result of an accident, the Plan will pay Benefits as described below to you or to your Designated Beneficiary. A copy of this policy is incorporated in this Plan by reference, and is available from the Fund Office upon request. In no event will the Fund pay more than one dismemberment Benefit per Accident.

2. **Amount of Benefit.**

    a. **Accidental Death.** If you die as a result of an Accident, the Fund will pay your Designated Beneficiary an Accidental death Benefit of $5,000, in accordance with the policy in place and on receipt of all required documentation. This Benefit is in addition to any death Benefit payable under "Death Benefits" described above.

    b. **Accidental Dismemberment.** The Fund will pay the following dismemberment Benefits in accordance with the policy in place and on receipt of all required documentation:

Loss of speech and hearing in both ears	$ 5,000
Quadriplegia	$ 5,000
Both hands	$ 5,000
Both feet	$ 5,000
Sight in both eyes	$ 5,000
One hand and one foot	$ 5,000
One hand or foot and sight in one eye	$ 5,000
Paraplegia or triplegia	$ 3,750
Severance of one limb	$ 2,500
Loss of sight in one eye	$ 2,500
Loss of speech or hearing in both ears	$ 2,500
Hemiplegia	$ 2,500

Loss of thumb and index finger on same hand	$ 1,250
Uniplegia	$ 1,250

You and your Beneficiaries may also be eligible for the following additional benefits available under The Hartford policy: Business Travel Benefit; Seat Belt/Air Bag Benefit; Helmet Benefit; Coma Benefit; Repatriation Benefit; Home Alteration or Vehicle Modification Benefit; Bereavement Counseling Benefit; Rehabilitative Training Benefit; Dependent (Child and Spouse) Education Benefit; Child Care Benefit; Critical Burn Benefit; Felonious Assault Benefit; and Accelerated Benefit/ Terminal Condition Coverage Benefit. See The Hartford policy for more information on these Benefits.

3. **Limits on Accidental Dismemberment Benefits.** In no event will the Fund pay more than one dismemberment Benefit per Accident. Moreover, the Fund will not pay any Accidental death or dismemberment Benefits if the death or dismemberment was the result of illness rather than Accidental injury.

IMPORTANT NOTE: Supplemental Life Insurance Coverage: In addition to the Benefits that are available through the Fund's Plan of Benefits, The Hartford also offers Fund Participants the opportunity to purchase supplemental life insurance coverage directly from The Hartford. While the Fund permits The Hartford to offer this supplemental coverage directly to Participants, the Fund is not responsible for and has no control over the terms, availability or administration of the supplemental coverage.

SECTION 17
EXCLUSIONS

WHAT INFORMATION IS IN THIS SECTION? This Section describes the Plan's General Exclusions, as well as those specific to the Major Medical and Accidental Death and Dismemberment Benefits.

1. Exclusions:
2. Major Medical Exclusions
3. Accidental Death and Dismemberment Benefits Exclusions

1. Exclusions: The Fund will not pay Benefits if 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. In addition, the Fund will not pay Benefits if the Claim is subject to any of the exclusions set forth below:

a. Medical Necessity: The Fund will not pay Benefits if the Service is not Medically Necessary as determined by the Trustees in reliance upon the Plan's professional Medical Advisors.

b. Lack of Eligibility: The Fund will not pay Benefits if the Service was rendered at a time when the individual was not Eligible for Benefits as described in the "Eligibility" section above.

c. Certain Actions by the Participant or Eligible Dependent.

i. Alcohol and Drugs: The Fund will not pay Benefits (i) (except for substance abuse Benefits summarized in the "Mental/Nervous/Substance Abuse Benefits" section) if the Service is rendered coincident to the patient's driving with a blood alcohol limit at or in excess of the applicable lawful limit; (ii) as coincident with the patient's ingesting an illegal substance; and / or (iii) coincident with the patient's participation in an illegal activity.

ii. False or Misleading Information: The Fund will not pay Benefits if the Service is rendered as a result of the patient's submission to a Provider of incorrect, false or misleading information, or the Provider is paid as a result of the patient's submission (or the patient's Provider's submission) to the Plan of incorrect, false or misleading information. False or misleading information includes, but is not limited to, failing to inform the Fund of a change in status, **for example**, a divorce. (See, below, in the "Coordination of Benefits and Subrogation" section for a description of the Fund's rights if Benefits are paid pursuant to false, incorrect or misleading information.)

iii. Failure to Comply with Fund Rules: The Fund may reduce or deny Benefits if the Service was rendered when the patient (or the patient's

Provider) failed to comply with the Plan's Managed Care Program or other administrative and informational requirements of the Plan.

iv. **Outside Employment for Wage or Profit:** The Fund will not pay Benefits if the Service is rendered as a result of injury or illness arising from any non-covered employment for wage or profit. For purposes of this paragraph, covered employment means employment for which Contributions are made to the Plan.

v. **Vehicle Racing Other than Bicycle Racing:** The Fund will not pay Benefits if the Service is rendered as a result of injury incurred from the individual's participation in vehicle racing of any sort, other than bicycle racing.

vi. **Competition for Prizes:** The Fund will not pay Benefits if the Service is rendered as a result of injury incurred as a result in 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 or is a bona fide wellness program sponsored by the Fund or your employer.

vii. **Coordination of Benefits:** The Service is rendered and the patient attempts to make this Plan primary by failing to comply with the requirements of other primary insurance. See the Coordination of Benefit rules summarized in the "Coordination of Benefits and Subrogation" section

d. Certain Item Condition or Service Exclusions.

i. **Personal Comfort Items:** The Fund will not pay Benefits if the Service is for personal comfort items. "Personal Comfort," means a Service that the Trustees, acting in reliance upon the Plan's Medical Advisors, find 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, electronic controlled thermal therapy, and modifications to home, vehicle, etc.), except as may specifically be provided separately under the Fund's Death and Accidental Death and Dismemberment policy.

ii. **Pregnancy of Non-Spouse Dependent:** The Fund will not pay Benefits if the Service is for the pregnancy of an Eligible Dependent Child or for any expenses related to a surrogate pregnancy.

iii. **Sexual Dysfunction, Impotency or Fertility:** The Fund will not pay Benefits if the Service relates to the diagnosis and treatment of sexual dysfunction, impotency or infertility except as specifically required by applicable law.

iv. **Cosmetic Services:** The Fund will not pay Benefits if 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.

v. **Diet and Exercise (except bona fide wellness programs):** The Fund will not pay Benefits if 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 or if the Services are "A" or "B" recommended Services, Treatment, counseling or screening as determined by the U.S. Preventive Services Task Force.

vi. **Visual or Orthoptic Therapy:** The Fund will not pay Benefits if the Service is visual or orthoptic therapy.

e. Other Coverage.

i. **Worker's Compensation Claims:** The Fund will not pay Benefits if the Service is compensable under worker's compensation or similar law.

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

iii. **Governmental or Other Coverage:** The Fund will not pay Benefits to the extent that the Service is payable by Other Insurance, including government-sponsored insurance.

f. Miscellaneous.

i. **Unqualified or Uncertified Provider:** The Fund will not pay Benefits if the Service is performed by a Provider that is unqualified, uncertified, or not licensed from the appropriate authority to perform the Service.

ii. **No responsibility for Claim:** The Fund will not pay Benefits if the Participant or Eligible Dependent does not have a legal responsibility to pay for the Service rendered.

iii. **Military Service or Act of War**: The Fund will not pay Benefits if the Service is rendered as a result of injury or illness from military Service or an act of war.

iv. **Trustee Discretion.** 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's Participants and Beneficiaries.

2. **Major Medical Exclusions:** The Major Medical provisions of the Plan, summarized in the "Major Medical Benefits" section, do not provide for payment of Major Medical Benefits for the following:

    a. No Major Medical Benefits are payable if the Service is described in the following sections: "Physician, Physical Therapy, and Immunization Benefits and Benefits for Preventive Care Services Provided by Your Physician"; "Outpatient Diagnostics Benefits"; "Hearing and Vision Benefits"; "Dental, Orthodontic and Orthognathic Surgery Benefits", unless Services for orthognathic surgery are received from a Non-Network Provider/ Orthodontic; and "Prescription Drug Benefits."

    b. Non-Surgical Foot Treatment; Orthotics: No Major Medical Benefits are payable if the Service relates to non-surgical treatment for foot conditions, other than orthotics.

    ***IMPORTANT NOTE**: Benefits are available under other Plan provisions for pre-certified orthotics, but only if the Plan's Medical Advisor certifies that the foot orthotics are Medically Necessary to treat the Patient for diabetes or peripheral vascular disease.*

    c. Chiropractic Benefits: No Major Medical Benefits are payable if the Service is rendered by a chiropractor unless it is Medically Necessary equipment (**for example**, a TENS unit prescribed by a chiropractor). For office visits to a chiropractor, the Plan will pay Benefits up to $25 per visit, up to a 20 visits per Eligible Family Member per Benefit Year under the Physician Office Visit provisions of the Plan.

    d. Immunizations; Check Ups; Physical Exams: No Major Medical Benefits are payable if the Service relates to immunizations, health checkups, routine physical examinations, or injections where no diagnosis is made.

    ***IMPORTANT NOTE:** These may be payable under other provisions of the Plan and may be payable as Services or Treatments recommended by the U.S. Preventive Services Task Force.*

    e. Excessive Hospital Days: No Major Medical Benefits are payable if the Service is 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.

3. **Accidental Death and Dismemberment Benefits Exclusions.** See the "Death Benefits" section for additional exclusions that apply specifically to the Accidental Death and Dismemberment Benefits provided under the Plan.

SECTION 18
COORDINATION OF BENEFITS
AND SUBROGATION

WHAT INFORMATION IS IN THIS SECTION? This Section describes Fund's rules regarding Coordination of Benefits and your responsibilities with respect to the Fund's Rights of Subrogation and Right to Reimbursement from a Third Party.

Coordination of Benefits:

1. *General.*
2. *Medicare and Other Insurance Available Under a Government Program*
3. *Primary Plan Determination Rules*
4. *Dependent Children, including Adult Dependent Child*
5. *Coordination of Out Of Pocket costs*
6. *Other COB rules*
7. *Coordination of Determinations of Medical Necessity*

Subrogation/Reimbursement

1. *General*
2. *Subrogation Rules apply to auto accidents (as well as third party)*
3. *Fund Will Advance Payment On an Express and Automatic Condition that the Fund Will Be Reimbursed from Any Third Party Recovery*
4. *Constructive Trust*
5. *Plan May Be Subrogated to Your Rights Against a Third Party*
6. *Attorneys' Fees*
7. *You Must Cooperate with the Plan's Right to Reimbursement*
8. *Future Medical Expenses*
9. *Workers Compensation Settlements (Lump Sum Commutation)*

COORDINATION OF BENEFITS

1. General. The Fund coordinates the Benefits available under the Plan with comparable benefits that you or your Dependents may have under Other Insurance. This includes private insurance as well as Medicare, Medicaid or other governmental benefits. The Fund will pay Benefits in accordance with the Medicare Secondary Payor statute and other applicable laws. In addition, this Section describes how the Fund will coordinate out of pocket costs with "Other" Coverage.

a. The **key terms** in this section are "Primary" Insurance and "Secondary" or "Other" Insurance. When this Plan is "Primary," the Fund will pay on your claims first and then any remaining balance can be paid by the "Secondary" or "Other" Insurance.

IMPORTANT NOTE: *In no event will payment from the Fund, when combined with benefits available under Other Insurance, exceed 100% of*

the amount payable under the Plan, regardless of whether this Plan is Primary or Secondary.

2. **Medicare and Other Insurance Available Under a Government Program.** While this Plan covers active Employees, when Medicare and Other Insurance is available under any government program, the Fund will apply the appropriate Medicare Secondary Payor or other applicable rules.

3. **Primary Plan Determination Rules.** In determining whether Other Insurance is the Primary Plan, the Fund will apply the following rules:

    a. The Other Insurance will be the Primary plan when it is the Primary plan under the terms of that plan or if that plan does not include provisions for the coordination or nonduplication of benefits.

    b. The plan that covers an individual as an employee will be Primary; the plan that covers an individual as a Dependent may be Secondary (depending on the Coordination of Benefits rules).

    c. If your Dependent Child under age 19 is covered under the plans of two parents, the Primary Coverage will be the coverage of the person whose birthday occurs first in a calendar year; except that,

        i. If the other plan does not have this rule, its alternate rule will govern; and

        ii. In the case of a dependent child of divorced or separated parents, the rules in the next subsection will apply.

4. **Dependent Children, including Adult Dependent Child**. Unless there is a valid Qualified Medical Child Support court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

    a. For a dependent child under age 19 whose parents are married or are living together, whether or not they have ever been married:

        i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

        ii. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

    b. For a dependent child under age 19 whose parents are divorced or separated or are not living together, whether or not they have ever been married:

        i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for

the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan;

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

A. The plan covering the custodial parent;

B. The plan covering the custodial parent's spouse;

C. The plan covering the non-custodial parent; and then

D. The plan covering the non-custodial parent's spouse.

c. Adult Dependent Child: In the case of an adult Dependent Child age 19 and over who is not the subject of any court order regarding the provision of health insurance coverage, and considering not only the plan of a non-Participant parent but also the plan of the Dependent's spouse, the plan that has covered the Dependent Child for the longest period shall be the Primary Coverage.

5. Coordination of "Out of Pocket" Costs: The Fund limits out of pocket costs to the statutory maximum. Effective January 2015, this amount is equal to the Deductible permissible under the Internal Revenue Code for "high-deductible health plans." The Fund will coordinate the "out of pocket" maximum expenditures with Other Coverage. The Fund will remit to the individual a refund of the amount that exceeds the out-of-pocket maximum only if you are actually left with an unpaid balance after the benefits are coordinated with available Other Coverage.

6. Other COB Rules.

a. Automobile Insurance. In all cases, this Plan is Secondary to any automobile insurance. In addition, this Plan will not pay any Benefits until the automobile insurance has paid its full policy limit. If you are required by applicable state law to carry at least a minimum level of insurance but failed to do so, the Fund will pay Benefits as if it is paying Secondary to such coverage.

b. Supplemental Insurance Policies. If you or an Eligible Dependent purchase supplemental insurance (including, for motorcycle accidents), this Plan shall be Primary as compared to the supplemental insurance. "Supplemental medical coverage" is coverage that can be purchased under a motorcycle or automobile policy but only provides medical insurance coverage and only to the driver and his passengers. This coverage is secondary to any medical coverage provided by the Fund. "Supplemental medical coverage" must be distinguished from "Uninsured bodily injury coverage," which is broader liability coverage that covers medical claims as well as pain and suffering claims. "Uninsured bodily injury coverage" will be treated as Primary Coverage and the Plan's coverage as Secondary Coverage.

c. Special Rule for Former Employee. If you were previously covered under this Fund as an Employee and remain Eligible for Benefits from this Fund but become Eligible for Other Insurance through a new Employer, the Other Insurance will be Primary.

d. Coordination with Medicare. Provided that all payments are made in accordance with applicable Medicare Secondary Payer rules, in any case in which the Plan is properly Secondary to Medicare, the Plan will pay Benefits for you or your Eligible Dependent only as Secondary payer of Benefits, without regard to whether you or Eligible Dependent submit the claim to Medicare for payment as the Primary payer.

e. In any case in which the Plan is Secondary to Other Insurance (other than Medicare, to the extent the Plan is required to pay as Primary) pursuant to the Plan's coordination of benefits rules, the Plan will pay Benefits for you or Eligible Dependent only as the Secondary payer of Benefits.

7. Coordination of Determinations of Medical Necessity. In the case where this Plan is Secondary to Other Insurance, and the Other Insurance has denied a claim on the ground that the Service is not Medically Necessary as defined under that Other Insurance, you or your Eligible Dependent must first exhaust the administrative remedies available under that Other Insurance before submitting the claim to this Fund to pay as the Secondary payor. If you or your Eligible Dependent exhaust the administrative remedies of the Other Insurance, the Fund will evaluate the claim by applying this Plan's Medical Necessity criteria.

1. **General.** If you or an Eligible Dependent become ill or injured as a result of a third party's actions, or if you are injured on the premises of another person (**for example**, you fell on your neighbor's patio), 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 applicable federal or state causes of action that may provide legal and/or equitable relief to the Plan.

   Regardless of the jurisdiction in which the action is brought, the "make whole" doctrine does not apply to the Fund's right of reimbursement and subrogation. The Fund's rights of reimbursement and subrogation are for the full amount of all related benefits and are not offset by legal costs, fees or expenses incurred by the claimant or plaintiff, except as specifically set forth in this Section. An example of this is as follows:

   > **For example**, Mary Jones is enrolled in the Plan. Ms. Jones's car is rear-ended by Mr. Williams and Ms. Jones is injured and receives medical care. The Plan paid medical benefits of $25,000 for Ms. Jones's care. Ms. Jones then sues Mr. Williams and recovers $50,000 through an out-of-court settlement of the lawsuit. Ms. Jones, however, was not "made whole" by the settlement because her damages (including medical expenses, pain and suffering, and property damage) exceeded the $50,000 she received in the settlement. Although Ms. Jones was not "made whole" by the settlement, she is required to repay the Plan the $25,000 it paid in medical expenses from the $50,000 she recovered in the lawsuit.

   If a Dependent Spouse or Child is the injured party and receives Benefits pursuant to these rules, the Dependent Spouse or Child is responsible to protect the Fund's interests as set forth in this Section. If the Dependent Spouse or Child is a plaintiff in an action to recover any monies, damages, etc. related to the accident or injury for which the Fund has paid claims, the Participant agrees to be a party in that action for the purpose of protecting the Fund's subrogation rights.

2. **These Subrogation Rules apply to auto accidents (as well as injuries or illness caused by a third party)**. The Fund will only cover medical expenses related to an auto accident on a subrogated basis and only after the maximum liability has been paid by the motor vehicle insurance carrier. In other words, the Fund will consider the payment of medical expenses only after benefits from the automobile insurance carrier have been exhausted. The subrogation rules above also apply if you are injured while repairing your car or by any other contact with your car.

3. **Fund Will Advance Payment On an Express and Automatic Condition that the Fund Will Be Reimbursed from Any Third Party Recovery.** The Plan will generally treat 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, but not limited to, any recovery from your automobile (including "uninsured motorist coverage" under your policy) or Other

Insurance carrier. You and your attorney further agree to provide the Fund with full documentation of any expenditures you make with money otherwise payable to the Fund so that the Fund may trace these expenditures and recover an amount equal to its subrogation lien or reimbursement interest.

4. **Constructive Trust.** You and your attorney agree and are required, as a condition of the Fund providing any Benefits for you under this Plan, to hold all money you receive in constructive trust for the Fund, regardless of whether you execute a subrogation agreement. This means that you must treat all dollars you receive from the third party as if you are holding them to repay the Fund before you pay anyone else. Your attorney must place these funds in a restricted account and make payment first to the Fund before taking fees or providing payment to you. As noted above, by accepting these Benefits, you and your attorney agree not to dissipate any of the proceeds of the recovery before the Fund's subrogation lien or reimbursement interest is remitted to the Fund to the Fund's satisfaction. You and your attorney further agree to provide the Fund with full documentation of any expenditures you make with money otherwise payable to the Fund so that the Fund may trace these expenditures and recover an amount equal to its subrogation lien or reimbursement interest.

5. **Plan May Be Subrogated to Your Rights Against a Third Party.** 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 or 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.

6. **Attorneys' Fees.** Any reimbursement amounts that the Plan receives from a third party shall not be reduced by any attorneys' fees greater than 20%, unless the Plan has consented to a higher fee in writing. You will be responsible for any attorneys' fees above this amount.

> ***IMPORTANT NOTE****: The Fund will make no reimbursement for attorneys' fees if you, an Eligible Dependent, or an attorney fails to cooperate with the Fund in protecting the Fund's subrogation rights. The Fund claims an interest of 100% of any third-party recovery until the resolution of the Fund's subrogation lien or reimbursement interest concerning that recovery. If any attorney accepts a fee in a worker's compensation, tort or any other matter after having ignored the Fund's subrogation rights, the Fund will claim an interest in the attorney's entire fee as well as in the proceeds retained by the client.*

7. **You Must Cooperate with the Plan's Right to Reimbursement.** 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 this Plan, to hold all money you receive in constructive trust for the Fund, regardless of whether you sign a subrogation agreement.

   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.

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

   > **For example,** John Smith is enrolled in the Plan and is 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 offset Benefits that it pays against any other future Benefits until the expenses exceed $26,000.

9. **Workers Compensation Settlements (Lump Sum Commutation).** You should contact your own attorney for advice about whether to accept a workers' compensation settlement. 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 Benefits for any of your medical expenses, not just for your work-related injury expenses, until your medical expenses exceed your lump sum commutation.

SECTION 19
AMENDMENT AND TERMINATION

WHAT INFORMATION IS IN THIS SECTION? This Section includes information about the Plan and Trust, Amendment and Termination.

1. Plan and Trust Amendment
2. Plan and Trust Termination

1. **Plan and Trust Amendment.** The Trustees may amend this Plan, or any other plan of the Fund, in any manner and at any time, provided that the amendment is consistent with the provisions of the Trust Agreement, ERISA and other applicable federal or state law. Amendments may include, although are not in any way limited to, adding, modifying, or deleting Benefits provided under this Plan.

    a. No amendment shall cause any of the assets of the Fund to revert to any Employer.

    b. Any amendment shall be effective as of the date set by resolution of the Trustees.

    c. Amendments shall be in written form and shall be adopted in a manner consistent with applicable procedures for Trustee action in the Trust Agreement.

    d. No amendment that affects the responsibilities or rights of a Trustee may be made without the Trustee's written consent.

2. **Plan and Trust Termination.** The Central Pennsylvania Teamsters Health and Welfare Fund shall terminate the Plan if the Trustees, by appropriate resolution, vote to terminate the Plan. The Plan also may terminate in the event that the obligation by all Employers to make Contributions as required by Collective Bargaining Agreements shall terminate. Any termination of the Plan shall be consistent with the applicable provisions of the Trust Agreement and with the requirements of IRC Code Section 501 (c)(9).

SECTION 20
DELINQUENT CONTRIBUTIONS

WHAT INFORMATION IS IN THIS SECTION? This Section provides information about the Fund's rights to enforce an employer's obligation to make timely contributions to the Fund.

1. **Enforcement:** If an Employer fails to pay any Contribution when due, the Fund shall send notice of such failure to the Employer. If the Employer fails to make payment within 10 days after receipt of the notice, the delinquency will be referred to legal counsel. A Contribution shall be considered as a "plan asset" and shall include both those Contributions that have been paid to the Fund and those that are due and owing to the Fund. In appropriate cases, the Fund may seek, in addition to the Contribution owed, one or more of the following amounts:

    a. **Interest on unpaid Contributions:** For purposes of this Section, interest shall be computed at the rate charged by Internal Revenue Service for delinquent income tax due and owing, which interest shall be charged until the date of receipt by the Fund;

    b. **Liquidated damages. Liquidated damages shall be assessed in an amount equal to the greater of:**

        i. Interest on the unpaid Contributions; or

        ii. Damages in an amount equal to 20% (or such higher percentage as may be permitted under applicable federal or state law) of the amount determined by the court to be due as an unpaid Contribution.

    c. **Reasonable attorney's fees;**

    d. **Costs of the action;**

    e. **Reasonable accounting and auditing fees;**

    f. **Such other legal or equitable relief as the court deems appropriate.**

2. **Jurisdiction:** The Trustees may bring appropriate action against an Employer hereunder in either the federal or state courts.

3. **Other Actions:** The Fund may enforce its rights to Contributions in any manner appropriate under applicable federal or state law.

4. **Collective Bargaining Agreements:** To the extent the provisions of this Section and any Collective Bargaining Agreement conflict, the provisions of this Section shall be controlling on the Employer.

5. **Audits:** The Trustees and/or the Administrator, in their sole discretion, may institute a field program providing for the systematic audit of Employers, whereunder the Trustees and/or Administrator, or a representative appointed by the Trustees and/or Administrator, shall have the right to audit the records of an Employer for the purpose of determining the accuracy of the Employer's Contributions to the Fund.

SECTION 21
PLAN ADMINISTRATION

WHAT INFORMATION IS IN THIS SECTION? This Section defines this Plan in connection with the operation or administration of the Plan in accordance with the Trust Agreement.

1. *Named Fiduciary and Plan Administrator*
2. *Final Authority of Trustees*
3. *Monies Held in Trust*
4. *General Powers and Duties of the Trustees*
5. *Discharge of Duties*
6. *Fiduciary Responsibility*
7. *Actions Brought Under This Plan*
8. *Joinder of Other Local Unions and Employee and Employer Groups*
9. *Plan Effect on Employee-Employee Relationship*
10. *Receipt of Benefits Not Evidence of Entitlement to Benefits or Entitlement to Participation in the Plan*
11. *Facility of Payment Provision*
12. *Nonassignment of Benefit Payments.*
13. *Separability and Saving Clause*
14. *Spendthrift Clause – Alienation of Benefits*
15. *Agent for Service of Process*
16. *Notices-Presentment of Invoices for Payment*
17. *Submission of Claims*
18. *Status of Spouse*
19. *Payment and Other Procedures*
20. *Physical Examination and Autopsy*
21. *Right of Recovery*
22. *Alternative Benefits*
23. *Change in Family Status*
24. *Timing of Payment for Covered Services and Items*
25. *Information Required for Coordination of Benefits*
26. *Cooperation of Participant and Others*
27. *Withholding Payment of Benefits*
28. *Termination of Participation by an Employer*
29. *Options If Employer Fails to Remit Timely Contributions*
30. *Uniformity*
31. *Construction*
32. *Lost Participant, Dependent, or Beneficiary*
33. *Exclusion of Dependent Child from Coverage*

1. **Named Fiduciary and Plan Administrator**. The Trustees shall be the Named Fiduciary and Plan Administrator for the Fund and the Plan, except to the extent that the Trustees have properly delegated the responsibility for claim appeals brought under Section 503 of ERISA to another "named fiduciary."

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

3. **Monies Held in Trust.** All monies contributed to the Fund shall be held in trust by the Trustees for the exclusive benefit of the Participants, their Dependents and beneficiaries. In no event shall any assets of the Fund be used for, or diverted to, purposes other than those set forth in the Fund's Trust Agreement or this Plan. The Trustees shall have the right to commingle assets of the Plan with other Fund plans, so that all or any part of the assets of the Plan or plans are invested as a single trust.

4. **General Powers and Duties of the Trustees.** The Trustees shall, by way of illustration but not limitation, have the following powers and duties:

    a. All those powers and duties set forth in the Trust Agreement, or in this Plan.

    b. To do all acts, whether or not expressly authorized in the Trust Agreement or this Plan, that the Trustees may deem necessary or reasonable in the administration, operation, amendment, or termination of the Fund, this Plan, and the other plans comprising the Fund.

5. **Discharge of Duties.** Trustees and other Fiduciaries shall discharge their duties with respect to the Fund solely in the interest of the Participants, their Dependents and beneficiaries, and for the exclusive purpose of providing Benefits to such individuals and defraying the reasonable expenses associated with administering this Plan. All actions shall be taken in a manner consistent with the requirements of the Fund's governing documents and applicable federal and state law.

6. **Fiduciary Responsibility.** The Trustees may allocate or delegate fiduciary responsibility to various Trustees and other Fiduciaries in accordance with applicable law. A Trustee or other Fiduciary may serve in more than one Fiduciary capacity hereunder.

7. **Actions Brought Under This Plan.** No action of any kind shall be brought in any forum with respect to any claim under this Plan unless the individual has exhausted the Claim Procedures described in the "Claim Appeals" section that follows. In any event, no action of any kind shall be brought against the Fund after one calendar year following receipt of the Claim Review Opinion. This limitations period will start to run as of (a) the actual date of receipt of the Claim Review Decision by the aggrieved party, as reflected either by a USPS "return receipt" card or UPS delivery receipt; or, if these

documents are not available, (b) three days following the Funds' mailing of the Claim Review Decision, as documented in the Funds' records.

8. **Joinder of Other Local Unions and Employee and Employer Groups.** If Local Unions or their successors, or groups of employees, or groups of employers, should desire to participate in this Plan, they may do so by executing a Participation Agreement prepared at that time, with the consent of the Trustees. A Participation Agreement shall include, but shall not be limited to, an agreement to be bound by the provisions of the Trust Agreement and this Plan. The Trustees shall be fully empowered to negotiate and execute the Participation Agreement, and to bind all parties in interest to the Participation Agreement.

9. **Plan Effect on Employee-Employee Relationship.** The establishment of the Fund, the Plan, or the creation of any fund or account or the payment of any Benefit or Benefits under the Trust Agreement or Plan, shall not create any right in or for any Employee, Participant, Dependent, beneficiary or any other person or entity, to be or to continue as an Employee of any Employer or any other right.

10. **Receipt of Benefits Not Evidence of Entitlement to Benefits or Entitlement to Participation in the Plan.** The establishment of the Fund and the Plan, the creation of any fund or account, or the payment of any Benefits under the Trust Agreement or Plan shall not create any right in or for any Employee, Participant, Dependent, beneficiary or any other person or entity to receive or continue to receive any Benefits from the Fund or to continue to be a Participant, Dependent or beneficiary under the Plan. If an individual receives payment of Benefits because of a mistake of fact or mistake of law, the Fund reserves the right to require the individual to make full repayment to the Fund of the Benefits paid.

11. **Facility of Payment Provision.** The Plan may pay Benefits directly to the Participant, whether such Benefits are payable for Services to the Participant or his or her Dependent, and the Plan may pay Benefits directly to the beneficiary of a Participant, as appropriate. The Plan also may pay Benefits due to or for a Participant, Dependent or beneficiary to the person having legal custody of the payee, to the legal guardian of the payee, pursuant to a QMCSO, or to the person or entity who or that may be furnishing the Services to the individual. Disbursement made to payees as set forth in this Plan shall be sufficient to discharge the Plan's obligation to make payment of Benefits under the Plan.

12. **Nonassignment of Benefit Payments**. Except as required by applicable law, the right of any Participant or Dependent to receive any benefit payments under a self-insured Benefit under the Plan is personal to such Participant or Dependent and is not assignable in whole or in part to any person or entity, including a health care provider, nor may benefits of coverage under the Plan be transferred at any time. Under no circumstances will the Plan's direct payment of any amounts to an In-Network Provider constitute a waiver of this nonassignment provision with respect to any party, including a Non-Network Provider.

13. **Separability and Saving Clause.** If a provision of this Plan is held to be invalid or illegal, in whole or in part, or as to any person or instance, such invalidity or illegality shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if the Provision had not been included.

14. **Spendthrift Clause - Alienation of Benefits**. Except as provided in the provisions of this Plan regarding Qualified Medical Child Support Orders or unless otherwise required by law, no individual shall have any right to assign, anticipate or transfer any assets held by the Fund or Benefits due under the Plan. To the extent permitted by law, the assets of the Fund shall not be subject to seizure by legal process or be, in any way, subject to the claims of the creditors of a Participant, Dependent, or beneficiary for any reason including, but not limited to, the following: contracts, debts, torts, alimony, support, divorce, domestic relations orders, insolvency, or bankruptcy.

15. **Agent for Service of Process.** The Trustees or the Administrator of the Plan are the agents for acceptance of service of process of any action or proceeding regarding this Plan. Service shall be made at their place of business or at the Fund Office during normal business hours.

16. **Notices-Presentment of Invoices for Payment.** Any notice required under this Plan, unless otherwise specified in the Plan, shall be sufficient if in writing and forwarded by mail or hand delivery to the last address, as filed with the Fund, of the Employer, Employee, Local Union, Participant, Dependent, beneficiary, or other person or entity to whom notice must be given. No invoice shall be honored for Benefit payment purposes unless it has been presented to the Fund at the Fund Office and date stamped by the Fund on or before the last date allowed under the Plan for invoice presentment. Mailing or other substitutes for presentment shall not be deemed presentment.

17. **Submission of Claims.** The Fund will not pay medical Benefits for claims that are not presented within one year from the date on which the Services were rendered. In the case of death Benefits, and Accidental death Benefits, the Fund will not pay any such Benefits for claims that are not presented within one year from the date of death, or dismemberment, as applicable.

18. **Status of Spouse.** The status of a Spouse shall be determined on the basis of the laws in effect in the state of the celebration of the marriage at the time the marriage was celebrated. The Fund shall require that a Participant who wishes to claim that an individual is a Common Law Spouse provide the Fund with certification of that status, including, but not limited to, an affidavit by the Participant that the individual is a Common Law Spouse. The Fund requires that a Participant submit to the Fund a divorce decree entered by a court of competent jurisdiction before deleting a Spouse from the list of Eligible Dependents on account of a divorce or separation. The Participant shall be responsible for any and all claims paid by the Fund on behalf of the spouse following the date of the entry of divorce, regardless of whether the Participant has submitted the divorce decree to the Fund. In no event shall the Fund recognize a common law marriage entered into in Pennsylvania after January 1, 2005.

19. **Payment and Other Procedures.** Payment and other procedures for all Benefits shall be governed by the rules and regulations of the Fund. At the Trustees' discretion, these rules and regulations may include rules and regulations established by Network Providers.

20. **Physical Examination and Autopsy.** The Fund shall have the right to examine an individual claiming Benefits or for whom Benefits are claimed, as well as the circumstances giving rise to the injury, illness, or conditions for which Benefits are claimed. Such examinations shall be performed by Physicians or other appropriate persons and may occur more than one time during the pendency of a claim. The Fund also shall have the right to require an autopsy when an individual for whom Benefits are payable has died.

21. **Right of Recovery:**

    a. **Against the Participant, Dependent, or Other Payee.** If the Fund has made an erroneous payment to a Participant, Dependent, or other payee (including a Provider), the Fund shall be entitled to recover such excess payment, including attorneys' fees expended in connection with such recovery, by proceeding directly against the Participant, Dependent, or payee for such amount, or by offsetting such erroneous payment against any other Benefits payable to the Participant, Dependent, Family, payee, or any of them, in the future.

    b. **Against a Provider.** If the Fund has made a payment on behalf of a Participant, Dependent, or other payee to a Provider in an amount in excess of the amount due under the Plan, the Fund shall be entitled to recover such excess payment, including attorneys' fees, expended in connection with such recovery, by proceeding directly against the Provider for such amount and against any other individuals for whom the Benefits are payable under the Plan. The Fund may also, to the extent permitted under applicable law and existing contracts, deduct such overpayment from balances otherwise owed to the Provider.

22. **Alternative Benefits.** The Trustees reserve the right to pay Benefits for an alternative Service that is equivalent in utility or quality to, but is less costly to the Fund than, the Service requested. The Trustees also reserve the right to pay Benefits not otherwise authorized in this Plan when the payment of such Benefits would be less costly to the Fund, in the near term or in light of long-term potential costs, than authorized Benefits.

23. **Change in Family Status.** Each Participant shall give prompt written notice, pursuant to the format established by the rules and regulations of the Fund, of any change in Family status, including marriage, divorce, birth of a child, marriage of a child, addition or deletion of a new Dependent, death of a Dependent, or otherwise. Failure to furnish such notice in a timely manner may result in a denial of Benefits, unless the Participant is able to show that he or she could not have timely furnished the notice, that the notice was furnished as soon as reasonably possible, and that the Fund was not prejudiced by the delay. In addition, should a Participant or Dependent fail to notify the Fund of a change in Family status, and the Fund thereafter pays Benefits for an individual who is no longer Eligible for Benefits after the change in Family status, the Fund may hold the Participant

and Dependent jointly and severally liable for any and all such Benefits as well as all costs, including attorneys' fees and other professional fees, incurred by the, Fund in recovering such Benefits. At the discretion of the Trustees, the amount of such Benefits may be offset against future Benefits payable for the Participant or any other Family member.

24. **Timing of Payment for Covered Services and Items.** The Fund will pay Benefits only after the Participant or Dependent has received the Service and after the Fund has received a proper invoice for payment or reimbursement, as applicable.

25. **Information Required for Coordination of Benefits.** The Fund may require certification from any Participant or Dependent that Benefits claimed are not payable under Other Insurance. The Fund may also request, and the Participant or Dependent shall not decline to provide, permission for the Fund to receive confirmation from a Dependent's employer about the whether the Dependent has or is eligible for health benefits coverage from the Dependent's employer. Failure to provide this information, or cooperate with the Fund's obtaining the information, or the failure to provide correct information, may result in a denial of Benefits or in an action for reimbursement, as applicable.

26. **Cooperation of Participant and Others.** The Fund may require that a Participant, Dependent, Provider or other payee, or the legal counsel of any of these individuals, provide certain information necessary to process a claim for Benefits. Any party's failure to cooperate with the Fund by failing to provide information or by providing false information may result in the denial of the claim for Benefits, or an action for reimbursement, as applicable.

27. **Withholding Payment of Benefits.** If any dispute arises as to the proper person or persons to whom any payment of Benefits shall be made out of the Fund, the Fund may, to the extent permitted by applicable law, withhold such payment until a final adjudication of the dispute by a court of competent jurisdiction or until the Fund, its Trustees, employees, or agents shall have been protected fully against loss by means of an indemnification agreement or bond that the Trustees, in their sole judgment, determines to be adequate.

28. **Termination of Participation by an Employer.** Notwithstanding the fact that an Employer is current in its Contributions to the Fund, the Trustees may terminate Benefit Coverage for that Employer's Employees for any reason as of the last day of any Benefit Period not earlier than four months after the date of the adoption of a resolution to this effect and the communication thereof, by written notice, to the terminated Employer.

29. **Options If Employer Fails to Remit Timely Contributions.** If an Employer fails to remit timely Contributions to the Fund, as required by the applicable Collective Bargaining Agreement, the Fund shall offer either continuation coverage under COBRA or permit the individual to purchase Coverage by remitting the "shortage," as described in the "Eligibility" section, above.

30. Uniformity. All provisions hereof shall be interpreted and applied in a uniform and non-discriminatory manner. All similarly-situated individuals in the same bargaining unit shall have the same level of Benefits.

31. Construction. The Central Pennsylvania Teamsters Health and Welfare Fund, Plan 13Y, was established pursuant to, inter alia, the laws of the Commonwealth of Pennsylvania. All issues pertaining to the validity and construction hereof, and of the acts and transactions of the parties hereto and hereunder, shall be determined in accordance with the laws of the Commonwealth of Pennsylvania, except to the extent such laws are preempted by ERISA or other applicable federal or state law.

32. Lost Participant, Dependent, or Beneficiary. If a Benefit is due to a Participant, Dependent, or Beneficiary under the terms of the Plan, but the Fund is unable to make the payment because the Fund is unable, after reasonable efforts, to locate the individual for a period of six years after the Benefit becomes payable, the Benefit shall be forfeited to the Fund and used for general Fund administration purposes. If the Participant, Dependent, or beneficiary is subsequently located, the Benefit may be restored by the Fund as a charge against the Fund, at the discretion of the Trustees. The Fund shall not pay any interest on a restored amount, unless such interest is required by law. These provisions shall not be interpreted to require the Fund to pay claims that are over one year old.

33. Exclusion of Dependent Child from Coverage. In certain, limited circumstances, a Participant who either covers a Dependent Child under age 19 or who covers a Dependent Child age 18 and over who is Disabled, may seek to exclude such Dependent from Benefit Coverage under this Plan. The Section provides the exclusive basis for such an exclusion.

a. To the extent permitted by applicable law, the Fund's Trustees may permit a Participant to request that a Dependent otherwise eligible for Benefits be deleted from benefit Coverage under the Fund. This Section provides the exclusive basis for such an action. The Fund will not provide any compensation or incentive to any individual to delete a Department from benefit Coverage. The Fund may require that the Participant and Dependent execute appropriate documentation before permitting the Dependent's coverage to be terminated. Any action taken under this Section will be taken in a manner consistent with the requirements of applicable state or federal law.

b. Requirements for Exclusion of a Dependent. All of the following requirements must be satisfied for a Dependent to be excluded from Benefit Coverage.

c. The Participant's request to delete the Dependent from Benefits Coverage must be in writing and, if the Dependent is not a minor, a copy of the request must be provided to the affected Dependent.

d. The Participant's written request must explain with particularity the reasons why the Participant is seeking the exclusion.

e. The Trustees must conclude, in their sole discretion, that exclusion from Benefit Coverage does not violate any applicable provision of state or federal law.

f. Restoration of Benefits Coverage. Once Benefit Coverage has been terminated for a Dependent under this Section, such Benefit Coverage can be restored, consistent with the Fund's Special Enrollment rules, upon the written request of the Participant of the Dependent, provided that the Dependent remains Eligible for Benefits under the terms of the Plan.

SECTION 22
CLAIM APPEALS

WHAT INFORMATION IS IN THIS SECTION? This Section sets forth the protections the Fund has in place so you can appeal the denial of a claim for benefits.

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

A. Network claims will be submitted for you by the Provider. Non-Network claims should be submitted directly to the Fund Office. Claim forms are available at the Fund Office or on the website (if needed in the event of an injury), and also may be available at an Employer's worksite or Local Union office. All claims for payment of Benefits from the Plan must be submitted within one 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. 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 does the Fund categorize claims?

A. There are four types of claims:

- Post-Service Claim: If you have already received the Service or treatment, the claim is a "post-service" claim. Post-service claims will likely be the majority of claims that you or your Providers submit. For certain treatment or Services, the Fund may limit the number of visits (**for example**, for Physical Therapy) or days of Hospitalization based on Medical Necessity.

- Concurrent Claims: 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."

- Pre-Service Claim: Certain Services and procedures require pre-authorization or precertification. These claims are called "pre-service claims".

- Urgent Care Claim. The different types of claims, and the time limits for processing these claims, are described below.

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

A. Urgent Care Claims: An urgent care claim is a claim for treatment that the treating Physician believes must be provided immediately or the Patient's health or life could be jeopardized or the Patient will suffer severe pain that cannot otherwise be managed. Your claim must be certified as an "urgent care" claim by a Physician.

If your claim includes all of the information the Fund needs to process your claim, you will receive a response as soon as possible but no later than 72 hours after your request for review is received. If your claim does not include all of the information needed, you will be contacted within 24 hours and told what information you need to submit to support your claim. You will have up to 48 hours to submit the requested information. You will receive a response, including the reason for the decision as 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 response orally, including by telephone, if the situation so warrants.

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

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

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

A. A pre-service claim must be submitted when the Fund requires advance approval or certification prior to receiving medical treatment or Services. In many instances, pre-service claims may be submitted directly by the medical Provider. The Fund will provide a response not later than 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 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 45 days to submit this

information. After you submit the required information, your claim will be processed during the balance of time remaining before consideration of your claim was suspended.

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

A. Post-Service Care Claim: A post-service claim is a claim for Benefits for treatment or Services that you have already received. In many instances, post-Service claims may be submitted directly by the medical Provider to the Fund. The Fund will provide a response not later than 30 days after it receives your request, unless it cannot do so because you (or your Provider) have not submitted all of the information needed to process the claim or for other reasons beyond the Fund's 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 30-day period that an additional 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 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, or by email to hwfund@centralpateamsters.com.

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

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

(1) The specific reasons for the denial (**for example**, you were not Eligible for Benefits at the time you applied for Benefits);

(2) The specific plan provisions under which your claim was denied;

(3) If an internal rule, guideline or protocol was relied upon to make the decision, you will be provided with the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;

(4) If the decision turned on medical necessity or whether a treatment was Experimental, you will be provided with either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or a statement that it will be provided to you free of charge upon request;

(5) A description and explanation of the information you must submit in order to perfect your claim;

(6) A description of the procedures you must follow to appeal the denial of your claim to the Board of Trustees.

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

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

> ***IMPORTANT NOTE****: Appeal of the denial of an urgent care claim may initially be submitted by telephone or email.*
>
> *You may also request an "external review," as detailed in the following pages.*

Q. Does the Fund have to continue coverage for my claim while my appeal is pending?

A. The Fund is required to provide continued coverage pending the outcome of an appeal, provided that you remain Eligible for Benefits. However, if your appeal is regarding the Fund's decision to rescind coverage, the Fund will not continue coverage during the pendency of this appeal.

Q. What are my rights on appeal?

A. Your rights when you request a review of the denial of a claim:

(1) Your appeal will be considered by the Board of Trustees. Information relating to your appeal will be accepted for the Trustees' consideration at a hearing conducted under the Fund's rules. You will have the right to appeal by telephone or other electronic method determined by the Trustees as well as by submitting documents or information via standard delivery or electronic mail. 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. The Board of Trustees will review all information that you submit as well as the

Fund's records in making a determination about your request for review. In deciding your claim, the Board of Trustees will not grant any deference to the initial decision of the Fund staff. Rather, the Board of Trustees will make its own decision based on the facts and circumstances relevant to your claim.

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

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

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

(1) The specific reasons for their determination;

(2) The Plan provisions on which the Trustees based their determination;

(3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for Benefits;

(4) If an internal rule, guideline or protocol was relied upon to make the decision, the Board of Trustees will provide either the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;

(5) If the decision turned on medical necessity or whether a treatment was Experimental, the Board of Trustees will provide either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or will provide the explanation to you free of charge upon request;

(6) You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office.

(7) You have the right to bring an action against the Fund under Section 502(a) ERISA, 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 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 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 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 days after the decision is made.

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

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

A. If the Board of Trustees fail to act within the time lines set forth above or fails to provide you with the information described above, your request for review is deemed denied. This means that you will be considered to have exhausted the Fund's review procedures and may proceed to take action against the Fund in federal district court, should you so choose.

Q. What if I wish to have my claim evaluated by an independent party following an adverse benefit decision by the Fund?

A. If you have received an adverse benefit determination from the Fund, you (or your authorized representative) may request an "external review" of the plan's final decision. This is a review of the Fund's denial of a payment or the Fund's refusal to authorize care that you have sought. The

external review will be performed by an "independent review organization," ("IRO") engaged by the Fund.

Q. What is an "independent review organization"?

A. An "independent review organization" ("IRO") uses qualified individuals to undertake a review process, independent of all affected parties, to determine whether a health care service is medically necessary and appropriate or experimental/investigational. Under federal law, the IRO must be properly accredited; not be owned by or have material professional, financial or familial relationships with the Fund or its personnel.

Q. Who pays the fees to the IRO for the external review?

A. The Fund is responsible for paying the IRO's fees.

Q. Can I request an external review for any type of Fund adverse determination?

A. No. The external review can be requested only for adverse benefit determinations that involve:

- Medical necessity;
- Appropriateness;
- Health care setting;
- Level of care;
- Effectiveness of a covered Benefit
- Whether a treatment is experimental or investigational; or
- Any other matter that involves medical judgment

In addition, if your health insurance is retroactively cancelled, you may also request an external review. Retroactive cancellation is sometimes called rescission of coverage. It means that the plan cancelled your coverage back to an earlier date.

Q. If the IRO reverses the Fund's adverse determination, does the Fund have to cover my claim?

A. Yes. The IRO's determination is binding on the Fund. It is binding on you only to the extent that other remedies are not available under state or federal law (**for example**, you are still permitted to sue the Fund under ERISA section 502(a)(1)(B)) in the event the IRO upholds the Fund's denial of your claim.

Q. Are there different kinds of external review, depending on the urgency of my claim?

A. Yes. There is a standard external review and, for urgent cases, an expedited (faster than usual) external review.

Q. How do I request a standard external review?

A. You may submit a standard external review request via mail or fax for an external review no later than four months after you receive the final internal adverse benefit determination notice. To request an external review, a person must provide the information listed below. For your convenience, the Fund will provide you with a form on which to make your request. Using the form will also help ensure that you submit all information needed to consider your request for external review:

- Name;
- Address;
- Phone;
- Email address;
- Patient's signature if person filing the appeal is not the patient;
- A brief description of the reason you disagree with your plan's denial decision. In addition, you may also submit documents to support the claim, such as physicians' letters, reports, bills, medical records, and explanation of benefits (EOB) forms; Letters sent to the Fund or to your providers about the denied claim; and Letters received from the Fund or your providers regarding your claim.

Q. What address should I use to submit my External Review Request?

You may mail a request for external review to:

By Postal Mail:
Central Pennsylvania Teamsters Health & Welfare Fund
P.O. Box 15224
Reading, PA 19612-5224

By Phone: 610-320-5500

By Fax: 610-320-9236

By Email: hwfund@centralpateamstres.com

Q. What happens after I submit my request?

Within five business days of receiving your request, the Fund will turn over to the independent reviewer all documents and information used to make the final internal adverse benefit determination. If the plan fails to timely provide the documents and information, the IRO will suspend the review and shall reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify the claimant and the plan.

After the IRO receives the documentation from the Fund, the IRO will timely notify you in writing of acceptance for external review eligibility. You will be able to submit, in writing, within ten business days following the date of receipt of the notice information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

Q. Is the IRO required to share the information I submit to the IRO with the Fund?

A. Yes. Upon receipt of any information submitted by the claimant, the IRO will, within one business day, forward the information to the Fund. Upon receipt of any such information, the Fund may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. However, the Fund's reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Fund decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Fund must provide written notice of its decision to the claimant and to the IRO, at which time, the IRO will terminate the external review.

Q. Does the IRO accept the Fund's decision or make its own determination about my claim?

A. For both a standard and an expedited external review, the IRO will review all of the information and documents timely received, will review the claim "de novo," that is, the IRO takes a completely fresh look at your claim, and will not be bound by any decisions or conclusions reached during the Fund's internal claims and/or appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence- based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

Q. When will I receive the determination of the IRO?

A. The IRO will then provide you with written notice of the final external review decision as soon as possible, but no later than 45 days after the examiner receives the request for an external review.

Q. What will be included in the decision of the IRO?

A. The written decision of the IRO for both the standard and expedited external review will include the following information. (If in response to a request for an expedited external review the IRO provides an initial oral response, this information will not be included in the oral response. However, the IRO will provide it in the written response that will follow.) The IRO response will include:

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

(2) The date the IRO received the assignment to conduct the external review and the date of the decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding on the plan except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;

(6) A statement that judicial review may be available to the claimant;

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Q. When can I request an "expedited" external review?

A. You may request an "expedited" external review when:

The patient has asked for an expedited internal appeal and an expedited external review at the same time, and the timeframe for an expedited internal appeal (72 hours) would place the person's life, health or ability to regain maximum function in danger.

OR

The patient has completed an internal appeal with the Fund and the decision was not in his or her favor, and:

- The timeframe for a standard external review (45 days) would place the person's life, health or ability to regain maximum function in danger, or

- The decision is about admission, care availability, continued stay, or emergency health care services where the person has not been discharged from the facility.

Q. What information must I submit in order to request an "expedited" external review?

A. For your convenience, the Fund can provide you with a form on which to make your request. Using the form will also help ensure that you submit all information needed to consider your request for external review. You must include the following information:

- Name and Address;
- Phone;
- Email address;
- Why the request is urgent;
- Patient's signature if the person filing the appeal is not the patient;
- A brief description of the reason you disagree with the Fund's denial decision.

Q. Do I have to submit my request for an expedited external review in writing?

A. No. A patient may also request an expedited review by calling 601-320-5500. The 72-hour timeframe for an expedited request begins when the Fund receives a written request (e.g. via fax) or when a phone call ends.

Q. Where do I submit my request for an Expedited Review?

By Mail: Central Pennsylvania Teamsters Health and Welfare Fund, PO Box 15224, Reading, PA 19612-5224

By Phone: 610-320-5500

By Fax: 610-320-9236

By Email: hwfund@centralpateamsters.com

Q. When will I receive the independent reviewer's determination in my expedited external review?

A. The Fund will provide the IRO with all documents and information used to make the internal adverse benefit decision as expeditiously as possible. The IRO will give the claimant and the Fund the external review decision as quickly as medical circumstances require, but no later than within 72 hours of receiving the request. The independent reviewer may give the external review decision orally, but it must be followed up by a written version of the decision within 48 hours of the oral notification.

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

A. If your request for review is denied the Board of Trustees' written notice will include the following information (in the case of an urgent claim, the following information may initially be provided orally but will be followed with written confirmation no later than three days after the original decision is rendered):

(1) The specific reasons for the denial;

(2) The specific plan provisions under which your claim was denied;

(3) A description of the relevant documents and information to which the Board of Trustees referred in making its decision, as well as the assurance that you will be provided with access to these documents;

(4) If an internal rule, guideline or protocol was relied upon to make the decision, the Board of Trustees will provide either the rule, guideline or protocol itself or an explanation that the rule, guideline or protocol was relied on and that a copy will be available to you at no charge upon your request;

(5) If the decision turned on medical necessity or whether a treatment was Experimental, the Board of Trustees will provide either an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or will state the explanation to you free of charge upon request;

(6) A statement that you may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State regulatory agency; and

(7) A statement that you have the right to bring an action against the Fund under Section 502(a) of ERISA after you have exhausted all levels of appeal required under this claim procedure.

Q. Are there other ways that I can use to appeal an adverse determination of the Fund?

A. No. The procedures specified in this section shall be the sole and exclusive procedures available to any individual who is dissatisfied with an Eligibility determination, Benefit award or denial, or any other action by the Fund.

Q. Do the Trustees have the authority to make determinations of my appeal?

A. Yes. The Trustees shall have full and exclusive discretionary authority to determine all questions regarding all such issues, including Coverage and Eligibility. The Trustees shall have full and exclusive discretionary authority to construe and interpret all Plan provisions, including ambiguous provisions, and to construe and interpret all rules and regulations and procedures of the Fund and this Plan. In addition, the Trustees shall have full and exclusive discretionary authority to determine the relevant facts, and to apply the facts to the law and to the terms of the

Plan. Any such determination or construction made by the Trustees shall be binding upon all parties, and is entitled to the maximum deference permitted by law. No such determination or construction shall be subject to the grievance or arbitration procedures established in any Collective Bargaining Agreement.

***IMPORTANT NOTE**: Actions Brought Under This Plan. No action of any kind shall be brought in any forum with respect to any claim under this Plan unless the individual has exhausted the Claim Procedures described above. Any such litigation that challenges a claim review decision must be filed within one (1) calendar year of the Claimant's actual or constructive receipt of the claim review decision that the Claimant intends to challenge. Receipt of the Trustees' decision may be determined to occur on (a) the actual date of receipt of the Claim Review Decision by the aggrieved party, as reflected either by a USPS "return receipt" card or UPS delivery receipt; or, if these documents are not available, (b) three days following the Funds' mailing of the Claim Review Decision, as documented in the Funds' records. The Trustees reserve the right to adopt such policies and procedures as may be necessary to implement this section.*

SECTION 23
IMPORTANT FEDERAL LAWS APPLICABLE TO THIS PLAN

What is in this Section? This Section includes important information about the federal laws that protect your rights relating to health benefits. These include COBRA (continuation coverage), HIPAA, Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP), Newborns' and Mothers' Health Protection Act, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. §§ 4301 et seq., Qualified Medical Child Support Orders ("QMCSOs"), the Women's Health and Cancer Rights Act, and Genetic Information Nondiscrimination Act of 2008.

A. Continuation Coverage, or "COBRA"

If you lose coverage for health benefits under this Plan, you may be Eligible to continue your health benefits coverage by purchasing "COBRA" continuation coverage. This coverage is described in detail below. You may also have other health coverage alternatives that may be available to you through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

Your health benefits coverage under the Fund may be terminated because you have experienced a "qualifying event." This term is described below. The following sections explain that "qualified beneficiaries" have the legal right to continue group health care coverage, generally known as "COBRA Continuation Coverage," for a period of time even after a qualifying event. Under the law, a qualified beneficiary is any employee, his or her Spouse or Dependent Child who was covered by the Plan when a qualifying event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A Child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered employee during a period of COBRA Continuation Coverage is also a qualified "beneficiary." A person who becomes the new Spouse of an employee during a period of COBRA Continuation Coverage is not a qualified beneficiary. Each individual covered by the Fund will have the right to make his or her own decision about continuation coverage.

QUALIFYING EVENTS:

Qualified beneficiaries are entitled to COBRA Continuation Coverage when qualifying events (which are specified in the law and described below) occur, and as a result of the qualifying event, coverage of that qualified beneficiary ends. A qualifying event triggers the opportunity to elect COBRA when the covered individual loses health care coverage under this Plan. If a covered individual has a qualifying event but does not lose his or her health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) or loses his or her health coverage but does not have a qualifying event, then the individual is not entitle to COBRA Continuation Coverage.

Events that Apply to Employee

- You no longer work for an Employer that participates in the Fund; or

- Your working hours are reduced so that you no longer meet the eligibility requirements for coverage; or

Events that Apply to Spouses

- You stop working for an Employer that participates in the Fund, (ii) have your hours reduced causing loss of coverage, or (iii) you become covered by Medicare; or

- You die or become divorced or legally separated from your Spouse.

Events that Apply to Dependent Children

(Dependents include Eligible Dependent Children.

> ***IMPORTANT NOTE****: The definition of Dependent includes any newborn Child or Child adopted or placed with you for adoption if you have notified the Fund within 30 days of the birth, adoption or placement for adoption.*

- You stop working for an Employer that participates in the Fund, (ii) have your hours reduced causing loss of coverage, or (iii) you become covered by Medicare; or

- Your parent is divorced from the parent who is employed by an Employer that participates in the Fund, or

- The Child ceases to be a "Dependent" under the terms of the Plan.

TYPE OF COVERAGE

Generally, you can elect to receive the same type of coverage you had immediately prior to the qualifying event. However, you also may change coverage status (that is, single, family, etc.) by contacting the Fund Office. In addition, your benefits will change if the Fund's benefit plans change.

Maximum Coverage Period

You may elect to continue coverage up to a maximum period as follows:

- Up to 18 months from the date coverage is lost in the event of the Employee's termination of employment or a reduction in working hours provided you were not reinstated during that time; or

- Up to 29 months if the employee is found by the Social Security Administration to have been disabled within 60 days of the date he or she terminated employment, but only if the

disabled person notifies the Plan Administrator of the determination within 60 days after he or she receives it and before the end of the 18 month coverage period; or

- Up to 36 months in all other cases.

If you have elected continuation coverage following a termination of employment, reduction in hours, or resolution of grievance arbitration, and a second qualifying event occurs, your total period of continuation coverage may last up to 36 months from the date coverage would have been lost on account of the employee's termination of employment or reduction in hours.

IMPORTANT NOTE: *COBRA Continuation Coverage begins on the date you otherwise would lose your medical coverage.*

COST OF COBRA CONTINUATION COVERAGE:

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will be made in your COBRA Continuation Coverage. The charge for the coverage is equal to the Fund's cost of providing group coverage plus two percent. The two percent charge covers a portion of the Fund's cost to provide you this coverage. If there is an increase or decrease in the Fund's cost, your future premiums will be adjusted accordingly.

NOTIFICATION REQUIREMENTS:

<u>You Must Notify Us</u>

If you are divorced or become covered under Medicare, or one of your Children ceases to qualify as a Dependent under the Plan, or you experience a second qualifying event (as described later in this section) you must notify the Plan Administrator in writing as soon as possible, but no later than 60 days from the later of: (1) the date of the qualifying event; or (2) the date you would lose coverage due to the qualifying event.

<u>We Will Notify You</u>

The Plan Administrator will notify you within 14 days of the date you advise us of one of the above events or of the date your Employer advises us of your termination of employment for any reason as well as death or entitlement to Medicare or of your reduction in hours.

ELECTION OF CONTINUATION COVERAGE:

You will have at least 60 days in which to elect continuation coverage. This election period will end on the later of (1) 60 days from the date you would otherwise lose coverage (except for making a COBRA election) or (2) 60 days from the date we mail you notice of your continuation coverage and provide you with an election form.

***IMPORTANT NOTE**: If you incur covered expenses during the election period before you have made an election, your claims will not be processed until the Fund receives your election forms and payment of your first premium.*

IF YOU AND/OR ANY OF YOUR ELIGIBLE DEPENDENTS DO NOT CHOOSE COBRA COVERAGE WITHIN **60 DAYS** AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

Grace Periods

Once you elect COBRA, the initial payment for the COBRA Continuation Coverage is due to the Fund Office 45 days after COBRA Continuation Coverage is elected. At that time, payment must be made for the full period back to the initial period of eligibility. If this payment is not made when due, COBRA Continuation Coverage will not take effect. Under this Plan, after the initial COBRA payment, monthly payments are due on the 25th day of the month for coverage in the next month but you will have a 30 day grace period to pay the monthly premiums. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Failure to Elect COBRA Continuation Coverage

In considering whether to elect COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law, as noted below:

- You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; and electing COBRA may help you not have such a gap; and

- You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you.

Special Enrollment Rights

If you elect COBRA, you have the same special and open enrollment rights as an active Participant. The special enrollment rights under federal law also allow you to request special enrollment under another group health plan for which you are otherwise Eligible (such as a plan sponsored by your Spouse's Employer) within 30 days after your group health coverage ends because of the qualifying events listed in this section. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a qualifying event but the Fund Office determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, become entitled to Medicare, or if a covered Child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse and/or Child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

Notifying the Plan: To extend COBRA when a second qualifying event occurs, you must notify the Fund Office in writing within 60 days of a second qualifying event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage.

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

In no case is an employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Extended COBRA Continuation Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits, the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare (whichever is sooner).

This extension is available only if: the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; and you or another family member notifies the Plan by sending a written notification to the Fund Office of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member (failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage); and that notice is received by the Fund Office before the end of the 18-month COBRA Continuation period. During the additional 11-month period COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% charge applicable to the COBRA family unit (but only if the disabled person is covered). The Fund Office must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

TERMINATION OF COBRA COVERAGE:

Your continuation coverage will end when one of the following occurs:

- The last day of the 18, 29, or 36 month period described above.
- You fail to pay the premium for your continuation coverage when it is due. However, there is a 30 day grace period before we will actually cut off coverage for failing to pay your premium.
- The date after you elect COBRA on which you first become covered under another group health plan.
- The Fund ceases to provide benefits to any Participant; or
- The date after you elect COBRA on which you first become entitled to Medicare.

COORDINATION WITH SUBSIDIZED COVERAGE

If there is a qualifying event but your Employer or the Fund provides coverage without charge, or on account of your taking a leave of absence pursuant to the Family and Medical Leave Act of 1993, then COBRA continuation coverage does not begin until the date your subsidized coverage ceases. This rule applies to self-pay coverage as well. (The rules for self-payment are set forth in the "Eligibility" section, above.). So, if you elect self-pay coverage, you will be entitled to continuation coverage after your self-pay coverage ends. You will have at least 60 days to make an election to accept or reject COBRA coverage beginning with the later of the date you would otherwise lose coverage or the date we provide you with notice of your COBRA rights and an election form. You will not receive coverage unless, within 45 days of the date you elect COBRA, you submit the applicable premium for the period from the date you lost coverage to the date of the payment.

B. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP). If you or your Children are eligible for Medicaid or CHIP and you're eligible for health coverage from your Employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your Children

aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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 be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an Employer-sponsored plan.

If you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Plan, the Fund must allow you to enroll in your Employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your Employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Information for Pennsylvania and New Jersey are listed below. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility.

PENNSYLVANIA – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

C. Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act) requires the Fund to pay for at least a 48-hour hospital stay following Childbirth (96-hour stay in the case of a cesarean section). The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to Childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn Child earlier. In addition, The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above. A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

D. Continuation Coverage Pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA)

In addition to COBRA, the Fund will provide continuation coverage pursuant to the terms of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) for all leaves while a Participant is serving in the uniformed services.

Service in the Uniformed Services. "Service in the uniformed services" generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

Election Rights. You have 60 days to elect USERRA continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. An employee "makes" his or her election as of the postmark date. If you elect USERRA continuation coverage within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If you do not elect USERRA continuation coverage within this period, your coverage under the Plan will end. If you do not make a timely election is made in a situation in which USERRA does not require you to provide advance notice of your service, your coverage will be reinstated on a retroactive basis upon your election to continue coverage (regardless of when it is received) and payment of all unpaid amounts due.

Maximum Continuation Period. The Fund will provide continuation coverage for a period of 24 months.

Type of Coverage. Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated Employees or Dependents that are not on service leave.

Cost. A person electing USERRA continuation coverage may be required to pay all or part of the cost of USERRA continuation coverage. If you perform service in the uniformed services for

fewer than 31 days, you are not required to pay for the coverage. If your service exceeds 30 days, the amount charged cannot exceed 102% of the cost to the Plan of providing the coverage. Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. You will be given a grace period of 30 days within which to make the payment.

Termination of USERRA Continuation Coverage. The USERRA continuation coverage may be terminated before the end of the Maximum Continuation Period for any of the following reasons:

- your Employer no longer provides group health coverage to any of its Employees;
- you do not pay the premium for USERRA continuation coverage on time (including the grace period);
- you fail to return from service or apply for a position of employment as required under USERRA; or
- your coverage is terminated for cause under the generally applicable terms of this Plan.

Rights Upon Reemployment. If you are reemployed after service in the uniformed services and has met all of the conditions set forth in USERRA, you will be entitled to the same Benefits that you would be entitled had the service in the uniformed services not occurred.

E. Qualified Medical Child Support Orders ("QMCSOs")

The Fund shall provide Benefit Coverage in accordance with the applicable requirements of any Qualified Medical Child Support Order as set forth in the provisions that follow: The Fund requires submission of a Medical Child Support Order for determination of its qualification only if payments of Benefits for the Alternate Recipient are to be made to the non-Participant parent.

Definitions:

Alternate Recipient. Any Child of a Participant who is recognized by a Medical Child Support Order as having a right to enrollment as a Dependent of the Participant under this Plan.

Interested Party. Any Participant, any Alternate Recipient; or any custodial parent or non-custodial parent of an Alternate Recipient, if such parent is the petitioner in the Medical Child Support Order proceeding.

Medical Child Support Order. Any judgment, decree, order, or administrative order (including approval of a domestic relations settlement agreement), which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive Benefit Coverage as a Dependent of the Participant under this Plan, which Order is made pursuant to a state domestic relations law or medical Child support law enacted under the Social Security Act of 1935, as amended.

Qualified Medical Child Support Order. A Medical Child Support Order that meets all of the requirements set forth in this section.

Requirements for Qualification:

What the Order Must Include. A Medical Child Support Order meets the requirements of this section only if such order clearly specifies:

- the name and last-known mailing address (if any) of the Participant, and the name and mailing address of each Alternate Recipient covered by the Medical Child Support Order; and
- the name of the Fund to which the Medical Child Support Order applies; and
- the name of the plan of the Fund to which the Medical Child Support Order applies; and
- a reasonable description of the type of Benefit Coverage to be provided under the Plan to an Alternate Recipient, or the manner in which such type of Benefit Coverage is to be determined; and
- the time-period to which such Medical Child Support Order applies.

What the Order Must Not Include. A Medical Child Support Order meets the requirements of this section only if such order clearly does not require:

- the Fund to provide any type or form of Benefit Coverage, or any option for Benefit Coverage. not otherwise provided under this Plan; or
- the Fund to provide increased Benefits of any type; or
- the Fund to provide for the payment of Benefits to an Alternate Recipient that Benefits are required to be paid to another Alternate Recipient under another Medical Child Support Order previously determined to be a Qualified Medical Child Support Order with respect to the Participant.

Procedures. In the case of any Medical Child Support Order received by the Fund, the Fund will notify promptly the Participant, Alternate Recipient and any other Interested Parties of the receipt of such order, and of the Fund's procedure for determining the qualified status of Medical Child Support Orders. Within a reasonable period after receipt of such order, the Fund will determine whether such order is a Qualified Medical Child Support Order, and shall notify Interested Parties of such determination. The Fund has established written procedures for determining the qualified status of Medical Child Support Orders and for administering Benefit Coverage under such Qualified Medical Child Support Orders. Alternate Recipients may designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to such Medical Child Support Order. The Fund will furnish the Alternate Recipient with copies of appropriate Plan documents. Alternate Recipients and related Interested Parties are bound by the Trust Agreement, the provisions of this Plan, and the rules and regulations of the Fund.

F. Women's Health and Cancer Rights Act (WHCRA) of 1998

Pursuant to the Women's Health and Cancer Rights Act of 1998, the Plan provides coverage for: All stages of reconstruction of the breast on which the mastectomy has been performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual Deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

G. HIPAA Privacy Notice

Below is the Notice provided to all Participants regarding how the Fund cares for your "protected health information." This Notice is also available on the Fund's website. We are providing this Notice from the Central Pennsylvania Teamsters Health & Welfare Fund (referred to in this Notice as the "Fund") in order to inform you about the way that your health information may be used by the Fund. A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), provides your health information with important protection.

The Fund is required by federal law to maintain the privacy of your protected health information ("PHI"). The Fund is also required by federal law to provide you with this description of the privacy policies and practices adopted by the Fund. The Fund must follow these policies and practices, but as permitted by law, the Fund reserves the right to amend or modify these privacy policies and practices.

Changes in our policies and practices may be required by changes in federal and state laws and regulations. Regardless of the reason for the change, we will provide you with notice of any material changes within 60 days of the date the change is adopted. The effective date of this notice is September 23, 2013.

Under HIPAA, how can the Fund use my protected health information ("PHI")? The Fund can use your PHI to facilitate your treatment, to make or obtain payment for your treatment and for health plan operations, including administration, oversight, and other legal purposes.

How may the Fund use my protected health information ("PHI") with respect to payment for my treatment? The Fund may use your PHI for the broad range of actions needed to make sure that the Fund can make payment for the services received by you and your family. The Fund may use your PHI for making payment to providers for services or treatment you received, for making arrangements for payment through one of the networks of providers through which the Fund provides benefits to you, as well as for coordinating payment to providers though other health plans under the Fund's coordination of benefits rule. **For example**, the Fund provides participants with access to a network of providers outside of this immediate geographic area. The Fund may provide your PHI to the network and directly to the provider in order to ensure that the provider receives the appropriate payment for the services that have been provided to you.

How does HIPAA permit the Fund to use my protected health information ("PHI") with respect to "health care operations?" The Fund may use your PHI for a broad range of actions required to assess the quality of the Fund's plan of benefits as well as for its administration and operations. These activities include, but are not limited to, ensuring that participants or their beneficiaries are eligible for benefits prior to making payment; taking corrective action to recoup overpayments and assessing health plan performance; reviewing the Fund's plan of benefits and determining whether a reduction in costs is possible; continuing case management and coordination of care; commissioning and reviewing actuarial studies relating to the cost of benefits and management studies relating to the operation and administration of the plan; resolving internal grievances; and undertaking medical review, legal, and auditing functions.

For example, the Fund may use PHI to determine the most cost-effective manner of providing vision benefits to its participants and beneficiaries.

May the Fund use my protected health information ("PHI") for purposes besides payment and health care operations? Yes. HIPAA permits the Fund to use your PHI for a number of other purposes, including informing you of treatment alternatives or other health–related benefits that may be of interest to you.

Because I am always on the road, my Spouse often calls to find out the status of my health claims and to get other information about me or my benefits. Can the Fund release information relating to payment of my claims to my Spouse? Unless you tell the Fund otherwise, the Fund will provide claims payment information to your Spouse **without** requiring an authorization from you. If you do NOT wish the Fund to provide your Spouse with this information, you must tell the Fund in writing that you do NOT wish the Fund to release claim payment information to your Spouse.

> ***IMPORTANT NOTE:*** *If you wish the Fund to release other information to your Spouse, you must file an authorization form with the Fund office. You can obtain release forms by calling the Fund office or visiting our website (www.centralpateamsters.com.*

May I call the Fund to get information about my Children's health claims? The Fund will provide a minor Child's parent, guardian (or person standing in *loco parentis* with respect to the Child) with payment information about the Child's claim. The Fund will carefully consider your written request for information other than claims payment information and will respond as permitted by these privacy policies and applicable state law.

> ***IMPORTANT NOTE****: If your Child is not a minor, the Fund generally cannot provide you with the Child's PHI, even if the Child is still covered under this Fund as your Dependent.*

Does HIPAA permit the Fund to disclose my protected health information ("PHI") to my Employer or insurer? Under HIPAA, the Fund generally cannot disclose your PHI to your Employer without your written authorization. It is important to note, however, that HIPAA does permit that the Fund disclose your PHI without your authorization to workers' compensation

insurers, state administrators, or others involved in the workers' compensation systems to the extent the disclosure is required by state or other law.

May the Fund release my protected health information ("PHI") to the Fund's plan sponsor? HIPAA does permit the Fund to disclose information to the "plan sponsor" for administrative functions. Here, the "plan sponsor" is the Fund's Board of Trustees. The Fund may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids or modify, amend, or terminate the plan.

May the Fund release my protected health information ("PHI") to law enforcement or other governmental entities? Your PHI may be disclosed to law enforcement agencies, without your authorization or permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting. The Fund may not disclose your PHI if you are the subject of an investigation that does not arise out of or is directly related to your receipt of health care or public benefits. In addition, the Fund may disclose your PHI in the course of a judicial or administrative proceeding if the Fund receives a court order, subpoena, discovery request or other lawful process. Before releasing this information, the Fund will make reasonable efforts either to notify you or to obtain an order protecting your PHI.

Would the Fund release my protected health information ("PHI") if my health or safety or public health or safety would be jeopardized if it did not? If the Fund has a good faith belief that your health or safety or public health or safety would be jeopardized if it did not disclose the information, the Fund will do so, after consideration of appropriate legal and ethical standards.

Must the Fund have an authorization to release my protected health information ("PHI")?

Yes, in many circumstances. **For example**, the following uses and disclosures of your PHI will be made only with your written authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of PHI;

Any other disclosure or use of your PHI for any other purpose not described in this notice requires your written authorization. This means that if you want your friend, relative, or union representative to check on the status of a claim you submitted or to advise when or if payment will be made, you must sign an authorization form and submit it to the Fund Office. If you change your mind after authorizing a use or disclosure of your PHI, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you provided written notice to the Fund of your decision to revoke the authorization.

May the Fund use or disclose my genetic information for underwriting purposes? No. The Fund is prohibited from using or disclosing genetic information for underwriting purposes.

What rights do I have under the federal privacy standards? Your rights to information under HIPAA include:

- the right to request restrictions on the use and disclosure of your PHI. The Fund will carefully consider, although is not required to honor, your request for restrictions;

- the right to restrict confidential communications concerning your medical conditions or treatment if you believe that disclosure of this information could endanger you (this means, **for example**, that you can make a written request that the Fund send information about your medical treatment to a post office box or an address different from your home address in order to ensure that your PHI remains confidential). The Fund will attempt to honor reasonable requests;
- the right to opt out of receiving fundraising communications prepared the Fund;
- the right to inspect and copy your PHI. The Fund may charge a reasonable fee for copying, assembling and postage;
- the right to an electronic copy of electronic medical records. The Fund will make every effort to provide access to PHI in the form or format you request, if it is readily producible in such form or format;
- the right to get notice of a breach of any of your unsecured PHI;
- the right to amend or submit corrections to your PHI. If you believe that the information in your records is inaccurate or incomplete, you may submit a written request to correct these records. The Fund may deny your request if, **for example**, you do not include the reason you wish to correct your records or if the records were not created by the Fund;
- the right to receive an accounting of how and to whom your PHI has been disclosed if it was disclosed for reasons other than payment or health care operations. Your written request for information must be submitted to the Fund and should state the period of time for which you are requesting an accounting;
- the right to file a complaint that your privacy rights have been violated to the Fund and to the Secretary of U.S. Department of Health & Human Services;
- the right to receive a printed copy of this notice. You can find this notice and authorization forms for release of PHI on the Fund's website at www.centralpateamsters.com.

***IMPORTANT NOTE**: You will not be penalized or otherwise retaliated against for filing a complaint;*

Complaints? Comments? Requests? The Fund has designated Cherie Mierzejewski, Health and Welfare Benefits Manager as the Privacy Officer. If you wish to request information that you have a right to receive, want to file a complaint with the Fund or if you have any comments or questions regarding this notice, contact Ms. Mierzejewski. The Fund can assess reasonable charges for copying and assembling documents you request as well as for postage.

H. Genetic Information Nondiscrimination Act of 2008

The Fund takes the required measures to comply with Genetic Information Nondiscrimination Act of 2008 (GINA), to prohibit discrimination in health coverage based on genetic information. Pursuant this law and the applicable regulations promulgating this statute, the Fund does not collect genetic information for underwriting purposes (prior to or in connection with enrollment); request or require genetic testing; or for adjusting group insurance premium or contribution rates.

I. THE U.S. DEPARTMENT OF LABOR STATEMENT OF YOUR RIGHTS UNDER ERISA

The U.S. Department of Labor requires that the following notice be provided to you. As a Participant in Plan 13Y, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

    a) Examine, without charge, at the Fund Office and at other specified locations, such as worksites and your Local Union office, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

    b) Obtain, upon written request to the Trustees, copies of documents governing the Plan, including insurance contracts as they relate to your Benefits and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The Trustees may impose a reasonable charge for the copies.

    c) Receive a summary of the Fund's annual financial report. The Board of Trustees is required by law to furnish each Participant with a copy of the summary annual report.

2. Continue Group Health Plan Coverage

    a) Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

    b) Reduction or elimination of exclusionary periods of coverage for preexisting conditions under this Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from this Plan (a) when you lose coverage under the Plan, (b) when you become entitled to elect COBRA continuation coverage, (c) when your COBRA continuation coverage ceases, (d) if you request it before losing coverage, or (e) if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

3. Prudent Actions by Plan Fiduciaries.

    a) In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and solely in the interest of you and the other Plan Participants and Dependents. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in

any way to prevent you from obtaining a health and welfare benefit or exercising your rights under ERISA.

4. Enforce Your Rights.

   a) If your claim for a health and welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

   b) Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Board of Trustees to provide the materials and pay you up to $110 a day (indexed for inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Board. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical Child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, **for example**, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Board of Trustees, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Central Pennsylvania Teamsters Health & Welfare Fund (“Fund”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Central Pennsylvania Teamsters Health & Welfare Fund:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters

- Information written in other languages

If you need these services, contact Joseph J. Samolewicz, Administrator.

If you believe that the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Joseph J. Samolewicz, Administrator, 1055 Spring Street, Wyomissing, PA 19610-1747, Toll Free in PA: 1-800-422-8330; Toll Free in USA: 1-800-331-0420, email address: jjsamolewicz@CentralPaTeamsters.com. You can file a grievance in person or by mail or email. If you need help filing a grievance, Mr. Samolewicz is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html .

Nondiscrimination statement for significant publications and signification communications that are small-size:

The Central Pennsylvania Teamsters Health & Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

GLOSSARY

The following words and phrases shall have the following meanings when used in this APD-13Y unless their context clearly indicates otherwise. These words are capitalized throughout the text of the APD-13Y.

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

Administrator. The person or persons appointed by the Trustees pursuant to the Trust Agreement to perform certain administrative or managerial duties for the Fund. The Administrator is not the Plan Administrator as that term is defined in ERISA § 3(16).

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.

Beneficiary. A person designated as such by a Participant in the manner required by the Fund, or by the terms of the Fund's Plan Documents, and who is or may become entitled to a Benefit from the Fund.

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 or 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. May include the following individuals who are under age 26 and are:

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

(b) A stepchild, that is, the child of the Participant's Spouse;

(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 that would allow a natural parent or other person to acquire or reacquire custody or guardianship in his or her 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 months.

(e) For purposes of this Plan, a Disabled Child is a Child who has been determined to be disabled by the Social Security Administration; who is not able to earn a living because of the disability, whose disability began prior to the date on which the Child would have lost Benefit Coverage because of age (age 26); and who is financially dependent on the Participant for support and maintenance as evidenced by, inter alia, documentation showing that the Participant claims the Disabled Child as a dependent for federal income tax purposes.

Code. The Internal Revenue Code of 1986, as amended, and the rules and regulation and guidance promulgated thereunder.

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. The Fund will not recognize any common law marriage entered into in Pennsylvania after January 1, 2005.

Contingent Beneficiary. A beneficiary who is or may be entitled to a death Benefit or accidental death Benefit under the Plan if the Designated Beneficiary predeceases the Participant.

Contribution. A payment made or required to be made by an Employer to the Fund pursuant to the terms of a Collective Bargaining Agreement, Participation Agreement or other written document as provided under the Fund's policies and procedures. A Contribution shall be considered as a "plan asset" and shall include those Contributions that have both been paid to the Fund and those that are due and owing to the Fund. In the event an Employer fails to pay any Contribution or other payment when due, such failure to pay promptly shall be a violation of such Employer's obligations hereunder. The Trustees shall treat unpaid delinquent Contributions as "plan assets" held in trust by the Employer on behalf of the Fund.

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 that is collected by a Provider.

Deductible. A charge for Services for which a Participant or Dependent is responsible, and that is deducted from Benefits paid by the Fund after the Services have been rendered.

Dependent. A "Dependent" may include: your Spouse and your Child, as defined in this Plan.

Designated Beneficiary. A person designated by a Participant or by the terms of the Plan who is or may become entitled to a death Benefit or accidental death Benefit under the Plan.

Disability (Disabled). A condition caused by an injury or illness as a result of which a Participant is completely unable to perform any work for wage or profit, any occupation, or any employment. A Participant is not Disabled if he or she is engaging in any work for wage or profit, any occupation, or any employment, even if he or she cannot perform his or her usual job.

Durable Medical Equipment. 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 appropriate for use in the home. Examples of Durable Medical Equipment are wheelchairs, canes, and walkers.

Eligible (Eligibility). An Employee or his or her Dependent is Eligible for Benefits when the Employer has made the Contributions required by the Collective Bargaining Agreement and the Employee has met the requirements set forth in the Fund's Plan Documents. To the extent permitted under the Fund's Plan Documents, the Fund will provide Benefits for a Participant for periods for which Contributions were remitted, provided that appropriate documentation supporting the claims is submitted to the Fund.

Emergency. "Emergency" means an unforeseeable condition or complaint of pain that 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.

(b) A common law employee who is engaged by or who is an employee of the Union or any Local Union that 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 that 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 Plan.

(e) A common law employee who had been employed pursuant to one of the Subparagraphs set forth 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) A person, represented in collective bargaining by an Employer or Employer association or conference, that is party to a Collective Bargaining Agreement between the Conference and a Local Union, which Collective Bargaining Agreement provides for payment to the Fund. Further, an "Employer" is a person 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.

(b) A person, not represented in collective bargaining by the Conference, but that has entered into a Collective Bargaining Agreement with a Local Union, which Collective Bargaining Agreement provides for payment of Contributions to the Fund. Further, an "Employer" is a person 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.

(c) A local Union that has entered into an agreement with the Fund whereby it is required to make Contributions for its Employees to the Fund.

(d) The Trust, Fund and/or the Central Pennsylvania Teamsters Pension Fund that, 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.

ERISA. The Employee Retirement Income Security Act of 1974, as amended, and the rules and regulations and other guidance promulgated thereunder**.**

Experimental or 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 or her Eligible Dependents.

Fund. The Central Pennsylvania Teamsters Health and Welfare Fund, and its successors.

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; provides diagnosis and treatment of surgical, medical, or mental (including substance abuse) conditions, and that 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 includes an Ambulatory Surgical Center.

> ***IMPORTANT NOTE****: The term Hospital does* ***not*** *include 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. Medically Necessary sub-acute or hospice care and skilled nursing facilities that have been pre-certified by the Fund's Medical Advisor, when care is provided in a manner consistent with the Fund's policies, rules and regulations.* ***Please note:*** *Skilled nursing facilies Benefits are limited to 15-day stays.*

Lifetime. A Participant or Dependent's Lifetime while covered under 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.

Medical Advisor. The Physician or other qualified individual or corporation that the Trustees engage to advise the Administrator and the Trustees on whether Services or Treatments are "Medically Necessary" or "Experimental or Investigational" as such terms are defined in this Plan as well as whether the Services or Treatments are consistent with the Fund's Plan of Benefits.

Medically Necessary. Services, Treatment and Items (collectively referred to as "Service") are "Medically Necessary" if they meet **all** of the criteria listed below:

(a) The Service is provided 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 (except to the extent that Benefits for such Service must be provided under section 715(a)(1) of ERISA and section 9815(a)(1) of the Code relating to coverage while individuals are participating in a clinical trial); 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 that provides Hospital or medical care benefits or Services on an insured or a prepayment basis;

(i) "Other insurance" does **not** include the coverage of a Spouse or Dependent under a "health savings account" as that term is defined under Code Section 223 and regulations thereunder. If (a) all of the plans covering the Spouse are high-deductible health plans or the Spouse elects a high-deductible health plan offered by the Spouse's employer and (b) the Spouse intends to contribute to a "health savings account" as that term is defined in the applicable federal law and regulations, this Plan cannot coordinate benefits with or provide any reimbursement for the primary high-deductible health plan's deductible.

(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).

Participant. An Employee who may be Eligible for Benefits for him or herself and his or her Dependents under the terms of the Plan.

Participation Agreement. An agreement between the Fund and an Employer, which agreement sets forth the terms and conditions governing the participation of that Employer's Employees in this Plan.

Patient. A Participant or Eligible Dependent receiving medical care.

Personal Comfort. "Personal Comfort" refers to a Service or Treatment that the Trustees, acting in reliance upon the Plan's Medical Advisors, find 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).

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 or her licensure and in accordance with all other applicable laws. The term Physician includes, **for example**, a Physician, surgeon, dentist, psychologist, nurse midwife, optometrist, podiatrist, or chiropractor.

Plan. The Central Pennsylvania Teamsters Health and Welfare Fund, Plan 13Y, 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).

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

Spouse. Your Spouse is the person to whom you are legally married under the laws of the state or country in which you were married.

Trustees. Those persons, including Employer Trustees and 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 that the Trustees may determine, in their sole discretion, is the appropriate compensation for various Services provided under the Plan. Unless otherwise indicated in this APD-13Y, 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. As of the effective date of this APD-13Y the Fund uses a database compiled by Fair Health. If there is no UCR for the particular Service rendered, the Plan will pay Benefits to Non-Network Providers a percentage of billed charges.

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.