CENTRAL PENNSYLVANIA TEAMSTERS Health and Welfare Fund

Active Plan Document for Plan 13

January 2023

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CENTRAL PENNSYLVANIA TEAMSTERS HEALTH & WELFARE FUND

1055 SPRING STREET WYOMISSING, PA 19610
IN PENNSYLVANIA:
(610) 320-5500 OR TOLL FREE: (800) 422-8330
TOLL FREE IN USA: (800) 331-0420

INTRODUCTION

The Board of Trustees (sometimes referred to hereinafter as "Trustees") of the Central Pennsylvania Teamsters Health & Welfare Fund is pleased to offer you this combined Plan Document and Summary Plan Description for Plan 13, called the "Active Plan Document-13" ("APD-13"). Because Plan 13's terms are complex, it is important that you take the time to acquaint yourself with its provisions. Plan 13's governing documents, including this APD-13, 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-13.

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

Only the entire Board of Trustees is authorized to interpret Plan 13's governing documents. No Employer or Union, nor any representative of any Employer or Union, acting in that capacity, is authorized to interpret Plan 13'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-13 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-13 sets forth the provisions of Plan 13 in effect as of January 1, 2023. You and your Family should read this entire APD-13. 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 13 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-13, 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 email address of the Fund Office is:

hwfund@centralpateamsters.com

The telephone numbers of the Fund Office are:

In Pennsylvania: 610-320-5500 or 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-13. These terms are defined in detail in the **GLOSSARY**.

SECTION 1 - GENERAL INFORMATION

A. NAME OF THE PLAN

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

B. 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.

C. 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

D. 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. A current list of Trustees and their contact information is available upon request from the Fund Office.

E. 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.

F. 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.

Example: The annual adult dental Benefits are limited to $1,000 per Benefit Year. This means that from January 1 through December 31 of each year an adult individual may receive a maximum of $1,000 in dental Benefits. No balance of Benefits remaining in one Benefit Year will be carried over to the next Benefit Year.

G. TYPE OF PLAN; PURPOSE

The Plan is a multiemployer self-insured health and welfare plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), created and 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).

H. AVAILABLE BENEFITS; SELF-INSURED BENEFITS; SELF-INSURED EXTERNALLY ADMINISTERED BENEFITS

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 use disorder Services, and Short-Term Disability. In addition, if your Employer makes Contributions to the Fund on your behalf, you may be Eligible to participate in a "health reimbursement arrangement" through the Fund.

In general, the Fund administers the Benefits listed above. For medical advice and other assistance, the Fund relies on its Medical Advisor:

Meritain Health
(800) 343-3140.

However, while the Plan self-insures the prescription Benefits, it administers the prescription Benefits through an agreement with:

Global Pharmaceutical Benefits, Inc. (GPB)
222 Lafayette Street
Newark, NJ 07105.

Similarly, the Plan self-insures the dental Benefits but administers them 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
PO Box 1525
Latham, NY 12110.

I. INSURED BENEFITS

The Plan has purchased insured coverage for Death and Accidental Death and Dismemberment Benefits through:

Lincoln Financial Group
PO Box 2649
Omaha, NE 68103.

J. 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.

K. AGENT FOR SERVICE OF PROCESS

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

SECTION 2 - ELIGIBILITY

A. ELIGIBILITY RULES FOR YOU AND YOUR ELIGIBLE DEPENDENTS: GENERAL

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; the Fund may only pay Benefits for individuals who meet the Eligibility requirements in this section.

B. CONTRIBUTIONS: GENERAL

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 monthly or 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-13 and such rules and regulations shall govern.*

1. Contributions: Composite and Component Rates

Some Employers contribute to the Plan using ***composite*** rates. Other Employers contribute to the Plan using ***component*** rates. A "Composite" rate is a fixed rate that is paid per Participant regardless of Participant's family status. A "Component" rate is a rate that varies depending on the Participant's number of Dependents. The Component rates include separate rates for single, married, single parent with Dependent Children, and Family. If your Union and Employer agree that the Employer will pay Contributions on a Component basis, your Employer must make Contributions that reflect your actual family status.

If your Employer makes Contributions on a Component basis, your new spouse, child, or stepchild can be covered effective the first day they become a Dependent, provided that the Employer pays the appropriate Contribution in the earliest Contribution Period after the individual becomes a Dependent.

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. If your Employer is a Component rate Employer, you must update your list of Eligible Dependents promptly so that your Employer contributes the proper Component rate. Failure to do so may result in a loss of coverage.*

2. Contributions: Employer Responsibility for Proper Contributions Under Component Rate Arrangements

If your Employer makes Contributions on a Component rate basis, the Employer is responsible for making Contributions that reflect your actual Family status. The Fund will inform the Employer of your actual Family status as soon as the Fund becomes aware of the status or any changes.

a) **Changed Premium Contribution for Change in Family Status:** If you incur a change in Family status, your Employer is responsible for making Contributions for the appropriate Family status effective on the date of the change in status. It is, therefore, essential that you promptly notify the Employer and the Fund of any changes in Family status. If you are responsible for contributing a portion of the cost of coverage on account of this changed status, you will be responsible

for making appropriate payments to your Employer as of the effective date of the changed status. Failure to do so may result in a loss of coverage.

3. Contributions: Changes between Monthly and Hourly Contribution Rates Pursuant to Collective Bargaining Agreement

If your Union and the Employer negotiate a change from making monthly Contributions to making hourly Contributions, you will have monthly Benefit Coverage until such time as hourly Benefit Coverage would be effective, assuming that the Employer makes all required Contributions for this continuous coverage. If the Employer doesn't make the required Contributions, you will be able to purchase Benefit Coverage under the "Continuation Coverage" provisions of the Plan, described in **Section 22 – Select Federal Laws Applicable to This Plan**.

Similarly, if your Union and Employer negotiate a change from making hourly Contributions to making monthly Contributions, you will have hourly Benefit Coverage until such time as monthly Benefit Coverage would be effective, assuming that the Employer makes all required Contributions for the continuous coverage. If the Employer does not make the required Contributions, you will be able to purchase Benefit Coverage under the Fund's "Continuation Coverage" provisions, described below.

4. Contributions: Premium Cost-Sharing by Employees

If your Collective Bargaining Agreement requires that you pay a portion of your health premium, your Employer is responsible for forwarding the full amount of the Contribution to the Fund.

5. 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 **Section 22 – Select Federal Laws Applicable to This Plan**). You should speak to your Union Business Representative about other remedies that may be provided by the terms of the Collective Bargaining Agreement.

C. CONTRIBUTIONS: HOURLY EMPLOYEES - 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**.

1. Hourly Contribution Period and Benefit Period

If Contributions are made on your behalf on an HOURLY rate basis, the terms Contribution Period and Benefit Period are defined as follows:

Contributions Made for at Least 420 Hours Credited In…		Result in Benefits Available for the Period of…
September, October, and November	⇨	January 1 through March 31
December, January, and February	⇨	April 1 through June 30
March, April, and May	⇨	July 1 through September 30
June, July, and August	⇨	October 1 through December 31

2. Contributions: Hourly Employees - 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.

3. Contributions: Hourly Employees - 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 **Section 22 – Select Federal Laws Applicable to This Plan**.

D. CONTRIBUTIONS: MONTHLY EMPLOYEES - CONTRIBUTION PERIODS AND BENEFIT PERIODS

1. Contribution Period; Benefit Period

You and your Eligible Dependents will receive Benefits from the Fund as of the first day of the Benefit Period immediately following receipt of the required Contribution made by your Employer. If Contributions are made on your behalf on a **MONTHLY** basis, the terms Contribution Period and Benefit Period are defined as follows:

Contributions Made for Hours Credited In…		Result in Benefits Available for the Period of…
November	⇨	January 1 to January 31
December	⇨	February 1 to February 28/29
January	⇨	March 1 to March 31
February	⇨	April 1 to April 30
March	⇨	May 1 to May 31
April	⇨	June 1 to June 30
May	⇨	July 1 to July 31
June	⇨	August 1 to August 31
July	⇨	September 1 to September 30
August	⇨	October 1 to October 31
September	⇨	November 1 to November 30
October	⇨	December 1 to December 31

2. Contributions: Monthly Employees - Employee Purchase of Coverage for the First 90 Days of Employment

You have the option to purchase up to three months of 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 monthly Contribution rate multiplied by the number of months (maximum of three months) for which you are seeking Benefits Coverage. Contact the Fund Office for more information on this option.

E. SPECIAL INSTANCES OF CONTINUED ELIGIBILITY APPLICABLE TO BOTH HOURLY AND MONTHLY EMPLOYEES

IMPORTANT NOTE: *None of the instances below of continued Eligibility apply to permit a new claim for short term Disability Benefits filed after your retirement because these Benefits are only available to Participants who are actively employed by an Employer obligated to make Contributions to the Fund and who is Eligible for Benefits on the date that the Disability began.*

1. Eligibility Termination While Disabled

If you become Disabled for a non-occupational Disability but lose coverage prior to the end of the period for which you are entitled to Short-Term Disability Benefits, you remain Eligible to continue to receive the Short-Term Disability Benefits and medical Benefits specifically related to the illness giving rise to your need for the Short-Term Disability Benefits, to a maximum of 26 weeks.

Example: John Smith stopped working for XYZ Company, a contributing Employer, on November 29, 2021 due to a non-job-related Disability. They remained Eligible for Benefits from the Plan until January 31, 2022. On December 1, 2021, they began receiving non-job-related Disability Benefits and their Disability ended on July 14, 2022. In this case, the Plan will continue to pay Disability Benefits and medical Benefits for the specific Disabling injury or illness, until May 31, 2022, even though their Benefit Coverage ended January 31, 2022.

2. 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.

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 2021, for hours worked in November 2021. After making this payment, the Company stopped making Contributions to the Plan. However, John Jackson continued working there until January 31, 2022, and Bill Jones continued working there until February 28, 2022. In this case, John Jackson will receive two months of Contribution credit and Bill Jones will receive the maximum three months of Contribution credit.

3. Accidental Death & Dismemberment (AD&D) 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 AD&D Benefits.

Example: John Williams stopped working for LL Corporation, a contributing Employer, on November 29, 2021. They remained Eligible for Benefits from the Plan until January 31, 2022. John Williams died in a car accident on February 28, 2022. The Plan will pay Death Benefits and AD&D Benefits to John Williams' Beneficiary.

4. 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.

Example: Jane Thomas stopped working for LMN Stores, a contributing Employer, on November 29, 2021. They remained Eligible for Benefits from the Plan until January 31, 2022. Jane Thomas was admitted to the Hospital from January 20 to February 10, 2022. The Plan will pay Hospitalization Benefits for Jane Thomas through February 10, 2022.

5. 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 **Section 22 – Select Federal Laws Applicable to This Plan**.

F. ENROLLING YOURSELF AND ELIGIBLE DEPENDENTS IN THE PLAN

1. Individuals Eligible for Enrollment: **Employee, Spouse and Child/Children - General**

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 court-ordered legal custody and sole or primary physical custody, and who meet the requirements below. (Please refer to the definition of Child/Children in the **GLOSSARY** for a more detailed description of these important terms.)

In order for your Eligible Dependents to be covered by the Plan, your Employer must pay the appropriate Contribution for them, as well as for you (you may also be required by your Collective Bargaining Agreement to pay part of the premium to your Employer). You must also provide appropriate documentation to the Fund Office**,** which may require you to provide any document it reasonably deems necessary to confirm or demonstrate your dependent's eligibility, including (but not limited to) marriage or birth certificates; court orders for guardianship, custody, or adoption; and tax returns demonstrating dependency.

a) Court-Ordered Legal Custody of a Child (for other than Placement for Adoption): If you have legal custody, on the basis of a court order or guardianship, and sole or primary physical custody of a Child who is not your natural, adopted, foster, or stepchild, you can enroll them as of the date of such physical custody. However, you must provide copies of the court order (including any changes or amendments made in the future), federal tax returns demonstrating that you claim the Child as your dependent for income tax purposes, and documentary evidence, sufficient for the Trustees to determine, in their sole discretion, that the Child resides with you. Such documents must be provided each year for the Child to maintain Eligibility in the Plan.

b) Disabled Child: If your Child (a) is eligible for Social Security benefits on account of a disability that arose prior to their 26th birthday and which disability prevents the Child from living independently; (b) is unmarried; and (c) earns less than $10,000 annually, they may be Eligible for Benefits Coverage after reaching age 26 so long as all of the conditions above are met. The Participant must submit supporting documentation as required by the Fund, including an annual statement reflecting the Social Security benefits. Except in the case in which the disability is permanent (**For Example**, significant intellectual disabilities), the Participant must submit an annual medical certification that the Child remains disabled.

2. Enrollment in the Fund

a) 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.

b) 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.

1) 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.

3. Optional Coverage for Participants and Dependents

a) Full Family Opt-Out Coverage: Your Employer and Union (or the parties to a Participation Agreement) can agree in the collective bargaining agreement (or Participation Agreement) that Participants can elect to waive Fund Coverage for themselves and their otherwise Eligible Dependents.

IMPORTANT NOTE: *(1) this "opt-out" is available only if the Employer and Union specifically agree to this in the CBA that covers your bargaining unit; and (2) this is a full family opt-out option, meaning that you and all family members will be waiving coverage from the Fund. You cannot remain in the Fund but waive coverage for your spouse or Dependents under this option.*

b) Special Enrollment Rights And Resuming Fund Coverage: If you have opted out of Fund Benefits Coverage, you may only resume Coverage for yourself and your Eligible Dependents during the Fund's annual Open Enrollment Period, or upon the loss of Other Insurance or the occurrence of a "life event" that changes your Coverage needs. A "life event" includes marriage, birth, adoption, or placement for adoption. For loss of Other Insurance or life events, you must request enrollment within 30 days of the loss of Coverage or life event, which triggers a Special Enrollment Right. A Special Enrollment Right also arises for you and your Eligible Dependents who lose coverage or gain eligibility to receive premium assistance under a State Children's Health Insurance Program (CHIP) or Medicaid. You or your Eligible Dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

For additional information, see the **Special Enrollment Provisions** section.

4. Coverage for Spouses

a) Spouse Must Generally Enroll in Their Employer's Coverage: If your Spouse works full-time and is eligible for coverage at their job, your Spouse must enroll in that coverage in order to be eligible to enroll in coverage under the Fund. Your Spouse must certify on an annual basis whether they work full-time and are eligible for other employer-sponsored coverage. When the Plan receives a claim for your Spouse, a Coordination of Benefits form will be sent to you if it has been longer than one year since we received an update regarding their employer-sponsored coverage. Any claims received for your Spouse will be pended until that form is returned to the Plan.

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 **SECTION 17 - COORDINATION OF BENEFITS & SUBROGATION**.

There are four situations where your Spouse does not have to enroll in health insurance at their 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 under a Collective Bargaining Agreement that permits "Dependent Opt-Out" under one of the Fund's other Plans; or

4) If your Spouse is eligible for and has elected Medicare Parts A and B, has provided all documentation required by the Fund and meets all applicable requirements:

- Your Spouse must be actively employed; and
- Your Spouse's employment is with an employer that (a) is not an Employer required to make Contributions to the Fund; (b) has fewer than 20 employees (i.e., is a "small employer" under applicable federal law); and

(c) whose health coverage, pursuant to the Medicare Secondary Payer Rules, would not be primary for the Spouse.

b) Medicare-Eligible Spouse Requests to Opt-Out:

- The Participant and Spouse must affirm on a form provided by the Fund and executed by the Participant and the Spouse that the Spouse requests to opt-out of Fund Benefit Coverage in favor of their Medicare coverage;
- The Fund will make no payment, credit or refund of any monies or Contributions or provide the Participant or their Employer with any benefit because the Spouse opts-out of Fund Benefit Coverage in favor of Medicare coverage;
- The Trustees must conclude, in their sole discretion, that the Spouse's opt-out of Fund Benefit Coverage in favor of Medicare coverage does not violate any applicable provision of state or federal law;
- Once the Spouse's Benefit Coverage has been terminated, such Benefit Coverage can be restored, consistent with the Fund's Special Enrollment rules, upon the written request of the Participant or Spouse, provided that the Spouse remains Eligible for Benefits under the terms of the Plan.
- The fact that a Spouse has opted out of Benefit Coverage under this section shall not affect the Contribution owed by the Employer of the Participant whose Spouse has opted out of Fund Benefits Coverage in favor of their Medicare coverage. In all such cases, the Employer will be obligated to pay the same Contribution that would have been due if the Spouse were still Eligible for Benefit Coverage under the Plan.

c) Spouses Working for Different Contributing Employers: Where (1) an Employee and a Spouse work for different Contributing Employers; and (2) where under the terms of a Collective Bargaining and the applicable Plan, the Employee may elect to opt-out of otherwise applicable Plan Coverage, the Employee may be covered under the Spouse's Plan. In such event, the otherwise applicable requirements that (a) each Spouse must enroll in coverage under their own employer's plan and (b) the Employee's Employer make Contributions to the Fund shall not apply.

d) 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. If your Employer pays on a Component basis, the Employer will not be responsible for Contributions for this Spouse or Dependent.

e) 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 "Select 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 becomes final unless your ex-Spouse elects and pays for COBRA continuation coverage.*** *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.*

f) 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.

SECTION 3 - MANAGED CARE PROGRAM, CLINICAL TRIAL COVERAGE, PREVENTIVE CARE COVERAGE

A. MANAGED CARE PROGRAM - GENERAL

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 ensure 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 their 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.*

B. ELEMENTS OF THE FUND'S MANAGED CARE PROGRAM

The Plan's Managed Care Program has four key elements, which are described below.

1. 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.

2. Limited Payment for Non-Network Providers

Except for Services subject to the No Surprises Act Protections, as described in paragraph D.3. below, 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. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.) After the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less any required Copayment and Coinsurance. Finally, you will be responsible for any balance bill from your Non-Network provider, that is, any amount remaining after the Fund has remitted its payment for claims. 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.

3. 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.

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.

4. Utilization Review

The Plan has a utilization review program under which the Fund's Medical Advisor reviews 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.**

C. 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.

1. Finding a Network Provider

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 offered by the Plan may change from time to time; when there is a Network change, the Fund will notify you. Upon notification, you will have 90 days to switch Providers before your Benefits will be considered Non-Network. **It is the Fund's intention to provide you the most current Network lists, but you should contact the Fund Office or the Fund's Medical Advisor to verify if a particular Provider is currently a Network Provider before receiving Services from that Provider.**

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 the Medical Advisor.*

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.

2. Continuing Coverage with a Network Provider who Leaves the Plan's Network

The No Surprises Act provides protections to "Continuing Care Patients" in circumstances where your treating physician or healthcare facility's network status changes in the midst of treatment.

If you are a Continuing Care Patient (as defined in the **GLOSSARY**) and the Plan's PPO terminates its contract with your Network Provider or facility, or your Benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, the Plan will:

- Notify you in a timely manner of the Plan's termination of its contracts with the Network Provider or facility and inform you of your right to elect continued transitional care from the provider or facility; and
- Allow you up to 90 days of continued coverage with Benefits paid on the same terms and conditions under the Plan as if the provider or facility had remained in the Network in order to allow time for you to transition your care to a Network Provider.

Example: Scott has diabetic neuropathy and needs to have their foot amputated. They finds a Network podiatric surgeon and schedules the surgery for June 2, 2023. Unfortunately, after the surgery is scheduled, the podiatric surgeon leaves the Network. The Fund notifies Scott on June 1, 2023 and provides Scott the right to elect continued

transitional care from the podiatric surgeon, and an opportunity to notify the Fund if Scott needs such transitional care.

Scott notifies the Fund that transitional care is needed. The Fund covers the surgery under the same terms and conditions that would have applied had the surgeon remained in Network, as well as follow-up care with the surgeon, as needed, until August 30, 2023.

D. NON-NETWORK PROVIDERS:

1. General:

The Plan limits the Benefits it pays for treatment by Non-Network Providers except in situations as noted in paragraph 3 below. 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.

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 as of a date selected by the Trustees. You will be responsible for any balance bill from your Non-Network provider, that is, any amount remaining after the Fund has remitted its payment for claims.

Example: John Smith receives treatment in a Non-Network Hospital. Assume that John Smith had already met their Deductible for the Benefit Year. The bill for these Services is $6,500. The UCR for this treatment is $5,000. John Smith is responsible for the Hospital Copayment of $100.00 and Coinsurance of $1,470 (30% x $4,900), totaling $1,570. In addition, the Non-Network Provider can balance bill John Smith for $1,500, the difference between the billed charge and the Fund's UCR.

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.

2. 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.

3. No Surprises Act Protections

The No Surprises Act provides certain billing protections to Participants who receive the following Services from Non-Network Providers: Emergency Services, non-Emergency Services provided at Network facilities, and air ambulance services. Claims for these Services where the No Surprises Act protections apply are referred to in this document as "NSA Claims."

a) **Coverage of Emergency Services:** Emergency Services provided by a Non-Network Provider or in a Non-Network Emergency Department will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or Services had been furnished by a Network Provider. In other words, the coinsurance percentage, and any Copayments applicable to such Services will be the same as if the Services were furnished by a Network Provider. Your coinsurance responsibility will be based on the Recognized Amount. Any cost-sharing payments you make with respect to covered non-Emergency Services will count toward your Network Deductible and Network out-of-pocket maximum in the same manner as those received from a Network Provider. The Fund will pay the Non-Network Provider or Emergency Department the Network rate for the Emergency Services, less your cost-sharing amounts, and Non-Network Provider or Emergency Department is prohibited from balance billing you for amounts that exceed your

cost-sharing responsibility until after you have been stabilized (and even then, you can only be balance billed in certain limited circumstances and upon your consent).

Example: Jake takes the family for a day's skiing to a ski hill that is two hours from their home. Jake's 12-year-old child, Ricky, takes a bad fall, and breaks their leg. Ricky is taken by ground ambulance to the nearest Emergency Department, which is at a Non-Network Hospital, to treat their injuries. Once Jake pays the required Deductible, Copayment and coinsurance (which will be based on the Recognized amount), Jake will have no further payment responsibility for Ricky's claims at the Non-Network Hospital with respect to those Emergency Services.

b) Coverage of Certain Non-Emergency Services Received from Non-Network Providers at Network-Facilities: Similar to Emergency Services, the non-Emergency items or Services received from a Non-Network Provider working at a Network facility will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or Services had been furnished by a Network Provider. In other words, the coinsurance percentage, and any Copayments applicable to such Services will be the same as if the Services were furnished by a Network Provider. Your coinsurance responsibility will be based on the Recognized Amount. The Fund will pay the Non-Network Provider the Network rate for the Services, less your cost-sharing amounts, and the Non-Network Provider is generally prohibited from balance billing you for charges that exceed your cost-sharing obligations. Any cost-sharing payments you make with respect to covered non-Emergency Services will count toward your Network deductible and Network out-of-pocket maximum in the same manner as those received from a Network Provider.

An exception applies with respect to certain Non-Network Providers who have provided timely notice to the Patient and received informed consent with respect to the Non-Network billing practices in compliance with the No Surprises Act. The notice must be provided at least 72 hours before the day of the appointment (or three hours in advance of services rendered in the case of a same-day appointment) and include the following:

- Notification that the Provider is a Non-Network Provider;
- Notification of the good faith estimated amount that the Provider may charge you for your treatment, including a notification that the provision of such estimate or consent to be treated does not constitute a contract with respect to the estimated charges;
- A statement that prior authorization or other care management limitations may be required in advance of receiving such treatment at the facility; and
- A clear statement that consent to receive such items and services from the Non-Network Provider is optional and that you may instead seek care from an available Network Provider, and that in such cases your cost-sharing responsibility will not exceed the responsibility that would apply with respect to such treatment that is furnished by a Network Provider.

If notice is required in connection with post-stabilization services being furnished by a Non-Network Provider at a Network Emergency Department, such notice must also include the names of any Network Providers at the facility who are able to treat you and your option to elect to be referred to one of those available Network Providers.

If the Patient properly consents prior to the receipt of Services and the exception applies, the applicable Non-Network coinsurance to be paid by the Participant will be based on the Allowable Charge, and the out-of-network Deductible and out-of-pocket maximum will apply.

No exception is available with respect to providers of Ancillary Services, however, or with respect to items or Services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or Services is furnished, regardless of whether the notice and consent requirements have been satisfied.

Example: A few months later, Jake takes their 16-year-old, Jamie, to the local ski hill. This time Jamie takes a bad fall. When ski patrol finds Jamie, they are unconscious and have a bad gash on their face. Jamie is taken to a regional Network Hospital. After Jamie is stabilized, the attending Physicians determine that Jamie requires surgery to repair a torn rotator cuff, which is urgent but not Emergency. While the orthopedic surgeon who performs the shoulder surgery is a Network Physician, the anesthesiologist who services the hospital is part of a Non-Network group.

Anesthesiology services are Ancillary Services subject to the No Surprises Act. Once Jake pays the required Deductible, Copayment and coinsurance (which will be based on the Recognized amount), Jake will have no further payment responsibility with respect to the anesthesiologist.

Example: After Jamie comes home and is recovered from the rotator cuff surgery, Jamie decides to get plastic surgery to minimize the scarring that occurred as a result of the injuries to their face. Although Network plastic surgeons are available, Jake and their spouse decide that they would rather use a uniquely skilled plastic surgeon who is able to operate in the Network Hospital but who is a Non-Network Provider.

When the procedure is scheduled, the Provider provides Jake proper notice and Jake consents. Jake will be responsible for the Non-Network Provider's fee, even if it is in excess of the payment the Fund will make.

c) **Coverage of Air Ambulance Services:** Non-Network air ambulance services will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or Services had been furnished by a Network air ambulance Provider. In other words, the coinsurance percentage, and any Copayments applicable to such Services will be the same as if the Services were furnished by a Network air ambulance Provider. Your coinsurance responsibility will be the lesser of the Qualifying Payment Amount or the billed amount. The Fund will pay the air ambulance Provider the Network rate, less your cost-sharing amounts, and the Non-Network air ambulance Provider is generally prohibited from balance billing you for charges that exceed your cost-sharing obligations. Any cost-sharing payments you make with respect to covered air ambulance Services will count toward your Network deductible and Network out-of-pocket maximum in the same manner as those received from a Network air ambulance Provider.

Example: Jake decides to go skiing one last time alone at the local ski hill. This time they take a bad fall, breaking their back and suffering a spinal cord injury. An air ambulance is summoned to take Jake to a facility that can handle their serious injuries.

Jake is responsible to pay the air ambulance company only the same deductible, copayment and coinsurance required by the Fund. Once Jake pays the deductible, copayment and coinsurance required by the Fund, they have no further responsibility to the air ambulance company.

4. 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-Condition Basis. For Example**, if you are Disabled, you typically receive no more than 26 weeks of temporary Disability Benefits for that Disability. However, you may be entitled to an additional 10 weeks of Short-Term Disability Benefits at a reduced rate, provided you meet the Fund's requirements summarized in **SECTION 14 - SHORT TERM DISABILITY**.

b) **Limits on a Per-Benefit Year Basis. For Example**, each Participant or Eligible Dependent, can receive up to $1,000 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 the dental Benefit network.

c) **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.

E. FUND PROVIDES BENEFITS ONLY FOR "MEDICALLY NECESSARY" SERVICES, TREATMENTS, AND ITEMS

1. General: 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.

2. Medically Necessary Care Does Not Include Experimental or Investigational Treatments

Expenses for treatment, procedures, devices, drugs, or medicines that the Trustees, in reliance upon the Plan's Medical Advisor, determine to be Experimental or Investigational will not be considered an eligible expense, and no Benefits shall be paid for that treatment, except for Off-Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses. See **SECTION 3 - MANAGED CARE PROGRAM, CLINICAL TRIAL COVERAGE, PREVENTIVE CARE COVERAGE** for more information.

3. Method for Determining Whether a Treatment is Experimental or Investigational under the Plan

The Trustees must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Trustees shall be guided by a reasonable interpretation of Plan provisions and the advice of the Plan's Medical Advisor. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Trustees will be final and binding on the Plan. The Trustees will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental or Investigational:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental or Investigational; or

2. If the drug, device, medical treatment or procedure or the Patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed, and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval, then it is deemed to be Experimental or Investigational; or

3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental or Investigational; or

4. If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental or Investigational.

   "Reliable Evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially

the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered Experimental if they are not commercially available for purchase or they are not approved by the FDA for general use.

Expenses for drugs, devices, services, medical treatments, or procedures related to an Experimental or Investigational treatment and complications from an Experimental or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental or Investigational treatment.

Final determination of Experimental or Investigational, Medical Necessity and whether a proposed drug, device, medical treatment, or procedure is covered under the Plan will be made by and in the sole discretion of the Trustees.

F. UTILIZATION REVIEW – GENERAL

Utilization review is a process through which the Trustees, in reliance upon the Plan's Medical Advisor, 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.** The Plan's Medical Advisor performs the utilization review for the Plan's Benefits.

Example: John Jones is brought into the Emergency Department for treatment of serious injuries following a car accident. Because John 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 John Jones was participating in an illegal street race, the Fund would deny payment for the charges because the Plan includes a specific exclusion for claims arising from the individual's participation in vehicle racing of any sort, other than bicycle racing.

1. Pre-Certification (Generally)

The following services are subject to pre-certification:

- Non-Emergency Hospitalization (including the number of days);
- All Inpatient treatment for any diagnosis;
- Surgery (inpatient and outpatient);
- Physical Therapy, including speech therapy, occupational therapy, and work hardening in excess of 24 visits per injury or illness;
- Hospital stays in connection with childbirth in excess of 48 hours for a vaginal delivery or 96 hours for following a cesarean section;
- Orthotics to treat conditions or the foot, ankle, knee, or spine;
- Sub-acute, hospice, or skilled nursing facilities; and
- Certain high-cost and other specialty drugs.

2. Pre-Certification (Hospitalization and Surgery)

All non-Emergency Hospitalization and surgery (both inpatient and outpatient, and both medical/surgical and mental health/substance use disorder) 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 started. 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 Newborns' and Mothers' Health Protection Act, No Surprises Act, or other applicable federal law or regulation.

3. Pre-Certification: (Number of Days for Hospitalization)

Upon a Patient's admission to the Hospital, the Fund's Medical Advisor will inform the Fund of the number of days of admission for which the Fund should pay and either the Fund or the Medical Advisor will so inform the Provider. The Fund will not pay Benefits for additional Hospital days unless approved under the Managed Care Program.

4. 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.

Example: Jane Smith's doctor asked for and received pre-certification for removal of Jane Smith's appendix and related surgical procedures. When Jane Smith's doctor submits their 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.

Example: John Jackson's doctor receives pre-certification for Medically Necessary surgery on June 1. John 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 John Jackson was not Eligible for Benefits at the time of the surgery.

5. Second or Third Opinion May Be Required

If the Plan's Medical Advisor recommends 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.

G. COVERAGE FOR CLINICAL TRIALS

1. General

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.

a) 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 their participation in the Approved Clinical Trial is appropriate.

b) 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 the Patient Protection and Affordable Care Act ("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.

c) 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.

d) 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.

H. 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. The Plan covers preventive care services and immunizations identified by United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Centers for Disease Control (CDC). A listing of covered Preventive Care Services can be found on the USPSTF website: uspreventiveservicetaskforce.org. 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 Benefits** section, section 4.D below, for more information.

Please Note: The Fund administers medical/surgical benefits and mental health/substance use disorder benefits in parity with each other, and the provisions of this section apply equally to each.

SECTION 4 – PHYSICIAN BENEFITS, PHYSICAL THERAPY BENEFITS, IMMUNIZATION AND INJECTIONS BENEFITS, & PREVENTIVE CARE SERVICES PROVIDED BY YOUR PHYSICIAN

A. PHYSICIAN SERVICES

1. Physician Office Visits – General

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.

a) Definitions. For this subsection A.1, the following applies:

1) Specialist means every Physician other than a Non-Specialist or a Chiropractor.

2) Non-Specialist means a general practitioner, an obstetrician/gynecologist, an internist, a pediatrician, a general doctor of osteopathy, or an urgent care facility practitioner. Mental Health and Substance Use Disorder Providers are considered Non-Specialists, as detailed further in Section 11.

b) 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.

c) 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.

Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.

d. 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.

2. 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.

a) Physician Visits While Hospitalized at a Network Facility:

1) Network Provider. For Medically Necessary inpatient visits from a Network Provider, the Plan will pay Benefits in full.

2) Non-Network Provider. Services provided by Non-Network Providers will be paid at the Network rate the Provider has obtained Participant consent to treatment after providing a notice satisfying specified criteria, as required by the No Surprises Act.

b) Physician Visits While Hospitalized at a Non-Network Facility: Non-Network Provider: For Medically Necessary inpatient visits from a Non-Network Provider, at a Non-Network Facility the Plan will pay Benefits in accordance with the

Plan's Medical provisions. This means that for Non-Network Providers, after the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less the required Coinsurance (30% of the amount payable by the Fund). You will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.)

B. PHYSICAL THERAPY

1. General

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, "therapeutic services" means Medically Necessary Physical Therapy 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 Fund will pay Benefits at the Network Rate for up to three (3) therapeutic services of treatment per day, less a Copayment of $10 per visit. Examples of therapeutic services would be whirlpools, massages, and various strength building and agility building exercises. Massage therapy is only a covered Benefit if performed by a licensed physical therapist.

b) **Non-Network Provider:** If you use a Non-Network Provider, the Plan pays up to the UCR for up to three (3) therapeutic services 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 Medical Benefits will be available. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.)

c) **Chiropractors:** The Fund will not pay Benefits to a chiropractor for the provision of Physical Therapy unless the chiropractor is a licensed physical therapist.

d) **Vestibular Therapy:** Vestibular Therapy, used to treat vestibular disorders, which are characterized by dizziness, vertigo, and trouble with balance, posture, and vision, is limited to 10 outpatient visits, instead of the general Physical Therapy limit of 24 visits.

C. IMMUNIZATION, INJECTIONS, AND INFUSIONS

1. Immunization and Injections (ACA Preventive Care) – General

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.

2. Immunization and Injections (Non-ACA Preventive Care) – General

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.

a) **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 for the office visit at the Network Rate and up to $25 towards the immunization or injection.

b) Non-Network Provider. If you receive a Medically Necessary immunization or injection and the Non-Network Provider charges separately for an office visit and the immunization or injection, the Fund will pay Benefits of up to $25 towards the immunization or injection and will pay Benefits for the office visit equal to the lesser of UCR or billed charges, less a $30 Copayment that you will have to pay per visit.

c) The rabies vaccine is only a covered Benefit if it is Medically Necessary for medical treatment after exposure. It is not a covered Benefit if it is administered as a preventive measure or if required for school or work purposes.

3. IV Therapy

IV Therapy provided on a Non-Network basis to Participants who are Medicare-primary is not subject to the Non-Network Deductible; the Participant would be responsible for the 30% Non-Network Coinsurance.

D. PREVENTIVE CARE SERVICES

1. General

The Affordable Care Act requires that the Fund provide benefits for certain preventive care Services by Network Providers without requiring a Copayment from the Patient. See **SECTION 3 - MANAGED CARE PROGRAM, CLINICAL TRIAL COVERAGE, PREVENTIVE CARE COVERAGE**.

***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 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) Limits, Copayments and Coinsurance for Services Related to Preventive Services: For education and training services that are not Preventive Care for the purposes of the PPACA, the Plan imposes a four-visit maximum Benefit. PPACA covered education, such as weight loss and diabetes management, is not subject to this limitation.

Although no Copayments or Coinsurance are imposed for PPACA-required "Preventive Care" Services rendered by a Network Provider, Copayments may be imposed for certain preventive care services in some situations, 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.

Please Note: The Fund administers medical/surgical benefits and mental health/substance use disorder benefits in parity with each other, and the provisions of this section apply equally to each.

SECTION 5 – HOSPITAL AND EMERGENCY BENEFITS

A. HOSPITALIZATION BENEFITS – GENERAL

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 **SECTION 11 - MENTAL HEALTH / SUBSTANCE USE DISORDER / AUTISM SPECTRUM DISORDER BENEFITS** for a fuller description of inpatient Benefits for mental health/substance use disorder Hospital admissions.) Private rooms are not covered by the Plan unless they are determined to be Medically Necessary.

1. 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.

a) **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.

b) **Non-Network Hospital in non-Emergency situations:** Except for NSA Claims, the Fund will pay a Non-Network Hospital the lesser of the UCR or the billed charges.

1) For Medically Necessary stays at a Non-Network Hospital, after the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less a $100 Hospital Copayment and Coinsurance (30% of the amount payable by the Fund). You will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.)

2) 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).

3) For NSA Claims, the Fund will pay the Non-Network Hospital the Network rate, less your $100 Copayment for each Hospital stay. The Non-Network Hospital is generally prohibited from balance billing you for charges that exceed your cost-sharing obligations. Your $100 Copayment will count toward your Network Deductible and Network out-of-pocket maximum in the same manner as if the Benefits were received at a Network Hospital.

c) **Medical Necessity:** If the Plan denies your room and board Benefits for a 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 Hospital room and board Services.

d) **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., their 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 and for coverage of Emergency Services, the Plan will pay Benefits in full if you use a Network Hospital.

b) **Non-Network Hospital:** Except for NSA Claims, if you use a Non-Network Hospital for a non-Emergency Service, after the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less Coinsurance (30% of the amount payable by the Fund). You will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.) For NSA Claims, the Fund will pay the Non-Network Hospital the Network rate. The Non-Network Hospital is generally prohibited from balance billing you.

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, after the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less Coinsurance (30% of the amount payable by the Fund). You will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.)

4. Emergency Department Services

a) **If you use an Emergency Department for a non-Emergency, the Plan may not pay any Benefits at all.**

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

c) **Emergency Department – Injury:** If you suffer an Accidental injury that requires Emergency care, the Plan will pay Benefits for Medically Necessary Emergency Department 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 Department: 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 Medical Benefits, which may not cover the full cost of these items.

e) Emergency Department – 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) Ground/Air Ambulance: The Fund provides Benefits for Medically Necessary ground and air ambulance services at the lesser of 100% of billed charges or UCR, as determined by the Trustees, and after a $100 Copayment is paid. This applies to both Network and Non-Network ground and air ambulance services.

If a member refuses transport, they are subject to an out of network copayment deductible and co-insurance charge.

Please Note: The Fund administers medical/surgical benefits and mental health/substance use disorder benefits in parity with each other, and the provisions of this section apply equally to each.

SECTION 6 - SURGICAL BENEFITS

A. 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.

1. Network Provider

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

2. Non-Network Provider

Except for NSA Claims, if you use a Non-Network Provider, after the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less Coinsurance (30% of the amount payable by the Fund). You will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.) For NSA Claims, the Fund will pay the Non-Network Provider the Network rate. The Non-Network provider is generally prohibited from balance billing you.

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

B. OUTPATIENT SURGICAL BENEFITS

1. Network Provider

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

2. Non-Network Provider

Except for NSA Claims, if you use a Non-Network Provider, after the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less a $100 Copayment and Coinsurance (30% of the amount payable by the Fund). You will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.)

For NSA Claims, the Fund will pay the Non-Network Provider the Network rate, less your $100 Copayment. The Non-Network Provider is generally prohibited from balance billing you for charges that exceed your cost-sharing obligations. Your $100 Copayment will count toward your Network Deductible and Network out-of-pocket maximum in the same manner as if the Surgical Benefits were provided by a Network Provider.

C. 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 generally do NOT include diagnostic Services. However, **For Example**, colonoscopies ordered on the basis of abnormal tests or visualizations are diagnostic AND preventive, so no Copayment will be charged.) Whether there will be a Copayment required will depend on whether you use a Network or a Non-Network Provider.

1. Network Provider

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

2. Non-Network Provider

Except for NSA Claims, if you use a Non-Network Provider, after the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less a $100 Copayment and Coinsurance (30% of the amount payable by the Fund). You will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.) For NSA Claims, the Fund will pay the Non-Network Provider the Network rate. The Non-Network Provider is generally prohibited from balance billing you.

D. 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 Medical provisions 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.** For additional information, see the section regarding **Women's Health and Cancer Rights Act (WHCRA) of 1998** for more information.

Please Note: The Fund administers medical/surgical benefits and mental health/substance use disorder benefits in parity with each other, and the provisions of this section apply equally to each.

SECTION 7 - OUTPATIENT DIAGNOSTIC BENEFITS

A. GENERAL: 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.

1. Network Provider

If you use a Network Provider, the Plan will pay Benefits in full. This applies to all Services under this section.

2. Non-Network Provider

Except for NSA Claims, if you use a Non-Network Provider, the Fund will pay Benefits up to the lesser of 70% of UCR, or 70% of billed charges. In addition, you will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.) For NSA Claims, the Fund will pay the Non-Network Provider the Network rate. The Non-Network Provider is generally prohibited from balance billing you.

B. 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 **SECTION 8 - DENTAL, ORTHODONTIC, AND ORTHOGNATHIC SURGERY BENEFITS** and **SECTION 9 - HEARING AND VISION BENEFITS** for more information). Contact the Fund Office with any questions you have on when other provisions of the Plan cover outpatient diagnostic Services.

Please Note: The Fund administers medical/surgical benefits and mental health/substance use disorder benefits in parity with each other, and the provisions of this section apply equally to each.

SECTION 8 - DENTAL, ORTHODONTIC, AND ORTHOGNATHIC SURGERY BENEFITS

A. DENTAL BENEFITS: GENERAL

Each covered individual in your Family is Eligible for the dental Benefits described below up to 100% of the rate established by the Fund's dental Network as accepted by the Trustees.

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

1. Dental Benefits: Network Providers

The Fund provides dental Benefits that are administered by its Network Provider. 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 Network Provider, the Provider will submit claims for you directly to the Network. You will be responsible for any charges over the annual benefit maximum. However, you will be charged for those Services at the Network rate.

2. 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 the Network for adjudication and reimbursement. You will be responsible for any charges over the rate established by the Fund's dental Network as accepted by the Trustees. A Non-Network provider is not required to accept the Fund's rate.

3. Benefit Limits (See Below for Additional Restrictions and Limitations)

a) Routine:

1) Network: 100% of contracted rate up to $1,000 per person per year.

2) Non-Network: Up to 100% of the rate established by the Fund's dental Network and accepted by the Trustees, up to $1,000 per person per year.

b) Accidental: Limited to $1,000 per person per injury.

B. DENTAL BENEFITS: SPECIAL RULES

1. 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.

2. 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.

3. 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.

Example: Jeannie was Eligible for Benefits in November 2021, but the procedure couldn't be finished until January 2022, after they lost coverage. The Service received in January 2022 is not covered.

4. Medical Benefits May Not be Used for Dental Benefits

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.

5. Special Rules for Dental Implants

a) Pre-Determination is mandatory for all Dental Implant requests. A pre-determination of the procedure must be completed before any implant-related services are rendered. Failure to complete the pre-determination process will result in coverage for all implant-related services being limited to the annual dental maximum under the Participant's Plan.

1) Dental Implants for Dependents under age 19 that are not medically necessary are subject to the Plan's annual dental maximum, as non-medically necessary pediatric dental services are not ACA "Essential Health Benefits."

b) Documentation Required. The Participant or their dentist must provide all required documentation demonstrating the dental and medical necessity of the implant to the Fund's dental advisor. Contact the Fund Office for details on what information is required and where the information should be submitted.

c) Medical and Dental Benefits Available for Implants. The components of the treatment and services for a dental implant will be payable as set forth immediately below:

1) Benefits for consultation, X-rays and miscellaneous Services related to the dental implant are payable under the available dental Benefit, up to applicable annual limit.

2) Medical/Surgical Benefits for the implant are payable at 100% of the Network rate, regardless of whether an in-network or out-of-network provider performs the procedure.

d) Abutment and Crown

1) In-Network: Medical/Surgical Benefits are available for the abutment and crown, payable at 80% of the Network contracted rate. The Patient is responsible for 20% of the cost of the Abutment and Crown;

2) Non-Network: Medical/Surgical Benefits are available for the abutment and crown, payable at 20% of the Network contracted rate. The Patient is responsible for the difference between the amount paid by the Fund and the amount billed by the Non-Network Provider.

e) The dental Benefit Network will administer payment for the approved implant, abutment and crown as Medical claims and payment for the remaining, related services under the Participant's dental plan, using the Network rates.

f) Where implants are placed solely for esthetic or cosmetic reasons, all implant-related services will be payable solely under the dental provisions of the Participant's Plan.

C. DENTAL BENEFITS: SERVICES AND TREATMENT

1. 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.

a) Cleaning During Pregnancy

Participants or their Spouses who are Pregnant are entitled to one additional cleaning during the pregnancy.

2. 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 Network 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.

3. Periodontal Cleanings

If you use a Network Provider, you will be Eligible for periodontal cleaning as provided under the 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.

4. 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 $1,000 per Accident. However, 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.

5. 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, which includes the requirement of Medical Necessity. 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.

6. Oral Surgery as Surgical and Not Dental Service

The Fund will generally 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.

7. Dental Procedures with Anesthesia

If a child aged 10 and under is having anxiety about a dental procedure, the Fund allows the Dental Provider to utilize a facility if the Dentist provides a note to the Fund. The Fund pays Benefits for Dental Services under the Dental Benefit and for the facility and anesthesia under the Medical Benefit. Children aged 11+ and Adults must have the procedure pre-certified for medical necessity to be performed in a facility.

D. 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 their 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.

E. 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 9 - HEARING AND VISION BENEFITS

A. HEARING BENEFITS: GENERAL

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

1. 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.

B. VISION BENEFITS: GENERAL

The Fund provides Benefits for Medically Necessary vision Services whether you use the Network Provider or a Non-Network Provider. You will likely receive greater value if you use 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. Network Vision Benefits

The Plan will pay Benefits for Medically Necessary vision Services if you use a Network Provider as follows:

a) Age 19 years or older: If you or your Dependent are age 19 or over, every two Benefit Years, you are Eligible for an eye exam with refraction and eyeglasses and/or prescription disposable contact lenses, as described immediately below. You are eligible to receive two pairs of eyeglasses, or one pair of eyeglasses and one order of disposable contact lenses. Many frames offered by Network Providers will be covered in full; however, some more expensive frames will be discounted $90. This credit will also apply at a Non-Network retail location. Patients are responsible for amounts over $90 (less any applicable discount). You will receive Benefits in full for prescription disposable contact lenses from a Network Provider, or a $95 credit towards any contacts from any other Provider.

b) If you or your Dependent are under age 19, every Benefit Year, you are Eligible for an eye exam with refraction. In addition, many frames offered by Network Providers will be covered in full; however, some more expensive frames will be discounted $90. This credit will also apply at a Non-Network retail location. Patients are responsible for amounts over $90 (less any applicable discount). You will receive Benefits in full for prescription disposable contact lenses from a Network Provider, or a $95 credit towards any contacts from any other 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 2021. In January 2022, Tom, Jr. obtains through the Fund new lenses for the frames they used in 2021. Because of the new lenses, Tom, Jr.'s eyeglasses are considered new eyeglasses, and Tom, Jr. will have no further allowance for eyeglasses until the 2023 Benefit Year.

c) Features for eyeglasses and soft daily wear contact lenses provided at no extra charge from Network Providers:

- 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
- Oversized Lenses; Post-Cataract Lenses
- Polycarbonate Lenses

- Scratch-Resistant Coating
- Intermediate Vision Lenses
- Glass Photochromic Lenses
- Ultraviolet (UV) Coating
- Blended Invisible Lenses
- Standard and Premium Brands of Progressive Addition Multifocal Lenses
- Standard ARC (Anti-Reflective Coating)

Please note this list is subject to change.

d) Lenses and Coatings available for an additional charge from Network Providers:

- Premium, Ultra, and Ultimate ARC (Anti-Reflective Coating)
- Premium Scratch-Resistant Coating
- Polarized Lenses
- Plastic Photosensitive Lenses
- High-Index Lenses
- Ultra and Ultimate Progressive Lenses
- Trivex Lenses
- Certain Disposable Contact Lenses
- Certain Soft Daily Wear Contact Lenses
- Certain High-Cost Frames
- Bule Light Filtering

Please note this list is subject to change.

IMPORTANT NOTE: *Gas Permeable (hard) contact lenses are* ***not covered*** *under the Fund's agreement with the Network. They are, however, covered under the Non-Network Benefits discussed in the next section.*

2. 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:

a) If you or your Dependent are age 19 or over, every two Benefit Years you are Eligible for an eye exam with refraction and eyeglasses and/or prescription contact lenses, as described immediately below. You are eligible to receive two sets of eyeglasses, or one set of eyeglasses and one order of contact lenses. You may receive up to $45 in Benefits for an eye examination, and up to $75 in Benefits for each pair of eyeglasses, or up to $75 for one pair of eyeglasses and up to $75 for one order of prescription contact lenses. These allowances are not transferable to other Benefit Years.

b) 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 up to $75 in Benefits for 1 complete pair of eyeglasses or contact lenses. These allowances are not transferable to other Benefit Years.

C. 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. The vision Benefits Network reviews each such request to determine Medical Necessity. These conditions include keratoconus, aphakia, anisometropia, 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 vision benefits provider or Medical Advisor.

D. 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 **SECTION 17 - COORDINATION OF BENEFITS & SUBROGATION**.

SECTION 10 - TRANSPLANT BENEFITS

A. TRANSPLANT BENEFITS: GENERAL

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.

1. 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 a Center of Excellence, otherwise the claim will be paid as a Non-Network benefit. A list of Centers of Excellence can be found on the Fund's website at https://www.centralpateamsters.com/health-welfare-fund/providers/.

2. Non-Network Provider

Except for NSA Claims, if you use a Non-Network Provider, after the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less a $100 copayment and Coinsurance (30% of the amount payable by the Fund). In addition, you will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. These Benefits are payment 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.

For NSA Claims, the Fund will pay the Non-Network Provider the Network rate, less your $100 Copayment. The Non-Network Provider is generally prohibited from balance billing you for charges that exceed your cost-sharing obligations. Your $100 Copayment will count toward your Network Deductible and Network out-of-pocket maximum in the same manner as if the Benefits were provided by a Network Provider.

B. 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.

C. BENEFITS FOR UNINSURED ORGAN DONOR

Transplant Benefits include treatments for the organ donor if they have no Other Insurance.

D. 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 11 - MENTAL HEALTH / SUBSTANCE USE DISORDER / AUTISM SPECTRUM DISORDER BENEFITS

The Plan will pay Benefits for Medically Necessary mental health or substance use disorder 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 health and substance use disorder treatment, as shown below.

1. Managed Care Requirement

Like all inpatient admissions, admissions for mental health and substance use disorder treatment are subject to the Fund's Managed Care Program. If you fail to pre-certify your Hospital stay or treatment, the Fund may limit or deny Benefits for the claims incurred, unless the Pre-Certification cannot be required pursuant to the Newborns' and Mothers' Health Protection Act, No Surprises Act, or other applicable federal law or regulation. If you have an Emergency admission for mental health or substance use disorder issues, you or your Provider must notify the Fund Office within two business days after treatment/Hospitalization starts.

2. Emergency Department Copayment

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

3. Network Hospital

If you receive treatment at a Network Hospital for a mental health/substance use disorder, following your payment of a $100 Copayment, you will receive Benefits equal to payment in full. This applies to treatments rendered by Network and Non-Network Providers.

4. Non-Network Hospital

For non-Emergency Medically Necessary stays at a Non-Network Hospital, after the Deductible is met, the Fund will pay Benefits of the remaining portion of the UCR less a $100 Hospital Copayment and Coinsurance (30% of the amount payable by the Fund). You will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.)

5. Medical Necessity

If the Plan denies your room and board Benefits for a 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 Hospital room and board Services.

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 health and substance use disorder, as follows:

1. 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.

2. Non-Network Provider.

Except for NSA Claims, if you use 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. In addition, you will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.)

For NSA Claims, the Fund will pay the Non-Network Provider the Network rate, less your $20 Copayment. The Non-Network Provider is generally prohibited from balance billing you for charges that exceed your cost-sharing obligations. Your $20 Copayment will count toward your Network Deductible and Network out-of-pocket maximum in the same manner as if the Benefits were provided by a Network Provider.

3. Preventive Care Services Provided Under This Section

In accordance with the terms of the ACA, 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 you receive treatment from a Network Provider. If, however, the counseling or screening is provided in conjunction with other mental health or substance use disorder Services or Treatment, you may be responsible for the Copayments for the additional Services or Treatment.

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 uspreventiveservicestaskforce.org.

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

D. AUTISM SPECTRUM DISORDER

The Fund will provide treatment of autism spectrum disorder/pervasive developmental disorders including behavioral therapy, which may include cognitive behavioral therapy, applied behavioral analysis ("ABA") therapy, or other therapies.

Please Note: The Fund administers medical/surgical benefits and mental health/substance use disorder benefits in parity with each other, and the provisions of this section apply equally to each.

SECTION 12 - PRESCRIPTION DRUG BENEFITS

A. PRESCRIPTION DRUG BENEFITS: GENERAL

The Plan pays Benefits for Medically Necessary prescription drugs. However, the Fund provides no Benefits for "Compound" drugs (a mixture of two or more drugs prepared by a pharmacist). The Trustees have delegated to the Fund's pharmacy benefit manager, based on its professional pharmaceutical knowledge and experience, the discretion to add or delete medications from the Fund's Formulary and Step Therapy List and to determine which classifications of prescription medications are subject to step therapy and to determine the appropriate step for such prescription medications. The Benefits available for prescription drugs depends on several factors, including whether:

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

The Fund's Formulary and Step Therapy List may change in the future without advance notice to you. The Fund's Formulary and Step Therapy List is furnished upon request, without charge, as a separate document and can also be found on the Fund's website at https://www.centralpateamsters.com/health-welfare-fund/health-and-welfare-benefit-plans/prescription-drug-benefits/. In addition, the Formulary and Step Therapy List 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 and Step Therapy List. However, if you are not certain whether a particular prescription drug is on the Formulary and Step Therapy List, contact the Fund Office.

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

1. Network Pharmacy

The Fund has a Network Provider for prescription drugs. If you fill your prescription at a Network Provider – participating pharmacy, you will receive a 34-day supply of the prescription, if you present your Fund Network Provider card and make the required Copayment:

a) **Generic Drugs:** Copayment of $5 unless your doctor has indicated on the prescription that a brand name drug is Medically Necessary, your prescription may be filled with a generic version of a brand name drug if available.

b) **Preferred Brand Name Drugs:** Copayment of $15 for a brand name drug that is listed on the Fund's Formulary.

c) **Non-Preferred Brand Name Drugs:** Copayment of $30 for a non-preferred brand name drug that is **NOT** listed on the Fund's Formulary.

2. Non-Network Pharmacy

If you fill your prescription at a non-Network Provider participating 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 the Network on your behalf. The reimbursement will be equal to the Network Provider wholesale price of the drug, less the per-prescription Copayment listed above under "Network Pharmacy."

3. Mail Order Prescription Drug Program

You can purchase Medically Necessary maintenance prescription drugs (**For Example**, high blood pressure medication) through the Network Provider'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 online by following the instructions found on the Fund's website at https://www.centralpateamsters.com/health-welfare-fund/health-and-welfare-benefit-plans/prescription-drug-benefits/.

The Copayments for Mail Order Prescription Drugs are:

a) **Generic:** $15 for generic drugs for up to a 90-day supply.

b) **Preferred Brand Name Drugs:** $30 for "preferred" brand name drugs for up to a 90-day supply.

c) **Non-Preferred Brand Name Drugs:** $60 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).

B. HIGH-COST DRUGS

1. Prescription Drugs Over $500

If your prescription medication costs $500 or more, the pharmacist **must call the Network Provider to get pre-authorization for the medication**. It is in your interest to notify the pharmacist that the phone number for the Network Provider is on the back of your prescription card.

2. 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.

C. 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 on the current Step II list if you 1) tried a Step I medication, 2) your physician provides documentation showing that you failed on the Step I medication, and 3) that the Step II medication is Medically Necessary.

IMPORTANT NOTE: 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.

IMPORTANT NOTE: *If you are prescribed a drug subject to Step Therapy, please contact the Fund to see if your medication is "grandfathered." While 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 and diagnoses, 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.* ***Some categories of Step Therapy drugs are not subject to grandfathering.***

Please note: **All brand contraceptives are considered Step II medications and are not subject to grandfathering.** Where there is a generic equivalent, the Fund covers only the generic, unless the prescription indicates to dispense the brand. In that case, the Provider must submit a letter to the Fund indicating that the generic is not tolerated.

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

a) General: 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.

b) 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.

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

D. 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.

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

1. Zohydro

The Fund will provide no benefits for Zohydro unless a request has been submitted to the Network Provider 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.

2. 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.

3. 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.

E. LIMITS ON SPECIFIC MEDICATIONS

1. Insulin Drugs

The Fund provide Benefits for new prescriptions for insulin medication subject to the Step Therapy List. You can receive a copy of the list by visiting the Fund's website or contacting the Fund Office, as detailed above.

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.*

2. Asthma Medication

The Fund will provide benefits for the Asthma medications listed on the Formulary (available on the Fund's website) 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. The Fund will only provide benefits for ADVAIR or BREO if your physician certifies in writing that you have tried other medication without success.

3. Limits on FDA "CLASS II" Pain Medications

The Fund will provide benefits for **a maximum of 15 days per script** for medications classified as CLASS II pain medications by the U.S. Food and Drug Administration.

4. No Benefits For "Reformulated" Medications

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

5. Coverage for Prescription Drugs Newly Released to the Market

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.)

F. PREVENTIVE SERVICES COVERED UNDER THIS SECTION

1. 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.

Example: Folic acid is one of the supplements recommended by the USPSTF for women who are capable of pregnancy. Emma, who is pregnant, is Eligible to receive folic acid with no Copayment. However, Jane, who had a full hysterectomy, is not Eligible to receive this supplement with no Copayment.

The website listing these items and Services can be found at uspreventiveservicestaskforce.org. 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.

2. 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.*

G. PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM

The Plan limits out-of-pocket costs for prescription drugs to $2,000 for single coverage and $4,000 for family coverage, per year. This prescription out-of-pocket limit applies to Medically Necessary prescription drugs received from Network Pharmacies.

However, the Plan does not count amounts applied to the cost of prescription drugs by a Manufacturer Assistance Program toward this prescription out-of-pocket maximum, nor towards the Out-of-Pocket Maximum described in SECTION 13(C) or any similar accumulator under the Plan. A "Manufacturer Assistance Program" is any program offered by a drug manufacturer or any other entity reduces the out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means.

Annually, the Plan reviews prescription drug claims and sends a letter to anyone who reaches the prescription out-of-pocket limit, informing them that they may be entitled to reimbursement for payments in excess of the limit. To receive reimbursement, the Participant must submit to the Fund Office receipts showing payment of the amounts above the limit and a notarized affidavit affirming they did not receive any benefits from a Manufacturer Assistance Program or any other source of coverage related to their out-of-pocket expenditures.

Please Note: The Fund administers medical/surgical benefits and mental health/substance use disorder benefits in parity with each other, and the provisions of this section apply equally to each.

SECTION 13 – OTHER MEDICAL BENEFITS

A. MEDICAL COVERAGE

Medical Benefits are provided for the following:

1. Non-inpatient nurse (RN or LPN) Services up to 240 hours per Benefit Year. Network Services are not subject to a deductible, with coinsurance of 10%; Non-Network Services are subject to the annual $3000 Deductible and Coinsurance of 30% of UCR. Except for NSA Claims, you will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Provider;

2. Non-inpatient nurse (RN or LPN) Services after 240 hours per Benefit Year, payable at 50% of the contracted rate for Network Services or the UCR for Non-Network Services. Except for NSA Claims, you will also be liable for any balance bill, that is, the difference between the Fund's UCR and the charges billed by the Provider;

3. Oxygen and its administration provided in Network are not subject to a deductible, with coinsurance of 10%; Non-Network Services are subject to the annual $3000 Deductible and Coinsurance of 30% of UCR;

4. Blood and blood plasma, except whole blood products; however, no Benefits are payable for blood or blood plasma donation. Network Services are not subject to a deductible, with coinsurance of 10%; Non-Network Services are subject to the annual $3000 Deductible and Coinsurance of 30% of UCR.;

5. The rental, purchase, or repair of Durable Medical Equipment, including wheelchairs, Hospital beds, crutches, and respirators. The Fund will pay Benefits for Network Services of 10% coinsurance with no deductible; Non-Network Services are subject to the annual $3000 Deductible and Coinsurance of 30% of UCR. You will also be liable for the difference between the Fund's UCR and the charges billed by the Provider;

6. The purchase or repair of orthopedic braces for individuals who have reached their maximum growth. Network Services are not subject to a deductible, with coinsurance of 10%; Non-Network Services are subject to the annual $3000 Deductible and Coinsurance of 30% of UCR. 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;

7. The purchase, replacement or repair of Medically Necessary artificial eyes, an artificial larynx, and prostheses for arms, hands and legs. Network Services are not subject to a deductible, with coinsurance of 10%; Non-Network Services are subject to the annual $3000 Deductible and Coinsurance of 30% of UCR.;

8. The purchase of mastectomy bras (2 per Benefit Year) and bra inserts (2 per breast per Benefit Year), subject to a Network coinsurance of 10% and a Non-Network coinsurance of 30%, but not subject to a deductible in either case; and

9. Pre-certified orthotics, but only if the Fund's Medical Advisor certifies that the foot orthotics are Medically Necessary, consistent with the Medical Advisor's Clinical Policy on Foot Orthotics and are required for certain conditions related to the foot, ankle, knee, or the spine. Network Services are not subject to a deductible, with coinsurance of 10%; Non-Network Services are subject to the annual $3000 Deductible and Coinsurance of 30% of UCR.

10. Nutritional Supplements (formulas), including amino-acid based elemental medical formula, prescribed as Medically Necessary for infants and children by a pediatric gastroenterologist or specialist, administered orally or enterally, for therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria as well as food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short-bowel syndrome. "Amino Acid-Based Ele-

mental Formula" shall be defined as a formula made of 100% free amino acids as the protein source. Nutritional Supplements are subject to a Network coinsurance of 10% and a Non-Network coinsurance of 30%, but not subject to a deductible in either case.

B. MEDICAL DEDUCTIBLE AND COINSURANCE

Once any required Deductible and/or coinsurance have been paid by you, the Fund will pay the remaining Network Claims or, for Non-Network Claims, at the lesser of the UCR or the billed charges, until the end of the Benefit Year, at which time the Deductible and/or coinsurance obligation will renew. In addition, if you use a Non-Network Provider, you will also be liable for any balance bill (that is, the difference between the Fund's UCR and the charges billed by the Non-Network Provider), except with respect to NSA Claims whether the Non-Network Provider is generally prohibited from balance billing you for chargers that exceed your cost-sharing obligations. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.)

1. Deductible

a) Network: There is no Deductible for Network Medical Claims.

b) Non-Network: For Non-Network Medical Claims, there is a $3,000 per-Patient Deductible each Benefit Year, other than for Durable Medical Equipment. No more than two such Deductibles ($6,000) shall be payable by a Family in any single Benefit Year.

2. Coinsurance

a) Network Claims: The Participant is responsible for coinsurance of 10% of the Network rate for Network claims. The Fund has a Network out-of-pocket co-insurance limit of $2,000 for individuals and $4,000 for families per Benefit Year.

b) Non-Network Claims: Except for NSA Claims, the Participant is generally responsible for 30% of the lesser of the UCR of billed charges. For Durable Medical Equipment and Supplies, the Coinsurance is 10% of the UCR, There is **no** maximum out-of-pocket for Coinsurance for Non-Network claims. (Please refer to the **GLOSSARY** to learn how the Usual, Customary & Reasonable rate ("UCR") is determined by the Fund.) For NSA Claims, the Participant's coinsurance responsibility is based on the Recognized Amount.

C. OUT-OF-POCKET MAXIMUM

In addition to the Plan's Coinsurance limit, the Plan operates in compliance with the Patient Protection and Affordable Care Act ("ACA"). Essential health Benefits (as defined in the ACA) provided by Network Providers are subject to a Network Out-of-Pocket Maximum that is set annually by the Department of Health and Human Services. This Network Out-of-Pocket Maximum includes applicable Deductibles, the Coinsurance limit, and co-payments due under the Plan.

While the total Out-of-Pocket Maximum 2023 is $9,100 for single coverage and $18,200 for family coverage, the Plan also splits that total Maximum between medical costs and prescription drug costs. The Plans applies a prescription drug out-of-pocket limit of $2,000 single/$4,000 family and applies the remainder of the ACA Out-of-Pocket Maximum to medical benefits. Thus, for 2023, the Plan's medical Out-of-Pocket Maximum would be $7,100 single/$14,200 family.

Annually, the Plan reviews medical claims and sends a letter to anyone who reaches the medical portion of the Out-of-Pocket Maximum, informing them that they may be entitled to reimbursement for payments in excess of the Maximum. To receive reimbursement, the Participant must submit to the Fund Office receipts showing payment of the amounts above the Maximum and a notarized affidavit affirming that they did not receive any benefits from any other source of coverage related to their out-of-pocket expenditures.

Please Note: The Fund administers medical/surgical benefits and mental health/substance use disorder benefits in parity with each other, and the provisions of this section apply equally to each.

SECTION 14 - SHORT TERM DISABILITY

A. SHORT TERM DISABILITY BENEFITS: GENERAL

1. Eligibility for Benefits

Eligibility for Short Term Disability is predicated on active enrollment in and eligibility for Benefits from the Plan. Should you become Disabled prior to gaining eligibility for Benefits (such as a Disability that occurs during a probationary period), you will not be eligible for Short Term Disability Benefits.

2. Applying for Short Term Disability

If you believe that you meet the eligibility requirements for Short Term Disability, you must contact the Fund Office for the application form. It is recommended that you complete the application as soon as possible after the onset of injury or illness so your benefits are not delayed.

3. Definition of Disability

In order to be Eligible for Short Term Disability Benefits, you must be "Disabled" as that term is defined in this Plan. Generally, you are treated as Disabled under the Plan if:

- You miss work as a result of an injury or illness; **and**
- Your Physician certifies on a form available from the Fund Office that as of the date of your injury or illness for which you seek Disability Benefits, you were completely unable to perform any gainful employment - at your regular job or any other job you have; **and**
- Your Physician certifies that you have seen a physician for your injury or illness within three days of its onset. If you are not seen by a physician for your Disability within three days of its onset, you are Eligible for Disability Benefits only from the day you are seen by a physician.

If your Employer denies that an injury has occurred, we will pay the claim as an illness and not as a work-related injury, and therefore Benefits would only be payable beginning on the 4th day of the illness.

a) Proof of Continuing Disability: Every four weeks, you must submit to the Fund Office proof that you remain Disabled in order to continue receiving Short Term Disability Benefits.

b) Exclusions: You will not be Eligible for Short Term Disability Benefits if any Exclusion applies to your claim.

B. DURATION OF BENEFITS

1. Initial Payment of Short-Term Disability Benefits

Benefits are payable beginning with the **first** day of missed work if on account of an injury, as long as your Employer certifies that you stopped working within one day of your injury and beginning with the **fourth** day of missed work if on account of an illness.

a) Length and Amount of Short-Term Disability Benefits for Job-Related Disabilities: For job-related Disabilities for which you are off fewer than 14 days, you are entitled to a maximum of seven days of Short-Term Disability Benefits, calculated on a per day basis at the rate of $275 per week (seven days). No Job-Related Short-Term Disability Benefits will be paid for any day for which you receive workers compensation Benefits.

b) Length and Amount of Short-Term Disability Benefits for Non-Job-Related Disabilities: For non-job-related Disabilities, you are entitled to a maximum of 26 weeks of Short-Term Disability Benefits at the weekly rate set forth above.

2. Additional Short Term Disability Benefits

If you continue to be Disabled beyond the 26-week period, you may be eligible for an additional 10 weeks of Short-Term Disability Benefits at $100 per week. In order to receive the additional 10 weeks of Benefits, you must submit a request to the Fund Office in writing with a written certification by your doctor that your Disability is continuous but temporary and not permanent in nature, and that the doctor expects that you will return to work. However, if you do not return to work at the conclusion of this additional 10-week Benefit, the Trustees may require that you repay the additional Benefit, in their sole discretion. By requesting and accepting the additional Benefit, you agree to repay the additional Benefits upon written request.

3. Attaining Eligibility for Short Term Disability after Injury or Onset of Illness

This subsection applies to you if your Employer contributes to a plan sponsored by the Board of Trustees that does not include Short Term Disability, and then transitions you to this Plan 13. If you suffered an injury or experienced the onset of an illness before your transition to this Plan, but less than 26 weeks before the effective date of such transition, you may be eligible for Short Term Disability Benefits under this section. Your eligibility consists of Benefits that would be payable between the effective date of your Plan 13 eligibility and 26 weeks after your injury or onset of illness. Should your disability be caused by illness, your eligibility for benefits commences on the fourth day after the effective date of Plan 13 eligibility.

C. THE PLAN DOES NOT PAY SHORT TERM DISABILITY BENEFITS UNDER THE FOLLOWING CIRCUMSTANCES, EVEN IF YOU OTHERWISE MEET THE PLAN'S DEFINITION OF DISABLED

1. You are receiving workers compensation payments and are away from work for more than 14 days;

2. Your injury was caused by, or is the result of an Accident in which you are sky-diving, or operating or otherwise riding a motorcycle, a motorized land vehicle (other than an automobile, a farm tractor, a lawn mower, or golf cart, all four of which are covered only if in regular use), a motorized or non-motorized air vehicle (that is, an airplane not operated by a commercial airline, a helicopter, a hang glider, a parachute, or a balloon) or a personal watercraft (such as a jet ski, not including boats);

    - Jack loves to go skydiving and hang-gliding. They were injured while skydiving and became Disabled under the terms of the Plan. They are not entitled to any Short-Term Disability Benefits.
    - Joe does not own a car and their motorcycle is their only form of transportation. They were injured when they skidded on a sharp curve and will be out of work for seven weeks. Although the Fund will provide Medical Benefits for Joe, there are no Short-Term Disability Benefits payable for injuries sustained as a result of a motorcycle accident.

3. Your injury or illness was the result of a condition for which Benefits are generally excluded (**For Example**, you are recovering from an automobile racing accident);

4. You are on strike, layoff, or leave of absence (unless your Disability began prior to the strike, layoff, or leave). If you became Disabled prior to the strike, layoff or leave of absence, the Fund will pay Short-Term Disability Benefits if you are recalled to work for your Employer but remain Disabled after the date of the recall. Benefits will be paid for up to 26 weeks beginning on the date of the recall to work. The Fund will not pay Short Term Disability Benefits if you are not recalled to work due to lack of seniority or comparable reasons;

    - Eleanor was on a leave of absence in order to care for their seriously ill child. During that time, they tripped and badly injured their ankle, rendering them Disabled. Because they became Disabled after they began their leave of absence, the Fund will not pay Short Term Disability Benefits. The Fund will not pay Short-Term Disability Benefits if you first became Disabled while on strike, layoff, or a leave of absence.

- Mike became Disabled when they fell off a ladder while cleaning the gutters on their house. Shortly afterwards, their Local went on strike against their Employer. Because Mike was already Disabled when the strike began, the Fund will continue to pay their Short-Term Disability Benefits.

5. You are enrolled in the Plan under COBRA continuation coverage;

6. Your injury was caused by, or is the result of, a motor vehicle accident. If you live in a state (**For Example**, Pennsylvania) in which you can purchase wage loss protection from your motor vehicle insurance carrier, the Fund will pay Short-Term Disability Benefits for the first five days of missed work caused by the motor vehicle accident Disability. If you live in a state in which you cannot purchase wage loss protection from your motor vehicle insurance carrier, the Fund will pay Short-Term Disability Benefits so long as you provide documentation required by the Fund to prove that you cannot purchase such protection in your state;

   - Jason lives in Pennsylvania. Although they could have elected wage loss coverage when they purchased automobile insurance, they decided not to do so. Jason was in a car accident that left them Disabled from work. Because they opted not to purchase wage loss coverage from their automobile insurance carrier, the Fund will only pay wage loss Benefits for the first five days of missed work caused by the motor vehicle accident. The Fund will not pay any additional wage loss benefits because they waived this coverage. If, however, Jason lived in a state in which they could not purchase wage loss protection from their motor vehicle insurance carrier, the Fund would pay Short Term Disability Benefits in accordance with the other rules of this section if they provided the documentation required by the Trustees demonstrating that they were not able to purchase wage loss protection from their carrier (and the other documentation required by this section).

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

   - Steve is employed by a Fund Contributing Employer and so is a Participant in the Fund. They also have a small business running a campground. Steve could have purchased liability insurance to protect them in the event of injuries while working on the campground but did not. Steve was badly injured while clearing a raccoon nest out of an empty campsite. The Fund will not pay Short Term Disability Benefits for Steve because they should have purchased liability coverage for their work at the campground.

8. You have received Disability Benefits for less than 26 weeks, return to work for a period of less than 30 days, and then return to "Disabled" status. At that time, you will be entitled only to the remaining weeks of your original 26 weeks of Disability Coverage. However, if you return to work for a period of 30 or more days and then return to "Disabled" status, you will be eligible for a new period of 26 weeks of Disability Benefits.

   NOTE: For the purposes of this subsection 8 and subsection 9.b below, "return(ed) to work" means that you are physically at work, and not taking vacation, personal time/PTO, or other non-disability leave.

9. Multiple Disabling Events:

   a) If you are receiving worker's compensation or other occupational disability benefits and, during that time, become Disabled and Eligible for non-occupational Short Term Disability Benefits due to a second, unrelated Disability, the Fund will not begin paying Short Term Disability Benefits until the date that you would have returned to work after your first Disability was resolved.

      Example: In December, Jim badly sprained an ankle because of a wet surface on the loading dock and was awarded workers compensation benefits. In February, while recovering from their injury, and unrelated to their injury, Jim catches the flu. Unfortunately, the flu turned into pneumonia. Although Jim was cleared to return to work from the ankle injury on February 15, Jim is Disabled by complications from pneumonia. In this situation, the Fund

would not pay Short Term benefits for Jim's pneumonia until after February 15, when they were cleared to return to work for their ankle injury.

b) If you are subsequently Disabled after you have returned to work for one day due to an injury or illness unrelated to an initial Disability, the Fund will pay Benefits for the second Disability as a new claim. However, if you received Short Term Disability but are again Disabled by the same injury or illness, the second Disability will be treated as the same as the first Disability unless you have returned to work for at least 30 calendar days.

Example: Joe was Disabled on account of injuries they suffered from a fall in their driveway and received Short Term Disability Benefits from May 1 through June 30. They returned to work on July 1 but on July 2 suffered a heart attack and was Disabled. The Fund will treat the heart-attack related Disability as separate from the Disability caused by the fall in their driveway.

Example: Eloise suffered a heart attack and received Short Term Disability benefits for 24 weeks. They returned to work but two weeks later they were again Disabled when they suffered a second cardiac event. Because there was a return to work for only two weeks, the Fund will treat the second period of Disability as related to the first and Eloise will be Eligible only for two more weeks of Short-Term Disability Benefits. However, if Eloise had returned to work for at least 30 days, the Fund would treat the Disability as separate from the first Disability and they would again be Eligible for 26 weeks of Disability Benefits.

D. SPECIAL ELIGIBILITY RULES FOR SHORT TERM BENEFITS FOR CASUAL EMPLOYEES

If you are a Casual Employee, that is, a non-Full-time Employee, you may be Eligible for Short Term Disability Benefits if you meet the following additional Eligibility requirements:

1. You must have Benefit Coverage for the month in which the Disability began; **and**

2. You must have received at least eight Employer paid hours during the Contribution Period quarter (i.e., the quarter immediately preceding the Benefit Period quarter); **and**

3. You must have an average of 140 hours or more of Employer-paid Contributions in the quarter immediately preceding the Contribution Period quarter (as described in 2. immediately above).

E. INTERPLAY OF SHORT-TERM DISABILITY AND MEDICAL BENEFITS

If you are receiving non-occupational Short Term Disability Benefits and incur medical claims as a result of the injury or illness for which you are receiving such Benefits, the Fund will provide medical Benefits Coverage to you for that particular injury or illness, even if your Employer has ceased making Contributions on your behalf. This Coverage will cease when you are no longer Eligible for non-occupational Short Term Disability Benefits. You shall be Eligible only for the medical Benefit Coverage to which you were entitled at the time you began to receive non-occupational Disability Benefits. No Benefits shall be payable for any other injury or illness you suffer unless you have timely elected COBRA continuation coverage and paid the required COBRA premiums.

F. SHORT TERM DISABILITY AND RETIREMENT

The hours of service used to determine an Employer's responsibility to continue contributions for a Participant receiving Short Term Disability Benefits are generally limited to those that were earned prior to a Participant's retirement effective date. However, under certain circumstances, an Employer may have an additional obligation to contribute based on the terms of the applicable collective bargaining agreement.

SECTION 15 - DEATH BENEFITS

A. DEATH BENEFITS: GENERAL

The Plan will purchase on your behalf a life insurance policy to provide Benefits for your Eligible Dependents in the event of your death. The Fund's Death and AD&D Benefits are provided under the terms and conditions of the insurance policy, which is incorporated in this Plan by reference and available from the Fund Office upon request. Subject to the terms of that policy, if you die, the Plan's insurer will pay Death Benefits of $35,000 to your Designated Beneficiary. If your Spouse dies, you will receive a Death Benefit of $2,000, and if your Child older than 14 days dies, you will receive a Death Benefit of $2,000 to make a claim for Death Benefits, contact the Fund Office for the proper paperwork. The insurer of the Death Benefit will be responsible for all claim payments and decisions related to this benefit.

B. BENEFICIARY DESIGNATION

You may designate a Beneficiary of your Death Benefit on a beneficiary designation form, available from the Fund Office. 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.

1. 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.

2. 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.

C. ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS: GENERAL

The Plan will purchase on your behalf an AD&D insurance policy 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's insurer 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.

To make a claim for AD&D Benefits, contact the Fund Office for the proper paperwork. The insurer of the Benefit will be responsible for all claim payments and decisions related to this benefit.

1. Amount of Benefit

a) Accidental Death

If you die as a result of an Accident, the Fund's insurer will pay your Designated Beneficiary an AD&D Benefit of $35,000, 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 (combined)	$ 35,000
Quadriplegia	$ 35,000
Both Hands	$ 35,000
Both Feet	$ 35,000
Sight in Both Eyes	$ 35,000
One Hand and One Foot	$ 35,000
One Hand or Foot And Sight in One Eye	$ 35,000
Paraplegia or Triplegia	$ 26,250
Loss of Sight in One Eye	$ 17,500
Loss of Speech or Hearing in Both Ears (not combined)	$ 17,500
Hemiplegia	$ 17,500
Loss of Thumb and Index Finger on Same Hand	$ 8,750
Uniplegia	$ 8,750

You and your Beneficiaries may also be eligible for the following additional benefits available under the accidental dismemberment portion of the 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 policy for more information on these Benefits.

c) Limits on AD&D Benefits

In no event will the Fund's insurer pay more than one dismemberment Benefit per Accident. Moreover, the Fund's insurer will not pay any AD&D Benefits if the death or dismemberment was the result of illness rather than Accidental injury.

SECTION 16 - EXCLUSIONS

A. EXCLUSIONS: GENERAL

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:

1. 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 Advisor.

2. 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 **SECTION 2 - ELIGIBILITY**.

3. Certain Actions by the Participant or Eligible Dependent

a) **Alcohol and Drugs:** The Fund will not pay Benefits (i) (except for substance use disorder Benefits summarized in **SECTION 11 - MENTAL HEALTH / SUBSTANCE USE DISORDER / AUTISM SPECTRUM DISORDER BENEFITS**) 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. However, the Fund, as required by federal law, will not deny benefits for an illness or injury resulting from domestic violence or a medical, mental health, or substance use disorder condition.

b) **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.

c) If an individual receives payment of Benefits because of fraud, or intentional misrepresentation, the Fund reserves the right to rescind coverage and require the individual to make full repayment to the Fund of the Benefits paid.

d) **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.

e) **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 the purposes of this paragraph, covered employment means employment for which Contributions are made to the Plan.

f) **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.

g) **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.

h) **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 **SECTION 17 - COORDINATION OF BENEFITS & SUBROGATION**.

4. **Certain Item, Condition, or Service Exclusions**

a) **Wraparound Services:** The Fund does not cover "wraparound services." Wraparound services consist of individualized care plans designed to allow children with special needs to remain in the classroom at school and can include access to a Mobile Therapist and Therapeutic Support Staff. Coverage for these services may be available through Medicaid.

b) **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 Advisor, 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 AD&D policy.

c) **Pregnancy of Non-Spouse Dependent:** The Fund will not pay Benefits if the Service is for the pregnancy of an Eligible Dependent Child.

d) **Surrogacy:** Any expenses related to a surrogate pregnancy, whether the Participant and Spouse are using a surrogate or whether the Participant or Spouse is acting as a surrogate, are not covered Benefits.

e) **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.

f) **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.

g) **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.

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

i) **Massage Therapy**: The Fund will not pay Benefits for massage therapy unless it is provided by a licensed physical therapist.

j) **Personal Protection Equipment**: The Fund will not pay Benefits for the purchase of personal protection equipment.

k) **Lotions and Ointments:** No Benefits are available for lotion or ointments, such as Biofreeze; however, over-the-counter lotion or ointment may be covered under the Health Reimbursement Arrangement. See **SECTION 23 - HEALTH REIMBURSEMENT ARRANGEMENT** for more information.

l) **Home Health Aides:** The Fund will not pay Benefits for home health aides.

5. **Other Coverage**

a) **Workers Compensation Claims:** The Fund will not pay Benefits if the Service is compensable under workers compensation or similar law.

b) 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.

c) Governmental or Other Insurance: The Fund will not pay Benefits to the extent that the Service is payable by Other Insurance, including government-sponsored insurance, except as may be required to comply with the Medicare Secondary Payer requirements.

6. Miscellaneous

a) 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.

b) Miscellaneous Charges: The Fund will not pay Benefits to a Provider or otherwise for the completion of forms. The Fund will not pay Benefits for any sales, income, or other tax incurred by a Participant or Eligible Dependent; for shipping and handling, regardless of the nature of the shipment; or for travel expenses related to the receipt of Services for any reason.

c) 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.

d) 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.

e) 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.

B. MEDICAL EXCLUSIONS

The Medical provisions of the Plan do not provide for payment of Medical Benefits for the following:

1. Non-Surgical Foot Treatment; Orthotics

No Medical Benefits are payable if the Service relates to non-surgical treatment for foot conditions, other than orthotics.

2. Chiropractic Benefits

No 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) or an office visit. No Benefits are payable to chiropractors for Physical Therapy treatment unless the chiropractor is a licensed physical therapist.

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.

3. Immunizations; Check Ups; Physical Exams

No 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.*

4. **Excessive Hospital Days**

   No 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.

5. **Blood/Plasma:** No Benefits are available for the donation of blood or blood plasma.

6. **Alopecia:** No Benefits are available for the treatment of alopecia.

C. SHORT-TERM DISABILITY AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS EXCLUSIONS

Please refer to the **SECTION 14 - SHORT TERM DISABILITY** for additional exclusions that apply specifically to the Short-Term Disability Benefits provided under the Plan. In addition, see **SECTION 15 - DEATH BENEFITS** for additional exclusions that apply specifically to the AD&D Benefits provided under the Plan.

Please Note: The Fund administers medical/surgical benefits and mental health/substance use disorder benefits in parity with each other, and the provisions of this section apply equally to each.

SECTION 17 - COORDINATION OF BENEFITS & SUBROGATION

A. COORDINATION OF BENEFITS: 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 Payer statute and other applicable laws. In addition, this section describes how the Fund will coordinate out-of-pocket costs with "Other" Coverage.

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.*

1. 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.

2. 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:

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

2) In the case of a Dependent Child of divorced or separated parents, the rules in the next subsection will apply.

d) 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:

1) 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.

2) 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 1) 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 1) 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:

- The plan covering the custodial parent;
- The plan covering the custodial parent's spouse;
- The plan covering the non-custodial parent; and then
- The plan covering the non-custodial parent's spouse.

e) 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.

3. 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 their 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.

4. 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.

B. SUBROGATION/REIMBURSEMENT: 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.

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

1. 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.

2. 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.

3. 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.

4. 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 their 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.

5. 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.*

6. 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.

7. 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.

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 John Smith's auto insurance paid the first $5,000 in claims. John Smith sues the driver of the other car. They recovered $45,000 for the accident. Of this, their 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). John 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.

8. 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 18 - AMENDMENT AND TERMINATION

A. 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.

- No amendment shall cause any of the assets of the Fund to revert to any Employer.
- Any amendment shall be effective as of the date set by resolution of the Trustees.
- Amendments shall be in written form and shall be adopted in a manner consistent with applicable procedures for Trustee action in the Trust Agreement.
- No amendment that affects the responsibilities or rights of a Trustee may be made without the Trustee's written consent.

B. 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 19 - DELINQUENT CONTRIBUTIONS

A. 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 amounts below.

1. 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 (as adjusted from time to time), which interest shall be charged until the date of receipt by the Fund.

2. Liquidated Damages

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

a) Interest on the unpaid Contributions; or

b) 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.

3. Other Amounts

Reasonable attorney's fees; costs of the action; reasonable accounting and auditing Fees; and such other legal or equitable relief as the court deems appropriate.

B. JURISDICTION

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

C. OTHER ACTIONS

The Fund may enforce its rights to Contributions in any manner appropriate under applicable federal or state law.

D. 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.

E. AUDIT OF EMPLOYERS

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 20 - PLAN ADMINISTRATION

A. 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."

B. 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.

C. 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.

D. GENERAL POWERS AND DUTIES OF THE TRUSTEES

The Trustees shall, by way of illustration but not limitation, have the following powers and duties:

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

2. 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.

E. 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.

F. 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.

G. 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 **SECTION 21 - CLAIM APPEALS**. 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.

H. JOINDER OF OTHER LOCAL UNIONS AND EMPLOYEE AND EMPLOYER GROUPS.

1. General

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.

2. Trustee Empowerment

The Trustees shall be fully empowered to negotiate and execute the Participation Agreement, and to bind all parties in interest to the Participation Agreement.

I. 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.

J. 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 fraud, or intentional misrepresentation, the Fund reserves the right to rescind coverage and require the individual to make full repayment to the Fund of the Benefits paid.

K. FACILITY OF PAYMENT PROVISION

The Plan may pay Benefits directly to the Participant, whether such Benefits are payable for Services to the Participant or their 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.

L. NONASSIGNMENT OF BENEFIT PAYMENTS

Except as required by applicable law, no Participant or Dependent may assign any rights to Benefits or any other right (legal or equitable) under the Plan. All rights under the Plan are personal to the Participant or Dependent and are not assignable in whole or in part to any person or entity, including a health care Provider, nor may Benefits coverage under the Plan be transferred at any time. Under no circumstances will the Plan's direct payment of any amounts to any Provider (Network or Non-Network) or prior authorization of Benefits provided under the Plan or by any party on behalf of the Plan constitute a waiver of this nonassignment provision with respect to any party.

M. 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.

N. 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.

O. 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.

P. 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.

Q. 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 Short-Term Disability Benefits, Death Benefits, and AD&D Benefits, the Fund will not pay any such Benefits for claims that are not presented within one year from the date of Disability, death, or dismemberment, as applicable.

R. 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.

S. 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. Note however, the Fund will only pay for an autopsy it requests; any other autopsy is not a covered benefit.

T. RIGHT OF RECOVERY

1. 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.

2. 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.

U. 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.

V. 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 they 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.

W. 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.

X. 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.

Y. 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.

Z. 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.

AA. 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 4 months after the date of the adoption of a resolution to this effect and the communication thereof, by written notice, to the terminated Employer.

BB. 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 **SECTION 2 - ELIGIBILITY**.

CC. 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.

DD. CONSTRUCTION

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

EE. 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.

FF. EXCLUSION OF DEPENDENT CHILD FROM COVERAGE

In certain, limited circumstances, a Participant who either covers a Dependent Child under age 26 or who covers a Dependent Child age 26 and over who is Disabled, may seek to exclude such Dependent from Benefit Coverage under this Plan. This section provides the exclusive basis for such an exclusion.

1. 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 removed 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 remove a Dependent 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.

2. Requirements for Exclusion of a Dependent

All of the following requirements must be satisfied for a Dependent to be removed from Benefit Coverage:

a) The Participant's request to remove 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.

b) The Participant's written request must explain with particularity the reasons why the Participant is seeking to remove the Dependent.

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

3. 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 applicable Participant, provided that the Dependent remains Eligible for Benefits under the terms of the Plan.

4. Employer's Contribution

The fact that a Dependent has been removed from Benefit Coverage under this section shall not affect the Contribution owed by the Employer of the Participant who requested the Dependent's removal from Benefit Coverage. In all such cases, the Employer will be obligated to pay, after the exclusion, the same Contribution that would have been due if the Dependent were still covered under the Plan.

GG. COMPONENT AND COMPOSITE RATES

The Trustees, acting in their sole discretion, shall have authority to establish rules pursuant to which an Employer may contribute to the Plan according to Component or Composite rates, provided that the Employer has authority to do so.

HH. NON-BARGAINING UNIT EMPLOYEES

The Trustees, acting in their sole discretion, shall have authority to establish rules pursuant to which non-bargaining unit employees may participate in the Plan, provided that such participation by non-bargaining unit employees complies with the applicable provisions of law.

SECTION 21 - CLAIM APPEALS

A. RULES FOR CLAIMS SUBMISSION TO THE PLAN

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 the onset of Disability, or they will not be processed.

B. AUTHORIZED REPRESENTATIVE

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.).

C. CATEGORIZATION OF CLAIMS

There are four types of claims. Please note that not every inquiry made to a Plan representative is a claim or appeal. A general request for information regarding claims, Benefits, or Coverage by the Plan will be addressed, but not using the procedures outlined below.

1. Post-Service Claims

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.

2. 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."

3. Pre-Service Claims

Certain Services and procedures require pre-authorization or pre-certification. These claims are called "pre-service claims."

4. Urgent Care Claims

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

D. 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.

E. CONCURRENT CARE CLAIMS

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.

F. PRE-SERVICE CLAIMS

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.

G. POST-SERVICE CLAIMS

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.

H. SUBMITTING CLAIMS FOR PROCESSING

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, electronic 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.

I. INFORMATION PROVIDED TO CLAIMANT IN EVENT OF DENIAL

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 and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal).

J. APPEAL OF CLAIMS DENIAL

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.*

K. CONTINUED COVERAGE FOR CLAIMS WHILE AN APPEAL IS PENDING

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.

L. RIGHTS ON APPEAL

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 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.

M. INFORMATION PROVIDED UPON DENIAL OF AN APPEAL

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. If there is a final adverse determination of your claim, you generally have the right to bring a civil action against the Fund under Section 502(a) ERISA, as amended, after you have followed and exhausted all levels of appeal required under these claim procedures.

N. TIMING FOR DECISIONS ON APPEAL

1. Urgent Care Claim

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.*

O. FAILURE OF BOARD OF TRUSTEES TO MAKE A DECISION WITHIN THE TIME DEADLINES

If the Board of Trustees fail to act within the timelines 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.

P. INDEPENDENT REVIEW FOLLOWING AN ADVERSE BENEFIT DECISION

If you have received an adverse benefit determination from the Fund, you (or your authorized representative) may request an "external review" of the Fund'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. An 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. There is a standard external review and, for urgent cases, an expedited (faster than usual) external review. The Fund is responsible for paying the IRO's fees.

An 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 Fund cancelled your coverage back to an earlier date.

An external review is also available with respect to adverse benefit decisions that involve NSA Claims (including coverage for Emergency Medical Services received at Non-Network facilities, certain services received from Non-Network providers at Network facilities, air ambulance services, services provided by Non-Network Providers believed to be Network Providers, and services provided to Continuing Care Patients [as defined in the **GLOSSARY**]) in order to determine compliance with the surprise billing and cost-sharing protections under the No Surprises Act.

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.

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

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:

In Pennsylvania: 610-320-5500 or 1-800-422-8330 - Toll Free
Outside of Pennsylvania: 1-800-331-0420 - Toll Free

By Fax:

(610) 320-9236

By Email:

hwfund@centralpateamsters.com

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 Fund 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 Fund.

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.

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. EXPEDITED EXTERNAL REVIEW

You may request an "expedited" external review when:

- The Patient has asked for an expedited internal appeal (or urgent care 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 their 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.

For your convenience, the Fund can provide you with a form on which to make your expedited external review request. Using the form will also help ensure that you submit all information needed to consider your request for expedited 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; and
- A brief description of the reason you disagree with the Fund's denial decision.

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. You can submit your request for an Expedited Review:

By Postal Mail:

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

By Fax:

(610) 320-9236

By Email:

hwfund@centralpateamsters.com

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.

R. FURTHER IRO REVIEW CONSIDERATIONS

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.

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.

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.

S. SPECIAL RULES FOR CLAIMS INVOLVING SHORT TERM DISABILITY

Initial Claim for Benefits: The Fund provides Short-Term Disability Benefits. You must contact the Fund Office to request an application for Benefits, then return the completed form to the Fund Office. The Fund will provide a response not later than 45 days after it receives your application for short term Disability Benefits, unless it cannot because you (or your Provider) have not submitted all of the information needed to process the claim or for other reasons beyond its control. If the delay is caused by circumstances beyond the control of the Fund, the Fund will notify you in advance of the expiration of the initial 45-day period that an additional 30 days are required. If the Fund determines that an additional 30-day period is required due to circumstances beyond the control of the Fund, the Fund will notify you in advance of the expiration of the first extension. The Fund will include in the notice of any extension an explanation of the standards used to determine if you are entitled to the Benefit and a description of both the unresolved issues that prevent a decision on the issues and the information that you can provide that will resolve these issues. You will have at least 45 days to present any required information. The Fund's consideration of your claim will be suspended when it informs you that additional information is required. After you submit the required information, the Fund will process your claim within the balance of time remaining before consideration of your claim was suspended.

If your claim is denied, you will receive the following information:

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

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

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

4. If the decision turned on medical necessity or whether a treatment was Experimental, the Fund will provide an explanation of the scientific or clinical judgment for the decision, applying this to your situation, or will provide the explanation to you free of charge upon request;

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

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

The Board of Trustees will generally provide a response to an appeal of an adverse decision on a Short-Term Disability claim after the regular meeting of the Board of Trustees that follows the submission of your request for appeal. If your request for appeal was filed less than 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.

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.

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.

T. BOARD OF TRUSTEES AUTHORITY WITH RESPECT TO APPEALS

The Board of 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 Fund's mailing of the Claim Review Decision, as documented in the Fund's records. The Trustees reserve the right to adopt such policies and procedures as may be necessary to implement this section.*

SECTION 22 – SELECT FEDERAL LAWS APPLICABLE TO THIS PLAN

A. CONTINUATION COVERAGE OR "COBRA"

This section explains COBRA continuation coverage, when it is available to you and your Dependents, and what you need to do to protect your rights under the law. If you lose coverage for health benefits under this Plan, you may be Eligible to continue your health benefits coverage temporarily by purchasing COBRA continuation coverage. This coverage is described in detail below. In addition to COBRA, you may be eligible to purchase coverage through the Health Insurance Marketplace, which you can learn more about by visiting www.HealthCare.gov or calling 1-800-318-2596. You may also qualify for a 30-day special enrollment period for another group health plan, such as a spouse's plan. These options may cost less than COBRA continuation coverage.

Your health benefits coverage under the Fund may be terminated because you have experienced a "qualifying event," described below. Following a qualifying event, "qualified beneficiaries" have the legal right to continue group health care coverage. Under the law, a qualified beneficiary is any employee, their Spouse, or a Dependent Child who was covered by the Plan when the 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 their own decision about continuation coverage.

QUALIFYING EVENTS

Qualified beneficiaries are entitled to COBRA Continuation Coverage when as a result of a qualifying event, coverage of that qualified beneficiary ends. If a covered individual has a qualifying event but does not lose their health care coverage under this Plan, (e.g. employee continues working even though entitled to Medicare) or loses their health coverage but does not have a qualifying event, then the individual is not entitled to COBRA Continuation Coverage.

Events that Apply to Employee

- You no longer work for an Employer that participates in the Fund, for any reason other than gross misconduct.
- Your working hours are reduced so that you no longer meet the eligibility requirements for coverage.

Events that Apply to Spouses of Employees

- Your spouse (i) stops working for an Employer that participates in the Fund, (ii) has their hours reduced causing loss of coverage, or (iii) becomes covered by Medicare.
- Your spouse dies.
- You become divorced from your Spouse.

Events that Apply to Dependent Children

- Your parent-employee dies.
- Your parent-employee (i) stops working for an Employer that participates in the Fund, (ii) has their hours reduced causing loss of coverage, or (iii) becomes covered by Medicare.
- Your parent is divorced from the parent who is employed by an Employer that participates in the Fund.
- The Child ceases to be a "Dependent" under the terms of the Plan.

***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.*

1. Type of Coverage

Generally, you can elect to receive the same type of coverage you had immediately prior to the qualifying event or 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 they were not reinstated and reestablished eligibility 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 they terminated employment, but only if the disabled person notifies the Plan Administrator of the determination within 60 days after they received 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.*

2. Cost of COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, you must pay for the level coverage you elect. 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 administrative costs to provide coverage. If there is an increase or decrease in the Fund's cost, your future premiums will be adjusted accordingly.

3. Notification Requirements

You Must Notify Us: 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 for the following qualifying events:

- Divorce,
- A Child ceasing to qualify as a Dependent under the Plan, or
- A second qualifying event. (See section 4.d below for additional information.)

We Will Contact You: The Plan Administrator will contact 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 the following qualifying events:

- Your termination of employment for any reason or of your reduction in hours,
- Death of the employee, or
- The employee becoming covered under Medicare.

4. Election of Continuation Coverage

You will have at least 60 days to elect continuation coverage through the Plan. This election period will end on the later of (1) 60 days from the date you lose coverage, or (2) 60 days from the date we provide notice of continuation coverage and an election form.

Each qualifying beneficiary has the independent right to elect continuation coverage. However, covered employees may elect coverage on behalf of their spouses, and parents may elect coverage on behalf of their Dependent children.

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 THE 60-DAY ELECTION PERIOD, YOU AND/OR THEY WILL LOSE HEALTH COVERAGE, AND THE RIGHT TO ELECT COVERAGE, FROM THIS PLAN.

a. Grace Period

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 qualifying event. 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. Payment is considered made when it is postmarked. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Once coverage is canceled, it cannot be reinstated for any reason.

b. Special Enrollment Rights

Your loss of coverage under this Plan entitles you to the special and open enrollment rights as provided. This special enrollment right under federal law also allows 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.

c. 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.

d. Extended COBRA Continuation Coverage for Spouses and Dependent Children 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 your termination of employment or reduction in hours, you die, become divorced, or 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, your Spouse, or your Dependent 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 individual entitled to COBRA Continuation Coverage for more than a total of 36 months.

e. 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, a covered Spouse, or a Dependent Child becomes totally and permanently disabled so as to be entitled to Social Security Disability Income benefits, the disabled person and any covered family members may be entitled to keep the COBRA Continuation Coverage for an additional 11 months, for a total of 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 disability began no later than 60 days after the termination of employment or reduction in hours;
- You or another family member sends a written notification to the Fund Office of the Social Security Administration determination within 60 days of receiving that determination; and
- The notice is received by the Fund Office before the end of the 18-month COBRA Continuation period.

During the 11-month extension, the Plan may charge an additional 50% for coverage, 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.

5. 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 termination of 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.
- The date after you elect COBRA on which you first become entitled to Medicare.

6. Coordination with Subsidized Coverage

If you experience 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, 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 **SECTION 2 - ELIGIBILITY**.) 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.

7. COBRA Questions

If you have a question about your COBRA continuation coverage rights, you, your Spouse, or your Dependents should contact the Fund Office. For more information about your rights under ERISA, including COBRA, PPACA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

To protect your family's rights, let the Fund Office know about any changes in the addresses of you, your Spouse, and your Dependents.

B. 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 them 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.

C. 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.

1. 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.

2. 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" their 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 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.

3. Maximum Continuation Period

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

4. 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.

5. 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.

6. 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.

7. Rights Upon Reemployment

If you are reemployed after service in the uniformed services and have 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.

D. 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.

1. Definitions

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

b) 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.

c) 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.

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

1) Requirements for Qualification:

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.

2) 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.

3) 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.

E. 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.

F. SPECIAL ENROLLMENT PROVISIONS

Under the Health Insurance Portability and Accountability Act (HIPAA), you have the right to enroll in the Plan under its "special enrollment provision" if you acquire a new Dependent, or if you decline coverage under this plan for yourself or an eligible Dependent while Other Insurance is in effect and later lose that Other Insurance for certain qualifying reasons. Notwithstanding the following rules, you and your family will be automatically enrolled in the Plan once you and your Dependents become eligible for Plan coverage.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you are entitled to enroll your new Dependents. To enroll a new Dependent, please contact the Benefits Office promptly following the marriage, birth, or adoption.

Loss of Other Insurance. Under HIPAA, if you were to decline enrollment under the Plan for yourself or for an eligible Dependent (including your Spouse) while other health insurance or group health plan coverage is in effect, you might be entitled to enroll yourself and your Dependents in the Plan at a later time if you or your Dependents lose eligibility for that Other Insurance (or if the employer stops contributing toward your or your Dependents' Other Insurance). Generally, all eligible individuals (employees and Dependents) automatically are enrolled in the Plan (regardless of whether such individuals have Other Insurance through another plan). However, this special enrollment right may be applicable if you have opted out of the Plan as set forth elsewhere in this booklet.

Loss of Medicaid or Children's Health Insurance Program (CHIP). If you decline enrollment for yourself or for an eligible Dependent (including your Spouse) while on Medicaid or CHIP you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that coverage.

Eligibility for Premium Assistance under Medicaid or CHIP. If you or your Dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or CHIP, you may be able to enroll yourself and your eligible Dependents.

G. HIPAA PRIVACY NOTICE

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that the Fund protect your health information. The Fund maintains a Privacy Notice as required by HIPAA, which is available on the Fund's website (https://www.centralpateamsters.com/privacy-policy/) or upon request from the Fund Office.

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 13, 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 the rights below.

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

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.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and solely in the interest of you and the other Plan Participants and 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.

5. 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.

J. NONDISCRIMINATION AND ACCESSIBILITY STATEMENT

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:
  1. Qualified sign language interpreters; or
  2. 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:
  1. Qualified interpreters; or
  2. 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.

SECTION 23 - HEALTH REIMBURSEMENT ARRANGEMENT

A. The Fund shall credit each eligible Participant with a sum that is based upon the amount of the HRA Contribution remitted to the Fund by their Employer each month. The amount or rate designated for Contribution to the HRA shall be in addition to the Contribution required to support the traditional Plan 13 Benefits, and shall be consistent in amount or rate, as applicable, for all members of the bargaining unit.

B. In order for an individual to be Eligible for this Benefit, the Participant must meet the following conditions: (i) their Employer must make a Contribution to support this HRA Benefit on such individual's behalf pursuant to a collective bargaining agreement; (ii) the individual must be covered by a group health plan (including the Plan) that does not consist solely of excepted Benefits and that provides minimum value; and (iii) such individual must not have accepted the Fund's annual offer to opt-out of and waive future reimbursements from the HRA Benefit.

C. The credited amounts described in this section shall be considered a "health reimbursement arrangement" as that term is described in IRC Sections 105 and 106 and regulations and guidance thereunder.

D. Each Eligible Participant shall be permitted to submit claims for unreimbursed medical expenses incurred while covered under this Plan (including COBRA coverage), provided that coverage is in place for the individual who incurred the expense. Except for UPS Participants who were previously covered under an HRA offered by the Fund, reimbursement is not permitted for expenses incurred (i) before April 1, 2021 and (ii) before or after the individual was a Participant or Dependent in the Plan or after the individual ceases to be a Participant or Dependent in the Plan.

   IMPORTANT NOTE: *If a Participant terminates employment with their Employer, the Participant will only be Eligible to receive reimbursement for claims that were incurred as a Fund Participant on account of their active employment or because they elected COBRA coverage, provided that the request for reimbursement is timely made and includes all required documentation.*

E. The only expenses for which reimbursement may be made are expenses that would generally qualify for the medical, dental and vision expenses deduction on the Participant's federal income taxes, whether or not the Participant actually takes that deduction. These expenses are described in IRC Section 213(d) and include, but are not limited to, Patient out-of-pocket costs for Physician, Hospital, Physical Therapy or Prescription medicines. Individuals who receive payment on any items under any Other Insurance coverage will only be reimbursed for any balances for which they are responsible.

F. A Participant must submit supporting documentation for each item or service demonstrating that the Participant (or Patient) actually paid the amount for which reimbursement is sought. The Fund will provide a "reimbursement expense" form to which this documentation must be attached. Examples of this documentation include but are not limited to the following:

   - For office visits, inpatient or outpatient facility copays — An itemized receipt or bill from the provider that includes the Patient's name, a description of the service, the original date of service and the Patient's portion of the charge.
   - For prescription drugs — A statement or receipt from the pharmacy including the Patient's name, the Rx number, the name of the drug, the date the prescription was filled, and the amount.
   - For over-the-counter health care-related products — An itemized cash register receipt with the merchant's name, name of the item/product, date, and amount. These include items like over-the-counter medicine, crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits.

G. Reimbursements shall be made to Participants within the Fund's regular claims processing protocol. Participants must submit all applications for reimbursement no later than one year after the date of service or the date the expense claim was incurred.

H. The maximum reimbursement amount that a Participant can receive is equal to their account balance at the time the reimbursement request is processed.

I. Any monies that are not expended in one plan year will be rolled over to the next plan year and will continue to be available to the individual for reimbursement of qualified medical expenses.

J. A Participant who is Eligible to elect COBRA but fails to do so, or who elects COBRA coverage but ceases COBRA coverage, will only be Eligible to receive reimbursement for claims that were incurred while the individual was a Participant on account of their active employment or because the individual elected COBRA coverage (provided that the request for reimbursement is timely made and includes all required documentation).

K. At no time will any Participant be Eligible to receive cash payment from the Fund under this HRA without documentation of qualified medical expenses.

GLOSSARY

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

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.

Ancillary Services: "Ancillary Services" are:

A. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;

B. Items and services provided by assistant surgeons, hospitalists, and intensivists;

C. Diagnostic services, including radiology and laboratory services; and

D. Items and services provided by a Non-Network Provider if there is no Network provider who can furnish such item or service at such facility.

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 their Dependent may be Eligible for Benefits under the Plan.

Benefit Year: The 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, which order grants the Participant legal custody and sole or primary physical custody of the Child, provided that both the initial and annual requirements detail in **SECTION 2 - ELIGIBILITY**, **Enrolling Yourself and Eligible Dependents in the Plan** are met. 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.

Further, for a child who is not the son, daughter, stepson or stepdaughter, or eligible foster child of the Participant, or who has not been legally adopted by or placed for legal adoption with the Participant, such child must also reside with the Participant.

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 AD&D Benefit under the Plan if the Designated Beneficiary predeceases the Participant.

Continuing Care Patient: An individual is a Continuing Care Patient with respect to a provider or facility if the individual is:

- Undergoing a course of treatment for a "serious and complex condition" from the provider or facility;
- Undergoing a course of institutional or inpatient care from the provider or facility;
- Scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Determined to be "terminally ill" and receiving treatment for such illness from such provider or facility.

An individual has a "serious and complex condition" if the individual has a condition that (a) in the case of an acute illness, is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b) in the case of a chronic illness or condition, is a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time. An individual is "terminally ill" if the individual has a medical prognosis that the individual's life expectancy is six months or less.

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 AD&D Benefit under the Plan.

Disability (Disabled; Disabling): 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 they are engaging in any work for wage or profit, any occupation, or any employment, even if they cannot perform their 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 their 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 a medical condition that is evidenced by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health (or, with respect to a pregnant person, the health of the person or their unborn child) in serious jeopardy, or seriously impair bodily functions or the function of any bodily organ or part. If symptoms exist that reasonably may be interpreted as an Emergency, that condition will be considered an Emergency even if the final diagnosis is of another condition. **For Example**, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an Emergency even if a final diagnosis of a heart attack is not made. If you are taken for treatment to the nearest Hospital or trauma center by the police, fire department, or ambulance under circumstances beyond your control, this too will be treated as an Emergency.

Emergency Department: Emergency Department means a Hospital outpatient department that provides Emergency Services or an independent, freestanding facility licensed separately from a Hospital that provides Emergency Services.

Emergency Services: Emergency Services means outpatient and inpatient services provided with respect to an Emergency and include treatment provided by and within the capabilities of the Emergency Department of a Hospital (including a Hospital outpatient department) or an independent, freestanding Emergency Department that is geographically separate and licensed separately from a Hospital under applicable state law, including an appropriate medical screening examination and ancillary services routinely available to the Emergency Department to evaluate such Emergency and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility). Emergency Services include treatment of an Emergency by an urgent care clinic or facility if such urgent care clinic or facility is permitted by applicable state licensure laws to provide such services.

Post-stabilization services provided by out-of-network providers and facilities generally also will be considered Emergency Services for purposes of applying the payment rules with respect to Emergency Services as set forth in the Schedule of Benefits unless certain

conditions are met. Post-stabilization services include outpatient observation, or an inpatient or outpatient stay that is related to the Emergency or with respect to the visit in which other Emergency Services are furnished.

Post-stabilization services at an out-of-network facility or from an out-of-network provider are not considered Emergency Services for payment purposes if (i) the attending emergency Physician or treating provider determines that the Patient is able to travel using non-medical transportation or nonemergency medical transportation to an available in-network provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition, (ii) the out-of-network facility or provider furnishing such services provides adequate notice to the Patient as required by federal law (including notice that the provider is an out-of-network provider with respect to the Plan, the estimated charges for treatment and any advance limitations that the Plan may put on the treatment, of the names of any in-network providers at the facility who are able to provide treatment, and notice that the Patient may elect to be referred to one of the in-network providers listed); and (iii) receives informed consent from the Patient to continued treatment despite the greater cost, in compliance with applicable law.

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: Experimental or Investigational means services, supplies, care, and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered.

Family (Family Members): A Participant and all of their Eligible Dependents.

Fund: The Central Pennsylvania Teamsters Health and Welfare Fund, Plan 13, as it may be amended from time to time. The Fund is a multiemployer self-insured health and welfare plan governed by ERISA.

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 use disorder) 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 facilities Benefits are limited to 15-day stays.*

Intensive Outpatient (Programs): Intensive outpatient programs (IOPs) typically provide up 3 to 4 hours of psychosocial treatment 1 to 4 days per week (usually 6 to 12 hours of treatment per week), mostly by using a group format, and are appropriate for Patients who need a type or frequency of psychosocial treatment that is not currently available in a standard outpatient setting but is available in an IOP. Criteria :

- Danger to self, low risk, for adult or danger to others, low risk
- Behavioral health disorder is present and appropriate for intensive outpatient program care
- Recommended treatment is necessary, appropriate, and not feasible at lower level of care
- Patient has sufficient ability to respond as planned to individual and group therapeutic interventions

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.

Managed Care Organization: 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 Advisor, 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 Provider(s): 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 Provider(s): 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 health benefits 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, self-insured or account-based arrangement, including health reimbursement arrangements or similar accounts, however denominated;

   1. "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.

   2. 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).

Partial Hospitalization (Programs): Partial hospitalization programs provide multidisciplinary behavioral care for six to eight hours per day, five to seven days per week (with Patients going home each evening or weekend) and are staffed similarly to the day shift of an inpatient unit. Admission to a partial hospital program may be preferable to an intensive outpatient program if:

- Daily, or near daily, management or immediate intervention is necessary.
- Conditions which may require this intensity of monitoring include medication and comprehensive symptom management; lack of resiliency and need for repeated reinforcement; extreme mood swings, hopelessness, or isolation with inadequate or unavailable community supports; and substance use monitoring.
- Immediate intervention may be necessary for crisis situations (i.e., volatile family situations) or when urgent behavioral activation is required (i.e., rapid improvement is necessary to return individual to vital role functioning)

Patients who are assessed to have significant potential for harm to self or others and require daily or near daily observation and safety planning may be more appropriately managed in a partial hospitalization program vs an intensive outpatient program.

Participant: An Employee who may be Eligible for Benefits for themselves and their 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 Advisor, 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 their licensure and in accordance with all other applicable laws. The term Physician includes, **For Example**, a doctor, surgeon, dentist, psychologist, nurse midwife, optometrist, podiatrist, or chiropractor.

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

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).

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.

Qualifying Payment Amount: The median in-Network rate recognized by the Plan for the respective services in the geographic region, calculated using the methodology specified in U.S. Department of Labor regulations.

Recognized Amount: "Recognized Amount" means an (i) amount determined by an applicable All-Payer Model Agreement under the Social Security Act, or, (ii) if there is no such applicable agreement, an amount determined by applicable state law, or (iii) if there is no such agreement and no amount determined by state law, the lesser of the billed amount or the Qualifying Payment Amount. Currently, there is no applicable All-Payer Model Agreement, nor any applicable state law, meaning that the Recognized Amount will be the lesser of the billed amount or the Qualifying Payment Amount.

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. The UCR is a percentile of a database that has been carefully selected by the Trustees. Unless otherwise indicated in this APD-13, 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-13, 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 using a percentage of billed charges as of a date selected by the Trustees.

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

CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND

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