Teamsters Welfare Fund of Northern New Jersey Local 723

Summary Plan Description

January 1, 2017

(Virar para la version en Español)

YOUR

WELFARE

FUND

BENEFITS

If there are any discrepancies between the English and Spanish version of this Summary Plan Description the English version overrides or supersedes the Spanish version.

Si hay alguna discrepancia entre la versión inglesa y española de este Resumen Plan Descripción la versión en inglés reemplaza o sustituye a la versión en español.

January 2017

Teamsters Welfare Fund of Northern New Jersey Local 723

714 Rahway Ave., Suite 3
Union, NJ 07083
(908) 688-0723

Union Trustee

John Humphrey
Teamsters Local 641
714 Rahway Ave., Suite 1
Union, NJ 07083

Employer Trustee

Bruce Bier
Richards Manufacturing
517 Lyons Ave.
Irvington, NJ 07111

Fund Administrator

Robin A. Modzelewski

Counsel

Mets, Shiro, McGovern & Paris, LLP

Accountant

Baratz & Associates, PA

Consultant

Summit Actuarial Services, LLC

A MESSAGE FROM THE BOARD OF TRUSTEES

Dear Participant:

The Board of Trustees is pleased to provide this booklet describing your benefits under the provisions of Teamsters Welfare Fund of Northern New Jersey Local 723. It includes all changes to the Welfare Fund Plan that were made through the date of printing in January 2017.

We continue our efforts to preserve and improve the comprehensive medical benefits for you and your eligible dependents. This booklet represents a summary of valuable information about your Welfare Plan, including when you and your dependents can become eligible for benefits, the types of coverage provided, how to file a claim for benefits, when your coverage will terminate and what you should do if a claim is denied.

The primary purpose of this Summary Plan Description (SPD) is to provide you with a general explanation of the most important features of the Plan in non-technical terms. It is important that you understand how the Plan works. We urge you to read this SPD very carefully. You must be familiar with the benefit programs in order to fully benefit from your health coverage. We recommend that you keep this SPD in a safe and convenient location so that you may refer to it whenever necessary. If you lose or misplace your copy, please feel free to request another one from the Welfare Fund Office.

We have made every effort to provide you with a clear description of the Plan in plain, everyday language. Certain words and phrases, however, may seem technical to you. If you still have questions after reading this summary, please contact the Welfare Fund Office.

This SPD contains a summary in English of your rights and benefits under the Teamsters Welfare Fund of Northern New Jersey Local 723. If you have difficulty understanding any part of this SPD, or in filing a claim, contact the Fund at 714 Rahway Avenue, Suite 3, Union, NJ 07083. If you have any questions about your benefits, please feel free to call the Fund Office at (908) 688-0723 for assistance.

Sincerely,

The Board of Trustees

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IMPORTANT:
This Summary Plan Description and the personnel at the Fund Office are the only authorized sources of Fund information for you. The Trustees of the Fund have not empowered anyone else to speak for them with regard to the Teamsters Welfare Fund of Northern NJ Local 723. No Employer, Union representative, supervisor or shop steward is in a position or authorized to discuss your rights with authority.

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Administrator at 908-688-0723. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PLAN INFORMATION

This Summary Plan Description sets forth the benefits for Employees who are eligible to participate in the full benefits of the Welfare Plan.

The Plan provides the following benefits: Hospital, Medical, Death, Accidental death and dismemberment, Prescription drug, Dental, and Vision.

COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to a number of Collective Bargaining Agreements. A copy of any such agreement may be obtained by participants and/or their beneficiaries upon written request to the Welfare Fund Office and is available for examination at the Welfare Fund office by Participants and/or their Beneficiaries.

NAME AND ADDRESS OF PLAN SPONSOR

Plan Sponsor:	Trustees of Teamsters Welfare Fund of Northern New Jersey Local 723 714 Rahway Ave., Suite 3 Union, NJ 07083 (908) 688-0723
Name of Plan:	Teamsters Welfare Fund of Northern New Jersey Local 723
Fund Administrator:	Robin A. Modzelewski, Fund Administrator Teamsters Welfare Fund of Northern New Jersey Local 723
Address of Plan:	714 Rahway Ave., Suite 3 Union, NJ 07083
Plan Number:	501
Employer Identification Number:	22-1736275
Plan Fiscal Year Ends:	December 31
Service of legal process should be made upon the Plan Trustees to:	Robin A. Modzelewski, Fund Administrator Teamsters Welfare Fund of Northern New Jersey Local 723 714 Rahway Ave., Suite 3 Union, NJ 07083 (908) 688-0723
Plan type:	Multi-Employer “ERISA” Welfare Plan

WELFARE FUND PRIVACY OFFICER

If you believe that your HIPAA privacy rights have been violated, you may file a complaint with the Welfare Fund in care of the Privacy Officer at the following address:

	Robin A. Modzelewski Teamsters Welfare Fund of Northern New Jersey Local 723 714 Rahway Ave., Suite 3 Union, NJ 07083 (908) 688-0723
You may also file a complaint with:	Secretary of the U.S. Department of Health and Human Services Hubert H. Humphrey Building 200 Independence Ave. S.W. Washington, D.C. 20201

CONTACT INFORMATION

WELFARE FUND OFFICE

Contact the Welfare Fund office to discuss all questions regarding the benefits available under the Plan.

Teamsters Welfare Fund of Northern New Jersey Local 723
714 Rahway Ave., Suite 3
Union, NJ 07083
(908) 688-0723

To Find Out About:	Contact:	Telephone Number:	Website:
ELIGIBILITY/BENEFITS	Fund Office	(908) 688-0723	None
CLAIM INQUIRIES	I.D.A.	(844) 294-9592	None
HOSPITAL PROVIDER LOCATOR NJ	AmeriHealth	(800) 445-4755	www.ahatpa.com/docs
HOSPITAL PROVIDER LOCATOR NY	MagnaCare, LLC	(800) 235-7330	www.magnacare.com
MEDICAL PROVIDER LOCATOR	MagnaCare, LLC	(800) 235-7330	www.magnacare.com
PRE-CERTIFICATION	MedWatch	(800) 605-5028	None
PRESCRIPTION PLAN	Specialized Pharmacy Solutions	(888) 272-1401	None
DENTAL PLAN	Delta Dental	(800) DELTA-OK	www.deltadentalnj.com
VISION PLAN	Vision Screening	(800) 652-0063	www.vscreening.com

TIP: The Fund provides you access to a network of doctors and hospitals that discount the fees for services they provide to eligible Participants. Your out-of-pocket expenses depend on whether you decide to go in-network or out-of-network for your care. The Fund pays for in-network services only. Out-of-network claims are not eligible.

DEFINITIONS

These are some of the terms used in your booklet. Some other terms are described as they are used. PLEASE READ THEM CAREFULLY. It can help you to better understand what your benefits are.

Accidental means a loss due solely to violent, external, and unintentional means.

Allowed Amount is the maximum amount of the billed charge of which the Plan deems payable for Covered Expenses rendered by participating providers and facilities or by non-participating providers and facilities. Plan provisions (Deductible, Co-insurance) are applied to allowable amounts. If your provider changes more than the Allowed Amount, you may have to pay the difference. This is referred to as “Balance Billing”.

Ambulatory Surgical Facility (or Ambulatory Surgical Center) means a health care facility in which surgery is performed on patients on an outpatient basis.

Appeal is a request for the Plan to review a decision. Please refer to the section on Appeal Procedures.

Beneficiary means the person entitled under the terms of the Plan to receive benefits under the Plan following the death of an active Employee Member.

Board of Trustees are the individuals with whom the Fund property is legally committed in trust. The Board has the legal obligation of managing Fund assets on behalf of the participants in the Fund.

Child - For purposes of this definition, "Child" means:

- Your legitimate child born of a valid marriage of yours;
- Your natural child of yours who is not a legitimate child born of a valid marriage, provided you submit satisfactory proof of your parenthood (birth certificate, voluntary acknowledgment of paternity, etc.);
- Any child legally adopted by you or any child placed in your home for the purpose of adoption;
- Any child determined by the Trustees to be an "alternate recipient" under the terms of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations by calling or writing the Welfare Fund Office.

C.O.B.R.A. means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Co-Insurance means the amount that you must pay for services or supplies received when you utilize the services of a network provider.

Co-Payment means the amount that must be paid by active Participants for certain services that are not fully paid under the Plan. The Co-payment is a flat-dollar payment that is the same for a given service provided to Participants regardless of the cost of the service.

Collective Bargaining Agreements were established between Employers and Teamster Local Union 641 ("Union") and have been maintained through succeeding agreements under which Employer contributions to the Plan are required.

Contributing Employer is an employer required to contribute to the Fund pursuant to the terms of a Collective Bargaining Agreement.

Covered Charges means the recognized fees as determined by the Trustees, which are covered under the Plan, for medical conditions covered under the Plan and based on valid medical need according to accepted standards of medical practice.

Covered Employment means work for which your employer must contribute to the Fund on your behalf.

Deductible means the amount that a covered participant must pay under the Plan for each calendar year and/or service before becoming eligible for payment of certain eligible expenses.

Dependent means:

- Your Spouse, while not legally separated from you
- Your Child (see “Definition of Child”):
  - Who is less than 26 years old; or
  - Who is age 26 or older and who is incapable of self-support due to mental incapacity, mental retardation or physical disability which began before the Child attained age 26 and is dependent upon you for support and maintenance. The coverage of such a Child will be continued for as long as you are eligible and for as long as the incapacity and dependency continue.

At the time the first claim is filed on behalf of the Child, you must furnish proof, at no expense to the Plan that the Child was so disabled before becoming age 26. However, if the required proof includes a physical examination

of the Child by a Doctor, the Plan will pay for the exam. If you do not provide the proper proof, the Child will not be covered beyond the date he becomes age 26. You must furnish proof of the Child's continued disability from time to time thereafter if requested by the Trustees (but not more often than once in a 12-month period). If proof is requested but not received on or before the date set by the Trustees, the Child's coverage will terminate on that date.

If a Child works for a Contributing Employer and is eligible for benefits under this Plan as an Employee, or if the Child is a full-time active member of the military service of any country, the Child is not considered a Dependent under this Plan (except as shown under "COBRA Coverage").

Disability or Disabled means your inability to perform substantially all of the duties of your occupation in Covered Employment because of a medically determined physical or mental Illness or Injury.

Eligible Charges and Eligible Expenses means, the maximum charges recognized by the Plan for reimbursement through the Fund's agreement with the medical network, which are incurred for medically necessary conditions that are eligible under this Plan.

Employee or Employee Member means an individual who is the Employee of an Employer who is covered under the terms of a Collective Bargaining Agreement. The Trustees shall have the sole and absolute discretion to verify whether an individual is an Employee of an Employer by applying a common-law test.

Employer means an Employer required to contribute to the Plan on behalf of Employees pursuant to a Collective Bargaining Agreement or other written agreement.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Emergency is defined as a medical condition which, if immediate medical attention is not provided, can reasonably be expected to lead to death, serious dysfunction of any bodily organ or part or other serious medical consequences. These conditions must be severe, sudden in onset and involve one or more of the major organ systems of the body, such as the cardiovascular, metabolic, respiratory, nervous, gastrointestinal or urinary system. If symptoms exist that reasonably may have been interpreted as an Emergency under the definition above, 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 the final diagnosis indicates that it was not actually a heart attack. In addition to medical conditions that are Emergencies as defined above, there are some conditions that result from accidents that appear to be serious and so threatening to a body part that emergency room treatment is recommended. These conditions will be considered Emergencies, even though they do not meet the definition above. Being taken for treatment to the nearest Hospital or trauma center by police, fire department or ambulance, when such transportation is made under circumstances over which the person has no control, will be considered an emergency.

Exclusive Provider Organization (EPO) means a group of selected physicians, specialists, Hospitals, and other treatment centers which have agreed to provide their services to Fund Participants and beneficiaries at a negotiated rate under the terms of an agreement. These medical providers are sometimes referred to as "In-Network providers" or "Panel providers" interchangeably throughout this booklet. Similarly, medical providers that are not under contract to provide services at negotiated rates are referred to as "Non-network", "Out-of-Network" and "Non-panel providers".

Experimental means:

- Any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is meant to investigate and is limited to research;
- Techniques that are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies;
- Procedures which are not proven in an objective way to have therapeutic value or benefit; and/or
- Any procedure or treatment which is obsolete or whose effectiveness is medically questionable.

Government approval of a procedure, equipment, treatment, drug, medicine or technique is not necessarily sufficient to prove that it is beneficial or appropriate or effective for a particular diagnosis or treatment of a covered person's particular condition. Any or all of the following five criteria may, within the Trustees' sole discretion, be applied in determining whether such procedure, etc., is experimental or investigative, obsolete or ineffective:

- Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these five criteria be met.

- Conclusive evidence from the published peer-reviewed medical literature must exist that the procedure has a definite positive effect on health outcomes.
- Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the procedure leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.

Fund Administrator means the person who is appointed by the Board of Trustees to handle the day to day operations of the Welfare Fund.

Fund Office means the office maintained by the Trustees of Teamsters Welfare Fund of Northern New Jersey Local 723, where the business of said Fund is conducted. It is located at 714 Rahway Ave., Suite 3, Union, NJ 07083. The telephone number is (908) 688-0723.

Hazardous Activity means but is not limited to, skydiving, race car driving, cliff climbing, etc.

HIPAA means the Health Insurance Portability and Accountability Act.

Hospice is a public agency or private organization (or a part of either), primarily engaged in providing a coordinated set of services at home or in outpatient or institutional settings to persons suffering from a terminal medical condition. The agency or organization (1) must be eligible to participate in Medicare; (2) must be appropriately licensed by the state in which it operates; (3) must have an interdisciplinary group of personnel that includes the services of at least one Doctor and one R.N.; (4) must maintain clinical records on all patients; (5) must meet the standards of the National Hospice Organization; and (6) must provide, either directly or under other arrangements, the services and supplies listed as Covered Expenses under the Hospice Benefit.

Hospital means an institution which:

- Is primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons.
- Maintains clinical records on all patients; and
- Has bylaws in effect with respect to its staff of physicians; and
- Has a requirement that every patient be under the care of a physician; and
- Provides 24-hour nursing service rendered or supervised by a registered professional nurse; and
- Has in effect a hospital utilization review plan; and
- Is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

Hospital does not mean any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility, and treatment of Drug Addicts or Alcoholics. It does NOT mean any institution that makes a charge that you or your dependents are not required to pay.

Illness means a bodily sickness, disorder or disease of the insured.

Investigational or Experimental means a service, supply, drug, or other treatment is Investigational or Experimental unless:

- The service, supply, drug, or treatment has received final approval from the appropriate governmental regulatory bodies;
- Scientific evidence permits conclusions concerning the effect of the service, supply, drug, or treatment on health outcomes;
- The service, supply, drug, or treatment is generally accepted as standard medical treatment of the condition being treated.

Injured means all damage to your body, or your eligible dependent's body which is caused by an accident **(excluding motor vehicle, motorcycle and any third party liability.)**

Medically Necessary means any service, treatment or supply, including a Hospital confinement, furnished or prescribed by a Physician or other licensed provider to identify or treat an Illness or injury, that:

- Is necessary for the diagnosis and treatment of the Illness or Injury for which it is performed
- Is based upon valid medical need;
- Meets generally accepted standards of medical practice;
- Is required for reason other than the convenience of the patient or provider; and
- Is the most appropriate level of service or supply that can safely be provided for the patient.

The fact that services or supplies are furnished or prescribed by a Physician or another licensed provider does not necessarily mean that they are **Medically Necessary**.

Medicare means the medical benefits provided by Title XVIII of the Federal Social Security Act, as amended from time to time.

Mental Health Treatment Facility means a facility, other than a Hospital, which provides treatment for Mental Illness pursuant to a written plan approved and monitored by a Physician or psychologist and which is licensed by the state or affiliated with a Hospital under a contractual agreement for patient referral.

Mental Illness means neurosis, psychopathy, psychoneurosis, psychosis or mental or emotional disease or disorder of any kind.

Motor Vehicle. The Plan does not provide any benefits for medical services that are necessary because of a motor vehicle accident. A "motor vehicle" is not limited to an automobile, truck or van. It includes motorcycle, moped, all-terrain vehicle, snowmobile and other recreational vehicles.

Physician means, a duly licensed Doctor of Medicine authorized to perform a particular medical or surgical service within the lawful scope of his/her practice, and shall also include Doctor of Osteopathy, Doctor of Podiatric Medicine, or a Doctor of Psychology with regard to Mental Health Benefits and Hospice Care, and a licensed Rehabilitative Therapist. No other providers are recognized.

Plan means the Teamsters Welfare Fund of Northern New Jersey Local 723, as amended from time to time, which sets forth the written rules and regulations governing the payment of benefits to Employees and Dependents under the Fund and which shall be funded from the Trust.

Plan Trustees means the Board of Trustees of the Plan.

Reasonable and Customary means the usual charge made by a person, a group or an entity which renders or furnishes the services, treatments or supplies that are eligible under this plan. In no event does it mean a charge in excess of the general level of charges made by others who render or furnish such services, treatments or supplies to persons:

- Who reside in the same area; and
- Whose illness is comparable in nature and severity. The term "area" means a county or such greater area that is necessary to obtain a representative cross section of the usual charges made.

Skilled Nursing Facility is an institution, or a distinct part of an institution, that complies with all licensing and legal requirements and that meets all of the following criteria:

- It is primarily engaged in providing inpatient skilled nursing care, physical restoration services and related services for patients who are convalescing from injury or sickness and who require medical or nursing care to assist them to reach a degree of body functioning to permit self-care in essential daily living activities.
- It provides 24-hour-a-day supervision by one or more Doctors or one or more R.N.s.
- It provides 24-a-day nursing services under the supervision of an R.N., and it has an R.N. on duty at least 8 hours a day.
- Every patient is under the supervision of a Doctor, and it has available at all times the services of a Doctor who is a staff member of general hospital.
- It maintains daily medical records on all patients, and it provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals.
- It has a utilization review plan.
- It has a transfer agreement with one or more Hospitals.
- It is eligible to participate under Medicare.
- It is not, other than incidentally, a place for rest, for Custodial Care, for the aged, for drug addicts, for alcoholics, a hotel, a place for the care and treatment of mental diseases or tuberculosis, or a similar institution.

Spouse means the legal spouse of a Participant. Spouse also includes the definition of spouse as mandated by the Windsor Decision.

Sudden & Serious means symptoms of such severity and pain that a prudent layperson could reasonably expect that the absence of immediate medical attention would result in: serious medical or mental health jeopardy; cause serious bodily function impairment or dysfunction of any organ; or cause disfigurement.

Substance Abuse refers to the impaired use of drugs and/or alcohol and/or continuous use in spite of adverse effects (inability to control use, interference with daily functioning and/or working and or social interest).

Third Party shall mean anyone other than this Fund including (but not limited to) your employer, tortfeasor(s) or any other entity or person(s).

Totally Disabled or Total Disability when used in reference to the health coverage provided by the Plan means, with respect to you, that you, due solely to injury or illness, are prevented from engaging in your regular or customary occupation or employment. With respect to an insured dependent, this means that he/she, due solely to injury or illness, is prevented from engaging in substantially all of the normal activities of a person of like age and gender who is in good health. All determinations as to a participants disabled status are made in the Plans' Trustees (or their designee[s]) sole and absolute discretion.

Trust means all cash, securities and other property that at the time of reference has been deposited in the trust account established pursuant to the Trust Agreement.

Trustee(s) means the individual Union Trustees, the individual Employer Trustees and, when acting as Trustees, their alternates and successors.

Trust Agreement means the Agreement and Declaration of Trust, as amended from time to time, which establishes the funding vehicle for the Plan and sets forth the respective rights, obligations and responsibilities of the Plan Administrator who are Board and the Trustees.

Union means Local 641, I.B.T. and any additional unions having Collective Bargaining Agreements with Employers requiring that contributions be made to the Teamsters Welfare Fund of Northern New Jersey Local 723 on behalf of Covered Employees.

Note: Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine unless the context clearly indicates the contrary.

IMPORTANT NOTICE

In the event there appears to be a conflict between the description of any Plan provision in this Summary Plan Description (SPD) and any other information you may have received, either written or orally, the language contained in this SPD is the official and governing language.

This SPD shall act as the Plan Document. The Trustees have **SOLE AND ABSOLUTE DISCRETION** with regard to the Plan and its interpretation. As the Plan is amended from time to time, you will be sent information in the form of a Summary of Material Modification (SMM) explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

ELIGIBILITY

MEMBER ELIGIBILITY

You are eligible for benefits if you are an active employee and your employment is subject to a Collective Bargaining Agreement or Participation Agreement and your Employer is required to make contributions to Teamsters Welfare Fund of Northern New Jersey Local 723. Participants are eligible for the benefits described in this Summary Plan Description when they are provided in the United States only.

INITIAL ELIGIBILITY

The initial eligibility period for benefits requires that the Teamsters Welfare Fund of Northern New Jersey Local 723 receives three consecutive full monthly contribution payments on your behalf from your employer. Your initial eligibility shall commence on the first day of the fourth (4^{th}) month of full time employment. If the rules of your Collective Bargaining Agreement or Participation Agreement (CBA) differ from this eligibility, the CBA rule will prevail; however, it will not be longer than the Affordable Care Act allows.

Effective Date of your Benefits

Once you have established your initial eligibility, you are entitled to benefits starting on the first day of the month which follows your initial eligibility period.

CONTINUING ELIGIBILITY

You will remain eligible to receive benefits provided contributions are continued to be received on your behalf.

DEPENDENT ELIGIBILITY

Generally, coverage for your Dependents begins at the same time your coverage begins, provided that family coverage has been elected and contributions to the Fund are being made on their behalf. The Fund requires proof of dependency in the form of original marriage certificate, dependent's original birth certificate and Social Security card. The Fund must receive proof within 45 days of the Participant's eligibility date; otherwise, you must wait until the Fund's next Open Enrollment period.

Your eligible Dependents are:

- Your legal spouse, unless legally separated.
- Your Child(ren), until the end of the month in which they reach age 26, with required documentation;
    - In order for a dependent child to be eligible for benefits, the child must be your biological child, placed for adoption or legally adopted. **Children born with other than spouse while you are married, will not be covered,** unless a Qualified Support Notice is received and proof of paternity – at the Participant's expense – is provided.
- Your unmarried Children, regardless of age, who are unable to support themselves because of a physical or mental disability, provided the incapacitating condition started before age 26;
    - Written evidence of such incapacity is sent to the Administrator with respect to any such child within 31 days after he/she attains the limiting age.
    - Proof that the child remains incapable must be presented to the Administrator from time to time with the Administrator's request; and
- Your adopted Children. However, adopted newborns will not be covered from the moment of birth if: (1) the health insurance of the Child's natural parents covers the newborn's initial hospital stay; (2) a notice revoking the adoption has been filed; or (3) one of the natural parents revokes their consent to the adoption.

Step children are not covered by this Plan.

NOTE: It is important to keep the Fund Office up to date on new Dependent Children and Spouses so they are added to the Plan. Not all Collective Bargaining Agreements (CBA) cover all dependents. Be sure to be familiar with your CBA relating to your health coverage.

SPECIAL ENROLLMENT

If you are declining enrollment for your eligible dependents because of other health coverage, you may be able to enroll them in this Plan if they lose eligibility for that other coverage (or if the employer stops contributing toward the other coverage). However, you must request enrollment within 45 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 45 days after the marriage, birth, adoption, or placement for adoption.

To request a special enrollment or obtain more information, contact the Fund Office at: 908-688-0723.

IMPORTANT NOTE:

When you acquire Dependents, or when your Dependents' status changes, it is absolutely necessary that you notify the Welfare Fund Office so that the Dependents may be properly insured, classified or terminated.

If you fail to enroll your eligible spouse and/or dependents within 45 days of birth or marriage, you must wait until the open enrollment period from **October 1st** through **October 31st** of every year to enroll them. Your coverage will become effective January 1st.

EFFECTIVE DATE OF DEPENDENT COVERAGE

Generally, coverage for your eligible dependents will begin on the same day that your coverage begins, providing acceptable proof is received by the Fund Office within 45 days. However, if your spouse and/or dependent(s) is in the hospital under treatment at the time your benefits start, benefits for your spouse and/or dependent(s) will not start until the day after discharge from the hospital. Dental and Vision coverage for Spouse and Dependent(s) will begin:

- After the member's effective date.
  - Eligible dependents are eligible for one dental exam and cleaning during first year of coverage.
- After they are properly enrolled according to Plan rules;

A dependent's coverage will not begin or continue unless you are eligible.

If you marry, have a baby or adopt a child, you must provide the Fund Office with the form of original marriage certificate, original birth certificate listing both parents' names or legal adoption papers within forty-five (45) days of the event. If you do not enroll your new dependents during the special enrollment period, they will not be covered and your next opportunity to enroll them will be during the Fund's Open Enrollment Period.

If a dependent is also eligible for benefits as an employee/participant covered by this plan, the child will not be considered an eligible dependent.

TERMINATION OF YOUR COVERAGE

Your coverage will terminate on the earliest of any the following:

- The first day of the month in which your employer ceases to make contributions on your behalf;
- The date you are no longer a member of a classification eligible for participation in the Plan;
- The date a change is made in the plan to terminate benefits for your class;
- The date you enter active service in the Armed Forces; or
- The date the plan terminates;

Example: If you were hospitalized May 25th through June 7th, and your employer's obligation to continue making contributions on your behalf ceases on May 31st, your eligibility for benefits terminates on May 31st 11:59 PM.

Upon termination of your coverage, you will be mailed information regarding your right to Continuation Coverage under COBRA (please refer to those sections of this SPD for details).

TERMINATION OF YOUR DEPENDENT'S BENEFITS

Your dependents' benefits will terminate on the earliest of the following:

- The date your benefits terminate;
- The date a change in the plan terminates Dependents' Benefits;
- The date a dependent enters active service in the Armed Forces; or
- The date a dependent is no longer an Eligible Dependent as defined.

If benefits terminate, there are provisions by which benefits can be extended by self-paying. You can determine your right by calling or writing to the Fund.

Benefits may also be denied or suspended if you or your eligible Dependents made a false statement in connection with obtaining coverage or claim payment.

CERTIFICATE OF CREDITABLE COVERAGE

When your coverage ends, you will automatically be provided with a Certificate of Creditable Coverage that indicates the period of time you were covered under the Plan. Such Certificate of Creditable Coverage will be provided to you after the Fund has been notified that coverage has been terminated. You may also request a Certificate of Creditable Coverage from the Fund Office at any time within the first 24 months after your coverage ends.

Certificates of creditable coverage indicate the period of time you and/or your Dependent(s) were covered under the Plan (including COBRA coverage), and contain certain additional information as required by law. This certificate may be necessary if you and/or your Dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered Dependents a health insurance policy within 63 days after your coverage under this Plan ends (including COBRA coverage).

Please address all requests for certificates of creditable coverage to:

Teamster Welfare Fund of Northern NJ Local 723
714 Rahway Ave., Suite 3
Union, NJ 07083
Telephone (908) 688-0723

REINSTATEMENT OF COVERAGE

If your coverage ends and you return to covered employment with the same employer within 6 months, your coverage will be reinstated after your employer begins contributions on your behalf. Any claim incurred during the period you were not eligible will not be covered." (See the COBRA section of this SPD for details on continuation coverage).

If you return to covered employment after 6 months or begin employment with a different contributing employer, you will be required to complete the Initial Eligibility period.

If you are absent from covered employment because of an authorized Family Leave, the above waiting periods shall not apply and you shall be immediately eligible for coverage the first day upon your return to covered employment, provided such return occurs immediately after your authorized leave.

If you are absent from covered employment because of military service, the above waiting periods shall not apply and you and your eligible dependents shall be covered according to the rules of the Military Service Rules Section of this SPD.

FINANCING

An important element of your Teamsters Welfare Fund of Northern NJ Local 723 is money. Where it comes from, how it is managed, and to what uses it may be put should be of interest to you.

Contributions are made by Employers who have an obligation to contribute to the Fund pursuant to a Collective Bargaining Agreement (CBA) or other written agreement. These contributions (along with investment income) are the sources, which provide Benefits from the Fund. Employers that are required to make contributions to the Fund are called Contributing Employers. Your Collective Bargaining Agreement may require that you pay a portion of the monthly contribution, which will be deducted from your pay.

All of the assets are held in trust by the Board of Trustees of Teamsters Welfare Fund of Northern NJ Local 723 for the Employees and his/her Eligible Dependents of the Plan. The Board of Trustees has the ultimate responsibility for the management of monies and may from time to time utilize the services of investment managers to invest Plan assets.

Benefits under the Plan shall not in any manner nor to any extent be assignable or transferable by any Participant, except an assignment to a provider of health services who provided you medical services for which the Fund pays benefits.

The Fund does not accept contributions directly from employees. However, if you elect coverage for your family members, you may be required to contribute to the cost of their coverage. Check with your Employer or Union to find out if your Employer requires contributions to be made by you for family coverage.

SCHEDULE OF BENEFITS

For Employee Member only:	
Life Insurance Benefit	$10,000.00
Accidental Death and Dismemberment Benefit Principal Sum	$20,000.00
For Employee Member and Dependents: Comprehensive Major Medical Expense Benefits	
Comprehensive Major Medical Expense Benefits	
Deductible Amount (per calendar year): Per Individual Family deductible (2 family members)	 $150.00 $300.00
Benefit Payable (after deductible): Eligible Charges	100% of eligible in-network charges
Co-pay on all emergency room visits:	$100.00
Annual Plan maximums	
Dental per person	$1,000.00
Impacted wisdom tooth removal	$1,500.00
Prescription per family After $7,500	$7,500.00 40% co-insurance
Vision (1 exam and/or lenses per year, frames every 2 years)	$120.00
Assistant surgeon allowance is 20% of the allowable primary surgeon's fee.	
Pregnancy benefits are not available for dependent children.	

SECOND SURGICAL OPINION

You may be hesitant when a surgeon recommends elective surgery (surgery that is not performed as an emergency). While it is not always required, if you wish to have a second opinion as to whether surgery is the most appropriate course of action, you should contact a qualified surgeon who specializes in the field for which surgery is recommended. For your health and/or safety, the Fund's Medical Manager may require a second surgical opinion in some instances.

EXPENSES THAT ARE NOT COVERED

In addition to the GENERAL EXCLUSIONS, no benefits are payable under this section:

- For consultation with a physician who is not a "legally qualified physician" as defined;
- For X-rays and tests not related to the proposed surgery;
- If you or your dependent is not examined in person by the physician who is rendering the opinion;
- If no written report is sent by the examining physician;
- If the consulting physician has a financial interest in the outcome of his opinion.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

If you die of any cause while you are eligible for Welfare Fund benefits – excluding COBRA coverage – the proceeds of your term life insurance will be paid to your beneficiary. If you die and have not designated a beneficiary, the life insurance will be paid to your estate. The proceeds may be paid in monthly or annual installments or as a lump sum. You are eligible for this benefit if you are an active Employee and your Employer makes the required contributions to the Fund.

Life Insurance Benefits are for Employees (Primary Participants) only. The benefits payable are as follows:

Life Insurance Benefit $10,000.00

BENEFICIARY

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time without the consent of your Spouse or Beneficiary, by completing a change of Beneficiary form with the Fund office. The change will be effective when the Fund receives the completed form at the Fund office.

ACCIDENTAL DEATH AND DISMEMBERMENT

Accidental Death and Dismemberment Benefit $20,000.00

You or your Beneficiary will be paid an amount indicated below if you are an eligible employee and as the direct result of an accident occurring while you are insured, you suffer one of the following losses within 90 days of the date of the accident:

- Life, both hands, both feet or sight in both eyes , , , 100%
- One hand and one foot 100%
- One hand and sight of one eye 100%
- One foot and sight of one eye 100%
- One hand, one foot or sight of one eye 50%

The benefit for loss of life is payable to your Beneficiary. The benefit for any other loss is payable to you.

If the Insured becomes paralyzed as a direct result of an accidental bodily injury sustained while covered under this Rider, the benefit percentages listed below are payable. Paralysis must occur within one year from the date of the accident causing the paralysis. The benefit payable is a percentage of the amount shown for the AD&D benefit, and is as follows:

- Quadriplegia (complete and irreversible paralysis of both upper and both low limbs) 100%
- Paraplegia (complete and irreversible paralysis of both lower limbs) 75%
- Hemiplegia (complete and irreversible paralysis of upper and lower limbs on one side of the body) 50%
- Uniplegia (total paralysis of one limb) 25%

CONVERSION PRIVILEGE

In the event of termination of your coverage under this Plan, the Group Life Policy permits you to convert your Life Insurance without physical examination to an individual Life Policy. You may convert to any one of the forms customarily issued by the insurer. You must make written application directly to the insurer within 31 days after termination of your coverage under this Plan.

LOSSES THAT ARE NOT COVERED

In addition to the GENERAL EXCLUSIONS, no benefit is payable under the Accidental Death and Dismemberment section, if the loss is caused directly or indirectly, wholly or partly, by:

- Bodily or mental illness or disease of any kind;
- Ptomaine or bacterial infection (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound) or hernia;
- Intentional self-destruction or self-inflicted injury, while sane or insane;
- Service in any military, naval or air force of any country while such country is engaged in war;
- Police duty as a member of any military, naval or air organization;
- Travel in any moving aircraft aboard which you are giving or receiving training or have any duties; or
- In the commission of a felony or any criminal activity.

PRE-CERTIFICATION

The Plan requires pre-certification for certain services. Before having the services, you must have your doctor call MedWatch at (800) 605-5028 for pre-certification. The Fund's medical manager will then work together with your doctor and the hospital to determine whether your treatment should be given on an outpatient basis and, if it is to be done in the hospital, just how long you should be confined.

Following are some examples of services that require pre-certification: all mental health treatment; chiropractic; physical therapy; all rehabilitation services; durable medical equipment; orthotics; podiatry; endoscopy; colonoscopy; all inpatient stays; all surgeries.

If you **do not get pre-approval,** your claim will be denied.

If you enter the hospital due to an emergency, please have your doctor call MedWatch at (800) 605-5028 within 48 hours of your admission to the hospital or, as soon as reasonably possible.

If you do not do this, the Plan will deny your claim.

HOSPITAL AND MEDICAL SURGICAL PLAN

This section describes the hospitalization benefits of the Plan. Hospitalizations are covered up to 120 days. It also covers certain other types of care, such as emergency room treatment, inpatient treatment and treatment for mental/nervous disorders.

When you are going to have any procedure, test or hospital stay requiring pre-certification, you must have your doctor call MedWatch at (800) 605-5028 before you enter the hospital or having the test performed. **If you go to a non-participating provider or hospital, the charges will not be covered.** The Trustees urge Participants to utilize Network providers. Hospitals and other health care providers who participate in a Network change from time to time; therefore, be sure that your provider is part of the Network before receiving care. You should verify the provider's participation, either by contacting the provider's office or the Network directly at the telephone number on your Identification Card or their web-site.

NETWORK PROVIDERS

The Fund has contracted with two medical networks, AmeriHealth and MagnaCare. Your participation in which network applies to you and your eligible dependents is as follows:

- For hospital benefits:
  - AmeriHealth is the participating hospital network for NJ.
  - MagnaCare is the participating hospital network for NY.
- For doctor, medical and surgical, etc. benefits:
  - MagnaCare is the participating network for all providers in NY and NJ.

Semi-Private Accommodations

If hospitalized in a legally constituted hospital and you are covered, the Fund will pay for semi-private or ward accommodations and other eligible ancillary hospital services for up to 30 days at 100% and the next 90 days at 60% in a calendar year or the Plan's maximum allowance.

All charges must be consistent with the diagnosis and treatment of the conditions for which hospitalization is required, **and** all expenses must be incurred as a legal obligation of the eligible Participant.

Private Room Accommodations

If hospitalized in a private room in a legally constituted hospital, the Fund will pay the average regular charges of the hospital for semi-private accommodations for bed, board (including special diets) and general nursing service, up to the limitations in the Summary of Benefits.

HOSPITAL SERVICES

The Plan covers most or all of your Medically Necessary care, after your deductible is satisfied, when you use a Participating hospital for surgery or treatment of illness or injury. Same day surgical services for non-emergency care must be performed at an office or free standing surgicenter unless performance in a hospital is medically necessary and pre-certified. Same day surgical services are covered when they:

- Are performed in a same-day surgery center or hospital outpatient surgical facility (only if medically necessary);
- Require the use of both surgical and operating and post-operative recovery rooms;
- May require either local or general anesthesia;
- Do not require inpatient hospital admission because it is not appropriate or medically necessary; and

You must have the surgicenter, Hospital and/or provider's office contact MedWatch at (800) 605-5028 to Pre-certify the treatment plan.

When your Participating Physician is prescribing laboratory or diagnostic testing, it is important that you remind your Physician to specify the use of a Participating laboratory for lab tests and Participating freestanding diagnostic center not affiliated with a hospital. You will be responsible for the bill if you utilize the services of a non-participating provider. The Plan will not pay benefits for any services performed by a Non-Participating laboratory or diagnostic testing center.

Lab tests, x-rays and other diagnostic tests will not be covered in a hospital with the exception of:

- being performed while an inpatient;
- pre-admission testing purposes;
- while having a surgical procedure;
- if these tests can only be performed at a hospital; and
- as part of an Emergency Room visit if a true emergency exists.

Payment to a Participating Hospital is subject to the deductible and are payable at the established Network rates.

If your eligible spouse or dependent(s), who have other primary medical coverage choose to use a Network provider, you will need to submit claims as usual to that medical care program as that program has primary responsibility for the claim, and the balance of the claim, if any, will be paid in accordance with the Coordination of Benefits (COB) rules.

MEDICAL MANAGEMENT SERVICES

The patient or family member must have their provider call MedWatch at (800) 605-5028 to receive pre-certification of certain medical management services. This call must be made at least 72 hours in advance of services being rendered or within 72 hours after an emergency.

Utilization Review is a program designed to help insure that all Eligible Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

This program consists of:

- Pre-certification of the medical necessity for the non-emergency services listed above;
- Retrospective review of the medical necessity of the listed services provided on an emergency basis;
- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or another health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for maximum reimbursement of the Plan.

HOW THE PROGRAM WORKS

Pre-certification. Before an eligible participant enters a medical care facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate of Plan reimbursement. A non-emergency stay in a medical care facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the provider. They must contact the utilization review administrator at the telephone number on you ID card **at least 72 hours before** services are scheduled to be rendered with the following information: Name and relationship of patient; Participant's social security number and Participant's address; Teamsters Welfare Fund of Northern New Jersey Local 723; name and telephone number of Physician; name of medical facility, date of admission and length of stay; diagnosis and/or type of surgery; and proposed rendering of listed medical services.

If the Covered Participant does not receive authorization, the benefit payment will be denied by the Fund.

Concurrent review and discharge planning will be administered by the utilization review department of MedWatch at (800) 605-5028, who will coordinate with the attending Physician, Medical Care Facility and Participant either the scheduled release or an extension of medical services.

Case Management is a program which will monitor patients and explore, discuss and recommend coordinated and/or alternate types of appropriate Medically Necessary care.

The plan of care may include some or all of the following: personal support to the patient; contacting the family to offer assistance and support; monitoring Hospital or Skilled Nursing Facility; determining alternative options; and assisting in obtaining any necessary equipment and services.

Case management occurs when this alternate benefit will be beneficial to both the patient and the Plan. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

EMERGENCY ROOM TREATMENT

Emergency room care is covered as follows:

- Emergency hospital service during the first visit for treatment of an accidental injury within 48 hours following such injury, or
- Emergency hospital care during the first visit for treatment within 48 hours of the onset of sudden and serious illness will be reimbursed. The Fund reserves the right to determine if the visit was a sudden and serious illness under accepted medical standards. The Trustees reserve the right to request any and all emergency room notes and/or charts prior to any benefits being paid.
- There will be no payment for emergency hospital service if the patient is admitted and the Fund makes payment for hospital confinement for that day.

The Hospital emergency room (ER) is very expensive because they are specially equipped to handle true emergencies. Do not use the ER for routine care or as a substitute for a doctor's visit. They are there to help you in case of accident, injury, or a life threatening illness. Use them wisely. Many conditions can be treated at an urgent care center. Familiarize yourself with a Participating urgent care center near you. An example of urgent care vs emergency room care is provided with your benefit package.

THIS BENEFIT PLAN IS IN-NETWORK ONLY. OUT-OF-NETWORK SERVICES ARE NOT COVERED.

Note: In the event the Trustees consider paying an out-of-network claim, the Plan will only pay 80% of Reasonable and Customary or the negotiated rate the provider agrees to accept.

SCHEDULE OF COVERED SERVICES AND SUPPLIES

Benefits are paid after meeting the annual deductible unless stated otherwise.

Service	Co-Pay	Note
ACNE OFFICE VISIT	$20	Covered up to age 19.
ALLERGY		
Testing	$20	
Shots	$20	
ANESTHESIA		Pre-certification required. Deductible does not apply.
Provider	$0	
CHEMOTHERAPY		Pre-certification required. Deductible does not apply.
Office	$0	
Outpatient	$0	
CHIROPRACTIC		Deductible does not apply.
Provider	$0	20 visit annual maximum.
X-rays	$0	MRI/CAT scans are not covered.
DIALYSIS		Pre-certification required. (Maximum of 30 months.)
Physician services	$0	
Facility	$0	
DIAGNOSTIC STUDIES	$150	Pre-certification required. Copayment applies to these Diagnostic Studies, such as Electromyogram (EMG), Nerve Conduction Studies (NCS), and Electroencephalogram (EEG). Deductible does not apply.
DURABLE MEDICAL EQUIPMENT		Pre-certification required.
Equipment	$0 / 20%	Pre-certification required. Rental fee up to purchase price. $500.00 paid at 100%; thereafter 20% co-insurance. Deductible does not apply.
EMERGENCY ROOM		
ER Visit	$100	Deductible does not apply.
ER Physician	$0	Services are covered, provided it is for a true emergency and the service is within 48 hours of the onset of the injury/illness.
EYE EXAM		For an eye exam, see the Vision Plan Section of this SPD. For a medical condition of the eye, be sure the doctor is a participating ophthalmologist.
HEARING		
Examination	$20	Hearing aids are not covered.
HOME INFUSION		Pre-certification required.
HOSPICE		Pre-certification required.
Outpatient/Home	$0	
Facility	$0	(30-day limit for respite care in home and 5-day limit inpatient.)
HOME HEALTH CARE		
Outpatient/Home	$0	Pre-certification required. Allowed up 40 visits per calendar year. Up to 6 weeks for home IV infusions.

HOSPITAL BENEFITS		Pre-certification required. Limit 120 days annually inpatient. First 30 days paid at 100% of allowable charges, next 90 days paid at 60% of allowable charges.
Facility Charges	$0	
Room & Board	inclusive	
Ancillary Charges	inclusive	
Outpatient	$0	
IMMUNIZATIONS	$0	Immunizations are covered for dependents up to age 19. HPV vaccinations are not covered. Shingles vaccinations (adults age 60 an over) and Flu shots are covered at participating pharmacies only.
LABORATORY	$10	Copayment applies in an office and standalone facility setting. Not covered in the Outpatient Hospital setting. Deductible does not apply.
MATERNITY		Pre-certification required. (Limited to 2 sonograms; 2 stress tests.)
Office	$0	(Global fee is covered; labs covered, must be medically necessary.)
Birthing Ctr./Hospital	$0	
MENTAL HEALTH		Pre-certification required. Limit 120 days annually inpatient. First 30
Facility	$0	days paid at 100% of allowable charges, next 90 days paid at 60%
Visits	$20	of allowable charges.
Clinic	not covered	
NURSERY		
Physician services	$0	
Facility charges	$0	
ORTHOTICS	$0	Pre-certification required. Maximum allowance of $375 once every 3 years. Deductible does not apply.
PHYSICIAN VISIT		
Office	$10	
Specialist	$20	
Hospital	$0	
Clinic	not covered	
PEDIATRICS		
Well baby	$0	
Well child	$0	Dependent children are eligible from age 6 up to age 19.
PODIATRY		Pre-certification required. See General Exclusions for restrictions.
Office visit	$20	
PREVENTIVE CARE WELL VISIT OVER AGE 19		
Office visit	$0	Limit one visit per year.
RADIOLOGY	$0	X-rays
RADIOLOGY (Advanced)	$50	Pre-certification required. Copayment applies to Advanced Radiology Services, including MRIs, MRAs, CAT, PET SPECT and Bone Scans.
SKILLED NURSING FACILITY OR ACCUTE INPATIENT REHAB		Pre-certification required. 10-day inpatient maximum per admission allowed if earlier discharge from a hospital for sub-acute care delivery.
Facility charge	$0	

PHYSICAL THERAPY		Pre-certification required.
Physical Therapy	$0	20 office visit maximum.
Occupational Therapy	$0	20 office visit maximum.
Speech Therapy	$0	20 office visit maximum due to accident or injury only.
SLEEP DISORDER		
Testing	$100	Pre-certification required. One test per 5 years up to $2,000 Plan maximum.
Treatment		Maximum allowance $1,500 per year for CPAP or BiPAP and equipment.
SURGERY		All procedures require pre-certification.
Office	$0	
Ambulatory	$0	
URGENT CARE CENTERS	$0	
WELL WOMAN		
Physician visit	$0	Office visit is limited to 1 visit annually. Deductible applies to visit only.
Mammogram	$0	
PAP smear	$0	
Bone density	$0	Limit 1 test every 3 years for women over 50.
WIG BENEFIT	$0	Pre-certification required. 1 wig every 2 years ($500 maximum) – in accordance with Woman's Health & Cancer Rights Act.

No claims are payable for sickness and/or injury relating to alcohol or substance abuse.

Lab work, x-rays, MRI's, and other diagnostic tests are <u>not covered</u> at a Hospital unless the test cannot be performed at a diagnostic center or participating labs. Out-of-network testing is not covered.

HOSPICE CARE

Hospice Care is a system of care for the terminally ill. It differs from traditional therapies in that it provides services for the family as well as the patient. Hospice teams help the patient and their family cope with the physical, psychological, spiritual, economic and social stress of a terminal illness, death and bereavement. When possible, hospice care is administered at home. The team of professionals may include physicians, nurses, psychiatrists, psychologists and social workers.

To receive benefits, the attending physician must certify **in writing** that the patient has a life expectancy of six (6) months (180 days) or less.

The Plan will reimburse up to your specific Plan maximum of the reasonable and customary charges for approved Hospice Care received from a Participating Network provider only. There are no benefits available for out-of-network providers. Covered services include:

INPATIENT CARE

- Care in a participating hospice facility is limited to 5 days and requires prior authorization.

OUTPATIENT CARE

- Charges made by a hospital or home health agency, for up to 30 home care visits with a maximum of 4 hours per day.
- Medical and surgical supplies, including the rental of durable equipment.
- Drugs and medications.
- Care rendered by a licensed social worker is limited to one visit per week. Payment is limited to the maximum Plan allowance.

HOSPICE BENEFIT EXCLUSIONS

In addition to the General Exclusions, the following are not covered expenses:

- Purchase of durable equipment.
- Charges in excess of the Fund's allowances or nursing shifts.
- Legal or financial advice.
- Services provided by a person who ordinarily resides in the patient's home or is a member of the patient's family.

HOME HEALTH CARE

Home Health Care benefits are provided as an alternative to continued hospitalization or skilled nursing facility care.

Benefits for home care services will be provided for as long as you would otherwise have had to stay in a hospital or skilled nursing facility up to the Plan maximum. The home care must be (1) planned with prior hospital discharge; (2) such plan must be approved in writing by a physician; and (3) the Fund must determine that such home care is medically necessary.

The home care services must be provided by or through a certified Home Health Care Agency. Home health care is covered up to your specific Plan allowance for in-network providers, based on medical necessity. No benefits are allowable for out-of-network providers. Coverage includes up to 40 visits per calendar year. IV Infusions are limited to 6 weeks. Each visit by a member of a home care team is counted as one (1) visit. For home health aides, four (4) hours of their services will be counted as one home care visit.

COMPREHENSIVE MAJOR MEDICAL EXPENSE BENEFITS

You and each of your eligible Dependents are entitled to this benefit if Eligible Charges incurred exceed the Deductible Amount. This benefit provides coverage for illness or injury that is not related to Employment or a Motor Vehicle injury.

YOUR BENEFITS

Your benefits are as provided and set forth in this SPD, and as may be amended by the Trustees after the printing of this booklet. The Trustees reserve the right to add benefits, delete benefits, as well as to terminate the Plan.

THE DEDUCTIBLE

The Deductible is an "out-of-pocket" expense which you and your dependents have to pay before you are entitled to Comprehensive Major Medical Expense Benefits. The Deductible is as follows:

- $150.00 Individual Deductible per Calendar Year
- $300.00 Family Deductible per Calendar Year

EXPENSES THAT ARE ELIGIBLE

Benefits are payable for reasonable and customary Plan allowances for services incurred for medically necessary treatment, services and supplies ordered by a Physician, except where other percentage payment is specified.

EXCLUSIONS: In addition to the GENERAL EXCLUSIONS, no benefits are payable under this section for:

- Services performed on or to the teeth, nerves of teeth, gingiva or alveolar processes. However, services are eligible for:
  - Tumors or cysts of the mouth.
  - Treatment due to an accidental injury to sound, natural teeth.
- Eye refractions, eyeglasses, hearing aids, implants, or their fitting, including therapy; or hospital charges; vision correction (keratotomy)
- Custodial care;
- The excision of impacted unerupted teeth;

- Any charges incurred relating to infertility; or impotence;

Important Reminders

- Participants should not assume that every doctor is a participating doctor. Participants are responsible for making sure that the doctor(s) that render service to them or their eligible dependents participate with the Plan. If you are not sure then you should contact the network in the Contacts Section of this SPD.
- Referrals to another doctor - Please make sure that if a participating doctor refers you to another doctor that the doctor you are being referred to participates with the Plan. Participants who utilize a network provider have the responsibility to make sure that they follow the Plan's guidelines.
- The Fund will not be responsible for any out of pocket cost a member may incur by not following the procedures listed.

DIALYSIS COVERAGE

An individual receiving outpatient dialysis treatment and related services may or may not be eligible for Medicare coverage. Benefits provided under this Plan for treatment received in connection with outpatient dialysis and related services are subject to the following provisions:

Although a Covered Person may not be eligible or obligated to apply for Medicare Part A and/or Part B, the Plan will provide benefits as described below regardless of whether or not the Covered Person is eligible or has enrolled for Medicare coverage.

- During the period of time that Medicare would otherwise have become, or is eligible to become, the secondary payer for outpatient dialysis treatment and related services, the Plan will pay these services at 125% of the then current Medicare allowable expense.
- During the period of time that Medicare would otherwise have become, or is eligible to become, the primary payer for outpatient dialysis treatment and related services, the Plan will pay these claims at 100% of the then current Medicare allowable expense.

The Plan cannot enroll you in Medicare; it is your decision and your responsibility to enroll in Medicare. If you or your Dependent obtains Medicare Part B coverage upon qualifying for Medicare coverage due to End Stage Renal Disease ("ESRD"), the Plan will reimburse you or your Dependent for the cost of the applicable Medicare Part B coverage. Requests for reimbursement must be submitted to the Plan Administrator per the Plan Administrator's policies and procedures as described below.

In order to ensure the correct coordination of claims payments between the Plan and Medicare, Participants are required to take the following steps:

1. Notify the Plan Administrator when you are diagnosed with a condition requiring outpatient dialysis treatment;
2. Notify the Plan Administrator if or when you begin to receive dialysis treatment;
3. Give the Plan Administrator a copy of your Medicare card, showing the effective date of the Part A & B coverage.

GENERAL RULES

Charges must be medically necessary. The Fund is intended to make reimbursement for medically necessary charges for the care of eligible Participants as the result of an injury, pregnancy, or sickness (unless otherwise indicated). Any service not prescribed by a physician as medically necessary will not be considered for reimbursement. The Fund reserves the right to request all medical records.

Charges must be incurred while covered. The Fund will not reimburse any expenses incurred by a person while such person is not eligible under the Fund.

Health care expenses for Maternity are covered for the member and spouse only. Maternity benefits are not Eligible Expenses for dependent children.

The Fund may apply any or all of the following five (5) criteria when determining whether a technology is experimental, investigational, obsolete, or ineffective:

- Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition. (Once FDA grants approval for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these five criteria be met);
- Conclusive evidence (from the published peer-viewed medical literature) must exist that the technology has a definite positive effect on health outcomes;

- Demonstrated evidence (as reflected in the published peer-viewed medical literature) must exist that over time the technology leads to improving health outcomes (i.e. the beneficial effects outweigh any harmful effects);
- Proof (as reflected in the published peer-viewed medical literature) must exist that the technology is either effective in improving health outcome or usable in an appropriate clinical contests in which established technology is not employable;
- Proof (as reflected in the published peer-viewed medical literature) must exist that improvement in health outcomes (as defined above) is possible in standard conditions of medical practice, outside clinical investigatory settings.

PRESCRIPTION DRUG PLAN

When your coverage starts, you will be issued a prescription drug identification card from Specialized Pharmacy Solutions, Inc., who administers the Plan. You may use your I.D. card at any participating pharmacy. How your prescription expenses are covered by the Drug Card Program or the Choice 90 Program depends on how and where you get them filled.

The Plan employs a three (3) tier co-pay program, which is outlined below.

TIP: To save even more money ask your doctor for drug samples during your next visit.

PRESCRIPTION CARD PROGRAM

To use the Drug Card Program, simply take each prescription or refill of a covered prescription drug (up to a 30-day supply or a 90-day supply at a Choice 90 pharmacy) to a participating pharmacy and your co-pays will be as follows:

Type of Drug	30 Day Co-Pay	Choice 90 Co-Pay
Generic	The greater of $5 or 20% (but not more than cost of drug)	$10 (but not more than cost of drug)
Formulary brand*	The greater of $15 or 20%	The greater of $30 or 20%
Non-preferred brand (not on formulary) *	The greater of $30 or 20%	The greater of $60 or 20%
Plan family maximum is $7,500, after which the following co-insurance applies:	After $7,500 40% co-insurance	After $7,500 40% co-insurance

***** If you choose a brand name drug when a medically equivalent generic is available, the Plan will only pay what it would have paid for the generic drug and you will be responsible for the balance of the cost.

Choice 90 pharmacies are available for your maintenance prescriptions. You can go to a participating Choice 90 pharmacy with your written prescription and get a 90-day supply of your medication

Generic Drugs

Generic drugs are drugs which are identified by their “official” (or chemical) name rather than a brand name.

Always ask your doctor to prescribe a generic drug whenever possible. This is to afford Participants the most coverage possible.

Immunizations

Adult immunizations are covered by the Prescription Plan at participating pharmacies only for the following:

- Flu shot
- Shingles Vaccine (age 60 and over only).

STEP THERAPY

Step Therapy is a program especially for people who take prescription drugs regularly for ongoing conditions like arthritis and high blood pressure. It helps you get an effective medication to treat your condition while keeping your costs as low as possible.

In Step Therapy, drugs are grouped in categories based on efficacy:

- **Front-line drugs** –These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

What is Step Therapy?

Step Therapy is a program designed to provide Participants the most clinically appropriate and cost effective therapies for many medical conditions. Clinical pharmacists continually monitor the newest information available to ensure the most effective drug regimens to improve and maintain the health of our Participants and their families.

EXCLUSIONS

The prescription Drug Benefit does not cover the following:

- Abortifacient Drugs or male contraceptives (e.g. condoms)
- Contraceptives. Unless taken for a medical condition with pre-approval.
- Drugs or medications that are considered “Step 2” medications except as allowed under the Step Therapy Program as set forth above.
- Infertility and impotency drugs.
- Injectables.
- Any drugs related to transsexual services.
- Medications and non-prescription items available over the counter, unless specified by the Plan.
- Vitamins, whether prescribed or not (Exception: Pre-Natal Vitamins).
- Food of any type, including infant formula.

PRESCRIPTION BENEFITS FOR MEDICARE ELIGIBLE PARTICIPANTS

If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D (Medicare’s Prescription Drug Plan).

Medicare covers prescription drug benefits under Part D. For Active Participants and/or their Dependents who are Medicare-eligible, this Plan offers “Creditable Coverage.” This means that the Plan’s prescription drug coverage is expected to pay out, on average, as much or more as the standard Medicare prescription drug benefit will pay. Since this Plan’s coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have this Plan’s prescription drug coverage. When you lose this coverage, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare’s annual enrollment period (October 15th - December 7th of each year) by calling 1-800-MEDICARE. If you would rather elect Medicare’s coverage, you can enroll in the Medicare Part D plan no sooner than 3 months prior to, through 3 months after, your 65th birthday; otherwise, you may incur a premium penalty. For more information about creditable coverage see Plan’s Notice of Creditable Coverage that will be mailed to you from the Plan once a year. You may request another copy of this Notice by calling the Fund Office and asking for one.

DENTAL PLAN

The Teamsters Welfare Fund of Northern New Jersey Local 723 Dental Plan, like the Medical Plan provides you and your eligible dependents with in-network dental benefits provided through Delta Dental, Inc. PPO. When you utilize the services of a Delta provider, your out-of-pocket cost will be lower.

If you utilize a non-participating provider, your claim will be denied. You will be responsible to pay the provider any amount charged.

SCHEDULE OF SERVICES

The Dental Plan covers the following schedule of services when they are rendered by a licensed dentist and when necessary and customary, as determined by the standards of generally accepted dental practice:

Basic Benefits

- Diagnostic - Procedures, such as examinations and x-rays, to assist the dentist in evaluating the existing conditions to determine the required dental treatment. Examinations and prophylaxis are allowable once every six months.
- Preventive - Procedures to assist in preventing oral disease including: Prophylaxis once every six months; Topical application of fluoride solutions up to age 19; Space maintainers.
- Oral Surgery - Procedures for extractions and other oral surgery including pre- and post-operative care. General anesthesia when administered by a dentist in conjunction with oral surgery performed by a dentist.
- Restorative - Procedures for treatment of carious lesions with amalgam, composite, porcelain or plastic restorations. Crowns, inlays and gold restorations will be provided when teeth cannot be restored with the above materials.
- Endodontics - Procedures for pulpal therapy and root canal filling.
- Periodontics - Procedures for treatment of the tissues supporting the teeth.
- Emergency Care - Necessary palliative treatment for minor dental pain.

Prosthodontics Benefits

- Procedures for construction of bridges, partial and complete dentures. Adjustment or repair of existing prosthetic appliances.

Orthodontic Benefits

- Procedures performed for eligible dependent children up to age 19 involving the use of an orthodontic appliance for treatment of malalignment of teeth and/or jaws that significantly interferes with their functions.

Limitations

Dental services are subject to the following limitations:

- Prophylaxes will be provided only once in any six (6) month period. Topical application of fluoride will be provided only to covered persons prior to attaining the age of 19. X-rays: Complete mouth x-rays are provided only once in a three-year period, unless special need is shown. Supplementary bitewing x-rays are provided not more than once every six months.
- Crowns, Inlays and Gold Restorations: Replacement will be made only after five years have elapsed following any prior provision of crowns, inlays or gold restorations. Benefits are allowed only if intracoronal restorations cannot adequately restore the tooth.
- Bridges & Dentures: Replacement will be made only after five years have elapsed following any prior provision of such appliances and if it is unsatisfactory and cannot be made satisfactory.
- Optional: In all cases in which the patient selects a more expensive plan of treatment than that which is customarily provided, the Plan will pay the applicable percentage of the lesser fee. The patient must pay the entire remainder of the dentist's fee not covered by the Plan.
    - Occlusion. Procedures, appliances or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and such cost is the responsibility of the

patient. Such procedures include, but are not limited to, equilibration, periodontal splinting, restoration of tooth structure lost due to attrition and restoration for malalignment of the teeth, including the treatment of temporomandibular joint dysfunction (TMJ).

- Dentures. The Plan will provide a standard cast chrome or acrylic denture. If in the construction of the denture the patient and the dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Plan will allow an appropriate amount for the standard denture toward such treatment and the patient must bear the difference in cost.
- Bridgework. Benefits for fixed bridgework will only be allowed if the abutment teeth are periodontally sound. In cases where teeth are missing bilaterally, an allowance will only be made for a partial denture.

- No benefits are available for any treatment started before a covered person became eligible for benefits under the Plan.
- No benefits are available for the treatment of Temporomandibular Joint Disorder (TMJ) under the Dental Plan. See the Major Medical Plan for this benefit.

How To Use The Program

Your participating dentist will perform an examination, and submit a treatment planning form if necessary, to determine how much of the charge will be your responsibility. Before treatment is started be sure you discuss with your dentist the total amount of his fee.

PAYMENT BY THE PLAN

The maximum amount payable by the Plan for dental services is as follows:

- Dental services per eligible Participant per year $1,000
- Lifetime maximum for eligible Orthodontic services $1,000
- Lifetime maximum for Wisdom Teeth/Bony Impactions $1,500

The Dental Plan will pay for eligible services as follows:

Preventive & Diagnostic	100% of maximum allowed fee.
Basic	80% of maximum allowed fee.
Crowns & Prosthodontics	50% of maximum allowed fee.

EXCLUSIONS

- Surgical procedures to correct congenital malformations or developmental malformations and procedures, appliances or restoration for cosmetic purposes or to increase vertical dimensions, restore occlusion or tooth structure lost by attrition. Typical exclusions in this category are facings for posterior crowns and restorations to mask discolored or mottled areas;
- Replacement of an existing denture more often than once every three years;
- Orthodontic treatment for any Participant other than an eligible unmarried Dependent child;
- Replacement of a lost or stolen appliance;
- Dental supplies or services for which benefits are provided under any Workers' Compensation policy or for treatment provided at a Veterans Administration Hospital or clinic;
- Any dental benefits which are covered by another Plan, or not rendered, prescribed, arranged or approved by a dentist at the American Dental Centers or are not specifically included in this Plan;
- Periodontic treatment, when rendered with any other services on the same day;
- Any routine dental services performed in a hospital will not be covered.
- Services that do not meet the standards of dental practice accepted by the American Dental Association;
- Tooth implants, myofunctional therapy, athletic mouth guards, oral hygiene, dietary or plaque control programs or other educational programs, duplicate prosthetic devices or appliances, bone grafts, programs, duplicate prosthetic devices or appliances, porcelain veneered crowns or pontics placed on or replacing a tooth posterior to the second bicuspid, to the extent the charges exceed the charge that would have been covered under the Plan for acrylic veneered crowns or pontics.
- Prescribed Drugs: Analgesics; Experimental Procedures; Oral Hygiene Instruction.

VISION BENEFITS

The Vision Care Plan is available to eligible Participants and their eligible dependents for an eye exam and/or frames and lenses. To be eligible, a Participant must meet the eligibility requirements of this Plan or your Collective Bargaining Agreement.

You and your eligible dependents must call Vision Screening, Inc. for an eye exam (refraction) and prescription eyeglasses (or contact lenses). For a location near you, call Vision Screening at (800) 652-0063 or the Fund Office.

Using this benefit will result in little or no out-of-pocket expense. To take advantage of this benefit, simply do the following:

- Call one of their conveniently located offices and make an appointment. Eligibility will be verified by Vision Screening, Inc.
- At your visit, you may choose from a wide variety of frames and plastic or glass lenses or contact lenses.
- Designer frames are also available. You may choose a designer frame and receive an allowance towards the price of the frame plus an additional discount off the frame price.
- If you desire a second pair of glasses, you will receive a discount off the price of the frame and lenses.
- When utilizing a participating provider, you should have your eye exam and have your eyeglass prescription filled at the same provider's office. This will insure your maximum benefit under the Plan.

Eligible Participants are eligible for one eye exam and/or lenses per year and one pair of frames every two years. The time you must wait between services is based on your date of service (**example:** your eye exam was March 25, and you obtained glasses March 30. You are eligible for an exam and/or lenses after March 25 of the following year and frames after March 30, after two years).

You may obtain services from a participating Vision Screening vision provider, who has agreed to provide discounted services to our participants.

NOTE: Ask in advance about costs so that you know how much, if anything, you have to pay in addition to the Plan allowance for services.

GENERAL EXCLUSIONS

In addition to any limits described under the sections which describe the benefits, there are specific limitations and exclusions with regard to all benefits. No benefits are payable for:

1. Air Ambulance and Air Transportation;
2. Abortion or maternity for dependents;
3. Elective abortion, except for an abortion when the eligible female's life would be endangered if the fetus was to be carried to term;
4. Acupuncture;
5. Acne treatment for Participants age 19 and older. No coverage for laser treatments, medical facials, etc.
6. Any and all treatment of alcoholism and drug addiction or abuse or primary and secondary illness caused by drug addiction or abuse such as overdose or primary and secondary illness caused by this abuse;
7. Adoption expenses;
8. Services provided for ambulette service;
9. Artificial mechanical organs; Artificial limbs and other prosthetics;
10. Bio feedback;
11. CAT and/or MRI scans when ordered by a Chiropractor;
12. Clinic visits;
13. Cochlear implants or hearing aids;
14. Counseling: Family, Marital, or Sexual;
15. Contraceptive management;
16. Cosmetic treatment and/or reconstructive surgery (except as required by the Women's Health and Cancer Rights Act);
17. Custodial convalescent care;
18. Dental services, except those required as the result of an accident and rendered within six months of the accident;
    a. Furnished in any setting other than a dentist's office for the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces, or other mechanical aids, or any other care, repair, removal, replacement, or treatment of the teeth, or surrounding tissues, except, (1) When necessitated by damage to sound natural teeth or surrounding issues as a result of a covered injury, or (2) For the excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst, or (3) For any other surgical procedure not involving any tooth structure, alveolar process, or gingival tissues;
19. Domestic violence;
20. Donor expenses;
21. Drug testing;
22. Education diagnosis (including but not limited to: development testing; ADHD, etc.);
23. Endoscopic plantar fasciotomy (heel spur);
24. Experimental or obsolete procedures. The Fund will not pay for any procedure if it is not generally regarded as effective or if it is experimental in the sense that its effectiveness is not generally recognized;
25. Genetic testing or counseling, chromosome testing and counseling, unless required with amniocentesis;
26. Hair loss including but not limited to any and all medications. Wigs will be covered only according to the Women's Health and Cancer Rights Act;
27. Hazardous activity, (e.g. jet skiing, motorcycling, ATV's, snowmobiling, sky diving and bungee jumping);
28. Holistic medical services;

29. Confinement in a hospital owned and operated by the United States Government or any agency thereof; or for the service, treatment or supplies, furnished by or at the direction of the United States Government or any agency thereof;
30. Confinement in a hospital owned or operated by a state, province or political subdivision, unless there is an unconditional requirement on the part of the covered person to pay such expenses without regard to any liability against others, contractual or otherwise;
31. Hyperbaric oxygen treatment;
32. Hypnosis;
33. Immunizations, except as allowed in the Prescription Plan and administered in a participating pharmacy;
34. Impotence;
35. Treatment of infertility including but not limited to artificial insemination, in-vitro fertilization or reversal of elective sterilization;
36. Infrared coagulation of hemorrhoids;
37. An injury or an illness that is employment-related or that is eligible under the Worker's Compensation Law, Occupational Disease Law or similar laws. This exclusion does not apply to the Accidental Death and Dismemberment Benefit. If you fail to file for workmen's compensation when injured on the job, the Fund will not be responsible for and charges in connection with that illness or injury;
38. An injury for which the Participant is entitled to recover from another person or organization;
39. For membership in, or fees, dues or charges incurred with regard to recreational facilities or fitness centers, even though prescribed by a physician;
40. Medical eye exam, when not performed by an ophthalmologist. (this does not include your vision exam through the Vision Benefits Plan);
41. Motor vehicle injuries, any and all related charges, including deductible arising from or related to motor vehicle accident. A Motor Vehicle is not limited to an automobile, truck or van. It includes motorcycle, moped, all-terrain vehicle, snowmobile and other recreational vehicles (including motorized scooters, etc).
    a. **Please note**, when you purchase or renew your automobile insurance you have the option of opting out of personal injury protection ("PIP") insurance. We urge you not to exercise that option. If you do, you will have no hospitalization or medical coverage if you or your dependent is involved in a motor vehicle accident.
42. Any treatment or stay in a Nursing Home;
43. Radial Keratotomy;
44. Services or supplies, which are furnished for personal convenience such as air conditioners, humidifiers, physical fitness equipment, TENS units, muscle/bone stimulators or other such devices;
45. Services rendered by a non-network or non-participating provider;
46. Private duty nursing;
47. Treatment of Temporomandibular Joint Syndrome (TMJ), Temporomandibular Joint Dysfunction or other condition of the joint linking the jaw bone (Mandible) and skull and the complex of muscles, nerves and other tissue related to the joint;
48. Transsexual changes and/or surgeries and the treatment thereof;
49. Varicose veins services and/or treatments (endovenous leg ablation procedures) if for cosmetic purposes;
50. Services, supplies or treatment which are not prescribed as medically necessary by a physician or cost containment group. This exclusion also applies to any hospital confinement (or any part of a confinement) that is not recommended or approved by a physician;
51. Weight management, diets, weight management programs or any surgeries related to weight management including weight loss surgeries;
52. Any injury incurred during any organized sports or recreation program conducted by a school, college or other social organization and/or any injury coverable by coverage of said school, college, university or other social organization;

53. Emergency Room Services to treat routine ailments, because you have no regular physician, or because it is late at night (and the need for treatment is not sudden or serious);
54. Expenses incurred as result of participation in activities which would constitute a felony, riot, insurrection, or domestic violence and/or injury due to the use of guns, firearms, or engaging in any criminal activity, etc.;
55. Any services rendered by the claimant's immediate family;
56. Any charges which you or your dependents are not required to pay;
57. Transplants;
58. Pain management (includes epidural injections);
59. Podiatry services for funguses, toenails, weak, strained, flat feet, bunions, imbalances, corns, or calluses (except if patient is diabetic);
60. Treatment of corns, calluses or toenails, except removing nail roots and care prescribed by an M.D. or D.O. treating metabolic or peripheral vascular disease;
61. Any treatment not deemed medically necessary;
62. Unnecessary services or supplies;
63. Services provided for vocational and/or educational training purposes;
    a. Coverage for medical services provided outside the United States;
64. Ultrasound and/or sonogram will be limited to 2 for each pregnancy; non-stress tests limited to 2 per pregnancy;
65. Expenses incurred as a result of war or an act of war, declared or undeclared;
66. Any benefit or service not listed as a covered benefit or service is excluded.

NOTE: Government approval does not necessarily render the technology as proven or as appropriate for effectively diagnosing or treating your particular conditions.

RIGHT TO RECOVER EXCESS OR ERRONEOUS PAYMENTS

The Plan has the right to recover amounts it has paid that are in excess of the maximum amount permitted to be paid under the Plan. These amounts may be recovered from any person to whom or for whom the payment was made (including, for example, the Employee Participant when payment was made for his or her covered Dependent), any other insurance companies, and any other organizations.

MEDICARE BENEFITS

COORDINATION OF BENEFITS PROVIDED FOR ELIGIBLE PARTICIPANTS WHO ARE ELIGIBLE FOR MEDICARE

Under the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") and the Deficit Reduction Act of 1984 ("DEFRA"), Employees who continue to work after age 65 for a Contributing Employer who has 20 or more employees after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules.

Under the Omnibus Budget Reconciliation Act of 1986 ("OBRA"), if the Fund covers 100 or more people, you (as an active employee) or your covered dependents who become entitled to Medicare disability may choose the Fund's coverage as the primary coverage by notifying the Fund Office.

If your Dependent Spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will pay its normal benefits for him or her before Medicare pays. If your spouse is covered under his or her own plan, that plan will pay first, this Plan will pay second, and Medicare will pay last.

You (and/or your Spouse) can decline coverage under this Plan. If you do, Medicare will be your only health care coverage. If you and/or your Spouse prefer Medicare as your only health care coverage when you are age 65, contact the Fund Administrator (or your Spouse should notify her own plan). Unless you make such a choice, this Plan will continue to pay primary benefits for you (and its normal benefits for your Spouse) as long as you remain eligible.

For Participants who are under 65 and entitled to Medicare because of End Stage Renal Disease, this Plan will be primary for the person's first 30 months of Medicare coverage and Medicare will be secondary. After the first 30 months, this Plan's coverage will be secondary for as long as the person remains eligible. In all other cases, this Plan will pay secondary to Medicare when it is allowed to do so by law.

You and your Spouse are each responsible for enrolling in Medicare Part A and Part B when eligible to do so. Part A provides Hospital benefits, while Part B covers such items as Doctors' services.

The Fund encourages Participants to enroll in Medicare Parts A and B when you become eligible. The Fund will be primary for your claims while you remain eligible and Medicare will be secondary until you retire. At that time, Medicare will be primary for your medical claims. If a Participant fails to enroll in Medicare when eligible to do so, you may be responsible to pay a higher premium when you do enroll. In order to be entitled to receive Medicare Part B benefits on the first day of the month in which a person becomes eligible for Part B, it is necessary to enroll in Part B in the three-month period prior to their 65th birthday. The law allows individuals to enroll up to three (3) months after they become eligible.

TIP: Medicare will contact you three (3) months before you turn age 65.

TIP: Coordination rules between health insurance (like this Plan) and Medicare is confusing. Many changes have happened over the past several years. Please confirm with the Fund office to ensure you are all set.

COORDINATION OF BENEFITS

Occasionally, individuals have health care coverage under two programs. When this happens, the two programs will coordinate their benefit payments so that the combined payments do not exceed the actual expenses incurred and/or Plan Allowances.

"Plan Allowances" are any necessary and reasonable expenses for medical services, treatment or supplies, eligible by one of the plans under which you or your dependents are eligible.

IMPORTANT: Participants' spouses who have health coverage available should elect said coverage as their primary coverage in order be eligible for Coordination of Benefits under this Plan. If the guidelines are not followed with your primary insurance, this Plan will not participate in Coordination of Benefits payment.

Our Coordination of Benefits Program establishes which health coverage program has primary responsibility. The primary health coverage program will reimburse you first. The secondary program will reimburse you for the remaining expenses, up to the allowable charges for the covered services.

To determine primary and secondary coverage, we use the following criteria:

- The health coverage program without a coordination of benefits provision similar to this one will have primary responsibility.
- The health coverage program listing the patient as the employee (rather than a dependent) will have primary responsibility.
- A dependent child covered under both parents' health coverage programs will receive coverage as follows:
  - The program of the parent having his or her birthday earlier in the calendar year (i.e., month and day) will have primary responsibility.
  - The health coverage program covering the parent longer will have primary responsibility, if the parents have the same birthday.
  - The father's health coverage program will have primary responsibility if the other health coverage program does not have a "birthday" provision and uses gender to determine primary responsibility.
  - A dependent child covered either by divorced or separated parents that have no court decree of financial responsibility for the child's health care expenses, will receive primary coverage under the custodial parent's health care program.

When the parents are divorced and there is a court decree providing that one parent is responsible for the child's health care expenses, the plan of that parent will be the Primary Plan. If there is no court decree and the parents are divorced or separated, the order of payment is as follows:

- The plan of the parent with legal custody is the Primary Plan.
- If the parent with custody has remarried, plans pay as follows:
  - The plan of the parent with custody; or
  - The stepparent's program (this Plan does not cover step-children); or
  - The program of the parent without legal custody; or
  - Joint Custody. If the specific terms of a court decree states that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in the steps for a dependent child with parent not separated or divorced.
- A dependent child covered by either divorced or separated parents that have a court decree specifying which parent has financial responsibility for the child's health care expenses will have primary coverage under that parent's contract if that parent's contract has actual knowledge of that decree.

- If the patient is both covered as an active employee or as a dependent of an active employee and coverage under another health care program as a laid-off employee, a retired employee or a dependent, then the active employee's health coverage program will have primary responsibility. However, if the other health coverage program does not have this rule and the two contracts do not agree on which coverage has primary responsibility, then this rule will not apply.
- If none of the previous rules apply, the health program that has covered the patient the longest will have primary responsibility.
- If a covered person under this Plan is also covered under a Health Maintenance Organization (HMO), this Plan will not provide benefits for any non-HMO treatment which would have been covered by the HMO if treatment had been obtained from the HMO.

RIGHT TO MAKE PAYMENTS TO OTHER ORGANIZATIONS

Whenever payments which should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this Plan and, to the extent of such payment, the Plan will be fully released from any liability regarding the person for whom payment was made.

CLAIM FILING AND APPEAL PROCEDURE

This section describes the procedures for filing claims for Benefits from the Plan. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

WHEN CLAIMS MUST BE FILED

Claims must be filed within 12 months following the date the charges were incurred. Claims filed later than 12 months after the charges were incurred will be denied.

Note: No plan benefits will be paid for any claim not submitted within 12 months.

If you or a Dependent incurs expenses for treatment of a sickness or injury**,** you must notify the Fund within 90 days of the date that the sickness started or the injury occurred. Your written proof of loss, claim form, and any other necessary documentation must be submitted within 12 months after the charges are incurred. If the Fund requires additional information from you to process your claim, you have 60 days from the date of the letter requesting the information. If you do not abide by this timetable, the Fund will deny the claim.

How to file a claim is on the back of your medical ID Card.

WHERE TO FILE CLAIMS

Your claim will be considered to have been filed as soon as it is received by the appropriate organization that is responsible for determining the initial determination of the claim. These are as follows:

1. Hospital and Medical Claims

You are generally not required to file a claim form in order to be reimbursed for Hospital or Medical/Surgical benefits because most claims are submitted directly by the Hospital or provider. You are not required to file a claim in order to be reimbursed for these benefits if you use a Participating Provider.

If you use an out-of-network provider for a non-emergency service, your claim will be denied. If you have a Hospital or medical claim to submit, you must submit a completed claim form to the Fund Office.

2. Dental Claims

If you use a Participating provider, there are no claim forms to file. This Plan provides in-network benefits only.

3. Vision Claims

Vision care is provided by the Vision Screening, Inc. network of providers. Please contact the Fund Office for a Participating Provider near you. There are no benefits available if you use an out-of-network provider.

4. Retail Prescription Claims

You do not need claim forms when visiting a participating pharmacy. Simply present your card and your prescription to the pharmacist. When you present a prescription to a pharmacy to be filled under the terms of this plan, that request is not considered a claim under these procedures. However, if your request for a prescription is denied in whole or in part, you may file a claim and appeal under these procedures. If you need to file a claim, contact the Fund Office.

AUTHORIZED REPRESENTATIVES

An Authorized Representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an Authorized Representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an Authorized Representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

Claims Procedures

The claims procedures for Benefits will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, a Post-Service Claim, an AD&D claim, a Life Insurance Claim, or a Request for Benefits that are not currently offered by the Health Fund's Plan of Benefits. Please read each section carefully to determine which procedure is applicable to your request for Benefits.

Medical Certification Program

The Fund has a Medical Precertification program as described elsewhere in this SPD.

You must contact that organization before receiving care:

- If you are going into the hospital.
- If your doctor is planning any surgery, whether or not hospitalization is planned.
- If your doctor is planning to order home health care services.
- If you are pregnant, in which case you should call when you know you are pregnant.
- If you are admitted to the hospital on an emergency basis, in which case the Health Organization must be notified within 72 hours after admission.

If you are unable to call, you should have the hospital, your doctor or a family member call your Health Organization at the telephone number on the back of your Medical ID card.

Pre-Service and Urgent Care Claims

A Pre-Service Claim is a claim for a Benefit for which the Plan requires approval of the Benefit (in whole or in part) before medical care is obtained.

If you improperly file a Pre-Service Claim, the Health Organization will notify you as soon as possible but not later than *5 days* after receipt of the claim, of the proper procedures to be followed in filing a claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the Health organization and it includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

For properly filed Pre-Service Claims, you and your Health Care Provider will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the health organization, and you are notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the health organization needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have at least *45 days* from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you respond to the request. The Health organization then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination. You have the right to appeal a denial of your Pre-Service Claim. (See “Review Process” and “Timing of Notice of Decision on Appeal” below.)

Urgent Care Claims

An Urgent Care Claim is any Pre-Service Claim for medical, dental or prescription care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

Whether your claim is an Urgent Care Claim is determined by the health organization applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a Physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

If you improperly file an Urgent Care Claim, the health organization will notify you as soon as possible but not later than *24 hours* after receipt of the claim of the proper procedures to be followed in filing a claim. This notification may be oral, unless you (or your representative) request written notification. You will only receive notification of a procedural failure if your claim is received by the Health organization and it includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

For properly filed Urgent Care Claims, the health organization will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than *72 hours* after receipt of the claim by the Health organization. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent Benefits are covered or payable, the health organization will notify you and/or your doctor as soon as possible, but not later than *24 hours* after receipt of the claim, of the specific information necessary to complete the claim. You will then have a period of no less than 48 hours, taking into account the circumstances, to provide the specified information to the Health organization. The Health organization will then notify you of the Benefit determination no later than 48 hours after the earlier of (i) the health organization's receipt of the specified information, or (ii) the end of the period afforded to you to provide the specified additional information.

Concurrent Claims

A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a Benefit. (An example of this type of claim would be an inpatient Hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

If you are receiving Concurrent Care Benefits and the Fund Office or health organization decides to reduce or terminate coverage for the course of treatment before the end of the previously approved treatment period, you will be notified of the Adverse Benefit Determination sufficiently in advance of the reduction or termination to allow you ample time to request a review of the decision and obtain a determination upon review before the Benefit is reduced or terminated.

If you make a claim to extend a course of treatment beyond the approved period of time or number of treatments, and the claim involves Urgent Care, the Fund Office or health organization will make a determination on your claim as soon as possible, taking into account medical emergencies, and will notify you of the decision within 24 hours after receipt of your claim, provided that your claim was filed at least 24 hours before expiration of the previously approved period of time or number of treatments.

Post-Service Claims

There are no claim forms to submit for your Health Organization's In-Network medical, for most Hospital, vision, dental and prescription drug Benefit claims. These providers will submit claims directly to the applicable payer under the terms of those contracts. Receipt of such Benefits from these providers does not constitute a claim.

The following procedure applies to Post-Service Claims. A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

When you need to submit a claim:

- Have your Physician either complete the Attending Physician's Statement section of the claim form (including Date of Service, CPT-4 code or ADA codes, ICD-9 (the diagnosis code), Billed charge, Number of Units (for anesthesia and certain other claims), Federal taxpayer identification number (TIN) of the provider, Billing name and address and If treatment is due to accident, accident details; **or**
- Submit a completed HCFA health insurance claim form, or have the provider submit an HIPAA-compliant electronic claims submission;
- Attach all itemized bills that describe the services rendered. (In most circumstances the Hospital will submit these claims directly to the address listed in this section for the applicable Benefit).

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

Mail any further bills or statements for services covered by the Plan to the applicable address as soon as you receive them.

Ordinarily, you will be notified of the decision on your Post-Service claim within *30 days* from receipt of the claim by the organization responsible for making the claims determination. This period may be extended one time for up to *15 days* if the extension is necessary due to matters beyond the control of the organization responsible for making the claims determination. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the organization expects to render a decision.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have at least *45 days* from receipt of the notification to supply the additional information. The normal period for making a decision on the claim will be suspended until the date you

respond to the request. The applicable organization then has *15 days* to make a decision on a Post-Service Claim and notify you of the determination.

NOTICE OF CLAIMS DECISION

You will be provided with written notice of a denial of a claim (whether denied in whole or in part) or any other Adverse Benefit Determination. This notice will state:

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal procedures and applicable time limits
- A statement of your right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

For all Pre-Service Claims (including Urgent Care Claims), you will receive notice of the determination even when the claim is approved.

REQUEST FOR REVIEW OF DENIED CLAIM

If your claim is denied in whole or in part, or if any Adverse Benefit Determination is made with respect to your claim, you may ask for a review.

Your request for review must be made in writing to the applicable organization as noted below:

- **Pre-Service, Urgent Care and Concurrent Claims Appeals**

  Appeals involving Pre-Service, Urgent Care, Concurrent Care, Inpatient Hospital Care and Mental Health may be made orally by calling your Health Organization at the telephone number on your ID card.

- **Post-Service Hospital, Medical, Dental, Vision and Prescription Drug Appeals**

  Appeals should be submitted in writing to the Board of Trustees at:

  The Board of Trustees
  Teamsters Welfare Fund of Northern NJ Local 723
  714 Rahway Ave., Suite 3
  Union, NJ 07083
  908-688-0723

Appeals need to be submitted in writing to the appropriate organization within *180 days* after you receive notice of denial.

REVIEW PROCESS

The review process works as follows:

You have the right to review, free of charge, documents relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Fund Office's or health organization's administrative processes for ensuring consistent decision-making; or it constitutes a statement of plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the organization responsible for the claim, without regard to whether their advice was relied upon in deciding your claim.

Your claim will be reviewed by a person who is not subordinate to (and shall not afford any deference to) the one who originally made the Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal

- **Pre-Service Claims:** You will receive a notice of decision on review within 30 days of receipt of the appeal.
- **Urgent Care Claims:** You will receive notice of a decision within 72 hours of receipt of the appeal.
- **Post-Service Claims:** Ordinarily, decisions on appeals involving all Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees of the Fund following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.
- **AD&D and Life Insurance Claims:** The decision will be made within 60 days of your request for review. An extension of 60 days may be granted for reasons beyond the control of the carrier. You will be advised in writing within the 60 days after receipt of your request for review if an additional period of time will be necessary to reach a final decision on your AD&D or life insurance claims.
- **Concurrent Care Claims:** See above section regarding concurrent claims.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination,
- Reference to the specific plan provision(s) on which the determination is based,
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge,
- A statement of your right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on review.
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Limitation on When a Lawsuit May be Started

You may not start a lawsuit to obtain Benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than 3 years after the end of the year in which medical or dental services were provided.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without you having to complete the special authorization form.

Claims Procedures

The claims procedures for benefits will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, a Post-Service Claim, an Accidental Death or Dismemberment claim (AD&D) claim, a claim for Life Insurance, or a request for benefits that are not currently offered by the Health Fund's Plan of Benefits. Please read each section carefully to determine which procedure is applicable to your request for benefits.

IMPORTANT: If you fail to pre-certify these services, benefits will not be paid.

Incompetence

In the event it is determined that a claimant is unable to care for his/her affairs because of illness, accident, or incapacity, either mental or physical, any payments due may, unless claim has been made therefore by a duly appointed guardian, committee, or other legal representative, be paid to the spouse or such other object of natural bounty or the claimant, as the Trustees will determine in their sole discretion.

Trustees' Right to Information

The Trustees have the right to require a participant or a dependent to produce and provide any and all evidence or proof of any fact which the Trustees, in their discretion, decide to be relevant or necessary. The failure to provide such information or evidence will justify any action of the trustees in denying any claim made by such participant or dependent. If any participant or dependent submits false information or false claims to the provider or to the Trustees, the Trustees shall have the right, in their sole discretion, to disqualify such participant or dependent from eligibility for benefits for any time period determined to be appropriate by the Trustees.

Mailing Address of Claimant

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last communicated to the Trustees and a letter, sent by first class mail, to such claimant is returned, any payments due the claimant will be held without interest until payment is successfully made.

Recovery of Certain Payments

The Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statements, information, or proof submitted, as well as any benefit payment made in error to a claimant or to a third party on a claimant's behalf, such recovery may be made by reducing other benefit payments made to or on behalf of the claimant, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. The Trustees have the authority to disqualify a participant and his or her dependents from coverage or from future benefits either for a specific dollar amount or for a specified period of time.

WORKERS' COMPENSATION

No benefits will be paid by the Fund for accidents or illnesses arising out of or as the result of employment. If you become disabled by an occupational accident or illness, be sure to report your disability to your Employer immediately. The Fund does not provide any benefits to members or dependents for accidents or illnesses covered by Workers' Compensation legislation.

FACILITY OF PAYMENT

If you or your dependents are not legally capable of giving valid receipt for a benefit payment, the Plan has the right (if there is no legal guardian) to pay the party the Plan believes is entitled to such payment. Once such payment is made, the Plan has no further obligation with respect to the amount so paid. If you name more than one Beneficiary, but do not say how much each Beneficiary should receive, the total amount will be shared equally by all surviving Beneficiaries. If there is no living Beneficiary when you die, the Company or Plan Supervisor will make the payment to your spouse; if none, to your children; if none, to your parents; and if none, to your brothers and sisters. However, the Plan has the option to make the payment to your estate.

EXAMINATIONS

The Plan has the right to have any eligible person examined as often as it may reasonably require while a claim is pending.

TRUSTEE AUTHORIZED DENIAL OR LOSS OF BENEFITS

The Trustees or their representatives are authorized to deny benefits. The following list outlines some circumstances or reasons that all or part of a person's claim may be denied by the Fund that would cause a person to lose benefits or to receive reduced benefits.

- The person on whose behalf you filed the claim was not eligible for benefits on the date the expenses were incurred (see the "Eligibility" section), or, in the case of a Dependent, the person does not meet the Plan's definition of a "Dependent".
- You did not file the claim within the Plan time limits (12 months from the date the charges were incurred) or you failed to furnish, when requested, information or documents available to you that were necessary to complete the claim within 60 days of such request.
- The expenses that were denied are not considered Covered Expenses under the Plan, or the expenses for which you filed the claim were not actually incurred.
- The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense.
- Some other plan was primarily responsible for paying benefits on the expenses.
- No payment, or a reduced payment, was made because some or all of the expenses were applied against a Deductible.
- The Plan of Benefits was terminated.
- The Trustees amended the Plan's eligibility rules or decreased Plan benefits.
- The Trustees reduced or temporarily suspended future benefit payments to a Covered Person in order to recover an overpayment of benefits previously made on that person's behalf.
- Benefits were reduced due to the fact that a noncompliance Deductible was applied because the procedures of the Medical Review Program were not followed.
- A non-EPO Hospital was used and reduced benefits were paid.

The list specified above is not an all-inclusive listing of the circumstances that may result in a claim denial or loss of benefits. It is truly representative of the types of circumstances, in addition to failure to meet the eligibility requirements for coverage under the Plan that may result in denial of claims or loss of benefits.

SUBROGATION

(Claims involving Third-Party Liability)

This provision applies to all Participants with respect to all of the benefits provided under this Plan. For the purpose of this provision, the terms "*you*" and "*your*" refer to all Members, covered Spouses and covered Dependents.

General

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your Illness or Injury or is otherwise responsible for your medical bills. The rules in this section govern how this Fund pays all benefits in such situations.

These rules have two (2) purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there are questions of third party liability, many months pass before the third party actually pays. These rules permit this Fund to pay your covered expenses and provide any other benefits to which you are entitled until your dispute with the third party is resolved.

Second, the rules protect this Fund from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable, in any way, for the injuries giving rise to these expenses, or that third party settles the claim which gave rise to the injuries without an admission of guilt, this Plan must be reimbursed for the relevant benefits it has advanced to you out of any recovery, whatsoever, that you receive that is, in any way, related to the event which caused you to incur the medical expenses. This is true whether or not the settlement is itemized.

Rights of Subrogation and Reimbursement

If you incur covered expenses for which a third party may be liable, or if you become entitled to other benefits as a result of the same events which caused you to incur the covered expenses, you are required to advise the Plan of the fact. By law, the Plan automatically acquires any and all rights which you may have against the third party.

In addition to its subrogation rights, the Fund has the right to be reimbursed for payments made to you or on your behalf, under these circumstances. The Plan must be reimbursed in full from any settlement, judgment, or other payment that you obtain from the liable third party. Other expenses, including attorneys' fees, cannot be taken out of the payment.

Assignment of Claim

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Fund. If this Fund recovers from the third party any amount in excess of the benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

Failure to Disclose and/or Cooperate

If you fail to tell this Fund that you have a claim against a third party; if you fail to assign your claim against the third party to this Fund when required to do so (**and** to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's Reimbursement Agreement and forms; if you and/or your attorneys fail to reimburse this Fund out of any payment you obtain from the third party; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if the Fund reduces the amount of its lien or otherwise limits its rights); then you are personally liable to this Fund for the reimbursement owed to this Fund by the third party. The Fund may offset the amount you owe from any future benefit claims, or if necessary, take legal action against you.

If any Participant files a claim for medical expenses or Loss of Time Benefits and a third party is legally responsible for paying those expenses, the Fund will not pay benefits on the claim unless the requirements of the Subrogation Rules stated below are met. A "third party" is any person or corporation (or any insurance company obligated to pay claims resulting from the acts of such a person or corporation) or any other entity which is or may be found legally responsible to pay your medical expenses. The Plan's subrogation rules will not apply to any amount paid under the Participant's own insurance policy. Also, these Subrogation Rules do not apply to benefits you recover under another employer-sponsored group health plan if that coverage is subject to Coordination of Benefits (C.O.B.).

Subrogation Rules

If a third party is responsible for paying expenses for which the Participant files a claim, the Fund will only pay benefits on the claim under the following conditions:

- The Participant must sign the Fund's Reimbursement Agreement that includes, but is not limited to, the following provisions:
  - The Participant agrees that the Participant will repay the Fund the amount of benefits which the Fund pays on the claim out of any recovery of expenses you receive, regardless of whether the recovery is sufficient to fully reimburse the loss; and
  - The Participant agrees that the Fund is entitled to a first priority lien on the proceeds of any recovery, to the extent of the full amount of benefits paid, regardless of whether the Participant is made whole by the recovery; and
  - The Participant agrees that, if the third party does not voluntarily pay the Participant for the incurred expenses and the Participant does not sue the third party for recovery of the expenses, the Fund has the right to sue the third party in the Participant's name to recover the amount it paid. In such a case, if there is a recovery or settlement, the Participant agrees that the Fund's expenses, costs and incurred attorney's fees will also be paid out of the recovery or settlement; and
  - The Participant agrees not to assign to another person the Participant's right to recover money from another source, and the Participant agrees that he or she will obtain the Fund's consent before releasing another person or entity from liability for any injury.
  - The Participant's attorney also must sign the agreement if: (1) the Participant enters into a contingent fee arrangement with the attorney to pursue the Participant's claim against a third party or (2) the claim is based on work-related injuries.
- If the Participant who is injured by a third party is an adult Dependent, the injured adult Dependent must sign the Reimbursement Agreement along with the Eligible Employee or Retiree. If the Participant who is injured by a third party is a minor Dependent Child, the Eligible Employee or Retiree, or any other adult authorized to act on behalf of the Child, must sign the Reimbursement Agreement on behalf of the Child.
- The Fund will be entitled to reimbursement out of any recovery. A recovery shall include all payments from another source the Participant receives or to which the Participant is entitled (including, but not limited to, any amounts allocated to a trust set up for the Participant or on the Participant's behalf). In the case of a minor Dependent Child, the minor Dependent Child, such Child's legal representative, and the Eligible Employee are obligated to reimburse the Fund out of any recovery received by or on behalf of the Dependent Child, Child's legal representative or the Eligible Employee.
- If the Participant obtains a recovery of incurred expenses and does not repay the Fund as the Participant agreed to do when the Participant signed the Reimbursement Agreement, the Fund may file suit against the Participant to recover expenses it paid on the Participant's claim and the attorney's fees and expenses incurred in filing such a suit. The Fund also has the right to reduce any future benefits to which the Participant may be entitled on claims for the Participant and the other eligible Members of the Participant's family until the proper amount has been recovered by the Fund.
- The Fund will not expect repayment of more than the benefits it pays on the claim or more than the amount of the Participant's gross recovery.
- The Fund will not be responsible for legal fees and expenses incurred by the Participant in obtaining a recovery except that, at the discretion of the Trustees, the Fund may agree to pay for a reasonable share of those fees and expenses actually incurred by the Participant in connection with the proof of and recoupment of the payments made by the Fund.
- Once a Participant has obtained a recovery, no further benefits are payable from the Fund for any claims related to the injury at issue, until the total of Covered Expenses arising out of the injury equals the gross amount of the recovery paid to or on behalf of the Participant. The Fund will then consider only the amount of claims that exceeds the amount of the gross recovery, except that in the event of a recovery insufficient to repay in full the benefits the Fund has paid on the claim, the Fund will continue to pay benefits for future claims related to the injury at issue until additional recovery sufficient to reimburse the Fund in full is obtained.

- The Participant must inform the Fund of the progress of any claim, settlement or legal action against the third party responsible for the Participant's injury and must respond to any inquiries made by the Fund as to such progress. The Participant must also inform the Fund of any attempts to settle, release, dismiss or discharge any claim, settlement or legal action against the third party.
- The Participant must furnish the Fund upon demand with all papers, documents or other information in his or her possession necessary for the proper recovery upon any claim, settlement or legal action against the third party.
- In the event that the Participant does not sign a Reimbursement Agreement and the Fund pays benefits on claims for which a third party is legally responsible, the Fund is entitled to a first priority lien on any recovery obtained by the Participant in the same manner as if the Participant had signed the Reimbursement Agreement.
- If the Participant suffers a work-related injury, the Fund will not pay benefits until (1) it receives a Reimbursement Agreement signed by the Participant and the Participant's attorney, (2) it receives confirmation in writing that the employer, or the employer's worker's compensation liability insurer, has denied responsibility for the injury and (3) the Participant demonstrates that he or she is pursuing a claim against the employer and/or the employer's worker's compensation insurer, unless the Trustees determine, in their discretion, that such a claim is not viable based on the facts and circumstances surrounding the injury.
- In the event that the Fund agrees to accept less than the full amount of the lien, the Participant and his or her attorney must sign a release consistent with this section. If the Participant and/or attorney fail to submit a signed release to the Fund when requested to do so, the Fund may demand payment of the balance owed to the Fund and/or deny future claims until the balance owed is recouped.

Restoration of Recovered Benefits

If a person has a claim which is subject to subrogation and the Plan pays benefits on the claim, the benefits paid by the Plan apply toward all applicable maximum benefit limitations, the same as benefits which are paid for non-subrogation claims. If the Plan pays benefits under the subrogation rules and recovers some or all of the benefits it paid through subrogation, the amount of benefits recovered may be restored to certain maximum benefits. The following rules apply to restoration of recovered benefits:

- Recovered benefits will not be restored to benefit maximums that pertain to a specific accident or injury.
- A restoration will be effective on the date the recovery is received by the Plan.
- Any increase in a maximum benefit due to a restoration will apply only to claims incurred on and after the date the subrogation recovery is received by the Plan.

PLAN CHANGE OR TERMINATION

It is anticipated that the Plan will remain in effect indefinitely. However, the Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under the Plan and (2) the eligibility rules.

This booklet includes information concerning the benefits provided by the Benefit Fund Trustees to Participants and their dependents and the circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits that a Participant or dependent might otherwise reasonably expect a Plan to provide. The benefits and eligibility rules applicable to Participants and their dependents have been established by the Trustees. The right to amend or modify the eligibility rules and plan of benefits for Participants and dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for Participants and their dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Trustees in accordance with their authority contained in the Agreement and Declaration of Trust.

No employee has a vested interest in the benefits provided for Participants and their dependents. In addition to the right to terminate any benefits of Participants and/or their dependents at any time, the Trustees also reserve the right in their sole and absolute discretion to terminate the program of benefits for Participants at any time, and there shall not be any vested right by any Participant or dependent or beneficiary nor any contractual rights thereafter. In addition, Participants and their dependents will have no priority with regard to the termination of this Plan.

Plan benefits and eligibility rules for eligible Participants are provided under a self-administered program and:

- Are not guaranteed;
- May be changed, amended or discontinued by the Board of Trustees at any time or eliminated entirely;
- Are subject to the Trust Agreement which establishes and governs the Fund's operations;
- Are payable only to the extent that in the judgment of the Trustees funds are available considering the desirability of maintaining other benefits.
- Are subject to the provisions of any group insurance policy purchased by the Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

If the Plan is changed or discontinued, it will not affect you or your beneficiary's right to any insured benefit to which you have already become entitled.

The Funds' Trustees have the power to interpret and apply the terms of this Summary Plan Description Booklet and also the Plan of Benefits and also the Fund's Trust Agreement.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

A Federal Law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires most employers sponsoring group health plans to offer employees and their families *(if eligible)* the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage would otherwise end (called "qualifying events"). This section outlines your rights and obligations with respect to continuation of the health benefits provided under the Plan.

To be eligible to continue coverage under COBRA, you must be enrolled in the Plan when your coverage ends because of a qualifying event.

COBRA ELIGIBILITY

Qualifying Events for You

COBRA coverage is available to you if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.

- You voluntarily or involuntarily terminate your employment for any reason (including retirement) other than gross misconduct.

Qualifying Events for Your Dependents

COBRA coverage is available to your eligible dependents if coverage would otherwise end if:

- Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program.
- You (the active employee) voluntarily or involuntarily terminate employment for any reason (including retirement) other than gross misconduct.
- You (the active employee) retire.
- You (the active employee) die, become divorced, legally separated or become entitled to Medicare.
- Your dependent child ceases to be eligible for Fund coverage. For example, he or she reaches the maximum age limit for coverage.

HOW COBRA COVERAGE WORKS

In order to have the opportunity to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, you and/or a family member must notify the Fund Office in writing of that event no later than 60 days after that event occurs. Notice should be sent to:

The Board of Trustees
Teamsters Welfare Fund of Northern NJ Local 723
714 Rahway Ave., Suite 3
Union, NJ 07083
908-688-0723

The Fund Office will send you information about COBRA coverage.

You should notify the Fund Office promptly and in writing of termination of employment, reduction in hours, retirement, or entitlement to Medicare. Your family members must notify the Fund Office promptly and in writing in the event of your death.

Under Federal Law your employer is required to notify the Fund on your behalf under these circumstances:

Your voluntary/involuntary termination	30 days
Your reduction of hours	30 days
Your death	30 days
Employer's bankruptcy	30 days
Your eligibility for Medicare	14 days of its learning of the event*
Your divorce or legal separation	14 days of its learning of the event*

*** You must notify the Fund Office within 60 days of the event.**

HOW TO ELECT COBRA CONTINUATION COVERAGE

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced, or that a dependent child loses dependent status, the Fund Office will provide you and your COBRA eligible dependents notice of the date that your coverage under the group ends and your rights to elect continuation of coverage under COBRA. Under the law you and or your eligible dependents will have the later of 60 days from the qualifying event or the date that the notice is sent by the Fund office to elect continuation of coverage. If the Fund does not receive election prior to the 60-day period, you will forfeit your rights for continuation.

Each qualified beneficiary has a right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in 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 event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

THE COBRA CONTINUATION COVERAGE THAT WILL BE PROVIDED

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on the Cost of COBRA Coverage for information about how much COBRA will cost you and about grace periods for payment of those amounts. 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.

COST OF COBRA COVERAGE

Individuals who continue full coverage under COBRA pay 102% of the Plan's cost, on an after-tax basis, except in cases of disability. See the section below entitled COBRA Coverage in Cases of Social Security Disability for details.

PAYING FOR COBRA COVERAGE

The amount you, your covered spouse, and/or your covered dependent child(ren) must pay for COBRA coverage will be payable monthly. The Plan is permitted to charge the full cost of coverage for similarly situated active employees and families, plus an additional 2% (for a total charge of 102%). The COBRA Continuation Coverage charge is different in cases of extended coverage due to Social Security disability. See that section for further information.

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage, and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first amounts due starting with the date COBRA coverage was elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month**. If payment is not received within 31 days after the 1st of the month, your COBRA coverage will terminate retroactive to the date of the last payment is received. Once coverage has been terminated, you will lose your right to continuation coverage.**

IMPORTANT NOTE: YOU MUST PAY THE FUND OFFICE MONTHLY!

The Fund is not required to issue payment notices. Payment is due on the first day of the month. Late payment will cause rejection of direct pay benefits. If you have any questions about COBRA continuation coverage, please contact the Fund Office.

COBRA AT-A-GLANCE

COBRA Coverage May Continue For:	If the Following Event Occurs and Coverage is Lost:	Maximum Length of COBRA Coverage:
You and Your Eligible Dependents	• Your employment ends (for example, you resign) for any reason except gross misconduct • Your regularly scheduled hours are reduced so that you are no longer eligible to participate in the Fund's welfare benefits program	18 months from the date of loss of coverage (29 months if you or your eligible dependent is Social Security disabled*).
Your Eligible Dependents Only	• You die • You are divorced or legally separated • Your child(ren) no longer qualifies as an eligible dependent under the Plan	36 months from the date of loss of coverage

* See COBRA Coverage in Cases of Social Security Disability for more details.

DURATION OF COBRA COVERAGE

Your COBRA coverage can continue for up to 18, 24, 29, or 36 months depending on the qualifying event.

The Continuation Coverage period begins on the date you and/or your dependents lose coverage (rather than on the date of the qualifying event).

18 Months

COBRA health coverage can continue for up to 18 months if you lose Fund health coverage because of:

- Your reduction in hours.
- Your change from active to inactive work status due to your:
  - Resignation.
  - Discharge (except for discharge for gross misconduct)
  - Disability.
  - Strike.
  - Layoff.
  - Retirement.
  - Leave of absence (other than leave under the Family and Medical Leave Act).

24 Months

COBRA health coverage can continue for up to a total of 24 months if you and/or your eligible dependent(s) elect coverage while you are performing Military Service in accordance with the USERRA Section of this SPD.

29 Months

COBRA health coverage can continue for up to a total of 29 months if you or an eligible dependent becomes permanently disabled (as determined by the Social Security Administration), within the first 60 days of COBRA coverage, and you or your dependent notifies the Fund Office of the determination no later than 60 days after it was received and before the end of the initial 18-month period.

36 Months

COBRA health coverage for your dependents can continue for up to a total of 36 months from the date any one of the following qualifying events occurs:

- Your death.
- Your divorce.
- Your dependent is no longer eligible for Fund coverage.

COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY

If you, your spouse, or any of your covered dependent child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first 60 days of COBRA coverage.
- The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- The Plan must be notified in writing by you or by the disabled covered person or another family member that the determination was received:
  - No later than 60 days after it was received; and
  - Before the 18-month COBRA continuation period ends.

This extended period of COBRA coverage will end at the **earlier** of:

- The last day of the month, 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled.

- The end of 29 months from the date of the COBRA qualifying event.
- The date the disabled individual becomes entitled to Medicare.

You must notify the Plan when you are no longer disabled.

COST OF COBRA COVERAGE IN CASES OF SOCIAL SECURITY DISABILITY

If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan will charge employees and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month period following the 18th month of COBRA Continuation Coverage. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

ACQUIRING A NEW DEPENDENT(S) WHILE COVERED BY COBRA OR OTHER HEALTH INSURANCE COVERAGE

If you acquire a new dependent through marriage, birth, or placement for adoption while you are enrolled in COBRA Continuation Coverage, you may add that dependent to your coverage for the balance of your COBRA coverage period.

To enroll your new dependent for COBRA coverage, you must notify the Fund Office in writing. There may be a change in your COBRA premium amount in order to cover the new dependent.

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36 months COBRA coverage period, COBRA coverage also will end for your newly added spouse. However, COBRA coverage can continue for your newly added newborn child, adopted child or child placed with you for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with the Fund for more details on how long COBRA coverage can last.

LOSS OF OTHER GROUP HEALTH PLAN COVERAGE OR OTHER HEALTH INSURANCE COVERAGE

If, while you (the member) are enrolled in COBRA Continuation Coverage, your spouse or eligible dependent lose their coverage under another group health plan, you may enroll them in your COBRA for the remainder of the period of continuation of coverage. However, adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

The loss of other coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause.

NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

In the event the Plan is notified of a qualifying event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Fund Office 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.

MULTIPLE QUALIFYING EVENTS WHILE COVERED BY COBRA

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, 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.

For example, assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your covered spouse for COBRA coverage. Three months after your COBRA coverage begins, you and your spouse divorce and your spouse is no longer eligible for Plan coverage. Your spouse can continue COBRA coverage for an additional 33 months, for a total of 36 months of 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 (the active employee) during the 18-month period of COBRA Continuation Coverage.

In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of Social Security disability). As a result, if you experience 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.

WHEN COBRA COVERAGE MAY BE TERMINATED

Once COBRA coverage has been elected, it may be terminated on the occurrence of any of the following events:

- The first day of the time period for which you don't pay the COBRA premiums within the required time period.
- The date on which the Plan is terminated.
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become covered by another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a preexisting condition that the covered person may have.
- The date, after the date of the COBRA election, on which you or your eligible dependent(s) first become entitled to Medicare (usually age 65).
- When active employee coverage would be terminated for cause (for example, you submit fraudulent claims to the Fund).
- When the employer that employed you prior to the qualifying event has stopped contributing to the Plan and (1) the employer establishes one or more group health plans covering a significant number of the employer's employees formerly covered under this Plan, or (2) the employer starts contributing to another multiemployer plan that is a group health plan.

NOTICE OF EARLY TERMINATION OF COBRA CONTINUATION COVERAGE

The Plan will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Fund Office determines that COBRA coverage will terminate early.

WHEN COBRA COVERAGE ENDS

Your COBRA coverage ends on the earliest of the date that:

- Any of the above-listed events occurs.
- The COBRA period (18, 29, or 36 months) ends.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires group health plans and group health insurance issuers to permit an employee or dependent that is eligible for but not enrolled in the plan to enroll when the employee or dependent is covered under Medicaid or CHIP and loses that coverage as a result of loss of eligibility or when the employee or dependent becomes eligible for Medicaid or CHIP assistance with respect to coverage under the group health plan. CHIPRA also created new notice requirements related to these special enrollment rights.

Employee Rights. The Act grants employees several important rights. Among them are the right to receive information about their pension or health benefit plans, to participate in timely and fair processes for benefit claims, to elect to temporarily continue group health coverage after losing coverage, to receive certificates verifying health coverage under a plan, and to recover benefits due under the plan.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The FMLA provides an entitlement of up to 12 weeks of job-protected, unpaid leave during any 12-month period for the following reasons:

- Birth and care of the employee's child, or placement for adoption or foster care of a child with the employee;
- Care of an immediate family member (spouse, child, parent) who has a serious health condition; or
- Care of the employee's own serious health condition.

The emergency leave benefit (of up to 12 weeks) now will be available to family members of active duty service members in the Armed Forces who are deployed to a foreign country.

In addition, under the Act, the caregiver leave benefit (of up to 26 weeks) now includes leave to take care of a child, spouse, parent or next of kin who (1) is a veteran, (2) is undergoing medical treatment, recuperation or therapy for serious injury or illness, and (3) was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the five years preceding the date of treatment. The medical treatment must be related to a serious injury or illness incurred while in the line of duty on active duty in the Armed Forces or which existed before the beginning of military service, and which was aggravated by service in the line of duty while on active duty.

If an employee was receiving group health benefits when leave began, an employer must maintain them at the same level and in the same manner during periods of FMLA leave as if the employee had continued to work. Usually, an employee may elect (or the employer may require) the use of any accrued paid leave (vacation, sick, personal, etc.) for periods of unpaid FMLA leave.

Employees may take FMLA leave in blocks of time less than the full 12 weeks on an intermittent or reduced leave basis when medically necessary. Taking intermittent leave for the placement, adoption, or foster care of a child is subject to the employer's approval. Intermittent leave taken for the birth and care of a child is also subject to the employer's approval except for pregnancy-related leave that would be considered leave for a serious health condition.

When the need for leave is foreseeable, an employee must give the employer at least 30 days' notice, or as much notice as is practicable. When the leave is not foreseeable, the employee must provide such notice as soon as possible.

An employer may require medical certification of a serious health condition from the employee's health care provider. An employer may also require periodic reports during the period of leave of the employee's status and intent to return to work, as well as "fitness-for-duty" certification upon return to work in appropriate situations.

An employee who returns from FMLA leave is entitled to be restored to the same or an equivalent job (defined as one with equivalent pay, benefits, responsibilities, etc.). The employee is not entitled to accrue benefits during periods of unpaid FMLA leave, but the employer must return him or her to employment with the same benefits at the same levels as existed when leave began.

Employers are required to post a notice for employees outlining the basic provisions of FMLA and are subject to a $100 civil money penalty per offense for willfully failing to post such notice. Employers are prohibited from discriminating against or interfering with employees who take FMLA leave.

Employee Rights

The FMLA provides that eligible employees of covered employers have a right to take up to 12 weeks of job-protected leave in any 12-month period for qualifying events without interference or restraint from their employers. The FMLA also gives employees the right to file a complaint with the Wage and Hour Division of the Department of Labor's Employment Standards Administration, file a private lawsuit under the Act (or cause a complaint or lawsuit to be filed), and testify or cooperate in other ways with an investigation or lawsuit without being fired or discriminated against in any other manner.

Compliance Assistance Available

The Wage and Hour Division of the Employment Standards Administration administers FMLA. More detailed information, including copies of explanatory brochures, may be obtained by contacting your local Wage and Hour Division office. In addition, the Wage and Hour Division has developed the *elaws* Family and Medical Leave Act Advisor, which is an online resource that answers a variety of commonly asked questions about FMLA, including employee eligibility, valid reasons for leave, notification responsibilities of employers and employees, and rights and benefits of employees. Compliance assistance information is also available from the Wage and Hour Division's Web site. For additional assistance, contact the Wage and Hour Division at 1-866-4USWAGE.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA amended the Employee Retirement Income Security Act (ERISA), to provide new rights and protections for participants and beneficiaries in group health plans. Understanding this amendment is important to your decisions about future health coverage. HIPAA contains protections for health coverage offered in connection with this Plan.

If you find a new job that offers health coverage, or if you are eligible for coverage under a family member's employment-based plan, HIPAA includes protections for coverage under group health plans that:

- Limit exclusions for preexisting conditions;
- Prohibit discrimination against employees and dependents based on their health status;
- Allow a special opportunity to enroll in a new plan to individuals in certain circumstances;
- If you choose to apply for an individual policy for yourself or your family, HIPAA includes protections for individual policies that:
  - Guarantee access to individual policies for people who qualify;
  - Guarantee renewability of individual policies.

What is a preexisting condition?

A preexisting condition is a medical condition present before your enrollment date in any new group health plan.

The Affordable Care Act prohibits any exclusion of coverage based on a preexisting condition.

MENTAL HEALTH PARITY AND ADDICTION ACT

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.

MILITARY SERVICE RULES

If an active Employee terminates covered employment due to military service covered by the Uniformed Services Employment and Reemployment Rights Act ("USERRA") and is subsequently reemployed by an Employer, he or she will immediately resume coverage under the Plan as if he or she had never left.

When you are discharged (not less than honorably) from the uniformed services, your full eligibility will be reinstated on the day you return to work with an Employer, provided that you return to employment:

- Within ninety (90) days from the date of discharge, if the period of service was more than one hundred eighty (180) days; or
- Within fourteen (14) days from the date of discharge, if the period of service was more than thirty (30) days but less than one hundred eighty (180) days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty (30) days.

If you are hospitalized or recovering from an injury caused by active duty, these time limits are extended up to two years.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military (see COBRA Section of this SPD for details).

If an active Employee terminates covered employment due to military service beyond the period allowed under USERRA and is subsequently reemployed by an Employer, Plan coverage is not immediately reinstated upon return to work. The formerly-active Employee will be treated as a new Employee for purposes of determining eligibility for Plan coverage or benefits, and must satisfy the eligibility requirements summarized in this booklet or in the Collective Bargaining Agreement.

If you have any questions about taking a leave, please speak directly with your Employer. If you have any questions about how a leave affects your benefits, please contact the Fund Office.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. This law applies both to persons covered by this Plan. In general, this plan may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth, the period begins at the time of the admission.

Although the NMHPA prohibits this Plan from restricting the length of a hospital stay in connection with childbirth, this Plan does not have to cover the full 48 or 96 hours in all cases. If an attending provider, after speaking with you, determines that either you or your child can be discharged before the 48-hour (or 96-hour) period, this Plan does not have to continue covering the stay for whichever one of you is ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to you or your newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. This Plan, hospital, insurance company, or HMO would NOT be an attending provider.

The Plan benefits relating to this Act are found in the benefits section of this SPD. Your health coverage provided by this Fund complies with NMHPA standards.

STATEMENT OF PRIVACY PRACTICES

This section describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The Trustees and the Fund office have always made the protection of your personal information a very important priority. We want you to have a clear understanding of how we use and safeguard your information.

This section describes how the Welfare Fund may use and disclose your Protected Health Information ("PHI"), defined below, in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law. It also describes you rights to access and control you PHI.

Federal legislation known as the Health Insurance Portability and Accountability Act ("HIPAA") requires the Fund to establish a formal policy and procedures for maintaining the privacy of your PHI.

This section is effective beginning in April 2003, and the Welfare Fund is required to comply with its terms. However, the Welfare Fund reserves the right to change its privacy practices and this section and to apply the changes to any PHI received or maintained by the Welfare Fund prior to that date. If a privacy practice is materially changed, a revised version of this section will be provided to Employees via first class mail, and to all other persons upon request. Any revised version of this section will be distributed within 60 days of the effective date of any material change to the Welfare Fund's policies.

PROTECTED HEALTH INFORMATION

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

USES AND DISCLOSURES OF HEALTH INFORMATION

Disclosure of Your PHI Generally Requires Your Written Authorization.

Except as provided by law, any use and disclosure of PHI will be made only with your written authorization.

YOUR INDIVIDUAL PRIVACY RIGHTS

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

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Welfare and HHS.

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

If you feel that any PHI kept by the Fund is incorrect or incomplete, you may request that the Fund amend it subject to certain exceptions. PHI is not subject to amendment if it was not created by the Fund, is not part of the designated record set you are permitted to inspect and copy, or if it is not kept by the Fund. The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written

statement disagreeing with the denial and have that statement included with any future disclosures of that PHI. You should make your request to amend PHI to the Fund's Privacy Officer, in writing, at the address below.

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

You may request that the Fund restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations. In addition, you may restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund is not required to agree to your request. You or your personal representative must submit your request for restrictions on uses and disclosures of your PHI in writing to the Fund's Privacy Officer at the address below.

You may also request to receive communications of PHI confidentially by alternative means or solely at an alternative location (for example, mailing information somewhere other than your home address) if it is feasible and reasonable. You or your personal representative will be required to request confidential communications of your PHI in writing. Make such requests to the attention of the Fund's Privacy Officer at the address below. Please note that the Plan must grant this request only if the individual states he or she would be in danger.

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

The Fund will recognize certain individuals as personal representatives without completion of an Appointment of Personal Representative form. For example, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable state law requires otherwise. Unemancipated minors may, however, request that the Fund restrict information that goes to family members if permitted by applicable state laws. Other documentation that may substitute for this form would include other official legal documentation that demonstrates that under relevant state law the representative is authorized to make health care decisions for you (for example, appointment as a legal guardian, or a health care power of attorney).

THE WELFARE FUND'S DUTIES

The Welfare Fund is required by law to maintain the privacy of your PHI and to provide you with this notice of its legal duties and privacy practices.

If you believe that your privacy rights have been violated, you may file a complaint with the Welfare Fund in care of the Privacy Officer at the following address:

Robin A. Modzelewski, Privacy Officer
Teamsters Welfare Fund of Northern NJ Local 723
714 Rahway Ave., Suite 3
Union, NJ 07083

You may also file a complaint with:

Secretary of the U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave. S.W.
Washington, D.C. 20201

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES

A Qualified Medical Child Support Order ("QMCSO") is a judgment, decree or order usually issued as part of a settlement agreement or divorce decree by a court of competent jurisdiction (or through an administrative process established under state law) that provides for child support or health care coverage for the child of a Plan participant. As long as a QMCSO conforms to statutory requirements, a child named in the QMCSO will be eligible for coverage.

If the Fund Administrator receives a court order requiring the Plan to provide health coverage to a child, the Fund Administrator will follow the order only if it is determined that the order is a QMCSO. When the Fund Administrator receives a medical child support order from a court, the Fund Administrator will promptly notify, in writing, the Participant and each of the children named in the order that the Fund Administrator received the order, and will deliver a copy of the Plan's procedures for determining whether the order is a QMCSO to them at the addresses listed on the order. The Fund Administrator will also notify each child named in the order of his or her right to designate a representative to receive copies of all notices regarding the order.

Within a reasonable period of time, the Fund Administrator will determine whether the order is a QMCSO and notify the participant and each child named in the order of the determination in writing. If claims are submitted to the Plan on behalf of the child or children named in the order while the Fund Administrator is determining whether the order is a QMCSO, the Plan will suspend payment of any benefits that are due until the order is determined to be a QMCSO. If the order is determined to be a QMCSO, children covered by the QMCSO will become covered Dependents of the Participant named in the QMCSO as of the first date to which the QMCSO applies, as if the participant enrolled them in the Plan and paid any required payments as of that date.

For a free copy of the Plan's QMCSO procedures, contact the Welfare Fund office.

THE WOMEN'S HEALTH AND CANCER RIGHTS

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans and insurance companies that provide coverage for mastectomies to provide certain mastectomy-related benefits or services to plan participants and beneficiaries. The Plan provides the benefits required under the WHCRA, and makes these benefits available to eligible participants and dependents.
Under the WHCRA, a group health plan participant or beneficiary who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy is entitled to coverage for the following:

- 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 treatment of physical complications at all stages of mastectomy, including lymph edema.

Coverage for these benefits or services will be provided in a manner determined in consultation with the participant's or beneficiary's attending Physician.

If you are a participant in the Plan, and are currently receiving, or in the future receive, benefits under the Plan in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event that you elect breast reconstruction. Your eligible Dependents are also entitled to coverage for these benefits or services on the same terms. Coverage for the mastectomy-related services or benefits required under the WHCRA will be subject to the same deductibles and co-insurance or co-payment provisions that apply with respect to other medical or surgical benefits provided under the Plan.

If you have any questions about the WHCRA please contact the Fund office.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and Fund 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.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself 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.

You should be provided a certificate of creditable coverage, free of charge, from your Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that 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 a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

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The benefits available to you under this Welfare Plan are generally intended to be tax free and are described in this Summary Plan Description (SPD). Any inconsistencies within this SPD will be governed by the Plan Trustees interpretation.

All provisions of the insured benefits are contained in the policies issued by the various insurance companies. Since the policies contain complete details, the final interpretation of any specific provision is governed by them.

When you become insured you will receive an identification card or certificate summarizing the provisions of the group policy that principally affect you.

The Funds' Trustees have the power to interpret and apply the terms of this Summary Plan Description Booklet and also the Plan of Benefits and also the Fund's Trust Agreement.

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