AMENDMENT TO THE PLAN AND PLAN TERMINATION

THE PROVISIONS OF THIS PLAN MAY BE AMENDED FROM TIME TO TIME BY A MAJORITY VOTE OF THE TRUSTEES. AMENDMENTS MAY INCLUDE INCREASES, MODIFICATIONS, REDUCTIONS, OR ELIMINATION OF CERTAIN BENEFITS. COPIES OF ALL AMENDMENTS ARE INCLUDED IN THE RECORDS AND MINUTES OF THE TRUSTEES' MEETINGS.

THIS PLAN MAY BE TERMINATED UNDER CIRCUMSTANCES SPECIFIED IN THE PLAN DOCUMENT. IN THE EVENT OF PLAN TERMINATION, ALL BENEFITS WILL TERMINATE.

IF YOU HAVE ANY QUESTIONS REGARDING PLAN COVERAGE OR BENEFITS, CALL THE FUND OFFICE AT THE NUMBER BELOW OR HAVE YOUR SERVICE PROVIDER CALL IN ADVANCE OF SERVICE.

PLEASE READ THIS SUMMARY CAREFULLY SO THAT YOU WILL BE WELL ACQUAINTED WITH ALL OF THE PLAN BENEFITS.

UNION TRUSTEES	MANAGEMENT TRUSTEES
DANNY L. BARTON	DAVID HEYDE
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INDIANA TEAMSTERS HEALTH BENEFITS FUND

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SUMMARY PLAN DESCRIPTION FOR THE INDIANA TEAMSTERS HEALTH BENEFITS FUND RETIREE PLAN

Effective January 1, 2017

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SUMMARY OF BENEFITS

The following Summary of Benefits is designed as a quick reference. For more complete information, consult the rest of this summary.

MEDICAL BENEFITS

Lifetime Maximum Benefit Per Covered Person While Covered by this Plan:

Home Health Care (including Skilled Nursing Facility (SNF) Unit)	$50,000
Hospice Care	$5,000
TMJ	$1,000

Annual (Calendar Year) Maximum Benefit Per Covered Person:

Medical	$100,000
Chiropractic	$800
Preventive Care	
Adult Annual Physical	$100
Mammogram	$150
Pap	$40
Acute, Sub-Acute, and Long Term Acute Rehabilitation (including SNF Unit)	Lesser of 14 days or $10,000
Pain Management - 6 Preauthorized procedures per year (inclusive of all charges, facility, provider, medication)	$300 per Procedure Date
Prescription Drugs (see Prescription Drug Program below)	$10,000

Co-insurance:

The Plan pays the percentage listed on the following pages for Covered Expenses Incurred by a Covered Person during a calendar year *after the applicable individual or family Deductible has been satisfied*.

Retiree Plan Medical Benefits
January 1, 2017

	IN NETWORK/ITHBF CLINIC	OUT OF NETWORK
	Plan Features	
Deductible (No Deductible for Services Provided in the ITHBF Clinic)		
Covered Person	$200	$400
Co-insurance% (No Co-insurance for Services Provided in the ITHBF Clinic)		
Covered Person	80% of $100,000	70% of $100,000
Maximum Annual Benefit	$100,000	
	Hospital Expenses	
Inpatient Hospital Expense *Must be Preauthorized*	80% after network deductible	$500 co-pay, then 70% Not applied to deductible
Outpatient Hospital Emergency Accident Expense *Must be Preauthorized*	$250 co-pay, then 80% Co-pay not applied to deductible	$500 co-pay, then 60% Co-pay not applied to deductible
Urgent or Immediate Care Center	80% after network deductible	80% after network deductible
Outpatient Hospital Diagnostic x-ray & lab *Must be Preauthorized (except for MRI and CT scan)*	80% after network deductible 100% for lab work at ITHBF Clinic	70% after out of network deductible
All outpatient surgeries or invasive procedures must be Preauthorized, including biopsy, dialysis, colonoscopy, endoscopy, infusion drugs, wound treatment and surgical procedures performed in office. Outpatient dialysis services subject to charge review and repricing procedures		

Psychiatric Expense – Inpatient *Must be Preauthorized*	70% after network deductible	60% after out of network deductible
Substance Abuse Expense – Inpatient *Must be Preauthorized*	70% after network deductible	60% after out of network deductible
Outpatient Cancer Expense *Must be Preauthorized* *Chemotherapy and radiation, as well as biopsy and all outpatient surgical procedures must be Preauthorized*	80% after network deductible	70% after out of network deductible
	Physician Expenses	
Physician Expense	80% after network deductible 100% for services provided in the ITHBF Clinic	70% after out of network deductible
Surgical Expense *Must be Preauthorized*	80% after network deductible	70% after out of network deductible
Cosmetic Surgery *Medically necessary for a personal injury from an accident or trauma, or disfiguring disease.* *Must be Preauthorized*	80% after network deductible	60% after out-of-network deductible
Chiropractic Expense (not subject to Deductible)	70% $50/visit max $800/year max	70% $50/visit max $800/year max
Psychiatric Expense – Out of hospital	70% after network deductible	50% after out of network deductible
Substance Abuse – Out of hospital	70% after network deductible	50% after out of network deductible
TMJ Expense (excluding oral appliances)	80% after network deductible $1,000/lifetime max	70% after out of network deductible $1,000/lifetime max
	Other Expenses	
Home Health Care Expense (including SNF Units) *Must be Preauthorized* *Home IV therapy must be Preauthorized*	80% after network deductible $50,000/lifetime max	60% after out of network deductible $50,000/lifetime max

Preventive Care *annual pap* *annual mammogram* *annual adult physical*	annual pap $40 benefit annual mammogram $150 benefit annual adult physical $100	
Prescription Drug *Specialty medications must be Preauthorized*	0% co-pay ITHBF Clinic/$10 co-pay generic retail/$20 co-pay generic mail order $25 co-pay on brand 30 day supply, only when generic not available. If you choose to purchase brand over generic, $10 co-pay plus difference between brand and generic. $10,000/year max	
Diagnostic Testing *Must be Preauthorized*	80% after network deductible 100% of services provided in the ITHBF Clinic	70% after out of network deductible
Biopsy, colonoscopy, endoscopy, and nuclear scans (such as PET/SPECT) must be Preauthorized		
Durable Medical Equipment *Preauthorized for expenses over $750*	80% after network deductible	70% after out of network deductible
Corrective appliances and prosthesis must be Preauthorized		
Hearing Aids	80% not subject to deductible $700/3-year max	80% not subject to deductible $700/3-year max
Hospice *Must be Preauthorized*	80% after network deductible $5,000/lifetime max	70% after out of network deductible $5,000/lifetime max
Ambulance *Must submit medical records* *Must be Preauthorized*	80% after network deductible	70% after network deductible
Acute, Sub-Acute, and Long Term Acute Rehabilitation (including SNF Units) *Must be Preauthorized*	80% after network deductible Lesser of 14 days or $10,000/year max	70% after out of network deductible Lesser of 14 days or $10,000/year max
Cardiac and pulmonary rehab ***Phase I*** *- Must be Preauthorized* ***Phase II – <u>Not Covered</u>***	80% after network deductible	70% after out of network deductible
Medical/OB/Gyn	80% after network deductible	70% after out of network deductible
Pain Management (including TENS units) *Must be Preauthorized*	80% after network deductible 6 procedures per year/$300 per procedure date (inclusive of all charges, facility, provider, medication)	70% after out of network deductible 6 procedure per year/$300 per procedure date (inclusive of all charges, facility, provider, medication)

Therapy *Physical, occupational, and speech therapy must be Preauthorized*	80% after network deductible	70% after out of network deductible
Single Organ Transplant *Must be Preauthorized*	80% after network deductible $3,250/day for first 45 days; up to $1,950/day for day 46 forward	70% after out of network deductible $3,250/day for first 45 days; up to $1,950/day for day 46 forward
Double Organ Transplant *Must be Preauthorized*	80% after network deductible up to $4,875/day for first 45 days; up to $2,925/day for day 46 forward	70% after out of network deductible up to $4,875/day for first 45 days; up to $2,925/day for day 46 forward
Specified Allogeneic or Autologous Bone Marrow Transplants *Must be Preauthorized*	80% after network deductible $3,250/day for first 45 days; up to $1,950 for day 46 forward	70% after out of network deductible $3,250/day for first 45 days; up to $1,950 for day 46 forward
All Other Allogeneic Bone Marrow or Organ Transplants *Must be Preauthorized*	80% after network deductible $1,625/day for first 45 days; up to $975 for day 46 forward	70% after out of network deductible $1,625/day for first 45 days; up to $975 for day 46 forward
Pre-Transplant Related Expenses *Must be Preauthorized*	80% after network deductible $10,000/year max	70% after out of network deductible $10,000/year max
Bone Marrow Harvesting *Must be Preauthorized*	80% after network deductible $10,000/year max for storage charges incurred for up to 60 days from removal from donor	70% after out of network deductible $10,000/year max for storage charges incurred for up to 60 days from removal from donor
Transplant Related Expenses for Transportation, Lodging and Meals *Must be Preauthorized*	80% after network deductible $200/day max; $10,000/year max; $0.25 mileage	70% after network deductible $200/day max; $10,000/year max; $0.25 mileage
Organ Procurement – Non-Living Donor, Post-Transplant Private Duty Nursing, Post-Transplant Home Health Care, Post-Transplant Rehabilitation, Post-Transplant Skilled Nursing, Post-Transplant Immunosuppressive Drugs *Must be Preauthorized*	80% after network deductible $10,000/year max for each	70% after out of network deductible $10,000/year max for each
Organ Procurement – Living Donor *Must be Preauthorized*	80% after network deductible $25,000/year max	70% after out of network deductible $25,000/year max

Final Medical Opinion for a Human Organ Transplant *Must be Preauthorized*	80% after network deductible $1,000/year max	70% after out of network deductible $1,000/year max

PRESCRIPTION DRUG COVERAGE

Deductible Per Person Per Calendar Year: None

Maximum Benefit Per Calendar Year: $10,000

Mandatory Use of Generic Drugs When Available: Whenever a Generic Drug is available, the Plan will pay no more than the Plan's normal cost of the Generic Drug (excluding the Covered Person's normal $10 co-pay for generic drugs). If the Covered Person chooses to obtain a Brand Name Drug when a Generic Drug is available, the Covered Person must pay the remaining full cost of the Brand Name Drug. This means that you will pay your generic co-pay plus the difference between the cost of the Brand Name Drug and the Generic Drug. This applies to prescription drugs obtained in a pharmacy and those obtained through the mail order option.

ITHBF Clinic Option (the prescriptions provided at the ITHBF Clinic are covered under the Plan at no cost to the Covered Person)

Generic:

Covered Person pays ……..$0 Co-pay per prescription

Limitation:

Limited to common generic prescription drugs at the ITHBF Clinic location and no prescriptions for pain medication.

Pharmacy Option

Generic:

Covered Person pays.....$10 Co-pay per prescription

Brand Name Drug (if no Generic Drug is available):

Covered Person pays.....$25 Co-pay per prescription if drug costs less than $100

.....greater of 20% of cost or $40 Co-pay per prescription if drug costs $100 or more

Limitation: 30 day supply

Mail Order Option

Generic:

Covered Person pays.....$20 Co-pay per prescription

Brand Name Drug (if no Generic Drug is available):

Covered Person pays.....$40 Co-pay per prescription if drug costs less than $100

.....greater of 20% of cost or $40 Co-pay per prescription if drug costs $100 or more

Limitation: 90 day supply

Note: All controlled substances have a quantity limit. Insulin and diabetic supplies and equipment are covered under your Prescription Drug Benefit, including syringes, needles, insulin, test strips and blood sugar measurement devices. Ostomy supplies and oral medications for cancer are covered under the medical portion of the Plan. Co-payments for prescription drugs do not accumulate to your annual Deductible. Off-label use of a prescription drug will not be covered except as expressly provided under the Prescription Drug Benefit described in detail later in this summary.

Contact your pharmacy benefit manager for information regarding Step Therapy, quantity limit and reimbursement of medications. All specialty medications require a Preauthorization. Zero benefits are payable if you fail to obtain Preauthorization.

Pharmacy Benefit Manager Customer Care Center: 1-888-354-0090

Refer to Prescription Drugs under Medical Benefits Coverage for complete details.

PREMIUM SCHEDULE

Post-2007 Retirees and all other New Retirees. For retirees who retire on or after January 1, 2008, monthly premiums for retiree medical coverage will be based on the retiree's age and monthly pension according to the schedule to be established by the Trustees for each calendar year. For example, the premium schedule for 2014 remains unchanged as follows:

If your age is:	If your monthly pension* is:		
	$0 - $2,100	$2,101 - $2,600	Over $2,600
	Your monthly health benefit premium** for 2014 will be:		
57 -58	$100/month	$150/month	$200/month
59-60	$75/month	$125/month	$175/month
61	$50/month	$100/month	$150/month
62 and over	None	None	None

**Your monthly pension is pension income from all sources including the Central States Pension Fund, the Indiana Teamsters Pension Fund, and any other monthly pension income. You will be required to provide the Trustees with a copy of your W-2, 1099s, and any other information they request. This does not include any Social Security disability payments.*
Premiums listed are the same whether the coverage is retiree-only or retiree + spouse. There are no other dependents allowed on the retiree coverage. These monthly rates will remain in effect through the month of the retiree's 62nd birthday.* ***The Trustees will review these rates each year and advise all retirees of any changes in rates at least 30 days in advance of the change.

Retirees and Spouse Who is Under Age 62. For retirees who retire and the spouse is under age 62 the following premium schedule applies:

If your age is:	If your monthly pension is:		
	$0 - $2,100	$2,101 - $2,600	Over $2,600
	Your monthly health benefit premium will be:		
Under 62	$50/month	$75/month	$100/month
62 and over	None	None	None

Grandfathered Retirees and Special Retirees. For individuals who were retired as of December 31, 2007, the monthly premiums for retiree medical coverage are based on the retiree's age and monthly pension, according to the schedule to be set by the Trustees for each calendar year. Also, for certain retirees who retire on or after January 1, 2008 and who satisfy the special eligibility rules set forth in Article IV, Section 3 of this summary, the monthly premiums for 2008 for retiree medical coverage will be the same as if the retiree had retired before January 1, 2008. For example, the premium schedule established in 2008 for then current Retirees ("Grandfathered Retirees") and Special Retirees was as follows:

If your age is:	If your monthly pension* is:		
	$1,600 - $2,100	$2,101 - $2,600	Over $2,600
	Your monthly health benefit premium** for 2014 will be:		
Under 62	$50/month	$75/month	$100/month
62 and over	None	None	None

**Your monthly pension is pension income from all sources including the Central States Teamsters Pension Fund, the Indiana Teamsters Pension Fund, and all pension income from any other source. You will be required to provide the Trustees with a copy of your W-2, 1099s, and any other information they request. This does not include any Social Security disability payments.*

Premiums listed are the same whether the coverage is retiree-only or retiree + spouse. There are no other dependents allowed on the retiree coverage. These monthly rates will remain in effect through the month of your 62nd birthday.* ***The Trustees will review these rates annually and advise retirees of any changes in rates at least 30 days in advance of the change.

These schedules are subject to change. The Trustees will advise you of any changes to the premium schedule that apply to you.

INTRODUCTION

The following is a summary explaining the Indiana Teamsters Health Benefits Fund Retiree Plan (the "Plan" or "Retiree Plan") offered by the Indiana Teamsters Health Benefits Fund ("Fund"), formerly known as the Local 135 Health Benefits Fund, for the benefit of its eligible retired members. This summary is presented in nontechnical terms and explains in general terms the benefits available under the Plan. This summary does not cover all fact situations, nor does it address all Plan provisions which are set forth in the underlying insurance policies or benefit plans.

This description is merely informative and does not create any legal rights. The actual underlying insurance policies and benefit plans are the only documents that create any rights which you, your beneficiaries, or Spouse may have under the Plan. As explained below, only the Trustees are authorized to make changes, determinations or interpretations of the Plan. Any differences between this summary and any attachments and a benefit plan document, or insurance policy, will be decided in favor of the insurance policies, programs and benefit plans. This summary and the attachments do not create any right to employment.

You may review or obtain copies of the actual benefit plans and the insurance policies by written request to the Fund, 1233 Shelby Street, Indianapolis, Indiana 46203. You are also welcome to examine copies of these documents which are kept at the Fund. If you have any questions or need additional information about the Plan, please contact the Fund.

Effective January 1, 2014, this Retiree Plan is a stand-alone, retiree only employee health benefit plan that is not subject to the Patient Protection and Affordable Care Act (the "Affordable Care Act"). Prior to 2014, the Retiree Plan was part of the Indiana Teamsters Health Benefits Plan, a "grandfathered health plan" under the Affordable Care Act. At all times, the benefits provided through the Retiree Plan have been funded through the Indiana Teamsters Health Benefits Fund, and its predecessor trust funds ("Fund"). The Trust Agreement for the Fund is a plan document that is part of this Plan. Questions regarding which legal protections apply under this Plan can be directed to the Plan Administrator at the Fund Office, 1233 Shelby Street, Indianapolis, Indiana 46203. You may also contact the Employee Benefits Security Administration at U.S. Department of Labor, 1-866-444-3272 or www.dol.gov/ebsa/healthcarereform.com.

SCHEDULE OF MEDICAL BENEFITS

Section 1. General Information

(a) Eligible Class of Retirees: Those Eligible Retirees who meet the eligibility requirements under the Plan, set forth in Article III.

(b) Deductibles: Only Preferred Provider charges will be applied to the Preferred Provider Deductible and only Non-preferred Provider charges will be applied to the Non-preferred Provider Deductible.

The individual Deductible is the dollar amount of Covered Expenses which each Covered Person must have Incurred during each calendar year before the Plan pays applicable benefits. The individual Deductible amount is shown on the Schedule of Benefits.

(c) Co-insurance: The Plan pays a specified percentage of Covered Expenses at the Reasonable and Customary Charge for Non-preferred Providers, or the percentage of the Negotiated Rate for Preferred Providers. That percentage is specified on the Schedule of Benefits. The Covered Person pays the balance, or the "Co-insurance" amount. For Non-preferred Providers, the Covered Person is responsible for the difference between the percentage the Plan paid and 100% of the billed amount.

(d) Maximum Benefit: The Schedule of Benefits contains an Annual Medical Maximum Benefit of $100,000 per Covered Person per calendar year, as well as separate Annual and Lifetime Maximum Benefit limitations for specified conditions. Any separate Maximum Benefit will include all such benefits paid by the Plan for the Covered Person during any and all periods of coverage under this Plan, whether services are provided by a Preferred Provider or a Non-preferred Provider. All separate Maximum Benefits are part of, and not in addition to, the Annual Medical Maximum Benefit. No more than the Maximum Benefit will be paid for any Covered Person while covered by this Plan.

Section 2. Medical Benefits Coverage

Upon proof satisfactory to the Plan Administrator that a Covered Person has Incurred eligible medical expenses for Medically Necessary services and/or supplies as set forth below, the Plan will pay the Reasonable and Customary Charges or Negotiated Rate for the treatment of an Illness or Injury after the Covered Person satisfies the applicable Deductible and Co-payment or Co-insurance and any other limitations set forth in the Plan and below.

(a) Preferred Provider or Non-preferred Provider: Covered Persons have the choice of using either a Preferred Provider or a Non-preferred Provider.

(1) Preferred Providers. A Preferred Provider is a Physician, Hospital or ancillary service provider which has an agreement in effect with the Preferred Provider Organization (PPO) to accept a reduced rate for services rendered to Covered Persons (the "Negotiated Rate") and who is listed as a participating provider by the PPO on the date the charge is Incurred. The Preferred Provider may not bill the Covered Person for any amount for a covered service or supply in excess of the Negotiated Rate. Covered Persons should

contact the Fund to determine whether a provider is participating. Participants can view a list of participating providers by visiting the Fund's web site at www.ITHBF.com.

(2) Non-Preferred Providers. A Non-preferred Provider is a Physician, Hospital or ancillary service provider that is not listed as a participating provider by the PPO at the time the charge is Incurred. The Plan will allow only the Reasonable and Customary Charge as a Covered Expense, typically at a reduced rate compared to what would be paid to an in-network provider. The Plan will pay the percentage of the Reasonable and Customary Charge shown in the Summary of Benefits for the services, supplies and treatment provided by the Non-preferred Provider (or such other lesser amount agreed to by the parties). The Covered Person is responsible for the remaining balance. This typically results in greater out-of-pocket expenses to the Covered Person.

(3) Referrals. Referrals to a Non-preferred Provider are covered as Non-preferred Provider services, supplies and treatments. It is the responsibility of the Covered Person to assure services to be rendered are performed by Preferred Providers in order to receive the Preferred Provider level of benefits.

(4) Exceptions. The following listing of exceptions represents services, supplies or treatments rendered by a Non-preferred Provider where Covered Expenses will be payable at the Preferred Provider level of benefits:

(A) Emergency treatment rendered at a Non-preferred facility. If the Covered Person is admitted to the Hospital on an Emergency basis, Covered Expenses will be payable at the Preferred Provider level.

(B) Non-preferred anesthesiologist if the operating surgeon is a Preferred Provider.

(C) Services provided by a radiologist, pathologist or technician for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a Non-preferred Provider when the facility rendering such services is a Preferred Provider.

(D) Diagnostic laboratory and surgical pathology tests referred to a Non-preferred Provider by a Preferred Provider.

(E) While the Covered Person is confined to a Preferred Provider Hospital, the Preferred Provider Physician requests a consultation from a Non-preferred Provider.

(F) Any Medically Necessary services, supplies and treatments not available through a Preferred Provider.

(G) Spouse residing outside the Preferred Provider Organization's service area, Covered Expenses will be payable at the Preferred Provider level of benefits.

(H) Covered Persons who do not have access to Preferred Providers within 35 miles of their place of residence, or for Emergency treatment rendered while traveling out-of-area.

(b) Eligible Medical Expenses: The following Medically Necessary expenses will be covered under the Plan:

(1) Acute, Sub-Acute, and Long Term Acute Rehabilitation. Acute, Sub-Acute, and Long Term Acute Rehabilitation Programs, including but not limited to programs designed to treat a variety of injuries which require extensive rehabilitation, are covered if the Covered Person is transferred directly from an acute care facility to an acute, sub-acute, long term acute care facility, or a skilled nursing facility unit. This benefit must be Preauthorized, subject to the limit in the Summary of Benefits.

(2) Ambulance Services. The Plan covers ambulance services by professional air or ground ambulance, subject to the restriction in the Summary of Benefits. Air ambulance service for organ/tissue transplants must be Preauthorized. Medical records are required to process claims.

Covered Expenses will include:

(A) Ambulance services for air or ground transportation for the Covered Person when Medically Necessary due to an Emergency from the place of Injury or Emergency condition to the nearest network or Preauthorized out of network Hospital where treatment can be given.

(B) Ambulance service is covered in a non-Emergency situation only to transport the Covered Person to or from a Hospital or between Hospitals for required treatment. Such transportation is covered only from the initial Hospital to the nearest Hospital qualified to render the special treatment.

(3) Chiropractic Care. Covered Expenses include initial consultation, x-rays and treatment, subject to the limits in the Summary of Benefits.

(4) Cosmetic Surgery. Cosmetic surgery or reconstructive surgery will be a Covered Expense, provided a Covered Person receives an Injury as a result of an Accident or trauma or disfiguring disease and as a result requires surgery. Cosmetic or reconstructive surgery and treatment must be for the purpose of restoring the Covered Person to his normal function immediately prior to the Accident. All cosmetic surgery must be Preauthorized.

(5) Dental Services. Covered Expenses will include repair of sound natural teeth or surrounding tissue provided it is the result of an Injury. Except as provided below, expenses that are not a result of an Injury are excluded from medical coverage. Treatment must begin within 6 months of the date of such Injury. Damage to the teeth as a result of chewing or biting will not be considered an Injury under this benefit. The following will also be considered Covered Expenses:

(A) The extraction of 6 or more teeth requiring confinement in a Hospital and for charges for the Medically Necessary procedures associated with the extractions.

(B) The removal of malignant tumors within the oral cavity.

Dental surgeries must be Preauthorized.

(6) Diagnostic Services and Supplies. Covered Expenses will include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray. Diagnostic services involving invasive procedures must be Preauthorized. Only 1 sleep study per lifetime is covered. Covered Expenses Incurred at the ITHBF Clinic include services for simple lab work related to routine physical examinations and CDL.

(7) Dialysis Services – In-Network. Dialysis services will be covered the same as other inpatient or outpatient medical services, as applicable, and claims will be subject to repricing in accordance with all applicable network agreements.

(8) Dialysis Services – Out-of-Network. Due to (1) the concentration of dialysis providers in many markets which may allow such providers to exercise control over prices for dialysis-related products and services, (2) the potential for discrimination by dialysis providers against non-governmental and non-commercial health plans which may lead to increased prices for dialysis-related products and services charged to members of such plans, (3) evidence of significant inflation of the prices charged to members of non-governmental and non-commercial health plans by dialysis providers, of the use of revenues from claims paid on behalf of members of such plans to subsidize reduced prices to other types of payer as incentives, and of the specific targeting of non-governmental and non-commercial plans as profit centers, and (4) the fiduciary obligation to preserve plan assets against charges which exceed reasonable value due to factors not beneficial to members, such as market concentration and discrimination in charges, and are used for purposes contrary to members' interests, such as subsidies for other plans and discriminatory profit-taking, the Trustees have adopted the following program for charge review and payment limitation for outpatient dialysis claims:

(A) The program will apply to all claims for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis.

(B) The program will apply to all such claims received on or after the effective date of the adoption of this provision, regardless of when the first claim for such products or services was received with respect to the member.

(C) All such claims will be subject to cost review to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator will consider factors including:

(1) Market concentration: The Plan Administrator will consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control will be counted as a single provider.

(2) Discrimination in charges: The Plan Administrator will consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(D) In the event that charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factor or factors increasing the charges for outpatient dialysis products and/or services for the claims under review, the Plan Administrator may, in the Plan Administrator's discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination the Plan Administrator may subject the claims, and all future claims for outpatient dialysis goods and services from the same provider with respect to the member, to the following payment limitations, under the following conditions:

(1) Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the member, claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

(2) Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to Covered Persons, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider will be subject to the limitations of this section.

(3) The maximum benefit payable to claims subject to the payment limitation will be the Reasonable and Customary Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

(4) The Plan Administrator will determine the Reasonable and Customary Charge based upon the average payment actually

made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

(5) The Covered Person, or where the right to benefits has been properly assigned the provider, may provide information with respect to the reasonable value of the supplies and/or services for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator will increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

(6) All charges must be billed in accordance with generally accepted industry standards.

(E) Where appropriate, and a willing appropriate provider acceptable to the Covered Person is available, the Plan Administrator may enter into an agreement or agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this provision and clearly state that it is intended to supersede it.

(F) The Plan Administrator will have full authority and discretion to interpret, administer and apply this provision, to the greatest extent permitted by law.

(9) Durable Medical Equipment. Rental or purchase, whichever is less costly, of Medically Necessary durable medical equipment which is prescribed by a Physician and meets the requirement of established criteria/guidelines and is required for therapeutic use by the Covered Person will be a Covered Expense. The cost of renting or purchasing the equipment will be based on Reasonable and Customary Charges. Repair or replacement of purchased durable medical equipment which is Medically Necessary due to normal use or physiological change in the patient's condition will be considered a Covered Expense. Durable medical equipment must be Preauthorized if the Covered Expense is over $750.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the Covered Person's condition, or where there exists a

reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the Covered Person's medical needs. Equipment and supplies used to treat diabetes are not considered durable medical equipment and are covered under the Prescription Drug Benefit.

(10) Hearing Aids. Covered Expenses include 1 hearing aid per ear every 3 years, subject to the limits shown in the Summary of Benefits. Batteries, repairs, warranties, and replacements of hearing aids are not covered. Hearing aid dispensing fees are not covered.

(11) Home Health Care. Covered Persons who are home bound by a Physician's order are eligible to receive Home Health Care benefits for physical therapy, occupational therapy, speech therapy, skilled nursing care, and the services of a masters level social worker or nutritionist, which must be Preauthorized. Covered Expenses include the following, subject to the limits in the Summary of Benefits:

(A) Charges Incurred for the services and supplies furnished by a Home Health Care Agency under a Home Health Care Plan and furnished in the Covered Person's home for care and treatment of a Covered Person's Illness or Injury are covered, subject to the limits shown in the Summary of Benefits.

(B) Covered services include:

(1) Services of certified advanced registered nurse-practitioner or Registered Nurse employed by or functioning pursuant to a contractual arrangement with a Home Health Care Agency;

(2) Services of a Licensed Practical Nurse employed by or functioning pursuant to a contractual arrangement with a Home Health Care Agency;

(3) Services of a licensed occupational therapist, licensed physical therapist, licensed speech therapist, or licensed respiratory therapist, all of whom are employed by or functioning pursuant to a contractual arrangement with a Home Health Care Agency;

(4) Durable medical equipment;

(5) Laboratory services;

(6) I.V. medications and medical supplies.

(C) The following services are not covered:

(1) All home health services not specifically listed as covered services;

(2) Services for which the individual is not, in the absence of this coverage, legally required to pay;

(3) Services performed by the Covered Person's immediate family or any person residing with the Covered Person;

(4) Services rendered by home health aides or sitters whether they are employed by a Home Health Care Agency or not;

(5) General housekeeping services;

(6) Services for Custodial Care.

(12) Hospice Care. Hospice care must be Preauthorized. Covered hospice care expenses include those Incurred in a health care program providing a coordinated set of services rendered at home, or as an Inpatient admission, or in a facility setting for a Covered Person suffering from a condition that has a terminal prognosis. Hospice benefits will be covered, based on Medicare guidelines and subject to the limit shown in the Summary of Benefits, but only if the Covered Person's attending Physician certifies that:

(A) The Covered Person is terminally ill;

(B) The Covered Person has a life expectancy of 6 months or less;

(C) The agency is Medicare certified as a hospice agency;

(D) There is a primary caregiver at home at all times if hospice care is provided in the home; and

(E) The Covered Person is not receiving any treatment, invasive or non-invasive, while in hospice.

Covered Expenses will include:

(A) Inpatient confinement in an approved hospice to include ancillary charges and Room and Board Charges;

(B) Services, supplies, medications, and treatment provided by a Hospice to a Covered Person in a home setting;

(C) Physician services, nursing care by a Registered Nurse or Licensed Practical Nurse, and/or care provided by a licensed social worker, nurse's aide, sitter, chaplain or registered dietician;

(D) Physical therapy, occupational therapy, speech therapy, cardiac therapy or respiratory therapy;

(E) Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements;

(F) Durable medical equipment used while in hospice care;

(G) Counseling services provided through the hospice;

(H) Bereavement counseling as a supportive service to Covered Persons in the terminally ill Covered Person's immediate family.

(13) Hospital/Surgery Center/Ambulatory Care Facilities. Inpatient and Outpatient Hospital admissions (23 hours or greater), and surgical procedures must be Preauthorized. Emergency Room services require medical records to process claims. Covered Expenses will include:

(A) Room and Board Charges for treatment in a Hospital, including intensive care units, cardiac care units and similar Medically Necessary accommodations. Covered Expenses for Room and Board will be limited to the Hospital's Semi-private Rate. Covered Expenses for intensive care or cardiac care units will be the Reasonable and Customary Charge for Non-preferred Providers and the Negotiated Rate for Preferred Providers. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the Covered Person. If the Hospital has only private rooms, Covered Expenses will include the Hospital's most frequent private room rate.

(B) Miscellaneous Hospital services, supplies, and treatments including, but not limited to:

(1) Admission fees, and other fees assessed by the Hospital for rendering services, supplies and treatments;

(2) Use of operating, treatment or delivery rooms;

(3) Anesthesia, anesthesia supplies and its administration by an employee of the Hospital;

(4) Medical and surgical dressings and supplies, casts and splints;

(5) Blood transfusions, including the cost of blood and blood byproducts;

(6) Drugs and medicines (except drugs not used or consumed in the Hospital);

(7) X-ray and diagnostic laboratory procedures and services;

(8) Oxygen and other gas therapy and the administration thereof;

(9) Respiratory/inhalation therapy, speech therapy (other than for congenital anomalies or learning disabilities) and physical therapy;

(10) Neuropsychological testing;

(11) Pathological and laboratory services;

(12) Radiology, ultrasound and nuclear medicine;

(13) EKG, EEG, and electronic diagnostic medical tests;

(14) Cardiac diagnostic studies.

(C) Services, supplies and treatments described above furnished by a Surgery Center, including follow-up care provided within 72 hours of a procedure.

(D) Expenses Incurred at a Skilled Nursing Facility are covered, up to 14 days, if such Covered Expenses are Medically Necessary immediately following an Inpatient hospitalization.

(14) Mastectomy (Women's Health and Cancer Rights Act of 1998). Covered mastectomy benefits are provided as required by the federal law known as the Women's Health and Cancer Rights Act of 1998.

(A) Covered Expenses will include eligible charges related to a Medically Necessary mastectomy.

(B) For a Covered Person who elects breast reconstruction in connection with such mastectomy, Covered Expenses will include:

(1) reconstruction of the surgically removed breast; and

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance.

(C) An external breast prosthesis will be covered once every 3 calendar years, unless recommended more frequently by a Physician. The first permanent internal breast prosthesis necessary because of a mastectomy will also be a Covered Expense.

(D) 2 mastectomy bras per Calendar Year, or as Medically Necessary.

(E) Physical complications from all stages of mastectomy, including lymphedemas will also be considered Covered Expenses following all Medically Necessary mastectomies.

(F) The Plan will not (i) deny any Covered Person eligibility or continued eligibility to enroll or to renew coverage under the terms

of the Plan solely for the purpose of avoiding the coverage provided under this section, or (ii) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce the provider to provide care to a Covered Person in a manner inconsistent with the coverage provided in this section.

(15) Medical Supplies. Any medical supplies must be deemed Medically Necessary by the Fund and be Preauthorized. Supplies used to treat diabetes are covered under the Prescription Drug Benefit.

(16) Outpatient Cancer Treatments. The Plan will pay Covered Expenses Incurred in association with services to a Covered Person for the treatment of cancer on an Outpatient basis. These benefits must be Preauthorized.

(17) Outpatient Pain Management. The Plan will pay Covered Expenses Incurred by the Covered Person for the Outpatient treatment of pain, subject to the limits in the Summary of Benefits. These benefits must be Preauthorized.

(18) Physician Services. Covered Expenses will include:

(A) Medical treatment, services and supplies including, but not limited to, office visits and Inpatient visits.

(B) Surgical treatment. Separate payment will not be made for Inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

For related operations or procedures performed through the same incision or in the same operative field, Covered Expenses will include the surgical allowance (Reasonable and Customary Charge or Negotiated Rate), payable at 100% for the primary procedure, plus 50% of the surgical allowance (Reasonable and Customary Charge or Negotiated Rate) for the secondary procedure, 25% for the tertiary procedure, and 10% for any additional procedure. However, no additional payment will be made for an incidental procedure performed through the same incision.

When 2 or more unrelated operations or procedures are performed at the same operative session, Covered Expenses will include the surgical allowance (Reasonable and Customary Charge or Negotiated Rate) for each procedure.

(C) Surgical assistance provided by a Physician if it is determined that the condition of the Covered Person or the type of surgical procedure requires such assistance.

(D) Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

(E) Consultations requested by the attending Physician during a Hospital confinement. Consultations do not include staff consultations which are required by a Hospital's rules and regulations.

(F) Services performed by a radiologist, pathologist or technician for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

(G) Services performed by a radiologist, pathologist or technician for diagnosis or treatment, including radiation therapy and chemotherapy.

(H) Allergy testing and serum.

(19) Pregnancy. Covered Expenses for pregnancy or complications of pregnancy will be provided for a Covered Retiree or Spouse.

The Plan will cover services, supplies and treatments for Medically Necessary abortions when the life of the mother would be endangered by continuation of the pregnancy, or when the fetus has a known condition incompatible with life, as determined by the Plan Administrator or its designee. Complications from an abortion will be a Covered Expense whether or not the abortion is a Covered Expense.

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

(20) Prescription Drugs. The Plan will cover prescription drugs and supplies as specified in the Summary of Benefits. Such drugs and supplies must be approved for general use by the Food and Drug Administration that are and must be dispensed by a licensed pharmacist, Physician or Dentist. The Plan will cover "off label" prescription drugs only when (i) all other labeled treatment options have been exhausted, (ii) the off-label use is determined to be Medically Necessary and is ordered by an Oncologist to meet the standard of care, (iii) the prescription is peer reviewed by a Case Management Oncologist, and (iv) coverage for the drug is preauthorized. Any 1 prescription is limited to a 30 day supply for the pharmacy option and a 90 day supply for the mail order option. Use of some formulary or any non-formulary drug or injectables will require prior authorization. You or your pharmacy may obtain a list of the Plan's formulary by contacting the Fund's office or from www.ITHBF.com. In general, under the mail order program, you will be mailed a 90-day supply of your prescription every 3 months.

(A) Excluded Expenses - The Plan will not pay charges for the following non-covered expenses: (1) hypodermic needles (except for diabetic

use); (2) support garments; (3) contraceptives other than oral contraceptives; (4) immunizing agents, injectable, blood or blood plasma, or medication prescribed for parental administration, except insulin; (5) smoking cessation programs (even if prescribed by a Physician); (6) lifestyle drugs, such as Rogaine, Viagra, Cialis, Levitra and similar medications; or (7) off-label use of a prescription drug, except as provided above.

The Plan reserves the right to require the Covered Person and/or the Covered Person's pharmacist to complete any necessary or required forms prior to payment of Covered Expenses.

(21) Preventive Care. The Plan will cover the preventive services listed below.

(A) Pap Test – 1 pap test a year for all female participants age 18 or older is covered. The office visit associated with this procedure will be subject to payment as a Physician's visit.

(B) Mammogram – Mammogram screening is covered on the following schedule as recommended by the American Medical Association:

(1) Before age 40 – 1 every 5 years;

(2) Age 40-49 – 1 every 2 years;

(3) Age 50 and over – 1 every year.

(C) Adult Annual Physical. Physician's charges for 1 general physical per calendar year are covered. Related tests are not covered unless listed in this section.

(D) Colonoscopy. Colonoscopy screening is covered once every 3 years starting at age 50. This benefit must be Preauthorized if conducted in connection with an upper GI endoscopy.

(22) Prostheses. The initial purchase, fitting, needed adjustment, repair and replacement of a prosthesis (other than dental) provided for functional or therapeutic reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ will be a Covered Expense. This benefit must be Preauthorized. A prosthesis ordered prior to the Covered Person's effective date of coverage is not covered, even if delivered after the effective date of coverage. Hydraulic and microcompression components are not covered. Repair or replacement of a prosthesis which is Medically Necessary due to normal use or physiological change in the patient's condition will be considered a Covered Expense. Additional coverage includes but is not limited to the initial pair of contact lenses or glasses (lenses and frames) following cataract surgery.

(23) Psychiatric Conditions/Substance Abuse. Inpatient benefits must be Preauthorized. The Plan covers the following Covered Expenses Incurred for Psychiatric

Conditions and Substance Abuse; provided such Covered Expenses are Incurred through services provided by a Physician, Psychologist, or Psychiatrist.

(A) Inpatient or Partial Confinement. The Plan will pay Covered Expenses, as shown in the Summary of Benefits, for confinement in a Hospital, Psychiatric Treatment Facility, or Alcohol or Drug Abuse Treatment Center, but excluding in a halfway house, for treatment, services and supplies related to the treatment of Psychiatric Conditions and for Substance Abuse. Covered Expenses will include:

(1) Inpatient detoxification and confinement in an accredited unit, but not to exceed 3 days;

(2) Individual psychotherapy;

(3) Group psychotherapy and family counseling; or

(4) Psychological testing (inpatient only).

(B) Outpatient. The Plan will pay Covered Expenses, as shown in the Summary of Benefits, for Outpatient treatment, services and supplies related to the treatment of Psychiatric Conditions and Substance Abuse.

(24) Radiation Therapy, Chemotherapy, and Oral Medications for Cancer. Covered Expenses will include radiation therapy, chemotherapy, and oral medications for cancer. These services must be Preauthorized.

(25) Special Equipment and Supplies. Covered Expenses will include Medically Necessary special equipment and supplies when indicated by established medical guidelines and criteria including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; allergy serums; crutches; electronic pacemakers; gaseous oxygen systems and the administration thereof; surgical dressings and other medical supplies ordered by a professional provider in connection with medical treatment, but not common first aid supplies.

(26) Sterilization. Covered Expenses will include elective sterilization procedures for the Covered Retiree or Covered Spouse. Reversal of sterilization is not a Covered Expense.

(27) Surcharges. Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a professional provider, Physician, Hospital, facility or any other health care provider will be a Covered Expense under the terms of the Plan.

(28) Surgical Expenses. These benefits must be Preauthorized. Covered Expenses will include charges for any operation a Covered Person is required to undergo as

a result of Accidental bodily Injury or Illness, provided that such operation must be performed by a legally qualified Physician or surgeon while coverage is in force as to such person. Covered Expenses include charges Incurred for cutting, suturing, correction of a fracture, reduction of dislocation, electrocauterization, tapping (paracentesis), administration of artificial pneumothorax, removal of stone or foreign body by endoscopic means or injection of sclerosing solution. The usual pre- and post-operative care is included. The Plan will pay for charges Incurred for multiple procedures where Medically Necessary as described in Section 2(18)(B), above.

(29) Therapy Services. Therapy services must be ordered by a Physician to aid restoration of normal function lost due to Illness or Injury. These benefits must be Preauthorized. Covered Expenses will include:

(A) Services performed by a professional provider for physical therapy or occupational therapy.

(B) Services performed by a professional provider for speech therapy, but only for the purpose of restoring speech ability or improving a condition resulting from Illness or Injury, and only if the therapy is expected to result in significant improvement of specific defects.

(C) Dialysis therapy or treatment.

(D) Respiratory/inhalation therapy.

(E) Occupational therapy.

(F) Phase I cardiac and pulmonary rehab only.

(G) Infusion therapy as ordered by a licensed Physician of specialty based on medical criteria and guidelines.

(30) TMJ. The Plan will cover the diagnosis and treatment of Temporomandibular Joint Disorders (TMJ), including office visits, tests, injections, therapy and surgery, subject to the limits in the Summary of Benefits, but only if the condition is diagnosed by an oral surgeon, an ENT or a neurologist. Oral appliances are not covered.

(31) Transcutaneous electrical nerve stimulation ("TENS") Units. TENS Units are covered, as pain management benefits, provided the administration of the unit is under the supervision of a pain management provider. Preauthorization is required.

(32) Transgender Services. Gender reassignment surgery and treatment, including but not limited to hormone therapy, surgery to change primary and/or secondary sex characteristics, and psychotherapy for purposes of exploring gender identity, provided such services are Medically Necessary (with no discrimination based on gender or gender identify) and subject to the Plan Administrator's or its designee's medical policy on transgender services.

(33) Transplant Expenses. This Plan provides benefits for single organ transplants (heart, liver, lung, pancreas, kidney, cornea), double organ transplants

(heart/lung, double lung, kidney/pancreas), allogeneic bone marrow transplants, and autologous bone marrow transplants, subject to the limits in the Summary of Benefits and subject to the requirements of any individualized case management arrangement. A maximum of 2 transplants (single and/or double) will be covered per lifetime. These benefits must be Preauthorized and Case Management is required. In addition, the Fund reserves the right to enter into a case rate agreement with the Provider and/or facility. All Preauthorized transplant services will be covered at the Preferred Provider rate, regardless of provider.

(A) Organ and Tissue Transplant Eligible Charges – Covered Expenses include services and supplies provided for an organ or tissue transplant, including Hospital, surgical, diagnostic, X-ray, Home Health Care, and other expenses incurred for the recipient of the transplant as provided for in this list of Eligible Medical Expenses, subject to the limitations set forth in the Schedule of Benefits. Expenses must be incurred at a facility approved by the Fund to be covered. The Plan will provide coverage for organ procurement, bone marrow harvesting, transportation, meals, & lodging, as set forth below and on the Schedule of Benefits.

(B) Donor Expenses – When the organ or tissue transplant requires the surgical removal of the donated organ or tissue from a living donor who is not a Covered Person, the services and supplies furnished to the donor will be covered as set forth on the Schedule of Benefits.

(C) Organ Procurement Expenses – As set forth in the Schedule of Benefits, the Plan will cover charges for services and supplies incurred for organ procurement from a non-living donor, including removal, preservation, and transportation of such organ, or for a living donor, including screening of potential donors, transporting the chosen donor to and from the transplant center, medical expenses associated with removal of the donated organ and the associated medical services rendered to the donor.

(D) Bone Marrow Harvesting Expenses – As set forth in the Schedule of Benefits, the Plan will pay charges incurred for services and supplies incurred for bone marrow harvesting.

(E) Transportation, Meals, & Lodging Expenses – If the transplant Hospital is at least 100 miles from the Covered Person's primary residence, the Plan will reimburse up to an Annual Maximum of $10,000 for transportation of the recipient to and from the transplant center, and transportation, lodging, and meals for 1 companion who accompanies the recipient to the transplant center, or 2 companions in the case of a minor recipient, as follows: a) lodging and meals $200 per day, and b) personal and rental auto mileage $0.25 per mile. Claimants must submit original receipts containing the date of service, place of service, itemized purchases and the billed amount.

Section 3. General Exclusions

The Plan does not cover certain charges under any circumstances, including but not limited to charges for the following services and supplies:

(1) Services or supplies (a) furnished by or for the U.S. Government, or by or for any other government unless payment is legally required, or (b) to the extent provided under any governmental program or law under which the individual is or could be covered, including Medicare.

(2) Expenses incurred during confinement in a Hospital owned and operated by the United States Government or any agency thereof or for service, treatments and supplies furnished by or at the direction of the United States Government or any agency thereof, except for Reasonable and Customary Charges for services and supplies which are billed, pursuant to federal law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are covered herein and which are not Incurred during or from service in the Armed Forces of the United States.

(3) Services and supplies in a Hospital owned or operated by any government outside the United States in which the Covered Person is entitled to receive benefits, except for Reasonable and Customary Charges for services and supplies which are billed, pursuant to federal law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are covered herein and which are not Incurred during or from service in the Armed Forces of the United States.

(4) Expenses Incurred during 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 another, contractual or otherwise.

(5) Examinations to determine the need for (or changes of) eyeglasses or lenses of any type except initial replacements for loss of the natural lens, and for eye surgery such as radial keratotomy or LASIK procedures, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring); contacts, eyeglasses and routine vision care.

(6) Physician's services or x-ray examinations involving 1 or more teeth, surrounding tissue or structure, the alveolar process, or the gums, except as specifically covered. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as malocclusion involving joints or muscles by methods including but not limited to, crowning, wiring, or repositioning teeth.

(7) Treatment of or removal of corns, calluses, or cutting of toenails, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral vascular disease. Orthotics or any other treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions, except as medically necessary for post-operative services or the treatment of a medical condition.

(8) Expenses Incurred for any non-Spouse dependent or for the newborn child of any Dependent.

(9) Expenses Incurred in an Extended Care Facility, assisted living arrangement, home for the aged, convalescent home, halfway house, or nursing home.

(10) Expenses Incurred in a Skilled Nursing Facility unless Medically Necessary immediately following an Inpatient hospitalization, subject to the day limit set forth above.

(11) Expenses incurred in a Hospital for personal or convenience items.

(12) Services furnished by a Physician, Psychiatrist, Psychologist, Dentist, Registered Nurse, Licensed Practical Nurse, speech therapist, occupational therapist, or physiotherapist who is a Close Relative or a resident of the Covered Person's household.

(13) Expenses Incurred that are excluded or limited elsewhere in the Plan or this Schedule of Medical Benefits.

(14) Cosmetic surgery or related Hospital admissions unless Medically Necessary for a personal Injury resulting from an Accident, or trauma, or disfiguring disease.

(15) Any services performed in connection with the enlargement, reduction, or change in appearance of a portion of the body, including, but not limited to, the face, neck, arms, abdomen, buttocks, hips, thighs, breasts, lips, jaws, chin, nose, or ears, except as otherwise provided under the mastectomy benefits in Section 2(b)(14).

(16) Surgical excision or reformation of any sagging skin of or on any part of the body, including but not limited to, the face, neck, abdomen, arms, legs, buttocks, or eyelids, except if recommended by a Physician to correct ptosis.

(17) Any services performed for scar removal or removal of tattoos, lesions, angioma and hemangioma.

(18) Hair transplantation.

(19) Penile implants or prosthesis.

(20) All cosmetic facial treatments, including chemical face peels, dermabrasion/microdermabrasion, removal of skin tags or b-9 moles not causing a functional defect or medical problem, long-term acne maintenance drugs, or any other cosmetic correction or abrasion of the skin, but not including medically necessary treatments or drugs.

(21) Services or supplies, including but not limited to drugs, medicines, or injectable insulin, for or in connection with an Illness or Injury that is an occupational Illness or occupational Injury or arises out of, or in the course of, any occupation or employment for wage or profit.

(22) Services and supplies rendered for any condition, Disability, or expense resulting from Injury or Illness caused by war, declared or undeclared, or any act of war or by participating in civil insurrection or a riot.

(23) Services and supplies rendered while a member of the Armed Forces of any state or country, except as required by the Uniformed Services Employment and Reemployment Rights Act of 1994.

(24) Services, medicines or supplies paid or payable under any group insurance policy, plan, or program to which any employer, on behalf of a Covered Person, contributes or makes payroll deductions; or any group insurance policy, plan, or program which is available through an employer or former employer as a result of sponsorship or membership in any association, union, student body or similar organization; or any benefits which are available under any government program; except as provided under "Coordination With Other Plans and Benefits." This exclusion will apply regardless of whether the person covered under the Plan is covered themselves under such other policy, plan, or program, or is merely the spouse of such person.

(25) Services provided for which payment or reimbursement is received by or for the account of the Covered Person as the result of a legal action or settlement.

(26) Services or supplies that are prohibited by any law of the jurisdiction in which the Covered Person resides at the time the charge is Incurred.

(27) Services for which charges are made which are in excess of the Reasonable and Customary Charges or Negotiated Rate.

(28) Services and supplies provided for Custodial Care or rest cures.

(29) Services and supplies provided by Christian Science practitioners.

(30) Hospital Emergency room services for a non-Emergency Illness or Injury.

(31) Cytotoxic testing and testing/analysis of hair for the diagnosis of an allergic condition.

(32) Premarital lab work, fertility drugs, fertility counseling and testing, actual or attempted impregnation or fertilization which involves either a Covered Person or a surrogate as a donor or recipient, the reversal of sterilization, services for the diagnosis and treatment of a condition of infertility, artificial insemination, embryo implants, in vitro fertilization ("IVF"), or gamete intra-fallopian transfer ("GIFT").

(33) Services and supplies Incurred by an individual prior to the effective date of coverage under the Plan as to such individual.

(34) Services and supplies provided for any supply, drug, device, facility, equipment, procedure, or treatment which is Experimental or not FDA approved, excluding “off label” drugs if (i) all other labeled treatment options have been exhausted, (ii) the off-label use is determined to be Medically Necessary and is ordered by an Oncologist to meet

the standard of care, (iii) the prescription is peer reviewed by a Case Management Oncologist, and (iv) coverage for the drug is preauthorized.

(35) Services and supplies rendered for any condition, Disability, or expense resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an assault or a felonious act.

(36) Services or supplies for education, special education, or job training, whether or not given in a facility that also provides medical or psychiatric treatment.

(37) Phase II cardiac and pulmonary rehabilitation.

(38) Patient education programs.

(39) Telephone consultations, charges for the completion of claim forms or charges for failure to keep scheduled appointments with a Physician, Dentist, or other service provider.

(40) Medical records.

(41) Personal hygiene and convenience items or services, such as air conditioners, humidifiers, hot tubs, whirlpools, swimming pools, physical exercise equipment, clothing, or hair prosthesis, even if such items are prescribed by a Physician.

(42) Hospitalization for environmental change or Physician charges connected with prescribing an environmental change.

(43) Room and Board Charge for days in which the Covered Person is permitted to leave a health care facility (a weekend pass, for example).

(44) Expenses Incurred by the Covered Person once the Covered Person leaves a medical facility, that are incurred against the medical advice of the Physician.

(45) For the treatment of morbid obesity, obesity, or any other type of weight control programs; non-Covered Charges include, but are not limited to: Hospital charges (Inpatient or Outpatient), Physician fees, office visits, diagnostic work-ups, labs, medications, diagnostic procedures, any weight control products, nutritional counseling, and surgery, including but not limited to, gastric bypass and gastroplasty. There are no covered benefits for previous weight reduction surgeries (any type of bariatric surgery for weight reduction regardless of the diagnosis) where there are/may be complications.

(46) Electrolysis depilation.

(47) Nasal surgery which is not Medically Necessary and is conducted for cosmetic purposes, including but not limited to rhinoplasties.

(48) Charges for Laetrile and its administration.

(49) Services and supplies which are not Medically Necessary for the diagnosis, care, or treatment of the physical or mental condition involved, even if such services or supplies are prescribed, recommended, or approved by the attending Physician.

(50) Services and supplies not specifically listed as "Eligible Medical Expenses" in this Schedule.

(51) Services or supplies that are not prescribed, recommended, and approved by the Covered Person's attending Physician.

(52) Private duty professional nursing services, nurse's aide and sitters.

(53) Vitamins, vitamin supplements, over-the-counter drugs, and nutritional supplements, even if prescribed by a Physician.

(54) Formula, diapers or underpads.

(55) Transcutaneous electrical nerve stimulation ("TENS") Units, unless the administration of the unit is under the supervision of a pain management provider.

(56) Services and supplies to aid the Covered Person in cessation of smoking cigarettes, including but not limited to nicotine patches, nicotine gum, hypnosis, and any drugs or medicines.

(57) Routine care (for example, well-baby physicals), except for the items specifically provided under preventive care benefits.

(58) Any confinement, examination, operation, services or treatment not recommended or performed by a Physician or any period of Disability during which the Covered Person is not under the regular care and attendance of a Physician.

(59) Stand-by surgeons.

(60) Massage therapy.

(61) Aquatherapy.

(62) Biofeedback.

(63) Holistic medicine.

(64) Any charges incurred by the Covered Person, as a result of an agreement to serve as a surrogate mother, including but not limited to any and all charges incurred by the surrogate mother for prenatal care and delivery of the child (regardless of whether the surrogate mother is a Covered Person, Spouse, or a non-Covered Person under the Plan), and any charges incurred by the child born to the surrogate mother.

(65) Internal device electrical transmission units (IDETs) for treatment and therapy.

(66) Services provided by a midwife or a birthing center.

(67) TMJ appliances.

(68) Dental implants regardless of diagnosis or cause.

(69) Contraceptives other than oral contraceptives.

(70) Diagnostic studies and medications provided during a hospice episode that are not related to the terminal illness.

(71) Animal to human transplants.

(72) Therapy services for Covered Persons who have attained maximum medical improvement from such therapy.

(73) Pectus excavatum repair.

(74) Rectus abdominal muscle repair.

(75) Pulse dye laser.

(76) Clinitron and electric beds.

(77) Liquid oxygen.

(78) Myoelectric prostheses.

(79) Prosthetic intervertebral disc replacement.

(80) Intradiscal electrothermal annulplasty (IEA also known as Spinecath intradiscal, electrothermal therapy (IDET)) for relief of discogenic pain.

(81) Kyphoplasty.

(82) Percutaneous intradiscal radiofrequency thermocoagulation (PIRDFT), also known as percutaneous radiofrequency thermomodulation or nucleoplasty.

(83) Epiduroscopy, epidural spinal endoscopy, spinal endoscopy, myeloscopy, epidural myeloscopy for the diagnosis and treatment of intractable low back pain.

(84) Epidural injections of lytic agents.

(85) Endoscopic spinal surgery; including Yeung Endoscopic Spinal Surgery System.

(86) Sacroiliac fusion for low back pain due to sacroiliac joint syndrome.

(87) Indwelling epidural Racz catheter to relieve back pain in Covered Persons with epidural adhesions, adhesive arachnoiditis, or failed back syndrome for multiple previous surgeries.

(88) Microendoscopic diskectomy procedure for decompression of lumbar spine stenosis or lumbar disc herniation.

(89) Artificial or mechanical devices designed to replace organs permanently or temporarily (other than a device used during surgery, such as a heart-lung machine).

(90) Charges the Covered Person would not be required to pay in the absence of coverage.

(91) Treatment received under any private or public research fund, government program or other funding program, regardless whether such funding was applied for, and regardless whether the Covered Person is legally responsible for the expenses.

(92) Transplants performed outside the United States (transplants performed in a U.S. protectorate are excluded).

(93) Scholastic education or vocational training.

(94) Cochlear implants.

(95) Genetic testing.

(96) Expenses Incurred for services or supplies furnished by a health care provider or health care institution designated by the Fund as having a history of submitting fraudulent claims to the Fund.

Section 4. Cost Containment and Utilization Management Procedures

(a) Prior Authorization (Preauthorization and/or Pre-Determination). The Fund will require prior authorization of all observation and inpatient admissions, outpatient procedures, diagnostic testing (except for MRI or CT scan), durable medical equipment, and other services as noted in the Schedule of Medical Benefits and throughout this summary, including:

- All transplant related services
- Inpatient hospitalization
- All outpatient surgical procedures including diagnostic colonoscopy, routine colonoscopy under age 50, endoscopy, biopsy and surgeries
- Nuclear medicine scans, such as PET/SPECT
- Certain diagnostic testing
- Durable medical equipment, for expenses over $750
- Home health care
- Home IV therapy
- Hospice care
- Dialysis
- Chemotherapy/radiation
- All rehabilitation services, including acute, sub-acute, long term acute, cardiac and pulmonary rehabilitation
- Physical therapy, occupational therapy and speech therapy

- Corrective appliances and prosthesis
- Infusion drugs
- Wound treatment
- Pain management
- TENS Unit
- Specialty prescription medications
- Emergency room
- Ambulance transportation ground and air
- Any "off label" use of prescription drugs

If Preauthorization or pre-certification is required and not obtained for Inpatient or Outpatient facility services, the provider is responsible for obtaining such pre-certification or Preauthorization and will be held financially responsible for any penalty associated with these services. In that case, the Covered Person will not be balance-billed for the reduction in coverage resulting from the provider's failure to pre-certify or Preauthorize coverage.

In emergency situations, you must seek Preauthorization within 2 days of incurring the service. In all other situations, you must seek Preauthorization at least 2 days in advance of incurring the services. The failure to timely Preauthorize coverage will result in a denial of benefits and/or a reduction in benefits paid.

(b) Individualized Case Management and Disease Management. The Fund offers individualized case management to help manage costs associated with catastrophic illnesses, chronic conditions, and diseases. Please contact the Fund's case management department if any of the following apply to you:

(1) You are diagnosed with a catastrophic illness or disease.

(2) Your Physician recommends an organ transplant (solid organ or bone marrow) – Case management required for organ transplants.

(3) Your Physician recommends a program of pain management.

(4) You need air ambulance services.

(5) You have a workers' compensation claim.

(6) You were injured in an auto accident or other accident involving another person or on someone else's property.

(7) You are diagnosed with diabetes, coronary artery or vascular disease, HIV/AIDS, or hypertension.

(8) You experience premature births, multiple births or any high risk pregnancy.

(9) You suspect any potential or suspected fraud in billing.

The Fund's case management department also provides information for high risk pregnancies, nutrition, discharge planning, and education assistance using the Internet. Please contact the case management phone number on the back of your benefits card if this information would be helpful to you.

(c) Newborns' and Mothers' Benefits. The Plan will not restrict any Inpatient Hospital confinement in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the Plan for prescribing a confinement not in excess of these time periods. However, the provisions in this Section 4 will apply to portions of the confinement in excess of these limits.

ARTICLE I. BENEFITS UNDER THE RETIREE PLAN

The Plan provides medical benefits to Covered Retirees and their Covered Spouses as explained in this summary.

ARTICLE II. PREMIUMS AND CONTRIBUTIONS

Contributing Employers pay premiums or contributions to the Fund for benefits, as determined by the Board of Trustees and any applicable Collective Bargaining Agreements. In addition, depending upon the date of your retirement, you are required to make premium payments for coverage under this Plan. The monthly premium payments are the same whether the coverage is for you only or for you and your spouse. The level of any required contributions that you must make is within the sole discretion of the Trustees. The Trustees may increase or decrease the amount of required contributions with 30 days advance notice; provided, however, if you meet the eligibility criteria set forth in Article IV, Section 3 of this summary, the required contributions will be in the same amounts that went into effect under the Plan on January 1, 2008 for retirees who were already retired as of December 31, 2007 ("Grandfathered Retirees"). You will be notified by the Trustees if you are required to make contributions and the amount of the contribution. Current premium amounts are listed in the Premium Schedule located at page 8 of this booklet.

ARTICLE III. ELIGIBILITY FOR BENEFITS

Certain retirees and spouses are eligible for group medical benefits, as applicable, under the governing Collective Bargaining Agreement, and/or as set forth in the Medical Benefit Schedule and Medical Benefit Summary contained in this booklet. Please see the Schedule and Summary for the eligibility requirements for those benefits.

ARTICLE IV. GENERAL PROVISIONS AND DEFINITIONS RELATING TO MEDICAL BENEFITS

Section 1. Introduction

The provisions of this Article IV, Summary of Benefits and the Schedule of Benefits describe the medical benefits provided under the Plan.

Section 2. Definitions

The following definitions apply with regard to this Plan:

(a) "Accident" means a sudden, unforeseen, and unintended event which results in you or your Dependent's bodily Injury, as determined by the Board of Trustees.

(b) "Actively at Work" or "Active Work" means you are available on a regular working day and able to perform the material duties of your job. You are considered Actively at Work on each regular paid vacation day or holiday, in accordance with the terms of the applicable Collective Bargaining Agreement, provided you were Actively at Work on the last preceding regular working day. You will not become ineligible solely due to a health status-related factor, as defined under the Health Insurance Portability and Accountability Act of 1996.

(c) "Alcohol and Drug Abuse Treatment Center" means an institution, other than a Hospital, which provides a program of medical and therapeutic treatment for alcohol or drug abuse and meets certain other criteria.

(d) "Annual Maximum" means the maximum benefit a Covered Person is eligible for in a calendar year.

(e) "Board of Trustees" means the board of trustees of the Indiana Teamsters Health Benefits Fund.

(f) "Chiropractic Care" means services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

(g) "Close Relative" means you or your spouse, or your or your spouse's child, brother, sister, or parent.

(h) "Co-insurance" means the percentage of a Covered Charge that you or your Dependent must pay for certain services or supplies. A benefit that requires a "Co-insurance" payment from you is subject to the Deductible.

(i) "Collective Bargaining Agreement" means any relevant collective bargaining agreement entered into between your Employer and the Union, which applies to your participation in the Plan. This includes any collective bargaining agreement that applied to you before you retired that applied to your participation in any other health benefit plan sponsored by the Fund, as well as any collective bargaining agreement between your former Employer from which you retired that provides for contributions to the Fund on behalf of active employees.

(j) "Contributing Employer" means any company that contributes to the Plan under the terms of a Collective Bargaining Agreement. A listing of Contributing Employers is available from the Plan Administrator on written request.

(k) "Covered Expense" means a medical, dental, or optical expense that, subject to any Deductible, Co-insurance or limitation, if applicable, is eligible for reimbursement under the Plan.

(l) "Covered Person," "Covered Retiree," or "Covered Spouse," means you and/or your covered Spouse if you meet the eligibility and coverage requirements for coverage under this Plan in Section 3 below.

(m) "Custodial Care" means care that assists a Covered Person who has a mental or physical Disability expected to continue for a prolonged period of time and who is not under active and specific medical, surgical, or psychiatric treatment which will reduce the Disability regardless of whether the person is under the care of a Physician or whether the Physician requests or recommends the care.

(n) "Deductible" means the amount, if any, of Covered Charges which you or your Dependent must pay each calendar year before the Plan pays for a Covered Charge, subject to any applicable limitations. The in-network Deductible is separate from the out-of-network Deductible.

(o) "Dependent" means your legally married spouse, under the laws of the State of Indiana, who is not legally divorced or separated from you. This Plan does not cover any non-Spouse Dependents. If you and your spouse are both Retirees, you will each be covered as Retirees, and not as Dependents or spouses.

(p) "Disability" means an Accidental bodily Illness or Injury that prevents you from working at your occupation and requires the regular care and attendance of legally qualified Physician or surgeon.

(q) "Eligible Retiree" means you, if you are a Union member who is a Retiree of a Contributing Employer and you meet the eligibility requirements set forth in Section 3 below, or you, if you are a retiree who was covered under another multiemployer health fund at the time of any merger of such fund with the Indiana Teamsters Health Benefits Fund, if the terms of the applicable merger agreement so provide.

(r) "Emergency" means a sudden and unexpected medical condition that, in the absence of immediate medical attention, could reasonably be expected to result in death or total Disability or cause serious damage to the patient, as determined by the Trustees.

(s) "Employer" means any association or entity who is bound by the Trust Agreement.

(t) "Experimental" means the use of any treatment, procedure, facility, equipment, drug, device, or supply not generally accepted as standard medical treatment under the professional standards of medical practice for the condition being treated, or any items requiring United States federal or other United States government agency approval which approval was not granted at the time services were provided, as determined by the Trustees.

(u) "Extended Care Facility" means a legally operated institution that: (i) for a fee provides convalescence or skilled nursing care with room, board, and 24-hour care by 1 or more professional nurses and other nursing personnel needed to provide adequate medical care; (ii) is under the full-time supervision of a Physician or Registered Nurse; (iii) keeps adequate medical records; and (iv) if not operated by a Physician, has the services of a Physician available under an established agreement.

(v) "Fund" means the Indiana Teamsters Health Benefits Fund, formerly known as the Local 135 Health Benefits Fund and the Local 135 Welfare Fund.

(w) "Home Health Care" means services and supplies provided to you or your Dependent, in your or your Dependent’s home by a Home Health Care Agency, as an alternative to Hospital Inpatient confinement that: (i) are recommended by a Physician, and (ii) are provided under the direct care of a Physician as part of a Home Health Care Plan, and (iii) are provided to you under a plan in which you are examined once every 60 days by a Physician.

(x) "Home Health Care Agency" means an institution which operates primarily to provide skilled nursing care and therapeutic services in your or your Dependent’s home, provided the Home Health Care Agency is approved and licensed by a state licensing agency, is federally certified as a Home Health Care Agency, and meets the requirements of Medicare.

(y) "Hospital" means an institution which: (i) is licensed without limitation as a Hospital under the laws of the state at the time and place Covered Charges are Incurred, (ii) is not, other than incidentally, a nursing home or a place of rest for the aged, drug addicts, alcoholics or for the treatment of tuberculosis or mental disorders; (iii) mainly provides Inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of Injured and Ill persons; (iv) has a staff of 1 or more licensed Physicians available at all times; (v) provides 24 hour per day nursing services by registered or graduate nurses; (vi) provides organized facilities for diagnosis and major surgery facilities; and (vii) operates for compensation from its patients; provided, however, if a unit or area of a Hospital is primarily operated for the care and convalescence of ambulatory patients or for rehabilitation purposes, confinement in such unit or area will not be considered Hospital confinement unless:

(a) such confinement is for purposes other than convalescence and rehabilitation; and

(b) the Covered Person is not ambulatory during such confinement.

(z) "Illness" means a sickness or disease or pregnancy (including delivery or miscarriage, and complications) which is not due to an Injury, which requires treatment by a Physician which is Incurred by you or your Dependent on or after the date of coverage under the Plan, excluding conditions arising from occupational Injury or Accident.

(aa) "Incurred" means the date on which a service or supply was rendered or furnished.

(bb) "Injury" means bodily damage or loss, occurring on or after the date of coverage, while still covered, as a result of an Accident which requires Physician treatment, excluding any condition arising from an occupational Injury or Accident.

(cc) "Inpatient" means confinement in a Hospital, hospice or Extended Care Facility as a patient for a period of 23 or more hours and for which a Room and Board Charge is Incurred.

(dd) “ITHBF Clinic” means 1 or more designated Indiana Teamsters Health Benefits clinics managed by Activate Healthcare, LLC and designated by the Fund to serve the primary care needs of any Covered Person.

(ee) "Medically Necessary" services and supplies means medical and dental services or supplies that are essential to the treatment of and consistent with the symptoms and diagnosis of an Illness or Injury under generally accepted professional standards of medical and dental practice, at the time and place Incurred and not solely for the convenience of the Covered Person, Physician, Psychologist, Chiropractor, Dentist, Psychiatrist, Licensed Practical Nurse or Registered Nurse, Home Health Care Agency, health care provider or health care institution or Hospital, that could not have been omitted without adversely affecting the Covered Person’s medical condition or the quality of the health care rendered. The fact that a Physician, Psychologist, Dentist, Chiropractor, Psychiatrist, L.P.N., or R.N. may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary or make the charge a Covered Charge under the Plan. The determination of Medical Necessity is solely for the purpose of determining the extent to which expenses Incurred by a Covered Person will be paid under the Plan and in no way interferes with the right of a Covered Person to choose a specific service, drug,

supply, procedure, level of care, or admission without regard to whether it is determined to be Medically Necessary.

(ff) "Negotiated Rate" means the rate the Preferred Providers have contracted to accept as payment in full for Covered Expenses of the Plan.

(gg) "Non-preferred Provider" means a Physician, Hospital, or other health care provider which is not listed as a participating provider by the Preferred Provider Organization at the time the services are rendered.

(hh) "Outpatient" means treatment for less than 23 hours without admission or registration as an Inpatient, whether provided at a Hospital, Surgery Center, laboratory or x-ray facility, or a Physician's office.

(ii) "Paid-In Pension" means a pension benefit that you earned in a Pension Plan as a result of contributions made on your behalf during your years of service with an Employer. A "20 year Paid-In Pension" means that your Employer contributed to a Pension Plan on your behalf for at least 20 years. A "30 year Paid-In Pension" means that your Employer contributed to a Pension Plan on your behalf for at least 30 years. This definition excludes any pension benefit that is based on or results from your Disability or any deferred Vested Pension benefit that is not a 20 or 30 year Paid-in Pension.

(jj) "Pension Plan" means the Central States Southeast & Southwest Areas Pension Plan, or the Indiana Teamsters Pension Plan, or any other pension plan that the Trustees, in their sole discretion, recognize as meeting the definition of Pension Plan for Purposes of this Plan.

(kk) "Plan Administrator" means the Board of Trustees, who is responsible for the day-to-day functions and management of the Fund, and all benefits provided through the Fund, including but not limited to this Plan, in accordance with Article VII.

(ll) "Preauthorization" (sometimes known as pre-determination) means gathering information and reviewing medical records *prior to* any requested procedure, treatment, or admission. Reviews are based on national guidelines established by medical peer reviews. This process allows providers and members to know of benefits and payments prior to the requested treatment and/or procedure. The Fund requires Preauthorization in many cases.

(mm) "Preferred Provider" means a Physician, Hospital or other health care facility who has an agreement in effect with the Preferred Provider Organization at the time services are rendered and which is listed as a participating provider by the PPO. Preferred Providers agree to accept the Negotiated Rate as payment in full.

(nn) "Preferred Provider Organization" means an organization who selects and contracts with certain Hospitals, Physicians, and other health care providers to provide services, supplies and treatment to Covered Persons at a Negotiated Rate.

(oo) "Prohibited Reemployment" means any of the following reemployment of the Retiree, including: (1) employment in any position, including a managerial or supervisory position, by a Contributing Employer of the Fund or an employer which was formerly a Contributing Employer of the Fund, (2) employment by any employer, other than a governmental agency, in

any position governed by a collective bargaining agreement between that employer and any affiliate of the International Brotherhood of Teamsters, or (3) employment, including self-employment, in the same industry in which the Retiree earned any contributory service credit in a Pension Plan.

(pp) "Psychiatric Conditions" means conditions of neurosis, psychosis, psychopathy, psychoneurosis, or mental or emotional disease or disorder of any kind, including, but not limited to, transgender therapy and treatments.

(qq) "Psychiatric Treatment Facility" means an institution, excluding a half-way house, which does not qualify as a Hospital but does provide a program of effective psychiatric treatment.

(rr) "Reasonable and Customary Charge" means the usual and customary charges made by a Physician or supplier of services or supplies within a specified area. If the Reasonable and Customary Charge cannot be easily determined, the Trustees will look to: (i) the complexity involved; (ii) the degree of professional skill required; and (iii) other pertinent factors. The determination of whether a charge is a Reasonable and Customary Charge will be made by the Trustees at their sole discretion.

(ss) "Retiree" means an individual who was covered by the Indiana Teamsters Health Benefits Fund when he or she ceased Active Work with a Contributing Employer to the Fund.

(tt) "Room and Board Charges" means the institution's charges for room and board and other institutional services and supplies made at a regular daily or weekly rate for occupancy in a room.

(uu) "Spouse" means your spouse, who is not legally divorced or separated from you. This Plan does not cover any non-spouse dependents.

(vv) "Substance Abuse" means a condition brought about when an individual uses alcohol or other drugs in such manner that such individual's health is impaired and/or his ability to control actions is lost, except when the condition results from the use of a Medically Necessary drug as prescribed by a Physician or Psychiatrist.

(ww) "Surgery Center" means a freestanding ambulatory surgical facility which meets certain licensing and other requirements.

(xx) "Therapy Services" means the services and supplies ordered by a Physician and used for the treatment of an Illness or Injury to promote the Covered Person's recovery.

(yy) "Union" means the union to which you are a member, or were a member when Actively at Work.

(zz) "Urgent or Immediate Care Center" means a legally operated facility of a Hospital separate from the regular emergency room of a Hospital, or a freestanding health center, which is staffed and equipped to provide medical care for non-life threatening Injuries and minor Illnesses which are not Emergencies. This center must be staffed by 1 or more Physicians during all hours of service.

(aaa) "Vested Pension" means a pension that is not based upon contributions made by or on your behalf during your years of service with an Employer.

Section 3. Retiree and Spouse Eligibility and Coverage

(a) Eligibility.

(1) Retiree Eligibility. If you retire on or after January 1, 2008, you will be eligible for medical benefits under this Retiree Plan and this summary once you have met the following eligibility requirements: (i) you retire on or after your 57th birthday but before your 65th birthday and you have a 20 year Paid-In Pension, and (ii) you participated continuously in the Indiana Teamsters Health Benefits Plan for at least 5 consecutive calendar years immediately preceding your retirement, or 7 of the 10 consecutive calendar years immediately preceding your retirement. You will not be eligible if you have a deferred vested or Disability pension, if you have insurance from other employment, if you are eligible for Medicare, or if you engage in Prohibited Reemployment.

If you have a 30 year Paid-In Pension and you retire on or after January 1, 2008 but before your 57th birthday, you will not be eligible for retiree medical benefits under this Retiree Plan until you reach age 57, unless you have a medical exception described below or you satisfy the special eligibility rules described below. However, you may still retire at any age and will become eligible for coverage once you meet these requirements. Also see the Late Enrollment rules under Section 3(c) below.

(2) Medical Exception Eligibility for Certain Retirees ("Special Retirees"). If you retire on or after January 1, 2008 for medical reasons that prevent you, in a doctor's opinion, from performing the normal duties of your job, the Trustees may choose to provide you with retiree medical benefits under this Retiree Plan even if you have not yet reached age 57. You must retire with a 30 year Paid-In Pension, meet the other eligibility criteria of this Plan (as set forth in subsection (1) above), and not be entitled to Social Security disability benefits.

It is solely within the Trustees' discretion as to whether to grant this special exception.

(3) Special Eligibility Rules for Certain Retirees ("Grandfathered Retirees"). If, as of December 31, 2007, you already had a 30-year Paid-in-Pension and met the other eligibility criteria for coverage under this Plan (as set forth in subsection (1) above), you will be eligible for retiree medical coverage when you retire, regardless of whether you have reached age 57 when you retire. In addition, your premium rates will be the same as if you had retired before January 1, 2008, regardless of the date you actually retire. Those rates for 2008 are listed in the Premium Schedule and will be updated from time to time. If, as of December 31, 2007, you have a 20-year Paid-in-Pension and are at least 57, you are also eligible to retire with the special premium rates.

This means that, as of December 31, 2007, if you were eligible to retire with full coverage under this Plan, you did not need to retire before January 1, 2008 in order to preserve your eligibility. The "old" eligibility rules that were in effect through December 31, 2007 will continue to apply to you at the time of your retirement, but beginning

January 1, 2008, all retirees will be required to pay a premium, regardless of retirement date.

(4) Dependent Eligibility. Your Spouse will be eligible for coverage on the date that you become covered under this Plan. No other Dependents are eligible for coverage under this Plan.

(b) Coverage.

(1) Retiree and Spouse Coverage. You and your Spouse will be covered on the date you retire if you satisfy the eligibility requirements in Section 3(a) above, or if you marry after your coverage under this Plan begins, your Spouse's coverage will begin on the date of your marriage, subject to the provisions for Spouse Coverage below.

If you are eligible for coverage under this Plan and do not elect coverage under this Plan at the time of your retirement, the Trustees may allow you to postpone the commencement of coverage under this Plan under the late enrollment rules described in Section 3(c) below , but you will not be able to postpone the date your coverage or your Spouse's coverage terminates, as set forth in Section 6.

(2) Spouse Coverage. Your Spouse will become covered under this Plan when the appropriate forms for electing coverage under this Plan have been completed, as described in Section 4 below.

(c) Late Enrollment.

(1) Retirement Before Age 57. If you retire on or after January 1, 2008 but before your 57th birthday and you otherwise meet the eligibility criteria for this retiree coverage in Section 3(a) above, you may elect COBRA continuation coverage under the Indiana Teamsters Health Benefits Plan ("Active Plan") that is also funded through the Indiana Teamsters Health Benefits Fund. In addition, you may later elect late coverage under this Plan on or after your 57th birthday, but only if you provide the Trustees with a Certificate of Creditable Coverage and have not incurred a "significant break in coverage," defined as a period of at least 63 consecutive days during which you did not have any coverage. Generally, this means that you may later elect coverage under this Plan on or after your 57th birthday only if you can demonstrate that you have had other health plan coverage in place and any break in that coverage was for fewer than 63 days.

(2) Retirement After Age 56. If you retire on or after January 1, 2008 and on or after your 57th birthday and otherwise meet the eligibility criteria for this retiree coverage in Section 3(a) above, you may either: (A) elect COBRA continuation coverage under the Indiana Teamsters Health Benefits Fund Active Plan; (B) immediately elect this coverage at the time of your retirement; or (C) if you provide the Trustees with a Certificate of Creditable Coverage and if you have not incurred a "significant break in coverage," defined as a period of at least 63 consecutive days during which you did not have any coverage, then you may later elect late coverage under this Plan at any time on or after your 57th birthday. Generally, this means that you may later elect coverage under this Plan on or after your 57th birthday only if you can demonstrate that you have had other health plan coverage in place and any break in that coverage was for fewer than 63 days.

Section 4. Change of Status

You must give written notice to the Trustees of: (i) change in address; (ii) entrance into the military by you or your Spouse; (iii) loss or acquisition of a Spouse; (iv) your marriage; (v) eligibility for or entitlement to Medicare benefits; (vi) divorce or legal separation from a Spouse; or (vii) any other change in status which may affect you or your Spouse's coverage under this Plan. You must notify the Trustees within 30 days of any change in status. **If you fail to do this, the Trustees have the discretion to require you to repay any claims that should not have been paid or to withhold future benefits from you. Also, if you fail to enroll a new Spouse within 30 days, coverage for the new Spouse will not be effective until the next annual enrollment period.**

Section 5. Termination of Coverage

(a) Termination of Coverage for Retirees. Subject to Section 8 of Article X or any Collective Bargaining Agreement, your Retiree coverage under this Plan will end on the **earliest** of the date :

(1) You are eligible for Medicare coverage;

(2) You reach your 65th birthday;

(3) The Plan or the Fund is terminated;

(4) Your former Employer ceases to be a Contributing Employer to the Fund;

(5) You become a full-time member of the Armed Forces;

(6) Of your death;

(7) You become eligible for coverage in the Active Plan by returning to work;

(8) You engage in Prohibited Reemployment;

(9) You are no longer an Eligible Retiree; or

(10) You fail to make any required contributions to the Fund.

(b) Termination of Coverage for Spouses. Subject to Sections 6(c) and Section 7 below, Section 8 of Article XI or any applicable Collective Bargaining Agreement, the date that coverage for your Spouse ends may depend upon the date your own coverage ends under this Plan. Generally, coverage for your Spouse will end on the **earliest** of the date :

(1) Your Spouse becomes eligible for Medicare coverage;

(2) Your Spouse reaches his or her 65th birthday;

(3) Your Spouse no longer meets the definition of "Spouse" or "Dependent";

(4) Your Spouse becomes a full-time member of the Armed Forces;

(5) Your Spouse fails to make any required contributions to the Fund;

(6) Your Retiree coverage terminates because your former Employer ceases to be a Contributing Employer to the Fund; or

(7) That is 3 years after the date your Retiree coverage terminated for any other reason.

(c) After your Retiree coverage terminates, your Spouse will remain covered under this Plan for no more than 3 years. The 3 year continuation of coverage described in Section 5(b)(7) above will run concurrently with any continuation coverage your Spouse is entitled to under Section 7. During this time, your Spouse must make any required contributions to the Fund.

Example: If you become eligible for Medicare you will lose your coverage under this Plan. Your spouse will remain covered for a maximum of 3 years from the date your coverage under this Plan terminates, unless one of the other events described above occurs before then. For example, if your Spouse becomes eligible for Medicare 1 year after you do, your Spouse will lose coverage under this Plan at that time.

Example: If you die, your Spouse will remain covered under this Plan for a maximum of 3 years from the date of your death. If one of the other events occurs before the 3 year period ends, her coverage under this Plan may end earlier. For example, if your Spouse becomes eligible for Medicare 2 years after you die, your Spouse will lose coverage under this Plan at that time.

Example: If your former employer stops contributing to the Indiana Teamsters Health Benefits Fund on behalf of that employer's active employees, coverage for both you and your Spouse will terminate at that time. In that instance, your Spouse will not remain covered under this Plan for an additional 3 years, except to the extent required by COBRA under Section 7.

If you or your Spouse have any questions about the duration of your coverage under this Plan, please contact the Fund Office.

Section 6. COBRA Continuation Coverage

COBRA gives you and your Dependents rights to continue health coverage Plan under certain circumstances. You or your Dependents may elect, at your cost, to continue group health coverage under the Active Plan or this Plan after certain Qualifying Events, described below. Upon your retirement, you and your Spouse have the option of either participating in this Plan or electing to continue coverage under the Active Plan pursuant to COBRA. At that time, any other Dependents that you have who are covered under the Active Plan will also have the option of electing to continue coverage under the Active Plan pursuant to COBRA. The provisions for continuing coverage under the Active Plan pursuant to COBRA are set forth in the plan documents that apply to the Indiana Teamsters Health Benefits Plan and may be obtained from the Fund Office.

When your coverage ends under this Plan, there is no continuation coverage for you. In some circumstances, continuation coverage under this Plan may be available to your Spouse, as provided below. This notice generally explains COBRA continuation coverage, when it may

become available to your Spouse under this Plan, your Spouse's right to receive it, and what your Spouse needs to do to protect that right.

(a) Right to Continuation Coverage. Only qualified beneficiaries may elect continuation coverage under this Plan. You are a qualified beneficiary if you are covered under this Plan on the date before a Qualifying Event and if you are a Spouse of an Eligible Retiree.

(b) Qualifying Events. The right to continuation coverage is triggered by any of 3 Qualifying Events which, but for the continued coverage, would result in a loss of coverage under this Plan. These Qualifying Events are:

(1) The Eligible Retiree's death;

(2) The Eligible Retiree's divorce or legal separation from his or her spouse; or

(3) The Eligible Retiree's becoming entitled to Medicare benefits.

Note that your Spouse will not necessarily have the right to continuation coverage if your former Employer stops contributing to the Plan. Your Spouse will have that right if one of the listed Qualifying Events occurs (in addition to cessation of contributions) and causes your Spouse to lose coverage under this Plan.

Also, if your former Employer stops contributing to the Plan and makes other group coverage available to employees who were previously covered by this Plan, then your Spouse will have no right to continuation under this Plan. Instead, your former Employer's new plan will have the obligation to provide continuation coverage to your Spouse.

(c) Period of Continuation Coverage. In the case of a Qualifying Event, continuation coverage may be for up to 36 months (as elected) after the Qualifying Event, unless it ends earlier as described in subparagraph (e) below.

(d) Continuation of Health Benefits Provided. The continuation coverage provided to a qualified beneficiary who elects coverage will be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan with respect to whom a Qualifying Event has not occurred. This means that any changes to the Plan will also apply during the period of the continuation coverage.

(e) End of Continuation Coverage. Continuation coverage will end earlier than the applicable time period if:

(1) timely payment of premiums for the continuation coverage are not made;

(2) the qualified beneficiary first becomes entitled to Medicare benefits after electing COBRA coverage; or

(3) the date on which your Employer ceases to provide any group health program to any employee.

(f) Election of Coverage. Your Spouse must elect continuation coverage within 60 days after the later of: (i) the date your Spouse would lose coverage due to the Qualifying Event, or (ii) the date on which notice of the right to continued coverage is sent by the Trustees. The election of continued coverage must be made on a form provided by the Trustees, and payment for coverage as described in the notice must be made when due. Your Spouse has an independent right to elect COBRA continuation coverage, however, an Eligible Retirees may elect COBRA continuation coverage on behalf of their Spouse.

(g) Cost of Continuation Coverage. Your Spouse is responsible for paying the cost of continuation coverage. The premiums are payable on a monthly basis. After a Qualifying Event, a notice will be provided which will specify the amount of the premium, to whom the premium is to be paid, and the day of each month the premium is due. Failure to pay premiums on a timely basis will result in the termination of coverage as of the first day of the month for which the premium is due. Payment of any premium is considered timely if made within 30 days after the due date. However, the premium for the time period between the date of the event which triggered continuation coverage and the date coverage is elected must be made within 45 days after the date of election. The Fund complies with all federal legislation regarding COBRA coverage. You will be notified if you may claim any premium reduction or subsidy.

(h) Notice to Trustees. Your Spouse is responsible for notifying the Trustees in the case of a Qualifying Event caused by the divorce or legal separation from the Eligible Retiree. Notice must be provided to the Trustees ***in writing*** as soon as possible, but no later than 60 days after the later of: (i) the date of the Qualifying Event, (ii) the date your Spouse would lose coverage due to the Qualifying Event, or (iii) the date you are notified of both your responsibility to provide notice and the Plan's procedure for providing such notice. *If you do not follow these procedures and notify the Trustees within these time frames, your Spouse will lose the right to elect COBRA continuation coverage.*

You or your Spouse must notify the Trustees if either of you dies, becomes entitled to Medicare benefits, or if you become divorced or legally separated.

Questions?

Questions concerning this Plan or your COBRA continuation coverage rights should be addressed to the Fund Administrative Office of the Indiana Teamsters Health Benefits Fund, located at 1233 Shelby Street, Indianapolis, Indiana 46203. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Officer of the U.S. Department of Labor's Employee Benefits Security administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through the EBSA's website).

Also, in order to protect your family's rights, if you have changed your marital status, or if you or any of your family members have changed addresses, please notify the Fund Administrative Office of the Indiana Teamsters Health Benefits Fund. You should also keep a copy of any notices you send to the Trustees for your records.

Section 7. Continuation of Coverage for Military Personnel

You will be offered the opportunity to continue medical coverage under the Plan for 24 months if you enter military service. During this time, you must pay 102% of any contribution amounts required unless your military service is not expected to exceed 30 days, in which case you will be required to make your normal contributions. Any coverage elected here will not affect your continuation coverage rights in Section 6 above; COBRA rights will be effective on termination of this extended military coverage.

Section 8. Medical Benefits

(a) Eligible Medical Expenses. You will be reimbursed for Medically Necessary Covered Charges that are Incurred on account of an Illness or Injury occurring to you or your Spouse, as provided in the Schedule of Benefits and the Summary of Medical Benefits. Such Covered Charges are subject to any Deductible, Co-payment, Co-insurance, Lifetime Maximum Benefit and any other limits set forth in the Summary of Benefits and the Schedule of Benefits.

(b) Cost Containment. If applicable, you and your Spouse will be reimbursed in accordance with any cost containment procedures set forth in the Schedule of Medical Benefits.

Section 9. Coordination with Medicare

Coverage under this Plan terminates upon you or your Spouse's Medicare eligibility, so this Plan does not coordinate benefits with Medicare.

Section 10. Coordination With Other Benefit Plans

The Plan has been designed to help meet the costs of Illness or Injury. Since it is not intended that greater benefits be paid to you other than your actual medical expenses, the amount of benefits payable under the Plan will take into account any coverage you or your Spouse have under any other plans. In other words, the benefits under the Plan will be coordinated with the benefits of the other plans.

If the Plan is primary, the Plan will pay its regular benefits in full. If the Plan is secondary, after the primary plan pays, the Plan will pay remaining Covered Charges up to 100%, after reduction by the amount the primary plan paid; provided, however, the Plan will not pay an amount greater than would have been paid if the Plan were primary. If the Plan is secondary, Preauthorization is not required, unless such primary plan pays $0 on the Covered Charges in which case the secondary plan will require Preauthorization.

Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs which are not covered by this Plan, which would otherwise be covered by the secondary coverage. This Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by this Plan.

There are a number of rules designed to coordinate different plans together. Under these rules, a plan that does not coordinate with other plans is always primary. If the plans do coordinate, benefits will be determined as follows:

(a) the plan covering the person as an employee, former employee or retiree pays before a plan covering the person as a dependent;

(b) The plan covering a person who has been laid off or who is a former employee or a retired employee and/or such person's dependents, will be determined after the benefits of the plan covering the person as an employee; and

(c) If none of the above rules determine how to coordinate different plans, the plan which has covered the person longer will pay first.

More information on coordination of benefits is available from the Trustees. The Trustees are entitled to any information needed to coordinate benefits. Any excess benefits paid may be recovered by the Trustees.

Section 11. Subrogation

This Plan reserves the right to subrogation and reimbursement of amounts paid for health benefits on your behalf if you recover any money from a third person in any circumstance, regardless of whether such recovery is characterized as payment for health benefits. The Plan has a lien against any funds you recover and the right to impose a constructive trust on such funds, or pursue such funds through any and all available remedies and relief. This provision applies if payment is made under this Plan for which you or your Spouse are or become entitled to receive payment from a third party for any Illness or Injury. By participation in this Plan, you are agreeing that the Plan is subrogated to all rights of you or Spouse. If you fail to comply with these provisions, you will not be eligible for any benefits under the Plan. The Plan may withhold benefits when a third party may be liable. You may be required to sign a subrogation agreement before any benefits are paid. By being covered under this Plan, you are agreeing to notify a third party in writing of the Plan's subrogation rights before receiving payment from a third party. You are also acknowledging that the Plan has the right to be paid first and in full from any settlement, judgment, or other money you receive, even if you are not made whole. You are also acknowledging that you are responsible for all expenses of recovery including attorney fees, which will not reduce the reimbursement to the Plan. The Plan will not pay any portion of your attorneys' fees or reduce its lien to reflect any fees you have agreed to pay. This is a full and complete right of subrogation; it exists even though you or your Spouse do not receive full compensation or recovery for all costs, injuries, damages, adjudged loss or debt. You are further agreeing to take action, furnish information, and execute and deliver instruments necessary to facilitate enforcement of these rights. The Trustees have full discretion and authority to interpret, administer, and pursue these subrogation and reimbursement rights on behalf of the Plan.

Section 12. Benefits Following Fund Merger

In the event of any merger of another fund with this Fund, the Trustees may take whatever actions they may deem necessary and appropriate to implement the terms of such merger, including but not limited to administering final claims from such other fund pursuant to the terms of any plan of benefits offered by that other fund and crediting service, benefits paid, Deductibles, Co-

pays, and Co-insurance maximum benefit limits incurred under such other fund toward any such amounts or limits applicable under this Plan.

Section 13. Rights Under the Women's Health and Cancer Rights Act of 1998

If you are receiving benefits in connection with a mastectomy and you elect breast reconstruction in connection with such mastectomy, the Plan will provide coverage in a manner determined in consultation with you and your attending Physician, for (1) reconstruction of the breast on which the mastectomy will be performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) prostheses and physical complications at all stages of mastectomy, including lymphedemas. This coverage is subject to Deductibles and Co-insurance provisions, which are described in detail in the Schedules of Benefits. In addition, the Plan will not (1) deny you eligibility or continued eligibility to enroll or to renew coverage under the terms of the Plan, solely for the purpose of avoiding this coverage, or (2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce the provider to provide care to you in a manner inconsistent with the required coverage.

Section 14. Genetic Information Nondiscrimination Act

Neither the Fund, nor this Plan, nor any Benefit Plan offered through the Fund will request, require or purchase your genetic information prior to your enrollment, to determine eligibility for benefits, to adjust premiums, or for any other reason related to the creation, renewal or replacement of health benefits under the Plan.

ARTICLE V. CLAIMS FOR BENEFITS

Section 1. Filing of Claim

All claims for benefits must be submitted to the Trustees within 1 year after the Covered Charge is Incurred. The claim should be mailed to the Indiana Teamsters Health Benefits Fund, 3150 US. Rt. 60, Ona, WV 25545.

The procedures below apply to all benefits that are subject to the requirements under Section 503 of the Employee Retirement Income Security Act of 1974 ("ERISA"). Section 3 applies to medical benefits. All notifications to a claimant for claim review, denial, approval and appeal may be done in writing or electronically, unless otherwise designated. Claims must be submitted within 1 year of the date the charges were Incurred.

Section 2. Definitions Used in this Claims Section

(a) The term "*denial*" means a denial, reduction, termination, or failure to provide or make payment for a benefit, including determinations based on eligibility, and, with respect to health benefits, a denial, reduction, termination or failure to provide or make payment for a benefit based on utilization review, or a failure to cover a benefit because it is determined to be Experimental or investigational or not Medically Necessary.

(b) The term "*health care professional*" means a Physician or other health care professional licensed, accredited, or certified to perform health services consistent with State law.

(c) The term "*post-service claim*" means any medical claim that is not an *urgent care claim* or a *pre-service claim*.

(d) The term "*pre-service claim*" means any medical claim where receipt of such benefit is conditioned on obtaining approval of the benefit before receiving medical care.

(e) The term "*preauthorization*" (sometimes known as Pre-Determination) means providers submit medical records to request a treatment and/or procedure be paid under the Plan provisions. Criteria and guidelines are established for reviews and approvals or denials are determined for benefit payments.

(f) The term "*urgent care claim*" means any claim for medical care or treatment where the failure to make a non-urgent care determination quickly (i) could seriously jeopardize your life or health or your ability to regain maximum function, or (ii) in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without such care or treatment.

(g) The term "*you*" means any claimant such as you or your spouse.

Section 3. Claims for Medical Benefits

Initial Claim. Any claim to receive medical benefits must be filed with the Trustees within 1 year of the date the charges were Incurred, and will be considered filed when it is received by the Trustees. If you fail to follow these claims procedures for filing an *urgent care claim* or a *pre-service claim*, you will be notified verbally (unless you request written notice) of the proper procedures to follow -- not later than 24 hours for *urgent care claims* and 5 days for *pre-service claims*. This special timing rule applies only to *urgent care claims* and *pre-service claims* that: (i) are received by the person or unit customarily responsible for handling such claims (such as the Trustees or Fund office staff); and (ii) specify a claimant, a medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

You may also be required to submit Physician statements to the Trustees. If the Trustees disagree with the Physician statements, the terms of the Plan will be followed in resolving any dispute.

Initial Review. When a claim for medical benefits has been properly filed, you will be notified of the approval or denial within the time periods set forth in the chart below.

Initial Denial. If any claim for medical benefits is denied, the denial notice will contain: (i) the specific reasons for the denial; (ii) references to applicable Plan provisions the denial is based on; (iii) a description of any additional material or information needed and why; (iv) a description of the review procedures and time limits; (v) the specific internal rule, guideline, protocol, or other similar criterion, if any ("rule"), relied upon in making the denial, or a statement that such "rule" was relied upon, with a free copy at request; (vi) if the denial is based on a Medical Necessity or Experimental treatment, either an explanation of the scientific or clinical judgment for the determination or a statement that the explanation will be provided for free upon request; and (vii) for *urgent care claims*, a description of the "expedited" review process applicable to such claims. For *urgent care claims*, the information in the notice may be provided verbally if you are given notification within 3 days after the oral notification.

Appeal(s) of Claim Denial. You may appeal a denied claim for medical benefits by filing a written appeal(s) with the Trustees within the time periods set forth in the chart below. If you do not file the appeal(s) within these time periods, the Trustee's decision will be final and binding. For *urgent care claims*, you may make a request for an "expedited" appeal verbally or in writing and the necessary information will be sent to you quickly (for example, by telephone or fax).

Send Appeals to:

Privacy Officer
Indiana Teamsters Health Benefits Fund
1233 Shelby Street
Indianapolis, IN 46203

Denial of Appeal(s). The plan uses a single level or a two-level appeal review process with respect to medical, dental, and/or optical benefits. You will receive notice of the Trustee's decision on appeal(s) within the time periods set forth in the chart below. In addition, if your claim is denied on appeal, the notice will contain a statement that you are entitled to receive, free and upon request, access to and copies of all documents, records, and other information relevant to your claim, as well as items (i), (ii), (v), and (vi) from the *Initial Denial* subsection above. The last decision on review will be final and binding.

Ongoing Treatments. If the Trustees have approved an ongoing course of treatment over a certain period of time or for a certain number of treatments, any reduction or termination of such course of treatment before the approved period of time or number of treatments end will be a "denial." You will be notified of the denial before the reduction or termination occurs.

For an *urgent care claim*, any request by you to extend the ongoing course of treatment will be decided no later than 24 hours after receipt of the *urgent care claim*, provided you file the claim at least 24 hours before the treatment expires.

Chart of Time Limits.

	MAXIMUM TIME LIMITS FOR:							
TYPE OF CLAIM	**Trustees to decide initial claim (if no additional information is needed) (whether adverse or not)**	**Extension of time for determining initial claim**	**Trustees to notify claimant of missing or incomplete information needed from claimant to decide initial claim**	**Trustees to notify claimant of claimant's failure to follow proper procedures**	**Claimant to then provide needed information**	**Trustees to decide claim after requesting additional information and notifying claimant (if applicable)**	**Claimant to file appeal(s)**	**Trustees to decide appeal(s)**
Urgent Care Claims	No later than 72 hours after receipt of claim.	None	No later than 24 hours after receipt of incomplete claim.	No later than 24 hours after receipt of improper claim.	Not less than 48 hours after receipt of notice.	No later than 48 hours after earlier of (i) the Trustee's receipt of additional information from claimant, or (ii) end of time period given to claimant to provide additional information (48 hours).	180 days after receipt of denial.	All appeals must be decided within 72 hours after the Trustee's receipt of appeal from claimant.

TYPE OF CLAIM	MAXIMUM TIME LIMITS FOR: Trustees to decide initial claim (if no additional information is needed) (whether adverse or not)	Extension of time for determining initial claim	Trustees to notify claimant of missing or incomplete information needed from claimant to decide initial claim	Trustees to notify claimant of claimant's failure to follow proper procedures	Claimant to then provide needed information	Trustees to decide claim after requesting additional information and notifying claimant (if applicable)	Claimant to file appeal(s)	Trustees to decide appeal(s)
Pre-Service Claims	No later than 15 days after receipt of claim.	One time 15-day extension allowed if (i) due to matters beyond the control of the Trustees, and (ii) Trustees notify claimant before end of initial 15-day time period of such extension and the date Trustees expect to render decision. If extension is due to claimant's failure to submit information, notice will describe required information.	Within initial 15-day time period.	No later than 5 days after receipt of improper claim.	At least 45 days after receipt of notice. ***Note***: Trustees may or may not request needed information from claimant.	No later than 15 days after earlier of (i) the Trustee's receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days).	180 days after receipt of denial.	30 days after the Trustee's receipt of appeal from claimant.
Post-Service Claims	No later than 30 days after receipt of claim.	One time 15-day extension allowed if (i) due to matters beyond the control of the Trustees, and (ii) Trustees notify claimant before end of initial 30-day time period of such extension and the date Trustees expect to render decision. If extension is due to claimant's failure to submit information, notice will describe required information.	Within initial 30-day time period.	N/A	At least 45 days after receipt of notice.	No later than 15 days after earlier of (i) the Trustee's receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days).	180 days after receipt of denial.	60 days after Trustee's receipt of appeal from claimant.

Section 4. For All Claims

Authorized Representative. You may have an authorized representative act on your behalf in pursuing a benefit claim or appeal, pursuant to reasonable procedures. For an *urgent care claim*, a health care professional with knowledge of your medical condition may act as your authorized representative.

Calculating Time Periods. The period of time within which an initial benefit determination or a determination on an appeal is required to be made will begin when a claim or appeal is filed regardless of whether the information necessary to make a determination accompanies the filing. However, if you fail to provide certain needed information, these time periods may be suspended (in other words, put on hold). See the Trustees for details.

Full and Fair Review. At your request and free of charge, you or your duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim, or you may submit written comments, documents, records, and other information relating to the claim. If timely requested, review of a denied claim will take into account all comments, documents, records, and other information submitted relating to your claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Board of Trustees has delegated all initial claims determinations to the Fund's internal claims processing staff, who consult with outside medical and vocational experts as required and appropriate. Appeals of medical claims will be reviewed by the Board of Trustees who is the named fiduciary of the Fund and who will be neither the individual nor subordinate of the individual who made the initial determination. Furthermore, such fiduciary will not give any weight to the initial determination. If any appeal is based, in whole or in part, on a medical judgment, the Trustees will consult with an appropriate health care professional who is neither the individual nor subordinate of the individual who was consulted in connection with any prior determination. The Trustees will identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination.

Mediation. Claimants may have other voluntary alternative dispute resolution options, such as mediation. For available options, claimants could contact their local U.S. Department of Labor Office and their State insurance regulatory agency.

Exhaustion of Remedies. If you fail to file a request for review of a denial, in whole or in part, of benefits in accordance with these procedures in this Article, you will have no right to review and no right to bring action, at law or in equity, in any court, and the denial of the claim will become final and binding on all persons for all purposes.

ARTICLE VI. CHANGES TO RETIREE PLAN

The Plan and any benefit under the Plan may be changed, added to, amended, modified, or terminated at any time by the Trustees, subject to the terms and conditions of any applicable Collective Bargaining Agreement. No employee, Retiree, Spouse, or beneficiary will have any vested interest in any benefit of the Plan, subject to the terms and conditions of any applicable Collective Bargaining Agreement.

ARTICLE VII. PLAN ADMINISTRATION

The Plan is administered by the Trustees in accordance with the Plan terms. The Trustees will establish the policies, interpretations, practices and procedures that apply to the Plan; provided that a person, committee, or organization may be designated to perform certain administrative functions. The Trustees have full power and authority to control and manage the Plan and may provide rules and regulations regarding the Plan. The Trustees have full and maximum legal discretionary authority to determine eligibility under the Plan, to construe and interpret the terms and provisions of the Plan, to resolve any ambiguities, inconsistencies, disputes and omissions, and to decide questions of Plan interpretation and those of fact relating to the Plan. All determinations and interpretations of the Trustees will be final, conclusive, and binding on all persons affected, subject to the terms and conditions of any applicable Collective Bargaining Agreement. The Plan Administrator has the discretionary authority to decide whether a charge is Reasonable and Customary. You will not be paid any benefits from the Plan unless the Trustees, in their sole discretion, determine that you are entitled to such benefits.

ARTICLE VIII. PRIVACY OF YOUR HEALTH INFORMATION

Section 1. Your Protected Health Information

Special privacy rules govern the Plan's use and disclosure of your Protected Health Information. "Protected Health Information" or "PHI" generally means information (including demographic information) that:

(a) identifies you or your spouse (you") (or with respect to which there is a reasonable basis to believe the information can be used to identify one of you);

(b) is created or received by your health care provider, a health plan, or a health care clearinghouse; and

(c) relates to your past, present, or future physical or mental health or condition; the provision of health care to you; or the past, present, or future payment for the provision of health care to you.

The Plan may use and disclose PHI for purposes related to your health care treatment, payment for your health care, and health care operations for the Retiree Plan, the Active Plan, or the Fund. This Plan, the Active Plan, and the Fund act as an organized health care arrangement under HIPAA and for this purpose are collectively referred to as the "Health Plan."

Section 2. Disclosures of Protected Health Information

(a) "Summary Health Information" generally means information that may be individually identifiable health information that summarizes your claims history, claims expenses, or type of claims experienced by you and others for whom the Trustees have provided health benefits under a group health plan. PHI may need to be disclosed to the Trustees from time to time. The Health Plan may Disclose "Summary Health Information" to the Trustees, if they request the Summary Health Information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under the Health Plan; or

(2) Modifying, amending, or terminating the Health Plan.

(b) The Health Plan may disclose to the Trustees information on whether you or your dependent(s) are participating in the Health Plan, or are enrolled in or have disenrolled from the Health Plan.

(c) The Health Plan may disclose PHI to the Trustees to carry out administration functions that the Trustees perform.

(d) In any event, the Heath Plan may <u>not</u>:

(1) Permit a health insurance issuer or HMO to disclose PHI to the Trustees except as permitted by this Section.

(2) Disclose (and may not permit a health insurance issuer or HMO to disclose) PHI to the Trustees unless a statement is included in the Plan's Notice of Privacy Practices that the Health Plan (or a health insurance issuer or HMO with respect to the Health Plan) may disclose PHI to the Trustees.

(3) Disclose PHI to the Trustees for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit program of the Trustees without your authorization.

Section 3. Uses and Disclosures by the Trustees

The Trustees may use and disclose PHI without your authorization for Health Plan administrative functions including payment activities and health care operations, or as required by law. The Trustees agree to the following:

(1) If the Trustees use an agent or subcontractor to assist it in performing these activities (such as claims administration), the agent's or subcontractor's use and disclosures of PHI must be limited to the same restrictions and conditions that apply to the Trustees with respect to such PHI and implement reasonable and appropriate safeguards to protect electronic PHI.

(2) Report any known improper use or disclosure of PHI or any security incident to the Health Plan if and when the Trustee becomes aware of such improper use or disclosure or security incident.

(3) When the Trustees no longer need the PHI, they must destroy or return the PHI that the Trustees received from the Plan to the Plan. If return or destruction is not feasible, they must continue to maintain the PHI in accordance with this Section.

(4) The Trustees will make PHI available to you in accordance with the access, amendment and accounting of disclosure requirements of the Health Insurance Portability and Accountability Act of 1996.

(5) The Trustees will limit the use, request and disclosure of PHI to the extent practicable to a limited data set of PHI, or, if needed, the minimum necessary to accomplish the intended purpose of such use, disclosure or request.

(6) The Trustees will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and liability of the electronic PHI.

(7) The Trustee will make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with HIPAA.

(8) To the extent the Trustees use or maintain an electronic health record (as defined in HIPAA) with respect to PHI, an individual has the right to receive an accounting of disclosures of such electronic health records made by the Trustees in the 3 years prior to the date on which the accounting is requested, including: (1) to carry out health care

treatment, payment and health care operations, (2) any disclosures not permitted by the Privacy Rule, (3) any disclosures the Trustees make pursuant to a "public policy" purpose, (4) any disclosures required by law, and (5) any disclosures made pursuant to an administrative or judicial order, subpoena, discovery request, qualified medical child support order, or workers' compensation program.

(9) The Trustees will comply with the regulations detailing the information to be collected about each disclosure of PHI in an electronic health record scheduled to be issued by the Secretary of the Department of Health and Human Services no later than 6 months after the Secretary adopts standards on accounting for disclosures.

(10) Upon any breach, the Trustees will evaluate whether such breach is a "Breach" requiring notice under HIPAA. Following the Trustee's discovery of a breach of unsecured protected health information, as defined in 45 CFR § 164.402, the Plan will make appropriate notifications as provided under HIPAA.

Please refer to the Plan's Notice of Privacy Practices for more information about how the Plan may use and disclose your PHI and your individual rights. That Notice is available from the Fund office and at www.ITHBF.com.

ARTICLE IX. MISCELLANEOUS

Section 1. Limitations of Rights and Obligations

The Plan does not constitute a contract between the Employer and any Eligible Employee, Eligible Retiree, or Spouse and is not a consideration for, or any inducement or condition of, the employment of any Eligible Employee. Nothing in the Plan will give any Eligible Employee the right to be retained in the service of Employer or to interfere with the right of Employer to discharge any Eligible Employee at any time, subject to the terms and conditions of any applicable Collective Bargaining Agreement.

Section 2. Nonalienation

No benefit under the Plan will be subject to voluntary or involuntary alienation or other legal or equitable process. However, the Plan may pay benefits directly to a provider of services if requested in writing by the Covered Person. The Plan will not recognize any assignment of appeal rights under the Plan to a Hospital, Physician, or other medical service provider.

Section 3. Right of Recovery

If payment is made under the Plan, which under the terms of the Plan should not have been made, the incorrect payment may be recovered from the person who received the payment or from any other appropriate party. If the incorrect payment is made directly to you or your Spouse, the amount of the incorrect payment may be deducted from future payments to you or your Spouse.

Section 4. Misrepresentation

Any material misrepresentation by you or your Spouse in making any application for coverage or receipt of benefits will render coverage null and void. The Trustees have the right to require you to provide any and all documentation that the Trustees deem necessary in order to

administer this Plan, including but not limited to requiring you to provide copies of your annual form W-2 so that the Trustees may verify that you are not engaged in Prohibited Reemployment and copies of your annual pension income to determine appropriate premium contribution levels.

Section 5. Protective Clause

The Trustees will not be responsible for the validity of any contract of insurance or benefit policy or contract by any benefit provider issued to the Plan, and/or Trust, or for the failure on the part of any insurance company to make payments thereunder.

Section 6. Facility of Payment

If, in the opinion of the Trustees, a valid release cannot be rendered by you or your Covered Spouse for payment of any benefit payable, such payment may be made directly to a health care provider, or to any guardian, conservator, or other individual or individuals who have custody or provide care and principal support of you or your Covered Spouse. In the event of your death, payment will be made to the personal representative of your estate. Any payment will be made by the Trustees in good faith and will fully discharge all liability to the extent of such payment.

Section 7. Eligibility for Medicaid

Benefits will be provided consistent with any assignment of rights made by or on your behalf as required by a state plan for medical assistance ("Medicaid"). For purposes of enrollment and entitlement to benefits, your or your Spouse's eligibility for or receipt of medical benefits under Medicaid will not be taken into account. The state will have a right to payments made under Medicaid when the Plan has a legal obligation to make such payment.

Section 8. Retroactive Cancellation of Coverage

If you knowingly or intentionally provide inaccurate or incomplete information in order to obtain or continue coverage, your coverage will be retroactively rescinded. In addition, the Plan will retroactively rescind your coverage in the event your premiums are not timely paid, if you fail to timely notify the Plan of a divorce or as a result of an administrative delay after termination of employment.

ARTICLE X. GENERAL INFORMATION

Section 1. Plan Name

The Retiree Plan is a stand-alone retiree health benefit plan provided through the Indiana Teamsters Health Benefits Fund.

Section 2. Plan Sponsor

The Plan Sponsor for the Plan is the Board of Trustees of the Indiana Teamsters Health Benefits Fund, 1233 Shelby Street, Indianapolis, Indiana 46203.

Section 3. Plan Administrator

The Plan Administrator for the Plan is the Board of Trustees of the Indiana Teamsters Health Benefits Fund, located at 1233 Shelby Street, Indianapolis, Indiana 46203. The telephone number is (317) 639-3573. For questions regarding the Plan, contact the Fund office.

Section 4. Employer Identification Number

The employer identification number assigned by the Internal Revenue Service to the Plan is 35-1074113.

Section 5. Agent for Service of Legal Process

Service for legal process may be made on the Board of Trustees of the Indiana Teamsters Health Benefits Fund at 1233 Shelby Street, Indianapolis, Indiana 46203.

Section 6. Plan Number

The Plan Number is 502.

Section 7. Plan Year

The Plan Year is the 12 month period beginning on each January 1 and ending on each December 31.

Section 8. Source of Financing

All benefits are funded through the Indiana Teamsters Health Benefits Fund, a multiemployer Taft-Hartley trust fund that is funded solely through contributions of Contributing Employers, employees, and/or retiree contributions, as applicable, pursuant to the provisions of the Plan, applicable Collective Bargaining Agreements, and/or other written agreements.

Section 9. Type of Plan

The Retiree Plan is an employee welfare benefit plan providing group medical benefits for Eligible Retirees and their Spouses.

Section 10. Effective Date

The effective date of the most recent Plan restatement is January 1, 2017.

Section 11. Trust

The Trust for the Plan is the Amended and Restated Trust Agreement for the Indiana Teamsters Health Benefits Plan and the Indiana Teamsters Health Benefits Fund Retiree Plan, dated January 1, 2014.

Section 12. Trustees

The Trustees for the Plan are:

UNION TRUSTEES

Mr. Danny L. Barton
Indiana Teamsters Health Benefits Fund
1233 Shelby Street
Indianapolis, Indiana 46203

Mr. Brian Buhle
Indiana Teamsters Health Benefits Fund
1233 Shelby Street
Indianapolis, Indiana 46203

Mr. Mike Hubrecht
Indiana Teamsters Health Benefits Fund
Local Union 135
1233 Shelby Street
Indianapolis, Indiana 46203

Mr. Robert Warnock, III
Indiana Teamsters Health Benefits Fund
Teamsters Local Union No. 364
2405 Edison Road
South Bend, Indiana 46615

EMPLOYER TRUSTEES

Mr. David Heyde
Indiana Teamsters Health Benefits Fund

E & B Paving, Inc.
1420 S. Union Street
Kokomo, Indiana 46902

Mr. Jim Nordhoff
Indiana Teamsters Health Benefits Fund
The Hoosier Company, Inc.
5421 W. 86th Street
P.O. Box 681064
Indianapolis, Indiana 46268

Mr. Eric Lis
Indiana Teamsters Health Benefits Fund
Glazers Corporation
5337 W. 78th Street
Indianapolis, IN 46268

Mr. Mike LaGrange
Indiana Teamsters Health Benefits Fund
Irving Materials Indiana
8032 North State Road 9
Greenfield, IN 46140

Section 13. Funding Policy

The Trust is funded by payments to the Indiana Teamsters Health Benefits Fund by Contributing Employers and employee and retiree contributions, as applicable. The Trust pays benefits for loss of time, medical, dental, and optical benefits. The Trust pays premiums to insurance companies for life and accidental death and dismemberment benefits. Health Insurance Issuer Information

The Plan provides only group self-funded retiree and spouse medical benefits under this Plan, and therefore are not guaranteed under any insurance policy. Certain benefits, such as organ transplant benefits, may be subject to a policy of reinsurance.

ARTICLE XI. RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

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

A. Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U. S. Department of Labor, such as detailed annual reports and Plan descriptions.

B. 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.

C. 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.

D. Continue health care coverage for the participant, the participant's spouse or dependents if there is a loss of coverage under the Plan as the result of a Qualifying Event. The participant or Dependent may have to pay for such coverage. Review this Plan/summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

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 the other Plan participants and beneficiaries.

No one, including the Fund, your Employer 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.

If your claim for your welfare benefit is denied in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request materials 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 which is denied or ignored in whole or in part, you may file suit in a state or federal court.

Although unlikely, if it should happen that Plan fiduciaries should 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 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, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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