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
GEORGE GERDES	DAVID HEYDE
ROBERT WARNOCK, III	SHAWN ALPERS
DUSTIN ROACH	MIKE FERRARA
JESSE MIKESELL	BRIAN L. WHITTAKER

INDIANA TEAMSTERS HEALTH BENEFITS FUND
6007 S HARDING ST., INDIANAPOLIS, INDIANA 46217

(317) 639-3573
1-800-859-6862
(317) 639-3548 (fax)

SUMMARY PLAN DESCRIPTION FOR THE INDIANA TEAMSTERS HEALTH BENEFITS PLAN

INDIANA 400 PLAN

Effective January 1, 2025

TABLE OF CONTENTS

PAGE

TABLE OF CONTENTS
(Continued)

PAGE

TABLE OF CONTENTS
(Continued)

PAGE

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)	30 days per lifetime
Hospice Care	6 months per lifetime
TMJ	$1,000

Annual (Calendar Year) Maximum Benefit Per Covered Person:

Chiropractic	$1,000
(*Chiropractic benefits are a standalone benefit under the Plan are not considered part of the major medical benefits. Receipt of chiropractic care under this provision does not entitle the participant to loss of time benefits*.)	
Acute, Sub-Acute, and Long-Term Acute Rehabilitation (including SNF Unit)	28 day limit
Pain Management – 6 Preauthorized procedures per year	

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* and until the applicable Out-of-Pocket Maximum limit has been reached. After that, the Plan pays one hundred percent (100%) of Covered Expenses for the remainder of the calendar year or until the Maximum Benefit has been reached. Refer to the Schedule of Medical Benefits - Out-of-Pocket Maximum Limit for a listing of charges not applicable to one hundred percent (100%) Co-insurance.

Plan 400 Medical Benefits
January 1, 2025 OUT

	IN NETWORK/ITHBF CLINIC	OUT OF NETWORK
	Plan Features	
Deductible (No Deductible for Services Provided in the ITHBF Clinic)		
Single	$250	$500
Family	$500	$1,000
Co-insurance% (No Co-insurance for Services Provided in the ITHBF Clinic)		
Single	80% of $10,000	60% of $15,000
Family	80% of $20,000	60% of $30,000
Out of Pocket (ITHBF Clinic services not subject to Out of Pocket Limits)		
Single	$2,000	$6,000
Family	$4,000	$12,000
	Hospital Expenses	
Inpatient Hospital Expense *Must be Preauthorized*	80% after network deductible	$500 co-pay, then 60% Not applied to deductible or out of pocket limit
Outpatient Hospital Emergency Accident Expense *Must be Preauthorized*	$250 co-pay, then 80% Co-pay not applied to deductible or out of pocket limit	$250 co-pay, then 80% Co-pay not applied to deductible or out of pocket limit
Urgent or Immediate Care Center	80% after network deductible	80% after out of 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	60% after out of network deductible
Psychiatric Expense – Inpatient *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
Psychiatric Expense – Out of hospital	80% after network deductible	60% after out of network deductible

Substance Abuse Expense – Inpatient *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
Substance Abuse – Out of hospital	80% 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	60% after out of network deductible
	Physician Expenses	
Physician Expense	80% after network deductible 100% for services provided in the ITHBF Clinic	60% after out of network deductible
Medical/OB/Gyn *All outpatient surgeries or invasive procedures must be Preauthorized, including biopsy, dialysis, colonoscopy, endoscopy, infusion drugs, and wound treatment* *Outpatient dialysis services subject to charge review and repricing procedures*	80% after network deductible	60% after out of network deductible
Surgical Expense *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
Diagnostic Testing *Must be Preauthorized* *Biopsy, colonoscopy, endoscopy, and nuclear scans (such as PET/SPECT), must be Preauthorized*	80% after network deductible 100% of services provided in ITHBF clinic.	60% after out of network deductible
Cosmetic Surgery Medically Necessary for a personal injury from an accident or trauma, or disfiguring disease	80% after network deductible	60% after out of network deductible

Must be Preauthorized		
Chiropractic Expense (not subject to Deductible or Out of Pocket limit)	60% $50/visit max $1,000/year max	60% $50/visit max $1,000/year max
TMJ Expense (excluding oral appliances)	80% after network deductible $1,000/lifetime max	60% 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 30 days per lifetime	60% after out of network deductible 30 days per lifetime
Preventive Care *As limited*	100%	60% after out of network deductible
Prescription Drug *(Specialty medications must be Preauthorized. Out-of-pocket costs incurred due to the failure to obtain preauthorization are not counted towards the Annual out-of-pocket maximum or deductible).* *Mandatory Mail Order for certain prescriptions. No deductible for prescription drugs, but subject to out of pocket maximum*	$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 available generic, $10 co-pay plus difference between brand and generic. Specialty medications are subject to a per-claim maximum of $50,000	
Durable Medical Equipment *Must be Preauthorized for expenses over $750* *Corrective appliances and prosthesis must be Preauthorized*	80% after network deductible	60% after out of network deductible
Hearing Aids	80% not subject to deductible $700/3-year max Per Aid	80% not subject to deductible $700/3-year max Per Aid
Hospice *Must be Preauthorized*	80% after network deductible 6 months per lifetime	60% after out of network deductible 6 months per lifetime
Ambulance *Must Submit Medical Records* *Must be Preauthorized*	80% after network deductible	80% after network deductible

Acute Inpatient Rehabilitation (including SNF Units) *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
*Cardiac and pulmonary rehab **Phase I** & II must be Preauthorized*	80% after network deductible	60% after out of network deductible
Pain Management (including TENS units) *Must be Preauthorized*	80% after network deductible 6 procedures per year	60% after out of network deductible 6 procedures per year
Therapy *Physical, occupational, and speech therapy must be Preauthorized*	80% after network deductible 100% if services are rendered at the ITHBF Clinic or, if through a referral by the ITHBF Clinic to an ATI Physical Therapy facility.	60% after out of network deductible
Single Organ Transplant *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
Double Organ Transplant *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
Specified Allogeneic or Autologous Bone Marrow Transplants *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
All Other Allogeneic Bone Marrow or Organ Transplants *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
Pre-Transplant Related Expenses *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
Bone Marrow Harvesting *Must be Preauthorized*	80% after network deductible charges incurred for up to 60 days from removal from donor	60% after out of network deductible 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	60% after out of 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	80% after network deductible	60% after out of network deductible

Immunosuppressive Drugs *Must be Preauthorized*		
Organ Procurement – Living Donor *Must be Preauthorized*	80% after network deductible	60% after out of network deductible
Final Medical Opinion for a Human Organ Transplant *Must be Preauthorized*	80% after network deductible	60% after out of network deductible

PRESCRIPTION DRUG PROGRAM

Deductible Per Calendar Year: None

Out-of-Pocket Max Per Calendar Year: $6,000 Single/$12,000 Family

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

<u>Retail 30-day supply</u>

Tier 1 - Generic:

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

Tier 2 – Preferred Brand Name Drug (if no Generic Drug is available):

Covered Person pays.....$25 Co-pay per prescription if total cost is $100 or less
$40 Co-pay per prescription if total cost is more than $100 but less than $200
20% co-insurance if total cost is $200 or more

Tier 3 – Non-Preferred Brand Name Dugs:

Covered Person pays.....$25 Co-pay per prescription if total cost is $100 or less
$40 Co-pay per prescription if total cost is more than $100 but less than $200
20% co-insurance if total cost is $200 or more

Limitation: 30 day supply

Retail 31- 90-day Supply

Tier 1 - Generic:
Covered Person pays.....$20 Co-pay per prescription

Tier 2 – Preferred Brand Name Drug (if no Generic Drug is available):
Covered Person pays.....$50 Co-pay per prescription if drug costs $300 or less
.....20% co-insurance if the cost is more than $300

Tier 3 – Non-Preferred Brand Name Dugs:

Covered Person pays.....$50 Co-pay per prescription if drug costs $300 or less
.....20% co-insurance if the cost is more than $300

Limitation: 90 day supply

Mail Order Option

Tier 1 - Generic:
Covered Person pays.....$20 Co-pay per prescription

Tier 2 – Preferred Brand Name Drug (if no Generic Drug is available):
Covered Person pays.....$50 Co-pay per prescription if drug costs $300 or less
.....20% co-insurance if the cost is more than $300
Tier 3 – Non-Preferred Brand Name Dugs:

Covered Person pays.....$50 Co-pay per prescription if drug costs $300 or less
.....20% co-insurance if the cost is more than $300

Limitation: 90 day supply

Specialty

Tier 1 - Generic:
Covered Person pays.....$10 Co-pay per prescription

Tier 2 – Preferred Brand Name Drug (if no Generic Drug is available):

Covered Person pays.....$25 Co-pay per prescription if drug costs $100 or less
.....$40 Co-pay per prescription if the drug costs $200 or less
.....20% co-insurance if the cost is more than $200

Tier 3 – Non-Preferred Brand Name Dugs:

Covered Person pays.....$25 Co-pay per prescription if drug costs $100 or less
.....$40 Co-pay per prescription if the drug costs $200 or less
.....20% co-insurance if the cost is more than $200

*Specialty medications are subject to a per claim maximum of $50,000

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 or Out-of-Pocket Maximum limit. 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 limits and reimbursement of medications. All specialty medications require a Preauthorization. Zero benefits are payable if you fail to obtain Preauthorization. Specialty medications are subject to a per claim maximum of $50,000.

Effective January 1, 2024, the Plan's Pharmacy Benefit Manager is Northwind Pharmaceuticals, LLC ("Northwind"). Members may contact Northwind's toll-free help desk with questions regarding covered pharmacy products and services from 8:00 am ET through 10:00 pm ET, Monday through Friday, and from 10:00 am ET through 7:00 pm ET on Saturday, and 10:30 am ET through 7:00 pm ET Sunday. Customer support service hours on nationally recognized holidays may vary.

Northwind's toll-free help desk: **1-866-490-2123**

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

Select Drugs and Products Program

Effective April 1, 2024, the Plan requires Covered Persons to enroll in the Select Drugs and Products Program when individuals are prescribed prescription drugs listed on a Select Drugs and Products List. This Program is paid by the Plan and provides matching of alternate funding

programs to Covered Persons. Contact the Specialty Contact Center for additional information regarding the Program at 877-869-7772.

The Select Drugs and Product list ("Specialty Drug List") is updated periodically by the Plan to address changes in prescription labeling, new market entrants, and safety and efficacy considerations and each listed item requires Plan prior authorization, step-therapy, and administrative review for coverage. Contact the Fund Office to confirm whether a prescription drug is on the most recent Specialty Drug List. All Specialty Drugs must be ordered through Northwind Pharmaceuticals, LLC.

All Covered Persons using listed specialty drugs are required to meet prior authorization, step-therapy, and administrative review criteria, which includes enrollment in the Program and adjudication of their Specialty Drug cost by an alternate funding program prior to meeting Plan coverage criteria. Specialty drugs are limited to a per claim maximum of $50,000. Failure to prior authorize and complete the requirements of the Select Drugs and Products Program will result in a cost containment penalty equal to a 100% reduction in benefits payable. This will be treated as an adverse benefit determination under the Plan and Covered Person will have an opportunity to (i) appeal that decision or (ii) comply with the requirements of the Program to avoid cost containment penalty.

Some alternate funding programs require verification of income as a condition of meeting alternate funding program criteria. In such cases, the Covered Person will be asked to provide this information directly to the alternate funding program, and such information will not be provided to the Plan and is not considered in determining coverage by the Plan.

All Specialty Drug prescriptions paid for by the Plan through the appeals process must be dispensed or coordinated by Northwind. Questions related to the Select Drugs and Products Program may be made directly to the Plan Specialty Contact Center by calling 877-869-7772.

DENTAL BENEFITS

Annual Maximum Benefit per Adult Covered Person: (excluding Orthodontic)	$1,500
Lifetime Maximum Orthodontic Benefit per Covered Dependent:	$1,000 up to age 26
Percentage of Reasonable and Customary Charges Payable By Plan:	
Crowns, fixed bridgework, gold inlays and onlays, and other related services only	60%
All other covered services	100%

Deductibles, Co-insurance and balance bill amounts do not accumulate to your medical Out-of-Pocket Maximum limit.

Pediatric Dental Benefit up to age 18: (*excluding Orthodontic)	No Limit* Based on Reasonable and Customary Based on Medical necessity

Optical Benefits

Annual Maximum Benefit per Adult Covered Person:

Examinations	$50
Contact Lenses	$80/pair
Lenses	$50-70 (depending upon Rx)
Frames	$80

Balance bill amounts for optical services do not accumulate to your annual Out-of-Pocket Maximum.

Pediatric Optical Benefit up to age 18:	No Limit Based on Reasonable and Customary Based on Medical necessity

Loss of Time Benefits

Disability Waiting Period

Injury	0 days
Illness	7 days

Weekly Benefit	$250.00
Maximum Benefit Period	26 weeks

Insured Benefits

Life Insurance	$11,000 per Employee
AD&D	$11,000 per Employee

INTRODUCTION

The following is a summary explaining the Indiana Teamsters Health Benefits Plan (the "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 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 Dependents 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. Your employment status is as provided under your applicable collective bargaining agreement.

You may review or obtain copies of the actual benefit plans and the insurance policies by written request to the Fund, 6007 S Harding St., Indianapolis, Indiana 46217. 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.

SCHEDULE OF MEDICAL BENEFITS

Section 1. General Information

(a) Eligible Class of Employees: Those Employees on whose behalf contributions are made by Contributing Employers pursuant to a Collective Bargaining Agreement providing for medical benefits and who have completed the Waiting Period and who are Actively at Work (unless not Actively at Work due to a health status-related factor).

(b) Waiting Period: Eight consecutive weeks during which contributions must be made on behalf of the Eligible Employee.

(c) Re-Establishing Eligibility: If an Employee becomes ineligible because the required Contributions are not made on his behalf, he will again become eligible the week the Contribution is made again. However, if the Employee is ineligible for coverage for twelve consecutive months, he must re-satisfy the Waiting Period.

(d) Co-pay: The Co-pay is the amount payable by the Covered Person for certain services, supplies or treatment. The services and applicable Co-pays are shown on the Schedule of Benefits. The Co-pay must be paid each time a treatment or service is rendered. The Co-pay will not be applied toward the following:

(1) The calendar year Deductible.

(2) The Out-of-Pocket Maximum.

(e) 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.

(1) Individual 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.

(2) Family Deductible. If, in any calendar year, covered members of a family Incur Covered Expenses that are subject to the Deductible that are equal to or greater than the dollar amount of the family Deductible shown on the Schedule of Benefits, then the family Deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family Deductible amount, but no more than each person's individual Deductible amount may be applied toward satisfaction of the family Deductible by any family member.

(f) 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 one hundred percent (100%) of the billed amount. The Covered Person's portion of the Co-insurance is applied to the Out-of-Pocket Maximum limit, to the extent required. For claims subject to the No Surprises Act, the amount the Plan will pay to the provider and the amount you pay may be different than as described in this provision. For more information on claims subject to the No Surprises Act, refer to the section in this document titled "Protections from Surprise Medical Bills."

(g) Out-of-Pocket Maximum Limit: After the Covered Person has Incurred an amount equal to the Out-of-Pocket Maximum limit listed on the Schedule of Benefits for Covered Expenses (after satisfaction of any applicable Deductibles), the Plan will begin to pay one hundred percent (100%) for Covered Expenses for the remainder of the calendar year.

After a covered family has Incurred a combined amount equal to the family Out-of-Pocket Maximum limit shown on the Schedule of Benefits, the Plan will pay one hundred percent (100%) of Covered Expenses for all covered family members for the remainder of the calendar year.

Only Preferred Provider charges will be applied to the Preferred Provider Out-of-Pocket Maximum limit and only Non-preferred Provider charges will be applied to the Non-preferred Provider Out-of-Pocket Maximum limit.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year Out-of-Pocket Maximum limit:

(1) Expenses for services, supplies and treatments not covered by this Plan, to include charges in excess of the Reasonable and Customary Charge or Negotiated Rate, as applicable.

(2) Deductible(s).

(3) Co-pays.

(4) Expenses Incurred as a result of failure to obtain Precertification.

(h) Maximum Benefit: The Lifetime Maximum Benefit payable on behalf of a Covered Person is shown on the Schedule of Benefits. The Lifetime Maximum Benefit applies to the entire time the Covered Person is covered under the Plan, including prior and subsequent restatements, either as an Employee, Dependent, qualified medical child support order Alternate Recipient or under COBRA. If the Covered Person's coverage under the Plan terminates and at a later date he again becomes covered under the Plan, the Lifetime Maximum Benefit will include all benefits paid by the Plan for the Covered Person during any period of coverage.

The Schedule of Benefits contains 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 Lifetime 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 call the number on the back of their insurance card to determine whether a provider is participating. If you rely on information from the Plan that inaccurately states that an out-of-network provider is in-network, you will only be subject to in-network cost sharing amounts.

(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. For claims subject to the No Surprises Act, the amount the Plan will pay to the provider and the amount you pay may be different than as described in this provision. For more information on claims subject to the No Surprises Act, refer to the section in this document titled “Protections from Surprise Medical Bills.”

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

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

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

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

(E) Dependents residing outside the Preferred Provider Organization's service area (for example, a full-time student), Covered Expenses will be payable at the Preferred Provider level of benefits.

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

You may have additional protections from out-of-network surprise bills under the No Surprises Act. For more information, refer to the Section 5 in this Article, titled "Protections from Surprise Medical Bills."

(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) Clinical Trials. The Plan covers benefits for certain clinical trials. To be considered a covered service, a clinical trial must be a phase I, II, III or IV clinical trial. It must also be a:

(A) Federally funded or approved trial;

(B) Trial conducted under an FDA investigational new drug application; or

(C) Drug trial that is exempt from requirement of an FDA investigational new drug application.

The Plan pays benefits for your clinical trial, provided you are diagnosed with cancer or another life-threatening condition, and you:

(A) Submit proof that your health care professional (who must be an in-network provider) is referring you to the clinical trial and that the clinical trial is considered appropriate for your care; or

(B) Provide medical and scientific information to the Fund Office that demonstrates that the clinical trial is appropriate for you.

If your clinical trial is approved, the Plan pays benefits for the reasonable routine covered services furnished in connection with your participation in the clinical trial. These services must already be considered covered services under the Plan. For example, if you require temporary hospitalization or monitoring in connection with the trial and there is an expense for the services, the Plan considers the services as covered services and pays benefits for the eligible expenses. Routine costs do not include:

(A) Investigational items, devices or services;

(B) Items and/or services provided for the sole purpose of data collection and analysis needs;

(C) Services that are inconsistent with widely accepted and established standards of care for a particular diagnosis; or

(D) Any other items that the Fund Office determines are not eligible routine expenses.

The Plan reserves the right to use reasonable medical management techniques to interpret and apply coverage provisions related to clinical trials. The Plan does not discriminate against you on the basis of your involvement in an approved clinical/

(5) 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.

(6) 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 but may be covered under the Schedule of Dental Benefits. Treatment must begin within six (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 six (6) or more teeth requiring confinement in a Hospital and for charges for the Medically Necessary procedures associated with the extractions.

(B) Facility charges in connection with providing dental services to children age 12 and under, but only if at least two (2) prior attempts to treat the child with pre medication in an office setting failed.

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

Dental surgeries must be Preauthorized.

(7) 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. Covered Expenses Incurred at the ITHBF Clinic include services for simple lab work related to routine physical examinations and CDL.

(8) 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.

(9) 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.

(10) 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 Total Covered Expense is over $750. All Rental Durable Medical Equipment must be Preauthorized.

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.

(11) Hearing Aids. Covered Expenses include one 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.

(12) 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.

(13) 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 six (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, nurses' 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.

(14) 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 seventy-two (72) hours of a procedure.

(D) Expenses Incurred at a Skilled Nursing Facility are covered, up to twenty-eight (28) days, if such Covered Expenses are Medically Necessary immediately following an Inpatient hospitalization.

(15) 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 three (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) Two 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.

(16) 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.

(17) 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.

(18) 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.

(19) 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 fifty percent (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 two (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.

(20) Pregnancy. Covered Expenses for pregnancy or complications of pregnancy will be provided for a covered Eligible Employee, a covered Spouse, and Dependent children.

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 forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (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.

(21) 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 one prescription is limited to a thirty (30) day supply for the pharmacy option and a ninety (90) day supply for the mail order option. Use of some formulary or any non-formulary drug or injectable 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 three months.

(A) Excluded Expenses - The Plan will not pay charges for the following non-covered expenses: (1) hypodermic needles (except for diabetic use), support garments;; (2) immunizing agents, injectable, blood or blood plasma, or medication prescribed for parental administration, except insulin; (3) smoking cessation programs (even if prescribed by a Physician) (except for the items specifically provided under preventive care benefits); (4) lifestyle drugs, such as Rogaine, Viagra, Cialis, Levitra and similar medications; or (5) 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.

(22) Preventive Care. The Plan pays 100% of eligible in-network preventive care services, up to the reasonable and customary charge. You do not have to meet a deductible requirement before the Plan pays benefits. Preventive care services received from an Out-of-Network provider will be paid under the Major Medical Benefit and will be subject to coinsurance and deductible requirements only if otherwise covered under the Plan.

The following list of preventive care services are currently covered under the Plan, as required by law. The listing may change from time to time based upon the recommendation of the United States Preventive Services Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health and Resources and Services Administration.

Preventive Benefits for Adults

Immunizations
Immunization vaccines for adults – doses, recommended ages, and recommended populations vary:

- Haemophilus influenzae type B
- Hepatitis A
- Hepatitis B
- Herpes Zoster (Shingles)
- Human Papillomavirus (HPV)
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella (Chicken Pox)

Cancer Related

- BRCA-Related Cancer: Risk Assessment, Genetic Counseling and Genetic Testing for women at increased risk
- Breast Cancer Mammography Screening for women ages 40 to 74
- Breast Cancer: Medications for Risk Reduction for women age 35+ at increased risk
- Cervical Cancer Screening for women age 21 to 65
- Colorectal Cancer Screening for adults age 45 to 75
- Lung Cancer Screening for adults age 55 to 80 with history of smoking
- Skin Cancer Prevention: Behavioral Counseling for children, parents of young children, adolescents and young adults (persons aged 6 months to 24 years) with fair skin type

Chronic Conditions

- Abdominal Aortic Aneurysm Screening for men age 65 to 75 who have ever smoked
- Abnormal Blood Glucose and Diabetes Mellitus (Type 2) Screening for adults aged 40 to 70 who are overweight or obese; Counseling Services for all adults with abnormal blood glucose.
- Anxiety Screening for adolescent and adult women, including those who are pregnant or postpartum
- Aspirin for the Prevention of Cardiovascular Disease and Colorectal Cancer for adults aged 50 to 59 years with risk factors.
- Depression Screening for all adults, including pregnant and postpartum women.
- Hepatitis B Screening for adults at increased risk
- Hepatitis C Screening for adults at increased risk
- Hypertension (High Blood Pressure) Screening for adults
- Latent Tuberculosis Infection for asymptomatic adults 18 years and older at increased risk
- Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions for adults with body max index (BMI) of ≥30
- Osteoporosis Screening for women aged 65+, Postmenopausal women younger than 65 at increased risk
- Statin Use for Prevention of Cardiovascular Disease (CVD) for adults aged 40 to 75 without history of CVD who have 1 or more risk factors and a calculated 10-year CVD event risk of 10%+.

Health Promotion

- Alcohol Misuse Screening and Counseling for adults
- Healthful Diet and Physical Activity for Cardiovascular Disease (CVD): Behavioral Counseling for overweight or obese adults with additional CVD risk factors
- Falls Prevention in Older Adults for community-dwelling adults, age 65+ at increased risk for falls
- Interpersonal, Domestic, and Intimate Partner Violence Screening and Counseling for women
- Tobacco Smoking Cessation: Behavioral and Pharmacotherapy Interventions for adults

- Well-Woman Preventive Visits

Sexual Health

- Chlamydia Screening for sexually active women under 24 years, and older women at increased risk
- Contraceptive Services and Counseling for women with reproductive capacity
- Gonorrhea Screening for sexually active women under 24 years, and older women at increased risk
- HIV Infection Counseling and Screening for women
- HIV Infection Screening for adults age 15 to 65, younger and older individuals at increased risk.
- Preexposure Prophylaxis (PrEP) for the Prevention of HIV Infection for persons at high risk of HIV.
- STI Counseling for adults at increased risk; all sexually active women
- STI Counseling for sexually active women
- Syphilis Screening for adults and adolescents at increased risk

Pregnancy Related

- Bacteriuria Screening for pregnant women
- Breastfeeding: Primary Care Interventions for pregnant and postpartum women
- Breastfeeding Support, Supplies, and Counseling for pregnant and postpartum women
- Depression Screening for adults, including pregnant and postpartum women.
- Diabetes Mellitus screening for postpartum women with a history of gestational diabetes
- Folic Acid Supplements to Prevent Neural Tube Defects for women planning or capable of pregnancy
- Gestational Diabetes Screening for pregnant women
- Hepatitis B Screening for pregnant women
- HIV Infection Screening for pregnant women
- Maternal Depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- Perinatal Depression Preventive Intervention for pregnant persons at increased risk
- Preeclampsia Preventive Aspirin for pregnant women at increased risk
- Preeclampsia Screening for pregnant women
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Syphilis Screening for pregnant women
- Tobacco Smoking Cessation: Behavioral Interventions for pregnant women who smoke

Preventive Benefits for Children

Immunizations

Immunization vaccines for children – doses, recommended ages, and recommended populations vary:

- Haemophilus influenzae type B
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Inactivated Polio
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Tetanus, Diphtheria, Pertussis
- Varicella (Chicken Pox)

Cancer-Related

- Cervical Dysplasia Screening at 21 years
- Skin Cancer Prevention: Behavioral Counseling for children, parents of young children, adolescents and young adults (persons aged 6 months to 24 years) with fair skin type

Chronic Conditions

- Anemia Screening based on risk factors and age
- Anxiety Screening for adolescent and adult women, including those who are pregnant or postpartum
- Autism Screening for children at 18 and 24 months
- Bilirubin Concentration Screening for newborns
- Blood Pressure Screening for children over 3 years, and under 3 years based on risk factors
- Blood Screening for newborns
- Critical Congenital Heart Defect Screening for newborns
- Depression Screening for adolescents beginning routinely at age 12
- Dyslipidemia Screening for all children once between 9 and 11 years and once between 17 and 21 years, and more often for children at higher risk of lipid disorders
- Hematocrit or Hemoglobin Screening for all children
- Hemoglobinopathies or Sickle Cell Screening for newborns
- Hepatitis B Screening for adolescents at high risk
- Hypothyroidism Screening for newborns
- Iron Supplements for children ages 6 to 12 months at risk for anemia
- Lead Screening for children at risk of exposure and based on age
- Maternal Depression screening for mothers of infants at 1, 2, 4, and 6-month visits
- Obesity Screening and counseling
- Phenylketonuria (PKU) Screening for newborns
- Tuberculin Testing for children at higher risk of tuberculosis and based on age

Health Promotion

- Alcohol, Tobacco, and Drug Use Assessments for adolescents
- Behavioral Assessments for children throughout childhood
- Body Mass Index (BMI) Measurements for children over 2 years
- Developmental Screening for children under age 3 and Developmental Surveillance throughout childhood
- Fluoride Chemoprevention Supplements for children without fluoride in their water source
- Fluoride Varnish for all infants and children as soon as teeth are present
- Gonorrhea Preventive Medication for the eyes of all newborns
- Head Circumference and Weight for Length Measurement for infants and young children
- Hearing Screening for children based on risk factors and age
- Height and Weight Measurements for all children
- Interpersonal and Domestic Violence Screening for adolescents
- Medical History for all children
- Oral Health Risk Assessment for children 6 months and 9 months, and later based on risk factors
- Vision Screening for children 3 to 6 years, and throughout childhood based on risk factors

Sexual Health

- HIV Screening once between 15 and 18 years of age, and for adolescents at higher risk
- Sexually Transmitted Infection (STI) Prevention Counseling and Screening for adolescents at higher

(23) 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.

(24) 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 three days;

(2) Individual psychotherapy;

(3) Group psychotherapy and family counseling; or

(4) Psychological testing.

(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.

(25) 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.

(26) 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.

(27) Sterilization. Covered Expenses will include elective sterilization procedures for the covered Employee or covered spouse. Reversal of sterilization is not a Covered Expense.

(28) 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.

(29) 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.

(30) 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. Preauthorized is required.

(31) 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. Physical therapy will be covered at the ITHBT Clinic at 100%; referrals to physical therapy at an ATI facility must be made by a professional at the ITHBT Clinic in order to be covered by the Plan.

(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 and Phase II cardiac and pulmonary rehab only.

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

(32) 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.

(33) 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.

(34) 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 one companion who accompanies the recipient to the transplant center, or two 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.

(35) Wigs. This Plan will reimburse the cost incurred by an eligible individual for the purchase of one wig per year. In order to be eligible for this benefit, the individual must be diagnosed with cancer.

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. Notwithstanding this exclusion, when applicable, the Plan provides coverage for vision care as specified in the Schedule of Optical Benefits.

(6) Physician's services or x-ray examinations involving one 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. Notwithstanding this exclusion, when applicable, the Plan provides coverage for dental care as specified in the Schedule of Dental Benefits.

(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 the newborn child of a Dependent child.

(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)(15).

(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 or Dependent 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) Patient education programs.

(38) 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.

(39) Medical records.

(40) 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.

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

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

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

(44) 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, any bariatric surgery, 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. This exclusion applies unless services are specifically provided under preventive care benefits.

(45) Electrolysis depilation.

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

(47) Charges for Laetrile and its administration.

(48) 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.

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

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

(51) Private duty professional nursing services, nurse’s aide and sitters.

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

(53) Formula, diapers or underpads.

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

(55) 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 (except for the items specifically provided under preventive care benefits).

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

(57) 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.

(58) Stand-by surgeons.

(59) Massage therapy.

(60) Aquatherapy.

(61) Biofeedback.

(62) Holistic medicine.

(63) 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, Dependent, or a non-Covered Person under the Plan), and any charges incurred by the child born to the surrogate mother unless and until the Plan is otherwise required to provide coverage for the child because the child is a Dependent as defined by the Plan.

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

(65) Services provided by an unlicensed or uncertified midwife or a midwife acting outside the scope of license or certification under applicable state law.

(66) TMJ appliances.

(67) Dental implants regardless of diagnosis or cause.

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

(69) Animal to human transplants.

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

(71) Pectus excavatum repair.

(72) Rectus abdominal muscle repair.

(73) Pulse dye laser.

(74) Clinitron and electric beds.

(75) Liquid oxygen.

(76) Myoelectric prostheses.

(77) Prosthetic intervertebral disc replacement.

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

(79) Kyphoplasty.

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

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

(82) Epidural injections of lytic agents.

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

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

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

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

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

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

(89) 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.

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

(91) Scholastic education or vocational training;

(92) Genetic testing;

(93) 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.

(94) Bariatric Surgery.

(95) Gene therapy, including any services, supplies and/or drugs related to gene therapy.

Section 4. Cost Containment and Utilization Management Procedures

(a) 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 is 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.

(b) 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 45, endoscopy, biopsy and surgeries
- Nuclear medicine scans, such as PET/SPECT
- Certain diagnostic testing
- Durable medical equipment ALL Rentals and 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.

(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.

Section 5. Protections from Surprise Medical Bills

Under a federal law called the No Surprises Act, you have protection against surprise medical bills from out-of-network providers and facilities. This law generally applies to Out-of-Network Emergency Services, services provided by out-of-network providers that are working at Out-of-Network facilities, and Out-of-Network Air Ambulance Services.

Out-of-Network Emergency Services. Covered Emergency Services are treated as In-Network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum, even if the services were received from an out-of-network Emergency facility. This means you will be responsible for the network cost-share

amount. The Plan will count any cost-sharing payments toward the in-network deductible and/or the in-network out-of-pocket maximums in the same manner it would count cost-sharing payments made for in-network Emergency Services. Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive Emergency Services from an out-of-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

Out-of-Network Providers at Network Facilities. Unless you consent to receiving services from the out-of-network provider (as described in this section), covered services performed by out-of-network providers at network facilities are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount, and the Plan will count any cost-sharing payments incurred for these services toward the in-network deductible and/or the in-network out-of-pocket maximums under the Plan in the same manner it would count cost-sharing payments made for in-network services. Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive services from an out-of-network provider at a network facility, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

Out-of-Network Air Ambulance Providers. Covered Air Ambulance Services are treated as in-network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount and the Plan will count any cost-sharing payments incurred for covered Air Ambulance Services toward the in-network deductible and/or the in-network out-of-pocket maximums in the same manner it would count cost-sharing payments made for in-network services. Your cost-sharing will be based on the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

If you receive Air Ambulance Services from an out-of-network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, including payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

Waiving Surprise Medical Bill Protections In certain circumstances, you can waive the balance billing and cost-sharing protections usually provided when you visit an Out-of-Network Provider who works at a Network Facility or an Out-of-Network emergency facility or provider after you are stabilized. This can occur if you are notified by the Out-of-Network Provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and waive the protections.

If you give informed consent to be treated by the Out-of-Network provider, then the Plan will treat these services as Out-of-Network. This means you will be subject to Out-of-Network cost-sharing, the provider can bill you for the balance directly, and the provider can balance bill you for the difference between what the provider charges and the amount paid by the Plan.

Plan Payment to Provider. The Plan will pay the provider or facility the Out-of-Network Rate minus any cost-sharing amounts (copayments, coinsurance, an/or amounts paid towards deductible) you paid.

Continuing Care. If you are receiving care from a network provider that becomes out-of-network, you may have certain rights to continue your course of treatment if you are a "continuing care patient." A continuing care patient is a patient that:

- is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under Social Security Act) and is receiving treatment for such illness from such provider or facility.

A serious and complex condition means a condition that

- in the case of an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that
    i. is life-threatening, degenerative, potentially disabling, or congenital; and
    ii. requires specialized medical care over a prolonged period of time.

If the Plan terminates its contract with your Network provider or facility or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, you will be notified of the change and informed of your right to elect to receive transitional care from the provider. You may choose to continue your course of treatment under the same terms and conditions as would have applied for an in-network provider for up to 90 days after the notice is provided or until you no longer qualify as a continuing care patient (whichever is earlier). Providers cannot balance bill you during this time.

Termination of a contract includes the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

SCHEDULE OF DENTAL BENEFITS

Section 1. General Information

(a) Eligible Class of Employees: Those employees on whose behalf contributions are made by Contributing Employers pursuant to a Collective Bargaining Agreement providing for dental benefits and who have completed the Waiting Period and who are Actively at Work (unless not Actively at Work due to a health status-related factor).

(b) Waiting Period: Eight consecutive weeks during which contributions must be made on behalf of the Eligible Employee.

(c) Re-Establishing Eligibility: If an employee becomes ineligible because the required Contributions are not made on his behalf, he will again become eligible the week the Contribution is made again. However, if the employee is ineligible for coverage for twelve consecutive months, he must re-satisfy the Waiting Period.

(d) Deductible: None.

(e) Annual Maximum Benefit for Adults: $1,500 per Adult Covered Person for all covered dental procedures (except Orthodontic) received in any calendar year. No Annual Maximum Benefit for dental benefits for Dependents up to the 18th birthday based on Reasonable and Customary and Medical Necessity (except Orthodontic).

(f) Co-insurance on Benefits: For covered dental procedures (except Orthodontic), the Plan will pay a percentage of the Reasonable and Customary Charge, as follows:

Crown, implants, fixed bridgework, gold inlays and onlays, and other related services 60%

All other 100%

(g) Maximum Orthodontic Benefit: The Plan will pay the first $1,000 of Covered Charges up to a Maximum Lifetime Benefit Limit of $1,000 per Dependent child up to the 26th birthday.

(h) Required Orthodontic Diagnostic Classification: The Plan will pay Orthodontic benefits, subject to the limitations set forth below, when the diagnostic classification is as follows:

(1) Angles Classification II or III, or

(2) Angles Classification I, if

a) Upper teeth protrude four or more millimeters over lower teeth, or

b) There is an overbite of four or more millimeters, or

c) Gum area is four or more millimeters too small or too large for the teeth (arch-length) by a discrepancy of four or more millimeters, or

d) Teeth are in cross-bite (extreme buccolingual version of teeth).

Section 2. Eligible Dental Expenses

The Plan will pay Reasonable and Customary Charges Incurred by a Covered Person for treatment provided by a Dentist to prevent dental problems, correct existing ones, and to replace teeth already missing or those that have to be extracted. Covered dental procedures include, but are not limited to, the following:

(a) Office visit during regular office hours, for oral examination (limited to once every 6 months)

(b) Prophylaxis or periodontal prophylaxis (cleaning) (limited to once every 6 months)

(c) Topical application of fluoride for Dependent children up to the age of 18, (limited to once every 6 months) as medically necessary per guidelines of the American Dental Association or American Pediatric Dental Society

(d) Full mouth x-rays (limited to once every 2 years)

(e) Bitewing x-rays (limited to once every 6 months)

(f) Sealant treatments, limited to Dependent children to age 14, as medically necessary per guidelines of the American Dental Association or American Pediatric Dental Society

(g) Restorative dental treatments and extractions

(h) Fillings and routine extractions

(i) Root canal treatments and similar services

(j) Oral surgery and anesthesia unless covered under the Medical Benefit

(k) Removal of impacted teeth unless covered under the Medical Benefit

(l) Alveoplasties

(m) General anesthesia when used in conjunction with oral surgical procedures

(n) Periodontal scaling and/or root planning (limited to once every 12 months for each Quad.)

(o) Gingivectomies or gingivoplasty

(p) Mucogingival surgery

(q) Osseous surgery

(r) Osseous graft

(s) Gingival curettage

(t) Local anesthesia

(u) General anesthesia when used in conjunction with periodontal procedures

(v) Fixed and removable prosthetic devices and related services

(w) Full or partial dentures (limited to every 3 years)

(x) Fixed bridgework, crowns, inlays and onlays

(y) Implants

(z) Repairs of dentures, partials, bridges and crowns

(aa) Orthodontic Benefits – Straightening of teeth where the Required Orthodontic Classification is present and the braces or active Orthodontic appliances are installed while the child is covered under the Plan (limited to Dependent children under the age of 26) (subject to $1,000 lifetime maximum)

Section 3. Dental Exclusions

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

(a) Treatment by someone other than a Dentist except for cleaning and scaling of teeth and application of fluoride by a licensed dental hygienist, when such services are rendered under the supervision and guidance of a Dentist.

(b) Services and supplies which are not necessary according to broadly accepted standards of dental practices, including services or supplies which are Experimental in nature.

(c) Services and supplies for cosmetic purposes.

(d) Orthodontic services and supplies for a Covered Person who is not a Dependent child.

(e) Services and supplies for which a Covered Person is not legally required to pay.

(f) Educational programs, such as plaque control, oral hygiene instruction or nutritional counseling.

(g) Failure to keep scheduled appointments or charges for completion of claim forms.

(h) Prescriptions (these are paid under your prescription benefits as set forth in the Summary of Medical Benefits).

(i) Fluoride application performed on a participant or spouse.

(j) In connection with restorative dentistry, temporary restorations, bases or sedative fillings.

(k) Sealants Incurred for Dependents to 14 years of age.

(l) Any charges for children who do not satisfy the definition of "Dependent" under Section 2(p) of Article IV.

(m) Expenses for duplication or replacements of crowns, bridgework, dentures or prosthetic devices less than three years after initial procedure, whether insertion, duplication or replacement.

(n) Expenses for relines made less than six months after insertion of dentures.

(o) Full-mouth x-rays more than once in any two year period.

(p) Bitewing x-rays, fluoride application, oral examination or prophylaxis (cleaning) more than once in any six month period.

(q) Precision attachments, specialized techniques, and personalization of dentures.

(r) Procedures, restorations and appliances to increase vertical dimension (the distance between the nose and chin).

(s) Facing or veneers or molar pontics.

(t) More than two consecutive abutments on any fixed bridgework. (Crowns splinted and extended beyond this will be payable as individual crowns.)

SCHEDULE OF OPTICAL BENEFITS

Section 1. General Information

(a) Eligible Class of Employees: Those employees on whose behalf Contributions are made by Contributing Employers pursuant to a Collective Bargaining Agreement providing for optical benefits and who have completed the Waiting Period and who are Actively at Work (unless not Actively at Work due to a health status-related factor).

(b) Waiting Period: Eight consecutive weeks during which Contributions must be made on behalf of the Eligible Employee.

(c) Re-Establishing Eligibility: If an employee becomes ineligible because the required Contributions are not made on his behalf, he will again become eligible the week the Contribution is made again. However, if the employee is ineligible for coverage for twelve consecutive months, he must re-satisfy the Waiting Period.

(d) Deductible: None.

(e) Eligible Optical Expenses: Charges Incurred by a Covered Person (while covered under the Plan) for specified vision care procedures performed by a licensed Vision Care Professional, subject to the Maximum Annual Eligible Expenses specified for the procedure in the Schedule of Vision Care Procedures below for an Adult Covered Person.

Section 2. Schedule of Vision Care Procedures

Procedure	Maximum Annual Eligible Expense
COMPLETE EXAMINATION	
Ophthalmologist (M.D.)	$50
Optometrist	$50
LENS PAIR	
Single Vision Rx	$50
Bi-Focal Rx	$60
Tri-Focal Rx	$70
Contacts	$80
FRAMES	
Frames	$80

Section 3. Vision Exclusions

Benefits will not be payable for the following non-Covered Expenses:

(a) more than one complete examination in any calendar year;

(b) more than one pair of lenses in any calendar year;

(c) more than one set of frames in any calendar year (contacts are considered to be lenses and frames);

(d) expenses Incurred for children who do not satisfy the definition of "Dependent" under Section 2(q) of Article IV.; or

(e) any loss or expense caused by, Incurred for, or resulting from:

(1) procedures or supplies furnished on account of a visual defect which arises out of, or in the course of, any occupation for wage or profit;

(2) declared or undeclared war, or any act thereof, or military or naval service of any country;

(3) vision care services or supplies furnished by or at the direction of the United States Government or any agency thereof;

(4) vision care services or supplies received from a medical department maintained by a mutual benefit association, labor union, trustee or other similar group;

(5) any medical or surgical treatment of the eye;

(6) sunglasses, plain or prescription, or safety lenses or goggles; or

(7) orthoptics, vision training or aniseikonia.

SCHEDULE OF LOSS OF TIME BENEFITS

Section 1. General Information

(a) Eligible Class of Employees: Those employees (excluding employees who have entered into a participation agreement by and between such employee and the Fund providing that no Loss of Time Benefits shall be provided) on whose behalf contributions are made by Contributing Employers pursuant to a Collective Bargaining Agreement providing for loss of time benefits and who have completed the Waiting Period and who are Actively at Work (unless not Actively at Work due to a health status-related factor).

(b) Waiting Period: Eight consecutive weeks during which Contributions must be made on behalf of the Eligible Employee.

(c) Re-Establishing Eligibility: If an employee becomes ineligible because required Contributions are not made on his behalf, he will again become eligible the week the Contribution is made again. However, if the employee is ineligible for coverage for twelve consecutive months, he must re-satisfy the Waiting Period.

Section 2. Loss of Time Benefits

(a) Eligible Employees who are Disabled will receive a weekly benefit of $250 during Disability. Benefits will begin on the first day of Disability caused by an Accidental Injury and on the eighth day of Disability caused by an Illness. Disability commencing more than 30 days after an Accidental Injury will be considered to be caused by Illness. If Disability benefits are due for a portion of a week, the benefit will be 1/7 of the weekly benefit for each day of Disability.

Successive periods of Disability due to the same cause, not separated by return to Active Work for 30 working days, will be considered one period of Disability. If your second Disability is not related to your first Disability, you must return to work for 1 day to begin a new Loss of Time period.

Claims for Loss of Time Benefits must be certified by a Physician. Loss of Time Benefits are not payable for work-related injuries. No Loss of Time Benefits will be paid to you if you receive any form of workers' compensation benefits, or any type of workers' compensation settlement, for the same Injury or period of Disability. If your workers' compensation claim is denied, no Loss of Time Benefits will be paid until the Trustees receive documentation of said denial. If a Plan pays Loss of Time Benefits and you later receive workers' compensation benefits or a workers' compensation settlement related to the same Injury or period of Disability, you must reimburse the Plan the full amount of the Loss of Time Benefits paid related to that Injury or period of Disability.

SCHEDULE OF LIFE INSURANCE BENEFITS

Section 1. General Information

(a) Eligible Class of Employees: Those employees on whose behalf Contributions are made by Contributing Employers pursuant to a Collective Bargaining Agreement providing for employee life insurance benefits and who have completed the Waiting Period and who are Actively at Work.

(b) Waiting Period: Eight consecutive weeks during which Contributions must be made on behalf of the Covered Person.

(c) Re-Establishing Eligibility: In the event that an Eligible Employee becomes ineligible due to a lack of the appropriate Contributions on his behalf, he will again become eligible the week the first Contribution is again made on his behalf; provided, however, that there is not more than a twelve-month interruption in coverage, in which case the employee must re-satisfy the Waiting Period.

Section 2. Description of Life Insurance Benefits

(a) Group Term Life Insurance: The Plan will provide Group Term Life Insurance on behalf of each Eligible Employee. In the event the Eligible Employee dies from any cause, the Plan will pay Life Insurance Benefits in the amount set forth below to the named beneficiary or to the person paying certain expenses (as outlined below in Facility of Payment). The Eligible Employee may change his or her named beneficiary at any time, pursuant to procedures established by the Plan Administrator. Life Insurance Benefits are non-assignable.

(b) Amount of Benefit:

Employee	$11,000

(c) Limitations: The Plan will not be liable hereunder for any loss caused by or contributed to by: (a) attempted suicide or intentional self-destruction, while sane or insane; (b) the intentional act of another during an altercation in which the Eligible Employee participated, other than as a spectator; (c) travel or flight in or descent from any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial route or chartered flight; (d) war or any act of war, whether declared or undeclared, or while in the Armed Forces of any country; (e) bodily or mental infirmity, ptomaine, bacterial infections (except pyogenic infections which will occur with and through accidental cut or wound), or by any other kind of disease; (f) any drug, except those drugs prescribed by a Physician, including narcotics and hallucinogens; (g) any gas or fumes, taken or inhaled voluntarily; or (h) by voluntary poisoning.

(d) Facility of Payment: If anyone has paid expenses for an Eligible Employee's last Disability and death, the Plan may reimburse him for the amount he has paid up to

$1,000. A satisfactory receipt will be proof of his expenses. The Plan will then pay the balance of the Life Insurance Benefits to the named beneficiary.

(e) Beneficiary: If the named beneficiary does not survive the Covered Person, the benefits will be paid to the surviving person or persons in the first of the following classes of beneficiaries of which a member survives the Covered Person: (a) spouse; (b) children, including legally adopted children; (c) parents; (d) brothers and sisters; (e) executor or administrator.

In determining such person or persons, the Plan may rely upon an affidavit by a member of any of the class of preference beneficiaries. Payment based upon such affidavit will be full acquittance unless, before such payment is made, the Plan has received written notice of a valid claim by some other person. If two or more persons become entitled to benefits as preference beneficiaries, they will share equally.

Any benefits for loss of life payable to a minor may be paid to the legally appointed guardian of the minor, or if there be no such guardian, to such adult or adults as have, in the opinion of the Plan Administrator, assumed custody and principal support of such minor.

A Covered Person may designate a beneficiary or may change a previously designated beneficiary by filing a properly completed written request on a form satisfactory to the Plan Administrator. Such designation or change will not take effect until received in writing by the Plan Administrator. When so received, even if the Covered Person is not then living, the request for change of beneficiary will take effect on the date the request was signed, subject to any payment made by the Plan before receiving such request. If more than one beneficiary is designated and the Covered Person has failed to specify their respective interests, the beneficiaries will share equally.

(f) Optional Settlement: The Covered Person or the named beneficiary may elect to have all or a portion of the proceeds of the insurance paid in monthly installments, the amounts and terms of which will be in accordance with the Plan's practice at the time election is made. Such election may be made only by means of a satisfactory written request filed with the Plan by the Covered Person, or the named beneficiary after the death of the Covered Person, if the named beneficiary is not the executor or administrator of the Covered Person's estate. The amount elected to be paid in monthly installments will not be more than $1,000 and no monthly installment will be less than $10.

(g) Extension: Any extension of benefits will be only as provided in the applicable insurance policy.

(h) Conversion Privilege for Covered Employees: Any conversion privileges will be only as provided in the applicable insurance policy.

SCHEDULE OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Section 1. General Information

(a) Eligible Class of Employees: Those employees on whose behalf Contributions are made by Contributing Employers pursuant to a Collective Bargaining Agreement and who have completed the Waiting Period.

(b) Waiting Period: Eight consecutive weeks during which Contributions must be made on behalf of the Eligible Employee.

(c) Re-Establishing Eligibility: In the event that an Eligible Employee becomes ineligible due to a lack of the appropriate Contributions on his behalf, he will again become eligible the week the first Contribution is again made on his behalf; provided, however, that there is not more than a twelve-month interruption in coverage, in which case the employee must re-satisfy the Waiting Period.

Section 2. Description of Accidental Death and Dismemberment Benefits

(a) Accidental Death and Dismemberment: When Accidental bodily Injury which was caused directly and independently of all other causes by external, violent, and Accidental means occurs while the insurance is in force as to the Eligible Employee, within ninety (90) days after the date of the Accident, the Plan will pay, in addition to any other benefit provided by the policy:

(1) the Principal Sum for loss of life; or

(2) one-half of the Principal Sum for loss of one hand by severance at or above the wrist, or loss of one foot by severance at or above the ankle, or irrecoverable loss of sight of one eye; or

(3) The Principal Sum for loss of more than one of the members enumerated in paragraph (2) above;

but the total payment for all such losses resulting from injuries due to the same Accident will not exceed the Principal Sum. If benefits are payable for loss of life, the Plan will have the right and opportunity to have an autopsy made when it is not forbidden by law.

(b) Principal Sum: The Principal Sum payable is $11,000.

(c) Limitations: The Plan will not be liable hereunder for any loss caused by or contributed to by: (a) attempted suicide or intentional self-destruction, while sane or insane; (b) the intentional act of another during an altercation in which the Eligible Employee participated, other than as a spectator; (c) travel or flight in or descent from any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial route or chartered flight; (d) war or any act of war, whether declared or undeclared, or while in the Armed Forces of any country; (e) bodily or mental infirmity, ptomaine, bacterial infections (except pyogenic infections which will occur with and through accidental cut or wound), or by any other kind of disease; (f) any drug,

except those drugs prescribed by a Physician, including narcotics and hallucinogens; (g) any gas or fumes, taken or inhaled voluntarily; or (h) by voluntary poisoning.

(d) Facility of Payment: The amount payable upon the death of the Eligible Employee will be paid: (a) if Life Insurance Benefits are provided, in accordance with the settlement provisions therein; (b) if Life Insurance Benefits are not provided in the policy, in accordance with the beneficiary designation of record effective at the time of payment. If no such designation is then effective, such benefits will be payable to the estate of the Eligible Employee.

ARTICLE I. BENEFITS UNDER THE PLAN

The Plan provides the following benefits to Covered Persons as explained in this summary.

BENEFIT	DETAILS OF BENEFIT
(1) Medical Benefits	(1) See Article IV, the Schedule of Medical Benefits and the Summaries of Medical Benefits and Prescription Drug Program
(2) Dental Benefits	(2) See Article IV, the Schedule of Dental Benefits and the Summary of Dental Benefits
(3) Optical Benefits	(3) See Article IV, the Schedule of Optical Benefits and the Summary of Optical Benefits
(4) Group Term Life Insurance and Accidental Death & Dismemberment Benefits	(4) See Article V and the Schedules of Life Insurance/AD&D Benefits
(5) Loss of Time Benefits	(5) See Article VI and the Schedule of Loss of Time Benefits

ARTICLE II. PREMIUMS AND CONTRIBUTIONS

Participating Employers and employees pay all premium or Contribution amounts for benefits under the Plan for employees, Dependents, and beneficiaries, as determined by the Board of Trustees and any applicable Collective Bargaining Agreements. You will be notified by your Employer if you are required to make Contributions and the amount of the Contribution.

ARTICLE III. ELIGIBILITY FOR BENEFITS

Certain employees are eligible for group medical/prescription drug, dental, optical, loss of time, group term life and accidental death and dismemberment benefits, as applicable, under the governing Collective Bargaining Agreement, and as set forth in the applicable benefit plan,

program, or insurance policy. Please see the applicable sections of this summary for the eligibility requirements.

ARTICLE IV. GENERAL PROVISIONS AND DEFINITIONS RELATING TO MEDICAL, DENTAL, AND OPTICAL BENEFITS

Section 1. Introduction

The provisions of this Article IV, the Summaries of Benefits and the Schedules of Benefits describe the medical, dental, and optical benefits provided under the Plan.

Section 2. Definitions

The following definitions apply with regard to the 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) “Air Ambulance Service” means medical transport by helicopter or airplane for patients.

(d) "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.

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

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

(g) "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.

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

(i) "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.

(j) "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.

(k) "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.

(l) "Co-pay" or "Co-payment" means the fixed amount of a Covered Charge that you or your Dependent must pay for certain services or supplies. A benefit that requires a "Co-pay" from you is not subject to the Deductible. Co-pays do not accumulate to your annual Out-of-Pocket Maximum.

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

(n) "Covered Person" means you and your covered Dependents.

(o) "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.

(p) "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.

(q) "Dependent" means your: (i) legally married spouse, under the laws of the State of Indiana, who is not legally divorced or separated from you; (ii) children who are under age 26.

The word "child" means your natural child, stepchild, or legally adopted child, or a child placed with you for adoption and eligible foster child. "Child" does not include your grandchild unless legally adopted by you or your spouse.

A child will continue to be considered a Dependent beyond the age of 26 if the child: (i) was a Dependent under the Plan before turning age 26, (ii) is physically or mentally disabled, which results in a functional limitation to employment or has a physical or mental impairment which limits the child's major life activities, and (iii) depends solely on you for support. The Plan will continue to cover such Dependent while your coverage remains in force, so long as incapacity continues, provided you have submitted proof of such incapacity to the Trustees within 31 days after the date: (i) such Dependent would otherwise have no longer been eligible to continue coverage as a Dependent or (ii) of such dependency. Proof of continued incapacity may be required by the Trustees from time to time.

In addition, a court order or divorce decree which specifies which parent is responsible for medical care will determine whether a child is covered under the Plan as a Dependent, if such child

would otherwise be considered a Dependent under the terms of the Plan. If you and your spouse are both Employees, your mutual Dependents may be covered under either name but not both. If you also qualify as a Dependent, you will be covered as an Employee and not as a Dependent.

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

(s) "Eligible Employee" means you, if you are an employee of a Contributing Employer on whose behalf the appropriate Contribution has been made to the Fund for the Waiting Period and thereafter.

(t) "Emergency" or "Emergency Medical Condition" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(u) "Emergency Services," with respect to an Emergency Medical Condition, means:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition
- Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department
- Further services that are furnished by an out-of-network provider or Out-of-Network Emergency Facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the hospital in which such further examination or treatment is furnished).

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

(w) "Experimental" means (1) 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, (2) 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, or (3) that, based on reliable evidence, are the subject of ongoing phase I, II or III clinical trials, or are under study to determine their maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.

(x) "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 one 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.

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

(z) "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.

(aa) "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.

(bb) "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 one or more licensed Physicians available at all times; (v) provides twenty-four (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.

(cc) "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 Dependents on or after the date of coverage under the Plan, excluding conditions arising from occupational Injury or Accident.

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

(ee) “Independent Freestanding Emergency Department” means a health care facility that (i) is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (ii) provides any “Emergency Services” as defined in this document.

(ff) "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.

(gg) "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.

(hh) “ITHBF Clinic” means one 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.

(ii) "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.

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

(kk) "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.

(ll) "Orthodontics" means the division of dentistry dealing with the prevention of teeth irregularities and malocclusions of jaws by wire appliances, braces, or other mechanical aids.

(mm) "Orthodontic Treatment" means any medical or dental service or supply furnished to prevent or to diagnose or to correct a misalignment of the teeth, the bite or the jaws or jaw joint relationships, whether or not to relieve pain; provided, however Orthodontic Treatment does not include the installation of a space maintainer or surgical procedure to correct malocclusion.

(nn) “Out-of-Network Emergency Facility” means an emergency department of a hospital, or an Independent Freestanding Emergency Department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service.

(oo) “Out-of-Network Rate” will be determined in the following order:

- the amount that the state approves under an All-Payer Model Agreement, if applicable
- the amount determined by a state law, if applicable;
- the payment amount agreed to by the Plan and provider or facility, if applicable;
- the amount approved under the independent dispute resolution (IDR) process.

(pp) "Out-of-Pocket Maximum" means the portion of Co-insurance you must pay before you are covered at 100% for Covered Expenses. The in-network Out-of-Pocket Maximum is separate from the out-of-network Out-of-Pocket Maximum

(qq) "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.

(rr) "Plan" means the Indiana Teamsters Health Benefits Plan.

(ss) "Plan Administrator" means the Board of Trustees, who are responsible for the day-to-day functions and management of the Plan in accordance with Article IX of the Plan.

(tt) "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.

(uu) "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.

(vv) "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.

(ww) "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.

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

(yy) “Qualifying Payment Amount (QPA)” generally means the median amount the Plan has contractually agreed to pay network providers, facilities, or providers of Air Ambulance Services for a particular covered service.

(zz) "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.

(aaa) "Recognized Amount," for items and services furnished by an Out-of-Network provider or Out-of-Network emergency facility, the Recognized Amount will be determined in the following order:

- An amount determined by an All-Payer Model Agreement, if applicable
- An amount determined by a specified state law, if applicable;
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

(bbb) "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.

(ccc) "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.

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

(eee) "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.

(fff) "Union" means the union to which you are a member, as set forth in the Collective Bargaining Agreement, which participates in and contributes to the Fund.

(ggg) "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 one or more Physicians during all hours of service.

(hhh) "Vision Care Professional" means (i) a person legally qualified and licensed to practice optometry or ophthalmology by the state, including an optometrist or ophthalmologist and (ii) a Physician allowed by his license to perform optical procedures under the laws of the state.

(iii) "Voluntary or Involuntary Termination of Employment" means the date on which you voluntarily or involuntarily cease to be Actively at Work with the Employer, including but not limited to voluntary or involuntary cessations of employment, layoff, retirement, Disability, and any leave of absence other than an FMLA leave.

(jjj) "Waiting Period" means the period of time established by the Board of Trustees that your Employer must make contributions on your behalf prior to becoming eligible for coverage under the Plan.

Section 3. Employee and Dependent Eligibility and Coverage

(a) Eligibility.

(1) Employee Eligibility. You will be eligible once you have completed the Waiting Period, if applicable, as set forth in the appropriate Schedule of Benefits. You will continue to be eligible from week to week, provided your Employer makes the appropriate Contribution on your behalf. If you become ineligible because the required Contributions are not made on your behalf, you will again become eligible the week the Contribution is made again. However, if you are ineligible for coverage for twelve consecutive months, you must re-satisfy the Waiting Period.

(2) Dependent Eligibility. Your Dependents will be eligible for coverage on the date that you become covered under the Plan or, if later, the date you acquire a Dependent, if on that date you are covered under the Plan. This date will be the date of your marriage, the date of the birth of your newborn child, the date a child is physically placed in your home for legal adoption, foster children, or step-children, the date your child loses coverage under a Medicaid or state children's health insurance plan ("CHIP") or the date your child becomes entitled to enroll based on the requirements of PPACA. See Change of Status Rules.

(b) Coverage.

(1) Employee and Dependent Coverage. If you are Actively at Work on the date you and/or your Dependents satisfy all eligibility requirements (and you have completed all enrollment forms within 30 days of when you, your spouse, or your qualifying child first become eligible for coverage or 60 days of a dependent gaining eligibility due to loss of coverage under Medicaid or CHIP), you and/or your Dependents will be covered on the day following satisfaction of the eligibility requirements. See Change of Status Rules.

If you are laid off work and then recalled to work from layoff so that you are again Actively at Work, you will be subject to all provisions of the Plan and will become covered under the Plan as set forth above; provided, however, you will not be required to satisfy the Waiting Period after the period of lay-off, except as provided under Section 3(a) above. Your Dependents will be covered under the Plan as provided under this Section.

(2) Coverage in the Event of Change in Classification. If you change job classifications, as defined by the applicable Collective Bargaining Agreement and, by reason of that change in classification, the benefits described in Articles IV, V, and VI applicable to you change, such change will take effect on the first day of the next benefit week following such change and will be applicable only to claims commencing after that date.

(3) Open Enrollment. The Plan will designate a period once each year prior to the start of the following Plan Year as Open Enrollment. During this Open Enrollment Period you may enroll yourself, your spouse, and your qualifying children or make changes to any of your benefit elections. **Open enrollment is October 1 to October 31.**

(4) No enrollment of you, your spouse, or your qualifying child will be permitted at any time other than during Initial Enrollment, Open Enrollment, or Special Enrollment (see below). Please note, if your employer is paying premiums on your behalf, you must still enroll yourself and any spouse or qualifying children in the Plan in order to be covered. If you fail to do so, no coverage will be provided until you properly and timely enroll for coverage during one of these enrollment opportunities. You must submit all required documents in order to enroll yourself and any Dependents in the Plan. **Required documents but not limited to are; Certified Birth Certificates, Certified Marriage License, Social Security Card, Court Documents. All documents have to be submitted to the Fund within 30 days of the enrollment. 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 or Dependent with all required documents within 30 days, you will not be able to enroll your dependents until the open enrollment period for coverage to be effective on January 1 of the following year.**

Section 4. Special Enrollment Periods

(a) Acquiring a New Dependent. If you are eligible for coverage under the Plan and you acquire a new Dependent, you may enroll the Dependent in the Plan within 30 days of your marriage or within 60 days of the birth, adoption, or placement for adoption of your child. Coverage under this subsection will become effective as of the date of the marriage, birth, adoption, or placement for adoption. See Change of Status Rules.

(b) Adding a Dependent Following Loss of Medicaid or CHIP Coverage. If your dependent child loses coverage under Medicaid or CHIP, you may enroll your dependent child in the Plan within 60 days of the loss of Medicaid or CHIP coverage. See Change of Status Rules.

(c) No Waiver of Coverage. Except as otherwise provided above with respect to the annual open enrollment period, you are not entitled to voluntarily waive or opt out of this coverage for you or your Dependents but must timely enroll you and/or your Dependents in order to be eligible for Plan coverage the upcoming Plan Year.

Section 5. 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 Dependents; (iii) loss or acquisition of a Dependent; (iv) your marriage; (v) a child ceasing to be a Dependent; (vi) eligibility for or entitlement to Medicare benefits; (vii) divorce or legal separation from a spouse; or (viii) any other change in status which may affect you or your Dependents' coverage under the Plan. You must notify the Trustees and present all required documents within 30 days of any change in status. **Required documents but not limited to are; Certified Birth Certificates, Certified Marriage License, Social Security Card, Court**

Documents. All documents have to be submitted to the Fund within 30 days of the status change. 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 or Dependent with all required documents within 30 days, you will not be able to enroll your dependents until the open enrollment period for coverage to be effective on January 1 of the following year.

Section 6. Termination of Coverage

Subject to Section 9 of this Article, Section 9 of Article XI, or any Collective Bargaining Agreement, coverage will end on the earliest of the date:

(1) the Plan is terminated;

(2) you are no longer an Eligible Employee, or your Dependent no longer meets the definition of a "Dependent";

(3) you Voluntarily or Involuntarily Terminate Employment;

(4) for your Dependents, the date your coverage terminates;

(5) the Employer fails to pay the Fund the required Contributions on your behalf;

(6) you become a full-time member of the Armed Forces;

(7) the date of your death; or

(8) the date coverage is terminated for a particular employment classification by modification of the Plan or a Collective Bargaining Agreement.

Section 7. Family and Medical Leave Act

(a) Right to Continue Coverage. The Family and Medical Leave Act of 1993 ("FMLA") generally allows certain employees the right to take an unpaid leave or a paid leave (if it has been earned) for a period of up to 12 work weeks in a 12 month period because of (i) the birth of a child, (ii) the placement of a child for adoption or foster care, (iii) the need to care for a family member (child, spouse, or parent) with a serious health condition, or (iv) because an employee's own serious health condition makes the employee unable to do his or her job. Notwithstanding any other provisions in this Summary to the contrary, under the FMLA you are entitled to continue medical, dental and optical coverage during the period you are on a FMLA leave, provided you or your Employer continues to pay any required Contributions. The medical, dental and optical coverage (as well as loss of time, life insurance and accidental death and dismemberment coverage) is the same as would be provided if you had been employed during the leave period. You may choose not to continue coverage during the FMLA leave, in which case you will be immediately reinstated to medical, dental, optical, loss of time, life insurance and accidental death and dismemberment coverage under the Plan when you return from the FMLA leave, without regard to proof of good health or any Waiting Period.

(b) Termination of Coverage. Except as provided under Section 9, FMLA coverage will terminate when:

(1) you inform the Employer of your intent not to return from FMLA leave;

(2) you fail to return from FMLA leave; or

(3) you exhaust your FMLA leave.

(c) Employee Contributions. Employees on FMLA leave are required to continue to pay any required employee Contributions toward coverage during the FMLA leave. Failure to pay your share of benefit Contributions within 30 days after the due date will result in termination of your coverage, subject to Section 9. If your coverage ends because you fail to make timely payment Contributions, you will be entitled to immediate reinstatement of coverage on your return from FMLA leave. Any changes by the Board of Trustees to employee Contributions will apply while you are on FMLA leave.

Section 8. COBRA Continuation Coverage

COBRA gives you and your Dependents rights to continue health coverage under the Plan under certain circumstances. You or your Dependents may elect, at your cost, to continue group health coverage under the Plan after certain Qualifying Events, described below. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, your right to receive it, and what you need to do to protect your right.

(a) Right to Continuation Coverage. Only qualified beneficiaries may elect continuation coverage under the Plan after a Qualifying Event. You are a qualified beneficiary if you are covered under the Plan on the date before a Qualifying Event and you are:

(1) an Eligible Employee;

(2) a spouse of an Eligible Employee;

(3) a Dependent child of an Eligible Employee; or

(4) a child born to or placed for adoption with you while you are covered under this continuation coverage.

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

(1) your death;

(2) your termination (other than by reason of gross misconduct) of employment, or a reduction of hours that would result in a termination of coverage under the Plan;

(3) your divorce or legal separation from your spouse;

(4) your becoming entitled to Medicare benefits; or

(5) a child ceasing to be a Dependent child under the eligibility requirements of the Plan.

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

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

(c) Period of Continuation Coverage. In the case of a Qualifying Event caused by termination of employment or reduction in hours, continuation coverage may be for up to 18 months (as elected) after the Qualifying Event, unless it ends earlier as described in subparagraph (e) below.

If a second or additional Qualifying Event occurs during the initial 18 month coverage period, the qualified beneficiary may elect to extend the continuation coverage for up to 36 months from the date of the earlier Qualifying Event. Provided, however, if you become entitled to Medicare benefits and then within 18 months experience a loss of coverage due to your termination or reduction in hours, the period of coverage for your Dependents who are qualified beneficiaries will be for up to 36 months from the date of your entitlement to Medicare.

If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to be disabled within 60 days of the initial continuation coverage due to your termination or reduction in hours, coverage for all qualified beneficiaries may be continued up to 29 months (from the date of the Qualifying Event) if notice of such disability determination is provided to the Trustees by the qualified beneficiary within 18 months of the Qualifying Event. The qualified beneficiary is responsible for notifying the Trustees of the disability determination within 60 days after the later of the following: (i) the date of the Medicare disability determination, (ii) the date the event occurs, (iii) the date the qualified beneficiary would lose coverage, or (iv) the date the qualified beneficiary is notified of both the responsibility to provide notice and the Plan's procedures for providing such notice. In addition, the qualified beneficiary is responsible for notifying the Trustees within 30 days of the date that the disabled qualified beneficiary is no longer disabled.

In the case of any other 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;

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

(4) the qualified beneficiary ceases to be disabled, if continuation coverage was due to disability.

(f) Election of Coverage. You and/or your Dependents must elect continuation coverage within 60 days after the later of: (i) the date the qualified beneficiary 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; provided, however, that the election period will be extended if you are eligible for Trade Act assistance. 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. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Eligible Employees may elect COBRA continuation coverage on behalf of their spouse, and parents may elect COBRA continuation coverage on behalf of their children.

(g) Cost of Continuation Coverage. The qualified beneficiary 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. Payment of any premium is considered timely if made within 15 days after the due date (plus a 15-day grace period). 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. Qualified beneficiaries are responsible for notifying the Trustees in the case of a Qualifying Event caused by:

(1) the divorce or legal separation from your spouse;

(2) a Dependent child ceasing to be a Dependent under the Plan;

(3) a second qualifying event that occurs during the initial 18-month COBRA continuation coverage period; or

(4) a determination of disability under Title II or Title XVI of the Social Security Act.

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 the qualified beneficiary 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. However, for a disability determination, the notice must be given within the initial 18 months of your COBRA coverage period and within 60 days after the later of the following: (i) the date of the Medicare disability determination, (ii) the date the event occurs, (iii) the date you would lose coverage, or (iv) the date you are notified of both the responsibility to provide notice and the Plan's procedures for providing such notice. In addition, the qualified beneficiary is responsible for notifying the Trustees within 30 days of the date that the disabled qualified beneficiary is no longer disabled. *If you do not follow these procedures and notify the Trustees within these time frames, you and your Dependents will lose the right to elect COBRA continuation coverage.*

Your Employer must notify the Trustees if your employment ends or your hours of employment are reduced, you are deceased, or you become entitled to Medicare benefits.

Any notification by the Plan to a qualified beneficiary who is your spouse will be treated as notification to all other qualified beneficiaries.

Questions?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Administrative Office of the Indiana Teamsters Health Benefits Fund, located at 6007 S. Harding St., Indianapolis, Indiana 46217. 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 9. Continuation of Coverage for Military Personnel

You will be offered the opportunity to continue medical, optical, and dental 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 8 above; COBRA rights will be effective on termination of this extended military coverage.

Section 10. Medical, Dental, and Optical 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 Dependents, 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, Maximum Lifetime 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 Dependents will be reimbursed in accordance with any cost containment procedures set forth in the Schedule of Medical Benefits.

(c) Eligible Dental Expense. A Covered Charge is one that is Incurred for preventive dental services or restorative dental services for you or your Dependent and for Orthodontic services provided to your Dependent child, as set forth in the Schedule of Dental Benefits. Such Covered Charge is subject to any maximum benefit limits set forth in the Summary of Dental Benefits.

(d) Eligible Optical Expense. A Covered Charge is one that is Incurred for vision care services as set forth in the Schedule of Optical Benefits. Such Covered Charge is subject to any maximum benefit limit set forth in the Summary of Optical Benefits.

Section 11. Coordination with Medicare

To the extent allowed under applicable law, coverage under the Plan will be secondary to coverage provided by Medicare, if you or your Dependents are eligible for Medicare. If under federal law the Plan is primary to Medicare and if you or your Dependents are eligible for Medicare and Incur a claim, coverage under the Plan will be paid subject to any Deductible, Co-insurance, Co-payment, exclusion, or other limitation as set forth in the Plan. In any event, if you or your Dependents choose not to be covered under the Plan and choose to be covered primarily under Medicare, Medicare will provide coverage and coverage under the Plan will terminate. You and your Dependents will be considered eligible for Medicare during any period you and your Dependents have coverage under Medicare, or while otherwise qualifying, do not have coverage solely because you and your Dependents have refused, discontinued, or failed to make any necessary application or contribution for Medicare coverage.

Section 12. 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, dental or optical expenses, the amount of benefits payable under the Plan will take into account any coverage you or your Dependents 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) when two plans cover the same child as a dependent:

(1) the plan of the parent whose birthday occurs earlier in the year pays first; but if both parents have the same birthday, the plan of the parent covered longer pays first if the parents are married or have never been married;

(2) if the parents are separated or divorced (i) the plan of the parent with custody pays first, then the plan of the parent without custody pays; (ii) if the parents have joint custody, the plan which covers the parent who has the earliest birthday (month and day) pays first; (iii) if the parent with custody has remarried, the plan of the parent with custody pays first, then the plan which covers the child as a stepchild pays, and then the plan of the parent without custody pays last; (iv) if the parent without custody has remarried, the plan of that parent will pay after any other plans have paid first; (v) if the parents have joint custody and one or both of the parents have remarried, the plans of the parents will pay first, then the plans of the stepparents will pay, provided that the plan which covers the parent or stepparent who has the earliest birthday (month and day) will pay before the plan of the other parent or stepparent; or (vi) as determined by court decree in any event.

(c) 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

(d) 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 13. Subrogation

The 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 the Plan for which you or your Dependents are or become entitled to receive payment from a third party for any Illness or Injury. By participation in the Plan, you are agreeing that the Plan is subrogated to all rights of you or your Dependents. 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 Dependents 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 14. Retiree Medical Benefits

Retiree medical benefits are available to eligible retirees as provided in the Indiana Teamsters Health Benefits Plan Retiree Program.

You will be eligible for coverage under the Retiree Program once you have met the following eligibility requirements: (i) if you retire on or after your 57th birthday but before your 65th birthday and you have a twenty year Paid-In Pension, and (ii) you participated continuously in the Indiana Teamsters Health Benefits Plan for at least five consecutive calendar years immediately preceding retirement, or seven of the ten consecutive calendar years immediately preceding 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. These terms are defined in the Retiree Program Summary Plan Description (SPD).

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 until you reach age 57, unless you meet a medical exception or satisfy other special eligibility rules described in the Retiree Program SPD. You may still retire at any age and may later become eligible for the Retiree Program once you meet the eligibility requirements.

Generally, you must enroll for coverage in the Retiree Program when you become eligible. The Trustees may permit you to enroll for coverage later 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 coverage.

Your Spouse will be eligible for coverage under the Retiree Program on the date that you become covered under the Retiree Program. No other Dependents are eligible for coverage under the Retiree Program.

Coverage under the Retiree Program generally ends when you or your spouse become eligible for Medicare and may end sooner. There are detailed rules in the Retiree Program regarding the duration of coverage under that program. You should refer to the Retiree Program SPD for more detail.

Also, depending upon your retirement date, you may be required to contribute to the cost of your coverage under the Retiree Program. You should refer to the Retiree Program SPD for information about the cost of this coverage.

Section 15. 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, Co-insurance maximum benefit limits, and Out-of-Pocket Maximum limits incurred under such other fund toward any such amounts or limits applicable under this Fund.

Section 16. 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 17. Genetic Information Nondiscrimination Act

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

Section 18. Non-Discrimination

Any provision of the Plan notwithstanding, the Plan shall at all times be interpreted, applied and administered so as to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Affordable Care Act. The Plan will not discriminate with respect to rules for eligibility or benefits based upon a health factor including:

- Health status;
- Medical condition;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability; or
- Disability.

Section 19. Provider Non-Discrimination

The Plan will not discriminate with respect to participation or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section does not require that the Plan contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. Nothing in this section shall be construed as preventing the Plan from establishing varying reimbursement rates based on quality or performance measures.

ARTICLE V. INSURED BENEFITS

Section 1. Life Insurance Benefits

You are eligible for group life insurance benefits. Please see the Schedule of Life Insurance Benefits and the Summary of Life Insurance Benefits for a description of those benefits.

Section 2. Accidental Death and Dismemberment Benefits

You are eligible for accidental death and dismemberment benefits. Please see the Schedule of Accidental Death and Dismemberment Benefits and the Summary of AD&D Benefits for a description of those benefits.

ARTICLE VI. LOSS OF TIME BENEFITS

Section 1. Benefits

You will be entitled to the Loss of Time benefits set forth in the Schedule of Loss of Time Benefits while you are covered under the Plan, subject to any FICA withholding that may apply.

Section 2. Timing of Benefits

Your benefits begin on the first day of your Disability, due to an Accidental bodily Injury, or the 8th day of your Disability due to Illness, and will continue for the period set forth in the Schedule of Loss of Time Benefits and the Summary of Loss of Time Benefits for each period of Disability. During this period of Disability, you will be entitled to continue medical coverage as set forth in Article IV.

Section 3. COBRA Continuation

During a period of Disability under this section, you and your Dependents will be entitled to continuation coverage for up to 26 weeks at no cost to you. Such continuation coverage will apply to, and be concurrent with, any COBRA continuation coverage you may be entitled to under Article IV, Section 9.

ARTICLE VII. CLAIMS FOR BENEFITS

Section 1. Filing of Claim

All claims for benefits must be submitted to the Trustees within one year after the Covered Charge is Incurred. The claim should be mailed to Indiana Teamsters Health Benefits Fund, 6007 S. Harding St., Indianapolis, Indiana 46217.

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 Loss of Time Benefits, and Section 4 applies to medical, dental, and optical ("health") benefits. Section 5 applies to Life Insurance and Accidental Death 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 one (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. The term "*denial*" also means rescissions of coverage, which is generally defined as a cancellation of coverage or discontinuance of coverage that has retroactive effect, unless attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

(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, your spouse, or your dependent.

Section 3. Claims for Loss of Time Benefits

Initial Claim. Any claim to receive Loss of Time benefits must be filed with the Trustees within 1 year after the date the charges were Incurred. As part of the claim, you must submit a Physician's statement and indicate the Injury or Illness causing your Loss of Time. If the Trustees disagree as to your initial or continuing Disability, the terms of the Plan will be followed in resolving a dispute. When the Trustees determine you have a Disability, you will be considered Disabled as of the start of the Disability.

Initial Review. When a Loss of Time claim has been properly filed, it will be reviewed and you will be notified, in writing or electronically, of the approval or denial within 45 days after the claim is received. If the Trustees need additional time to process the claim, the 45-day period may be extended twice, each extension period lasting no more than 30 additional days. You will receive written notice of the extension(s) before the initial 45-day period ends and before the first 30-day extension period ends, as applicable, explaining why the extension(s) is necessary and when a final decision will be made. The notice will also explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will have 45 days to provide any specified information to the Trustees.

Initial Denial. If any claim for Loss of Time benefits is denied, the denial notice will contain the following: (i) the specific reasons for the denial; (ii) references to 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, including a statement of the claimant's right to bring a civil action under ERISA; (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" does not exist; (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; (vii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and (viii) a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant, the views of medical or vocational experts

whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination (without regard to whether the advice was relied upon in making the benefit determination), and a disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

Appeal(s) of Claim Denial. You may appeal a denied claim for Loss of Time benefits by filing a written appeal with the Trustees within 180 days after you receive notice of the denial.

Send written appeals to:

Privacy Officer
Indiana Teamsters Health Benefits Plan
6007 S. Harding St.
Indianapolis, IN 46217

Denial of Appeal(s). You will receive notice of the Trustee's decision on appeal within 45 days after your appeal request is received, unless special circumstances require additional time to process the appeal. If so, the Trustees will notify you of the extension specifying why it is needed and when a final decision will be made (which will not be later than 90 days after the appeal is received).

In either case, if the Loss of Time claim is denied on appeal, you will be given notice stating that you are entitled to receive, free and upon request, access to and copies of all documents, records, and other information relating to your claim and notice of your right to bring an action under ERISA including any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim. The notice will also contain items (i), (ii), (v), (vi), and (viii) from the *Initial Denial* subsection above. The last decision on review will be final, conclusive, and binding on all persons.

Section 4. Claims for Medical, Dental and Optical Benefits

Initial Claim. Any claim to receive medical, dental and/or optical 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, dental, and/or vision 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, dental and/or vision benefits is denied, the denial notice will contain: (i) the specific reasons for the denial, including a description of the Plan's standard, if any, used in denying the claim; (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; (vii) a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meaning of these codes); (ix) a description of available internal appeals and external review procedures, including information about how to initiate an appeal; (x) disclosure the availability of—and contact information for—any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal claims and appeals and external review procedure; and (xi) 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, dental, and/or vision 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 Plan
6007 S. Harding St.
Indianapolis, IN 46217

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), (vi), (vii), (ix), and (x) from the *Initial Denial* subsection above. The notice will also include a discussion of the Trustee's decision. 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.
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 5. Claims for All Other Welfare Benefits

Initial Claim. Any claim to receive other welfare benefits (such as life and accidental death and dismemberment benefits) must be filed with the Trustees within one (1) year of the date of the Injury or death, and will be considered filed when it is received by the Trustees.

Initial Review. When a claim for other welfare benefits has been properly filed, you will be notified of the approval or denial within 90 days after the claim is received, unless special circumstances require an extension of time to process the claim. Written notice of any extension will be given to you before the end of the initial 90-day period – telling you why it is needed and when a final decision will be reached (which will be no later than 180 days after the claim was filed).

Initial Denial. If any claim for other welfare 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; and (iv) a description of the review procedures and time limits.

Appeal of Claim Denial. You may appeal a denied claim for other welfare benefits by filing a written appeal with the Trustees within 60 days after you receive notification of the denial. If you do not file the appeal within this time period, the Trustee's decision will be final and binding.

Send written appeals to:

Privacy Officer
Indiana Teamsters Health Benefits Plan
6007 S. Harding St.
Indianapolis, IN 46217

Denial of Appeal. You will receive notice of the Trustee's decision on appeal within 60 days after receipt of your appeal request, unless special circumstances require an extension of time to process the appeal. If so, the Trustees will notify you of the extension and when a final decision will be reached (which will not be later than 120 days after receipt of such appeal).

If your claim for other welfare benefits is denied on appeal, you will be given notice containing 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) and (ii) from the *Initial Denial* subsection above. A decision on review will be final and binding.

Section 6. External Review

The Patient Protection and Affordable Care Act requires non-grandfathered health plans, like the Fund's Plan, to have specific rules for external appeals processes. A claimant may request an external appeals review after an initial claim denial and subsequent internal review claim denial if the denied claim involves medical judgment (excluding those that involved only contractual or legal interpretation without any use of legal judgment) or rescission of coverage. External review

will also be available to dispute determinations that involve whether the Plan complied with the surprise billing and cost-sharing protections under the No Surprises Act.
For external appeal reviews, the following standards apply:

Request For External Review. Claimants will be allowed to file a request for an external review, provided that the request is filed within four months of the date of the Notice of the Adverse Benefit Determination.

Preliminary Review. Within five business days of receipt of the request for an external review, the Plan will complete a preliminary review of the request to determine whether the claimant was a participant in the Plan at the time of the service, whether the participant had exhausted all of the Plan's internal appeal processes and whether the claimant has provided all information and forms necessary to proceed with an external review.

Within one business day after the completion of the preliminary review, the Plan will issue a notification in writing to the participant identifying any deficiencies with regard to the ability to proceed to the external review process. The participant will then be entitled to supply information and materials needed to make the request complete. Note that for an urgent care issue, the preliminary review must be done immediately and the claimant must be then immediately notified.

Referral to Independent Review Organization (IRO). The Plan must contract with at least three IROs. Within five business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO; for an urgent care issue, the information must be sent electronically, by fax or other expeditious means. The IRO must provide written notice of its decision within 45 days of assignment; for urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.

Implementation of Reversal. Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

Section 7. 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, your claim file and all documents, records, and other information relevant to your claim, or you may submit written comments, documents, records, and other information and present evidence and testimony 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 Plan will provide you, free of charge, with any new or additional rationale and any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the appeal decision is made, in order to give you a reasonable opportunity to respond prior to that date.

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 (i) Loss of Time claims or (ii) medical, dental or vision 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. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

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 VIII. CHANGES TO 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, Dependent, 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 IX. 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 X. 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, your spouse, or your Dependent children ("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 medical, dental, and optical benefit plan programs of the Plan ("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 not:

(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 three (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 six (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 XI. MISCELLANEOUS

Section 1. Limitations of Rights and Obligations

The Plan does not constitute a contract between the Employer and any Eligible Employee 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 Dependent, the amount of the incorrect payment may be deducted from future payments to you or your Dependent.

Section 4. Misrepresentation

Any material misrepresentation by you or your Dependent in making any application for coverage or receipt of benefits will render coverage null and void.

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 for payment of any benefit payable, such payment may be made directly to a health care provider, the guardian or conservator, or the parents of a minor dependent child, or to an individual or individuals who have custody or provide care and principal support of such person. 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. Qualified Medical Child Support Orders

The Plan will provide benefits in accordance with any qualified medical child support order received by the Plan. You and any applicable child will be notified if the Plan receives a medical child support order and will be informed of the procedures relating to the order.

Section 8. 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 Dependent'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 9. 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 XII. GENERAL INFORMATION

Section 1. Plan Name

Indiana Teamsters Health Benefits Plan.

Section 2. Plan Sponsor

The Plan Sponsor for the Plan is the Board of Trustees of the Indiana Teamsters Health Benefits Fund, 6007 S. Harding St., Indianapolis, Indiana 46217.

Section 3. Plan Administrator

The Plan Administrator for the Plan is the Board of Trustees of the Indiana Teamsters Health Benefits Fund, located at 6007 S. Harding St., Indianapolis, Indiana 46217. 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 6007 S. Harding St., Indianapolis, Indiana 46217.

Section 6. Plan Number

The Plan Number is 501.

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

Participating Employer and employee Contributions, as applicable, pursuant to the provisions of the Plan and applicable Collective Bargaining Agreements and other written agreements.

Section 9. Type of Plan

Employee welfare benefit plan providing group medical, dental, optical, life, accidental death and dismemberment, and loss of time benefits for Eligible Employees and eligible Dependents.

Section 10. Effective Date

The effective date of the most recent Plan restatement is January 1, 2022.

Section 11. Trust

The Trust for the Plan is the Trust Agreement for the Indiana Teamsters Health Benefits Plan.

Section 12. Trustees

The Trustees for the Plan are:

UNION TRUSTEES

GEORGE GERDES
Indiana Teamsters Health Benefits Fund
2829 Madison Ave.
Indianapolis, IN 46225

ROBERT WARNOCK, III
Indiana Teamsters Health Benefits Fund
Teamsters Local Union No. 364
2405 Edison Road
South Bend, IN 46615

DUSTIN ROACH
Indiana Teamsters Health Benefits Fund
2829 Madison Ave.
Indianapolis, IN 46225

JESSE MIKESELL
Indiana Teamsters Health Benefits Fund
2829 Madison Ave.
Indianapolis, IN 46225

MANAGEMENT TRUSTEES

DAVID HEYDE
Indiana Teamsters Health Benefits Fund
E&B Paving, Inc.
1420 Union Street
Kokomo, IN 46902

SHAWN ALPERS
Indiana Teamsters Health Benefits Fund
Irving Materials Indiana
8032 North State Road 9
Greenfield, IN 46140

MIKE FERRARA
Indiana Teamsters Health Benefits Fund
Milestone Contractors, L.P.
3410 South 650 East
Columbus, IN 47202

BRIAN L. WHITTAKER
Indiana Teamsters Health Benefits Fund
Wearly Monuments Inc.
4000 W. Kilgore
Muncie, IN 47304

Section 13. Funding Policy

The Trust is funded by payments to the Indiana Teamsters Health Benefits Fund by Contributing Employers and employee 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.

Section 14. Health Insurance Issuer Information

The group loss of time, medical, dental, and optical benefits are self-funded by the Fund and therefore are not guaranteed under any insurance program.

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

As a participant in the 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.