Teamsters Joint Council 32–Employers Health and Welfare Fund

January 1, 2022

TEAMSTERS JOINT COUNCIL 32–EMPLOYERS HEALTH AND WELFARE FUND

Fund Office Address: 3001 Metro Drive, Suite 500
Bloomington, MN 55425
Bloomington Office: 952-854-0795 or 1-800-535-6373
Duluth Office: 218-727-0824 or 1-800-570-1012
Fax: 952-854-1632

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PLAN ADMINISTRATIVE MANAGER

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

IMPORTANT NOTICE

Benefits under these Plans will be paid only if the Board of Trustees (or its Plan Administrator) decides in its discretion that the applicant is entitled to them. The Plans will be interpreted and applied in the sole discretion of the Board of Trustees (or its delegate, including but not limited to, its Plan Administrator). Such decision will be final and binding on all persons covered by the Plans who are claiming any benefits under the Plan.

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To All Employees:

We are pleased to provide you with this new Summary Plan Description booklet. This booklet includes the Fund's eligibility rules and a summary of the Medical, Prescription Drug, Dental, Vision, Short-Term Disability, Death, and Accidental Death and Dismemberment ("AD&D") benefits provided. It also describes the Health Reimbursement Arrangement (HRA) that some, but not all, bargaining units have. Not all Collective Bargaining Agreements or other Participation Agreements provide for all benefits. If you have a question concerning which benefits are available to you, please call the Fund Office. The Fund was formed January 1, 2018 by the merger of three Teamster Health and Welfare Funds:

- Minnesota Teamsters Health and Welfare Plan (Local 120 Fund);
- The Beverage Drivers, Helpers and Inside Employees Union Local 792 Health and Welfare Fund (Local 792 Fund); and
- Teamsters Local 346 Health Fund (Local 346 Fund)

  (collectively, Legacy Health Plans).

Please take the time to read this booklet now. Refer to it when you need to file a claim for benefits for yourself or your Dependents.

When you or a Dependent enters a Hospital or are treated by a Physician or other eligible Provider, present your identification card to them. They will then be able to have your eligibility for Fund benefits verified through the Fund Office.

When you purchase prescription drugs at a participating pharmacy, present your identification card so you can enjoy the discounts the Fund has negotiated on your behalf. If you need help locating a participating pharmacy, you can call the Fund Office.

IF YOU HAVE ANY QUESTIONS REGARDING ELIGIBILITY FOR FUND BENEFITS, PLEASE CONTACT THE FUND OFFICE AT THE ADDRESS, PHONE NUMBER OR EMAIL ADDRESS REFERENCED ON PAGE iii and iv.

The Board of Trustees reserves the discretion and right to terminate, suspend, interpret, withdraw, amend, or modify the Plans sponsored by the Fund at any time without prior notice to participants to the extent permitted by law. To the extent retiree benefits are provided, they are not guaranteed or vested and are subject to modifications, change or termination as future circumstances may warrant. In addition, the tax treatment of these benefits is subject to change without notice, as determined by state, federal or local tax authorities.

The Board of Trustees strives to provide you and your Dependents with the best benefits possible consistent with the financial ability of the Fund.

Sincerely,

The Board of Trustees

IMPORTANT CONTACTS

If You need to:	Contact:	At:
Check Eligibility	Wilson-McShane Corporation	
	If You are a member of Locals 120, 792 or other local not listed	952-854-0795 or 1-800-535-6373
	If You are a member of Local 320 or 346	218-727-0824 or 1-800-570-1012
Ask a question about Medical Benefits	Wilson-McShane Corporation	
	If You are a member of Locals 120, 792 or other local not listed	952-854-0795 or 1-800-535-6373
	If You are a member of Local 320 or 346	218-727-0824 or 1-800-570-1012
Find a Network Provider for Medical Services	UMR – Website	https://www.umr.com/ select "Find a Provider" or 1-800-535-6373
UMR Utilization Management, or **UMR Complex Condition Care**		866-494-4502
Obtain Prior Authorization for Medical Services	Wilson-McShane Corporation	952-854-0795 or 1-800-535-6373
Find a Participating Pharmacy	Sav-Rx – Website	www.Sav-Rx.com or 1-800-228-3108
Find a Participating Dentist	Delta Dental – Website	www.deltadentalmn.org/members/
Ask a question about a dental claim	Wilson-McShane Corporation	952-854-0795 or 1-800-535-6373
File an HRA Claim	Wilson-McShane Corporation	952-854-0795 or 1-800-535-6373

IMPORTANT CONTACTS

If You need to:	Contact:	At:
File a Death Benefit Claim	Wilson-McShane Corporation	
	If You are a member of Locals 120, 792, or a local not listed	952-854-0795 or 1-800-535-6373
	If You are a member of Local 320 or 346	218-727-0824 or 1-800-570-1012
File an Accidental Death and Dismemberment (AD&D) Claim	Wilson-McShane Corporation	
	If You are a member of Locals 120, 792, or a local not listed	952-854-0795 or 1-800-535-6373
	If You are a member of Local 320 or 346	218-727-0824 or 1-800-570-1012
File a Short-Term Disability Claim	Wilson-McShane Corporation	
	If You are a member of Locals 120, 792, or a local not listed	952-854-0795 or 1-800-535-6373
	If You are a member of Local 320 or 346	218-727-0824 or 1-800-570-1012
Ask a question about Vision Benefits or Locate a VSP Network Provider	Vision Service Plan (VSP)	1-800-877-7195 or www.vsp.com
Add/Delete a Dependent	Wilson-McShane Corporation	952-854-0795 or 1-800-535-6373
Change your Address	Wilson-McShane Corporation	952-854-0795 or 1-800-535-6373

IMPORTANT CONTACTS

If You need to:	Contact:	At:
Obtain Plan documents	Wilson-McShane Corporation	
	If You are a member of Locals 120, 792, or a local not listed	952-854-0795 or 1-800-535-6373
	If You are a member of Local 320 or 346	218-727-0824 or 1-800-570-1012

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SCHEDULE OF BENEFITS

These pages include a high-level summary of your benefits. For a more complete explanation of your benefits, including eligibility requirements, limitations, and exclusions, You must refer to the full body of this Summary Plan Description booklet. The following summarizes the Medical, Prescription Drug, Dental, Vision, Weekly Disability, Death, and Accidental Death and Dismemberment and Healthcare Reimbursement Arrangement benefits offered through the Fund. Most, but not all bargaining or participation agreements provide for these benefits. If You have questions about which benefits You are eligible for, please contact the Fund Office. The Fund also offers a Health Reimbursement Arrangement (HRA) to bargaining units that provide for the benefit.

MEDICAL BENEFITS

The information below is a brief outline of your benefits. For more information, See Parts Two through Four of this booklet, beginning on page 30. Throughout Parts One through Four this booklet uses defined terms, which are capitalized. The definitions of these terms are found in the section titled “Medical Plan Definitions,” which begins on page 54.

Annual Deductible Amount:

	In-Network	Out-of-Network
Individual	$500/calendar year	$500/calendar year
Family	$1,500/calendar year	$1,500/calendar year

The Deductibles for In-Network and Out-of-Network services are combined and determined annually on a calendar-year basis.

Percentage Payable:

	In-Network	Out-of-Network
General rule for medical services, except as specified below	85%, after Deductible is met	75%, after Deductible is met
Autism Treatment	85%, Deductible does not apply	75%, after Deductible is Met
Bariatric Surgery	85% after deductible. Must use Designated Facility	No coverage
Chiropractic Services	85%, after Deductible is met	No coverage
Inpatient Hospital Services, including: **Facility fees**	85%, Deductible does not apply	No coverage except in limited situations **

	In-Network	Out-of-Network
Professional fees *Out-of-Network professional fees will be paid at In-Network benefit level if patient admitted to In-Network facility through Emergency Room.*	85%, after Deductible is met	75%, after Deductible is met
Inpatient Mental Health and Chemical Dependency Services, including inpatient hospital/ residential treatment facilities for adults and children and psychiatric treatment for emotionally disabled children	85%, Deductible does not apply	No coverage except in limited situations **
Medically Necessary hospitalization and anesthesia for dental care, including:		
Facility fees	85%, Deductible does not apply	No coverage except in limited situations **
Professional fees	85%, after Deductible is met	75%, Deductible does not apply
Newborn expenses (facility and professional fees)	85%, Deductible does not apply	75%, Deductible does not apply
Outpatient Mental Health and Chemical Dependency Services	85%, Deductible does not apply	75%, after Deductible is met

** Coverage provided for services qualifying as Emergency Care, care that is considered Continuity of Care, or care received when You or a Dependent are residing in or traveling in an area where an In-Network Provider is not available, and the inpatient services are Medically Necessary. When covered, Benefit is 85% for Emergency Care and 75% for non-emergency services.

	In-Network	Out-of-Network
ACA Mandated **Preventive Care, including routine health exams and tests, pre- and post-natal care, cancer screenings, women's preventive services and recommended immunizations**	100%, Deductible does not apply Flu shots and Covid-19 Vaccines received at in-Network Pharmacies covered at 100%	No coverage
Telemedicine visits	100%, if Doctor on Demand used Deductible does not apply	75%, after Deductible is met
Transplant Services, including:		
Facility Fees	85%, Deductible does not apply	No Coverage
Professional fees	85%, after Deductible is met. Must use Designated Facility	No Coverage

The Plan covers the following services, when a Participant elects to receive them from an Out-of-Network provider, at the same level of coverage the Plan provides when a Participant elects to receive the services from a network provider:

1. Voluntary family planning of the conception and bearing of children.
2. Testing and treatment of sexually transmitted diseases (other than HIV).
3. Testing for AIDS and other HIV-related conditions.
4. Medically Necessary emergency room services

For any other Out-of-Network claims, if a benefit is payable under the Plan, the Plan will calculate a benefit based on UMR's benchmark pricing. This pricing is not intended to represent a "usual, customary and reasonable charge."

For services provided outside of Minnesota, the Reasonable Expense for services from Out-of-Network Providers is commonly determined by affiliates of the Plan's PPO Network Provider. The difference between billed charges and Reasonable Expense amount can be significant and, unlike Co-payments and Co-insurance, does not apply toward the Plan's annual Out-of-Pocket maximum. Benefits are not available from Out-of-Network facilities except for care that constitutes Emergency Care, that is considered Continuity of

Care, or when You or a Dependent are traveling or residing in an area where an In-Network Provider is not available.

Medical Benefits with Separate Co-Payments

Emergency Room Facility	$200 Co-payment then 85%
Urgent Care	$25 Co-payment then 85%

Emergency room Co-payment is waived if there is an inpatient admission for the same condition within 48 hours.

Medical Benefits with Annual Visit or Dollar Limits

Chiropractic Services
Limited to 20 visits to In-Network Providers per calendar year.

Massage
Limited to 20 visits per calendar year.

Accidental Dental Services
For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the Injury. Coverage is limited to the initial course of treatment and/or initial restoration and subject to a $5,000 maximum. Services must be completed within 24 months of the date of Injury to be covered.

Wigs
Wigs for hair loss resulting from alopecia areata are subject to $350 maximum benefit per calendar year for In-Network Benefits and Out-of-Network Benefits combined.

Home Hospice Services
Respite care is limited to five days per episode, and respite care and continuous care combined are limited to 30 days.

Annual Medical Out-of-Pocket Maximum:

	In-Network	**Out-of-Network**
Individual	$2,500/calendar year	$2,500/calendar year
Family	$5,000/calendar year	$5,000/calendar year

The Out-of-Pocket limits for In-Network and Out-of-Network medical services are combined and are determined annually on a calendar year basis.

The following do not apply to the out-of-pocket limit:

- Deductibles
- Out-of-Network Benefits above the Reasonable Expense (see Definitions beginning on page 54)

- Any reduction in benefits for failure to obtain prior authorization, as required. Inpatient Hospital, Home Health Care, Residential Behavioral Health Facility, Skilled Nursing Facility, Skilled Nursing Care, Hospice Care, certain surgeries and procedures, and certain Durable Medical Equipment require prior authorization

- Any service or treatment that is not a Covered Charge

In no event, however, will the annual Out-of-Pocket expenses for medical and prescription drug Covered Charges combined exceed $7,350 per individual or $14,700 per family.

PRESCRIPTION DRUG BENEFITS

Annual Prescription Drug Out-of-Pocket Maximum:

	In-Network	Out-of-Network
Individual	$3,000/calendar year	No Coverage
Family	$7,000/calendar year	No Coverage

Prescription drug Co-payments and Co-insurance apply to the Annual Prescription Drug Out-of-Pocket Maximum. They do not apply toward the Annual Medical Out-of-Pocket Maximum.

	In-Network	Out-of-Network
Generic Drugs found on Network formulary (1 month supply)	$10 Co-pay or 20% of Cost, whichever is greater, up to a maximum of $50	No Coverage
Brand Name Drugs found on Network formulary (1 month supply)	$25 Co-pay or 30% of Cost, whichever is greater, up to a maximum of $150	No Coverage
Non-formulary Brand Drugs (1 month supply)	$25 Co-pay or 30% of Cost, whichever is greater, up to a maximum of $150	No Coverage
Specialty Drugs* (1 month supply)	$25 Co-pay or 30% of Cost, whichever is greater, up to a maximum of $150	No Coverage
* Generic specialty drugs for HIV or transplants can be filled for 90 days at a time and you will pay the 90-day generic co-pay.		
90-day Retail or Mail Order – Generic	$25 Co-pay or 15% of Cost, whichever is greater, up to a maximum of $125	No Coverage

	In-Network	Out-of-Network
90-day Retail or Mail Order – Brand Name Formulary	$62.50 Co-pay or 25% of Cost, whichever is greater, up to a maximum of $375	No Coverage
90-day Retail or Mail Order – Brand Name Non-Formulary	$62.50 Co-pay or 25% of Cost, whichever is greater, up to a maximum of $375	No Coverage

Step Therapy, Prior Authorization, and other cost and benefit management programs apply for certain medications.

Take Home Drugs:

Drugs dispensed by a hospital are payable under the medical portion of the Plan.

See Part Six beginning on page 63 for more information on Your prescription drug benefit.

WEEKLY DISABILITY BENEFITS (Active Employees Only. Retirees and Dependents Not Eligible)

Weekly Benefit:	$300 or 1/7th of the weekly amount if disabled less than a full week.
Maximum Disability Period:	26 weeks per illness, per Injury in a 12-month period
When Benefits Begin	
Accident/Injury	1st day of total disability
Illness (Including Pregnancy)	8th day after date Physician first finds You to be disabled

See Part Seven beginning on page 70 for more information on Your Disability benefits.

DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Death Benefits (Active Employees and Dependent(s) Only. Retirees and Retiree's Dependent(s) are Not Eligible other than limited grandfathered individuals from the Legacy Funds.)

Employee	$40,000
Spouse of Employee	$10,000
Children of Employee	Between $300 and $3,000 (depending on their age)

Accidental Death and Dismemberment (AD&D) Benefits (Active Employees Only, Retirees and Dependents Not Eligible)

Up to $80,000; the Plan will pay between $20,000 and $80,000 if You are seriously injured in an accident (depending on the severity of the accidental loss and Plan provisions). See Part Eight, beginning on page 74 for more information on Your Death and AD&D benefits.

SCHEDULE OF BENEFITS

DENTAL

Deductible Amount:

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating Dentist
Individual	$0	$25/calendar year	$25/calendar year
Family	$0	$75/calendar year	$75/calendar year

Deductible does not apply to Diagnostic and Preventive or Orthodontic Services.

Percentage Payable

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating ** Dentist
Diagnostic & Preventive Services	100%	100%	100%
Basic Service	100%	100%	100%
Endodontics	90%	80%	80%
Periodontics	90%	80%	80%
Oral Surgery	90%	80%	80%
Major Restorative Services	90%	80%	80%
Prosthetic Repairs and Adjustments	90%	80%	80%
Prosthetics	90%	80%	80%
Orthodontics	50%	50%	50%

** Dentists who are Delta PPO Dentists and Premier Dentists have signed a participating network agreement with Delta Dental agreeing to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge. The member is responsible for paying any difference to the non-participating dentists.

Benefit Maximums

Annual	$2,000
Lifetime Orthodontic	$1,000
Dental treatment relating to any incident of accidental Injury (covered)	$5,000

Orthodontics limited to those orthodontic treatment plans commenced on or after the eligible Dependent Child's eighth birthday and prior to the Dependent Child's nineteenth birthday.

All services (other than orthodontia) must be commenced and completed within one benefit year (January 1 – December 31).

There will be no carry-over payment from one benefit year to another.

A benefit will not be paid on a tooth replaced with an implant more than once in a lifetime.

See Section Nine beginning on page 79 for more information on Your Dental benefits.

VISION

These benefits are self-insured utilizing the Vision Service Plan (VSP) network.

If services are provided by a VSP-contracted provider, the following terms apply:

Frequency	Exam, Lenses or Contact Lenses and Frame once every calendar year Contact lenses are in lieu of lenses and frame
Frame Allowance	$130.00 retail frame allowance
Lens and Frame Copayment	$30.00 lens and frame
Elective Contact Lens Allowance	$130.00 elective contact lenses
Covered Lens Enhancements	Anti-reflective coating, UV coating, scratch coating, mirror, tints and photochromic Polycarbonate lenses for children
Exam Copayment	$15.00 vision exam and maximum of $60 contact lens exam

If benefits are not provided by a VSP-contracted provider, the following **reimbursements** apply:

Frequency	Same as above
Frame Reimbursement	$70.00
Lens Reimbursement **Single Vision** **Bifocal** **Trifocal** **Lenticular**	 $30.00 $50.00 $65.00 $100.00
Elective Contact Lens Reimbursement	$105.00
Exam Reimbursement	$45.00

See Part Ten beginning on page 96 for more information on Your Vision benefits.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) (Active Employees Only)

The HRA provides You with tax-free accounts to reimburse You for your and your eligible Dependents' medical, dental, vision and tax-qualified long-term care expenses that are not paid by other insurance plan(s). *Please note: to participate in the Fund's HRA, your Collective Bargaining Agreement must provide for it. To determine if your Collective Bargaining Agreement provides for HRA benefits, please contact Wilson-McShane Corporation at the address noted above.* See Part Eleven beginning on page 99 for more information about HRA benefits.

ELIGIBILITY

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PART ONE
ELIGIBILITY, SELF-PAYMENT AND TERMINATION PROVISIONS

Throughout Part I this booklet uses defined terms, which are capitalized. The definitions of these terms is found on page 54, in the section titled “Medical Plan Definitions.”

I. Contributing Employers

An employer shall become a contributing Employer as of the later of January 1, 2018 or the day it enters into a Collective Bargaining Agreement or other written Participation Agreement to contribute to the Teamsters Joint Council 32-Employers Health and Welfare Fund in accordance with said Agreement.

Effective January 1, 2018, employers became contributing Employers if they had bargained with Teamsters Locals 120, 346 and 792 to contribute to any of the following Legacy Health Funds, which merged to form this Fund:

- Minnesota Teamsters Health and Welfare Plan (Local 120 Fund);
- The Beverage Drivers, Helpers and Inside Employees Union Local 792 Health and Welfare Fund (Local 792 Fund); and
- Teamsters Local 346 Health Fund (Local 346 Fund)

(Collectively – Legacy Health Funds).

II. Who is Eligible to Participate?

A. Active Employees

All Employees of Employers who are in a job classification covered by a Collective Bargaining Agreement or a written Participation Agreement requiring contributions to be made on the Employee’s behalf to the Teamsters Joint Council 32-Employers Health and Welfare Fund are eligible to participate in the Plan. In addition, an Employee’s Spouse and eligible Dependent Children are eligible to begin coverage in the Plan at the same time as the eligible Employee begins coverage or the date the Employee acquires the Dependent, if later. To have eligibility the required contributions must be made on the Employee’s behalf and the required enrollment forms must be submitted.

NOTE: Certain Collective Bargaining Agreements require submitting an additional monthly or weekly Co-premium for enrolling your Dependents. Contact the Fund Administration Office for additional information.

B. Retirees

All retired Employees who met the initial and ongoing Retiree eligibility requirements of one of the Legacy Health Funds prior to January 1, 2018, or Employees who have retired on or after January 1, 2018 and meet the eligibility requirements of the Plan are eligible to participate. Continued Retiree eligibility requires the timely payment of Retiree premium. Non-Medicare Retirees participate in the same benefit options as actives except they are not eligible for Vision, Short-Term Disability Benefits, Death, Accidental Death and Dismemberment benefits or new contributions to the HRA. Medicare Retirees are limited

to Medicare supplemental plans offered through the Fund to certain groups of Retirees on a cost pass-through basis.

C. Eligible Dependents

Eligible Dependents of active Employees and Retirees are eligible for coverage subject to the provisions set forth below. Eligible Dependents are your lawfully married Spouse and Children, as defined below. Domestic Partners are not eligible under the Trust. You must submit an enrollment form to add your Dependents. The Trust will require documentation (such as marriage certificates, birth certificates, adoption papers, etc.) to add your Dependents. See Enrollment of Dependents on page 14 for further information on enrollment requirements.

Child or Children are defined as follows:

1. Children who are your blood descendants, stepchildren, foster children, adopted children and children placed for adoption from birth through the end of the month in which the child attains 26 years of age.

2. Children on or after age 26, who are incapable of self-sustaining employment by reason of mental retardation or physical handicap, unmarried and such incapacity began prior to attainment of age 26 and who are primarily financially dependent upon the Participant. Proof of the incapacity must be submitted to the Trustees within 31 days of the date the Dependent child's coverage would otherwise terminate, or, in the case of a newly eligible Participant, within 31 days after the Participant first becomes eligible under the Plan.

3. A child who is named in a Qualified Medical Child Support Order with which You and the Fund are obligated to comply.

4. Placement for adoption means the assumption and retention by a Participant of a legal obligation for total or partial support of a child in anticipation of the legal adoption of such child by the Participant.

5. Stepchildren are children of the Participant's Spouse.

6. Foster child means an individual who is placed with the Participant by an authorized placement agency or by judgment, decree, or other court order.

III. Active Employees and Their Eligible Dependents

Initial Eligibility and Commencement of Coverage

A. Active Employee Eligibility

A new Employee, or a previously eligible Employee who has lost eligibility, will satisfy initial eligibility, and have coverage for benefits commence in accordance with the terms of the Employee's Collective Bargaining Agreement or written non-bargaining unit agreement. Eligibility is established on a month-to-month basis for those agreements mandating monthly contributions and, on a week-to-week basis for those agreements mandating weekly contributions.

The Plan's general eligibility requirement is that an employee with weekly eligibility is eligible on the first day of the week (Sunday) following eight (8) consecutive weeks of contributions. If your employer contributes on a monthly basis the Plan will require an equivalent of eight weekly contributions before initial eligibility is established. Eligibility for employees with monthly eligibility will begin on the first of the month following receipt of the required contributions.

Self-payments cannot be made in order to satisfy initial eligibility, commencement of coverage for benefits, or reinstatement requirements.

Questions regarding eligibility should be addressed to the Fund Office.

The Trust has a separate initial eligibility rule for employees of Minnesota Public Sector Employers. Such employees are eligible on the first of the month after they begin employment provided that that their employer makes the required monthly contribution for their first month of employment.

B. Eligible Dependents of Active Employees

Most bargaining or participation agreements provide that your eligible Dependents are automatically covered if You enroll them in accordance with Plan requirements. Some bargaining agreements, however, may require a separate co-premium for dependent coverage or require You to affirmatively elect family coverage.

Under some Collective Bargaining Agreements, your contribution may be greater if You choose to cover your eligible Dependents. If You are required to make contributions on your Dependents, You must also pay contributions to the Fund in advance of a period (week or month, depending on your bargaining agreement) of coverage at the contribution rates set by the Board of Trustees. If You do not choose to enroll your eligible Dependents at the time You are initially eligible for coverage, You can only enroll them upon occurrence of special enrollment event, as described in Section V beginning on page 15.

IV. Retirees and Their Eligible Dependents

Initial Eligibility and Commencement of Coverage

A. Retiree Eligibility

All retired Employees of contributing employers who as of December 31, 2017 were participating as a retired Employee in any of the following Funds, are eligible for Plan benefits effective January 1, 2018:

- Minnesota Teamsters Health and Welfare Plan (Local 120 Fund);
- The Beverage Drivers, Helpers and Inside Employees Union Local 792 Health and Welfare Fund (Local 792 Fund); and
- Teamsters Local 346 Health Fund (Local 346 Fund)

These funds are referred to collectively as the "Legacy Health Funds."

ELIGIBILITY

All Employees who are in a job classification covered by a Collective Bargaining Agreement or a Participation Agreement on or after January 1, 2018 that requires contributions to be made on the Employee's behalf to the Teamsters Joint Council 32-Employers Health and Welfare Fund are eligible for retiree Plan benefits if you:

1. Are a retired Employee;

2. Meet the attained age and years of service requirements set forth below:

    a. **Retiree Group 1** – All Local 120 Fund Retirees and Local 346 Fund Retirees who retire on or after January 1, 2018. To be eligible the Retirees must have 20 Years of Service to be eligible for Retiree coverage from age 57 to age 59, or 10 Years of Service to be eligible for Retiree coverage from age 60 to 64. Your Years of Service with a Legacy Health Fund and this Fund both count toward this requirement.

    b. **Retiree Group 2** – Local 792 Fund Retirees who retire on or after January 1, 2018 must have 30 years of service to be eligible for Retiree coverage from age 50 to age 56, or 10 Years of Service to be eligible for Retiree coverage from age 57 to 64. Your Years of Service with a Legacy Health Fund and this Fund both count toward this requirement.

    c. **Retiree Group 3** – all covered Retirees who retired from the Local 346 or Local 792 Funds as of December 31, 2017 or earlier.

3. Were a Participant in the Active Plan immediately prior to retirement, or the Fund has affirmatively agreed to allow the Retirees of a newly participating Employer to participate in the Plan;

4. Elect in writing to participate in the Health Plan as a Retiree within 60 days of your retirement from an Employer; and

5. Make timely monthly self-payments in the amount required by the Board of Trustees. Self-payment must be paid to the Fund in advance of the month of coverage.

If You retire and do not elect to participate in the Health Plan as a Retiree within 60 days of your retirement, You will not be able to obtain coverage at a later date under this Plan. However, the Fund will allow a Retiree on a one-time basis to delay initial enrollment or to opt-out of Plan coverage if they are covered under another group health plan. Please note that it must be group health coverage. Coverage under an individual policy, such as MNSure or another Healthcare Exchange plan, will not qualify. The Retiree must still apply within the initial 60-day eligibility period for Retiree coverage, notify the Fund in writing and in advance of the intent to delay or opt-out of coverage and inform the Fund at the time coverage under the other group health plan ends. Coverage under this Plan and the other group health plan must be continuous (no gaps in coverage).

If You elect to participate, but later opt out of the Plan, You cannot later rejoin the Plan, regardless of evidence of continuous outside coverage.

The Board of Trustees reserves the discretionary right to interpret the Retiree eligibility rules, amend, or terminate Retiree coverage or change the amount of the self-payment required for Retiree coverage at any time. Retiree benefits are not vested and are not guaranteed.

Retiree Eligibility Ends When Retirees are Eligible to Enroll in Medicare. Coverage under the Fund's Retiree Plans ends when the Retiree or Spouse of the Retiree becomes eligible for Medicare. If You or your Spouse are eligible for Medicare as a result of End Stage Renal Disease, however, the Fund will continue to provide coverage for the period it is required to be primary under applicable law. Retirees who have participated in the Fund prior to Medicare eligibility may elect to participate in a Medicare Supplement option available through the Fund on a cost pass-through basis after becoming Medicare eligible.

B. Enrollment of Eligible Dependents of Retirees

When You first become eligible to participate in the Fund as a Retiree, You must elect whether You wish to cover only yourself or cover both yourself and your eligible Dependents.

Dependent coverage is only available if You submit a timely written application stating your intention to cover your eligible Dependents at the time You submit your initial retiree application. If You do not enroll your eligible Dependents at the time You become initially eligible or timely elect to delay your spouse's coverage because of other group health coverage, they may not be added later. However, if You acquire a new Spouse or eligible Dependent after your Retiree coverage starts You may add them within 30 days of acquiring them by providing written notice to the Fund Office. There is a separate cost for covering a Dependent under the Retiree Plan. Please contact the Fund Office for details (see page vi).

C. Retiree Coverage for Minnesota Public Employees

Minnesota Statutes grant public employees and their Dependents certain rights to continued health care coverage upon retirement and for peace officers and firefighters when they are killed or disabled in the line of duty. This section applies only to Participants employed by a Minnesota Public Employer.

1. Retiring Employees and their eligible Dependents may generally continue coverage in the Fund's Medical Plan if:

   - they qualify for a pension from their public employment, and
   - they pay the required monthly premium.

2. Peace Officers and Firefighters suffering from a disabling Injury received while employed and receiving a disability related pension can continue coverage in the Fund's Medical Plan.

3. Eligible Dependents of Peace Officer and Firefighters killed in the line of duty can continue coverage in the Fund's Medical Plan.

V. Special Enrollment of Dependents

A. Active Employees

Most bargaining agreements providing for coverage under this Plan includes coverage for your Dependents. To cover your Dependents, you must submit an enrollment form. If this is not done within 30 days of beginning coverage or acquiring a dependent, the Dependent's coverage will be effective on the first day of the month following the date the Fund receives the request for enrollment and any required enrollment information.

If your collective bargaining agreement requires a separate co-premium for covering Dependents, you must enroll a Dependent within 30 days of your coverage beginning, otherwise, you may only enroll a Dependent if a special enrollment event described in Section V. C. below occurs, or during the annual open enrollment.

B. Retirees

Dependents of Retirees are only covered under the Plan if the Retiree elects to cover Dependents at the time of initial eligibility. If a Retiree does not initially elect Dependent coverage, the Retiree can only add Dependent coverage later upon the occurrence of one of the special enrollment events listed below. Dependent Coverage under the Retiree Plan requires payment of a separate monthly premium.

C. Special Enrollment Events

1. You get married. Election of coverage for your Spouse must be made within 30 days from the date of marriage. Enrollment is effective on the date of marriage.

2. You become legally responsible for a Dependent Child or Children through birth, adoption, or placement for adoption. Election of coverage for your Child or Children must be made within 30 days of the date of birth, adoption, or placement of adoption. Enrollment is effective on the date of birth, date of adoption, or date of placement for adoption. A Dependent who loses eligibility under Children's Health Insurance Program (CHIP) or Medicaid program has 60 days to elect coverage under the Plan.

3. Your eligible Dependent(s) lose coverage under another health plan under COBRA which was exhausted, or coverage was not under COBRA and was terminated due to loss of eligibility, including legal separation, divorce, death, termination of employment, or reduction in hours of employment, or termination of employer contributions. (However, loss of eligibility does not include a loss due to failure of the individual or the Participant to pay premiums on a timely basis or termination of coverage for cause.) Election for coverage of your Dependent(s) must be made within 30 days of the exhaustion or termination of the other health coverage except for Children losing coverage under the CHIP or a Medicaid program who have 60 days. Enrollment is effective on the date of the loss of coverage, except that for Medicaid-eligible Dependents, enrollment is effective on the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Fund.

4. You have Dependents who are eligible for coverage under the Fund, that are not enrolled, and either of the following occurs:

   - Your Dependent loses eligibility under Medicaid or the CHIP, and You or your Dependent request coverage within 60 days after termination of Medicaid or CHIP, or

   - Your Dependent becomes eligible to participate in a financial assistance program through Medicaid or CHIP and You or your Dependent request coverage under the Fund within 60 days after becoming eligible for the assistance.

Enrollment is effective on the date of loss of eligibility for Medicaid or CHIP or the date your Dependent becomes eligible to participate in a financial assistance program through Medicaid or CHIP, except that for Medicaid-eligible Dependents, enrollment is effective on the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Fund.

D. Written Request

In order to request special enrollment of a Dependent, You must submit a written request to the Fund Office specifying the change in status, along with a copy of the official document demonstrating such change in status, and any additional information the Fund may require.

For Retirees, the increased self-pay contribution for Dependent coverage must be paid to the Fund at the time the Retiree submits a written request for special enrollment of a Dependent.

VI. Continuing Eligibility

Each Participant who has satisfied their initial eligibility requirement and for whom coverage for benefits has commenced shall continue to be eligible for benefits for each subsequent calendar week or month, whichever is applicable, provided the required full contribution has been paid to the Plan. Such required full contribution must be paid by the Employer or by self-payment by the Participant, if applicable, or by a combination thereof.

VII. Termination of Coverage

A. Active Employees

Your coverage will end if:

- You terminate employment with all contributing Employers (including layoff or leave of absence);

- Your hours are reduced so that You are not eligible for coverage under the Plan;

- Any required contributions for coverage are not made;

- Your employer ceases to have an obligation to contribute to the Fund;
- You enter military service for a period of 31 days or more; or
- You no longer meet the definition of an eligible Employee.

If one of these events occurs, coverage under the Plan will cease at midnight on the Saturday of the last week or midnight on the last day of the month, (depending on whether your employer contributes on a weekly or monthly basis), for which employer contributions on behalf of the Employee were received by the Fund Office. If an Employee has not made self-contributions as required on a timely basis, or has made contributions for the maximum period allowed under the Continuation of Coverage provisions of this Plan, the Employee's coverage will end at midnight on the Saturday of the week or midnight on the last day of the month, whichever is applicable.

Should your employer fail to make the required contribution on your behalf You will be notified of such delinquency and your coverage will terminate.

B. Retirees

A Retiree's coverage for Plan benefits will terminate at the earlier of the month the Retiree no longer meets the Fund's Retiree eligibility requirements, becomes eligible to enroll in Medicare, or the last day of the month for which the last required self-payment was made.

C. Dependents

1. **Spouse:** Coverage ends for your Spouse at midnight on the Saturday of the last week or midnight on the last day of the month in which any of the following happen, whichever is applicable depending on whether monthly or weekly contributions are made for your coverage:

   - Your coverage ends;
   - Your Spouse enters military service for a period of 31 days or more;
   - You and your Spouse are no longer married or are legally separated. (See COBRA Continuation of Coverage beginning on page 21 for alternative coverage a Participant's former spouse may elect.), or
   - Any required payment for Dependent coverage is not made.

   The Trust does require proof of marriage.

2. **Child or Children:** Dependent Children are eligible for benefits so long as they continue to meet the Plan's definition of "Child." (See page 54) The Fund does require proof of a dependent Child's eligibility.

Coverage ends for your dependent Child at midnight on the Saturday of the last week or midnight of the last day of the month in which any of the following happen, whichever is applicable depending on whether monthly or weekly contributions are made for your coverage:

- Your coverage ends

- Your child no longer meets the definition of Child;
- The Child goes into military service for a period of 31 days or more; or
- Any required payment for Dependent coverage is not made.

With the exception of handicapped Dependents over age 26, dependent Child coverage will end at midnight of the last day of the month in which your Child attains the age of 26. (See page 54 for Fund's definition of "Child")

D. Fund Termination

Coverage will terminate if the assets of the Fund are exhausted, or at the end of the month in which the Plan is terminated.

VIII. Rescission of Coverage and Obligation to Notify Plan

The Plan can retroactively cancel your coverage or your Dependents' coverage if You or any of your Dependents:

- Engage in any fraudulent act, practice, or omission in connection with coverage under the Plan;
- Make an intentional misrepresentation of material fact in connection with coverage under the Plan, or
- The Plan administratively determines that coverage has been mistakenly provided.

Your coverage and your Dependents' coverage may be treated as void from the time of the fraudulent act, practice, or omission or intentional misrepresentation. Additionally, You and your Dependents may be required to repay any benefits that You or your Dependents received after the time of the fraudulent act, practice, or omission or intentional misrepresentation. This does not affect the Plan's ability to prospectively terminate your coverage or the Plan's ability to retroactively cancel your coverage if You or your employer fails to make required Plan contributions or premium payments. The Trust may also retroactively terminate your coverage if there has been an administrative delay in receiving or processing information concerning your or your Dependent's eligibility.

Under the Plan rules, You have an affirmative obligation to notify the Fund Office of any event or change in circumstances that affects:

- Your eligibility for coverage under the Plan or your Dependents' eligibility for coverage under the Plan; or
- You or your Dependents' eligibility to receive payment from the Plan for a specific claim for benefits.

You must notify the Fund Office of any such event or change in circumstances within 30 days of the event or change in circumstances. If You fail to do so, you may be liable to repay the Fund for any benefits paid to your ineligible dependents.

IX. Reinstatement After Lapse in Coverage

A. Active Employees

Any Employee whose Fund coverage has terminated, or any Employee who has established initial eligibility but did not qualify to have coverage begin, and who within 12 consecutive months of that termination or initial eligibility date is subsequently employed in covered employment, shall again have coverage for Plan benefits beginning on the first day of the calendar month or the Sunday of the first week, whichever is applicable, in which he returns to employment with an Employer who is required to make a contribution because of hours worked by the Employee in such week or month.

B. Retirees

Any Retiree whose coverage has terminated under the Plan shall not be allowed to reinstate his or her eligibility for Plan benefits unless they have timely opted out of Retiree coverage to be covered under another group health plan (see page 13 for details). In order to reinstate eligibility, a Retiree who waived his initial opportunity to purchase or opted out of Retiree coverage must provide evidence of continuous coverage under another group health plan.

X. Military Service

The Employee's eligibility and that of the Employee's Dependents will be terminated at midnight on the Saturday of the week or midnight on the last day of the month, whichever is applicable, in which the Employee enters the military service for a period of 31 days or more.

If an Employee loses eligibility because of induction into the Armed Forces, the Employee will be reinstated for Plan benefits if the Employee returns to work within the time period established by USERRA:

- Periods of military service of up to 30 consecutive days. The Employee must report back to work for the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and safe transportation home, plus an eight-hour period for rest. If reporting back within this deadline is "impossible or unreasonable" through no fault of the employee, he or she must report back as soon as possible after the expiration of the eight-hour period.

- Periods of military service of 31-180 days. The Employee must submit a written or verbal application for reemployment not later than 14 days after the completion of the period of service. If this is impossible or unreasonable through no fault of the Employee, he or she must submit the application as soon as possible thereafter.

- Periods of military service of 181 days or more. The Employee must submit an application for reemployment not later than 90 days after completion of the period of service.

These deadlines to report to work or apply for reemployment can be extended up to two years to accommodate a period during which a person was hospitalized for or

convalescing from an injury or illness that occurred or was aggravated during a period of military service.

The Employee will be reinstated for coverage under these circumstances without any waiting period or exclusions, other than waiting periods or exclusions that would have applied even if there had been no absence for uniformed service. This rule does not apply to the coverage of any illness or Injury determined by the Secretary of Veterans' Affairs to have been incurred in, or aggravated during, performance of military duty.

Individuals performing military duty of more than 30 days may elect to continue employer sponsored health care for up to 24 months or the period of service, whichever is shorter; however, they must self-pay in the same manner and same amount as those who choose COBRA continuation of coverage. For military service of less than 31 days, health care coverage is provided as if the service member had remained employed.

XI. Qualified Medical Child Support Order Coverage

A Qualified Medical Child Support Order (QMCSO) means any court judgment, decree, or order, including a court's approval of a domestic relations settlement agreement, or any judgment, decree, or order issued through an administrative process established under state law which has the force and effect of law under applicable state law, that:

1. provides for child support payments related to health benefits with respect to a child or requires health benefit coverage for such child by the Plan, and is ordered under state domestic relations law; or

2. enforces a state law relating to medical child support payments with respect to the Plan; and

3. creates or recognizes the right of a child as an alternate recipient who is recognized under the order as having a right to be enrolled under the Plan to receive benefits derived from such child's relationship to a Participant in the Plan; and

4. includes the name and last known address of the Participant from whom such child's status as an alternate recipient under this Plan is derived and of each alternate recipient, a reasonable description of the type of coverage to be provided by the Plan, and the period for which coverage must be provided; and

5. does not require or purport to require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act; and

6. has been determined to be a Qualified Medical Child Support Order under reasonable procedures adopted and uniformly applied by the Plan.

The Plan Administrator will determine if a court order directing a Participant parent to provide health coverage of a Dependent Child is a Qualified Medical Child Support Order (QMCSO). The Plan has procedures established for the determination and administration of QMCSO's. QMCSO coverage under the Plan will be provided to a Dependent Child

upon application by the Participant parent. A copy of the written procedures for determining whether or not an order is "qualified" is available from the Fund Office upon request at no charge.

A. Benefits

The benefits provided under the Plan are those in effect for Dependents on the date QMCSO coverage commences or, if there are thereafter amendments to the Plan, the benefits in effect on the date charges are incurred for treatment.

B. Payment for Coverage

The additional contribution uniformly required of a Participant parent to cover a Dependent Child, if any, shall be paid in the amount and at such time as required under the rules of the Plan.

C. Termination

QMCSO coverage for a Dependent Child will terminate (i) if any required contribution is not timely paid as required under the Plan rules; or (ii) on the date the Participant parent's coverage terminates; or (iii) on the date the Child is no longer a Dependent Child under the provisions of the Plan. See COBRA Continuation Coverage provisions for the limited conditions under which coverage may be continued thereafter for a Dependent Child.

XII. COBRA – Continuation of Coverage by Self-Payment

COBRA coverage is available to You when You would otherwise lose your health coverage because of a qualifying event. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their health coverage because of a qualifying event.

A. What is COBRA Coverage?

COBRA continuation of coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." After a Qualifying Event, COBRA coverage is offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA coverage must self-pay for COBRA coverage.

If You are an Employee, You will become a Qualified Beneficiary if You lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or;
- Your employment ends for any reason other than your gross misconduct.

If You are the Spouse of an Employee or Retiree, You will become a Qualified Beneficiary if You lose your coverage under the Plan because of any of the following qualifying events:

- Your Spouse dies;

- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your Spouse.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Participant dies;
- The parent-Participant's hours of employment are reduced;
- The parent-Participant's employment ends for any reason other than his or her gross misconduct;
- The parent-Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The Child stops being eligible for coverage under the Plan as a Dependent.

B. When is COBRA Coverage Available?

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer or Employee must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Participant and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), You or the person seeking continuous coverage must notify the Plan Administrator within 60 days after the qualifying event occurs or the loss of coverage if later. You must provide this notice to: **Plan Administrator, Teamsters Joint Council 32-Employers Health and Welfare Fund, 3001 Metro Drive, Suite 500, Bloomington, Minnesota 55425. Failure to provide timely notice within this 60-day period will cause your coverage to end as it normally would under the terms of the Plan.**

In some cases, the Plan Administrator may ask You for additional documentation.

C. How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary

has an independent right to elect COBRA coverage. Covered Employees may elect COBRA coverage on behalf of their Spouses, and parents may elect COBRA coverage on behalf of their Children.

COBRA coverage is a temporary continuation of coverage. If the qualifying event is a termination of employment or reduction in hours, COBRA coverage can last for up to 18 months. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA coverage can last for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries other than the Employee can last until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA coverage can be extended.

Disability extension of 18-month period of continuation coverage

If You or any of your eligible Dependents is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The disability must have started prior to the 60th day of COBRA coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide notice to the Fund of the disability determination within 60 days of the disability determination or the beginning of your COBRA continuation coverage (if later) and prior to the end of the initial 18 months of COBRA. In some cases, the Plan Administrator may ask You for additional documentation.

Second qualifying event extension of 18-month period of coverage

If Your Spouse or Dependent Child on COBRA experiences another qualifying event while receiving 18 months of COBRA coverage, they can receive 18 additional months of COBRA coverage, for a maximum of 36 months. Notice of the second qualifying event must be given to the Plan within 60 days of the second qualifying event. This extension may be available to your Spouse and any Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

D. Coverage and Options

A qualified beneficiary may elect to continue medical and prescription drug coverage only or medical, prescription drug, dental and vision coverage Disability, death, and AD&D benefits are not available under COBRA.

The persons for whom coverage was selected may not be changed, except to add coverage for a new Spouse upon your marriage, or to add a new Dependent Child as a qualified beneficiary upon the Child's birth or placement for adoption with the Employee during the Employee's period of COBRA coverage.

The Plan is required to offer continued coverage which, as of the day before coverage terminated, is identical to similarly situated employees or family members who have not experienced a qualifying event. If coverage under the Plan is modified for similarly situated employees, the qualified beneficiary's coverage also will be modified.

A qualified beneficiary does not have to show insurability to choose continuation coverage.

E. Cost of COBRA and Making Self-Payments

The self-payment amount is set every 12 months in accordance with regulatory guidance. The required initial self-payment for COBRA coverage must be made not later than 45 days following the election to continue coverage. If you had weekly coverage through the Trust your first COBRA payment will be for any remaining weeks in the month for which you lost coverage. Subsequent COBRA payments will be on a monthly basis. Failure to do so will cause eligibility and coverage to terminate retroactively to the later of the Qualifying Event or loss of eligibility.

Subsequent self-payments must be made on or before the 1st day of the month for which the payment applies. Failure to make timely self-payments by the end of the month for which continuation coverage is sought will cause coverage and eligibility to terminate at the end of the month for which the last timely self-payment was made.

Coverage under COBRA must be continuous.

F. Termination of COBRA

The Trustees will not accept self-payments and provide coverage for qualified beneficiaries terminates if:

- the Plan no longer provides group health care coverage to any Employee;
- the required notice of a qualifying event is not provided by the qualified beneficiary within 60 days of its occurrence;
- the election for COBRA coverage is not made within 60 days following the date of coverage termination or receipt of the Fund Office explanation, whichever is later;
- the initial self-payment is not paid by the due date explained above;
- any required self-payments are not paid by the due date explained above;

- the person continuing coverage becomes covered under another group health care plan as an employee or dependent after such person's COBRA election date and waiting periods, if any, under such other group health care plan have been satisfied;

- the Employee's Employer ceases participation in the Plan unless it no longer offers coverage to any classification of employee who previously participated in the Plan;

- the maximum continuation coverage period is reached;

- for a Qualified Beneficiary entitled to the additional 11 months continuing coverage based on a disability extension – eligibility for continuing the disability extension will terminate when there has been a final determination that the disability no longer exists; or,

- the Qualified Beneficiary becomes entitled to Medicare after such person's COBRA election date (although other family members not entitled to Medicare will continue to be eligible for COBRA). However, if a qualified beneficiary becomes entitled to Medicare due to End Stage Renal Disease (ESRD), his coverage under COBRA will not terminate automatically because of eligibility for Medicare. In the case of ESRD, the Fund is the primary source of coverage for up to 30 months from the date of ESRD-based Medicare entitlement, provided the person is an active eligible Employee or Dependent or is covered under the Fund with COBRA continuation coverage. In the event the Fund's liability as the primary coverage for ESRD ends before the COBRA continuation period ends, the Fund will become secondary to Medicare for the balance of the continuation coverage for such person.

G. If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Office. 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, You also can contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional EBSA Offices are available through EBSA's website.)

H. Keep Your Plan Informed of Address Changes

In order to protect your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices You send to the Plan Administrator.

XIII. Health Coverage During Disability – Waiver of Premium

A. Waiver of Premium – Employee Only

If you, the Employee, are Totally Disabled you can extend health coverage (medical, prescription, drug, dental and vision) for you and any eligible Dependents without a

premium payment for up to a maximum of 26 weeks (less any weeks paid for by your Employer) pursuant to a collective bargaining agreement or applicable law. To be eligible for a waiver of premium you must be Totally Disabled as defined below, be under the ongoing care of a Physician, and apply within 90 days of the Total Disability beginning. A wavier of premium will not begin until any obligation to continue coverage pursuant to a collective bargaining agreement or applicable law is exhausted. Coverage pursuant to a waiver of premium will be secondary to medical benefits available to you under an automobile or other insurance policy. If your Total Disability results from an Illness or Injury for which the Plan may have a third-party reimbursement interest, you must complete the necessary third-party reimbursement forms to receive a waiver of premium. Eligibility for a waiver of premium is separate from your potential eligibility for Short-Term Disability benefits.

For purposes of the waiver of premium benefits, Total Disability is defined as a complete inability to perform any and every duty of your regular occupation at the time you became Totally Disabled, you are not otherwise gainfully employed and requires you to be under the ongoing care of a Physician.

A Waiver of Premium is not available or will end upon the earliest of the following events:

- You are no longer Totally Disabled;
- You are no longer under the ongoing care of a Physician;
- You have exhausted the maximum time period available to you;
- You are suspended from your employment or were terminated for cause;
- You are retired and receiving retirement benefits;
- You have commenced work with another employer; or
- You have failed to return a properly completed third-party reimbursement form or provide other necessary information.

Contact the Fund Office if you have questions about health coverage during a Total Disability.

B. Extension of Benefits for Disability Condition Only

If You as an Employee are unable to work due to your being Totally Disabled, the Plan will continue Your major medical benefits coverage for treatment of the Injury or Illness causing such Total Disability for an extended period of 15 months, provided that You:

- were covered by the Plan under the short-term disability benefit and have exhausted the total 26 weeks allowed; and
- are still Totally Disabled;

This coverage is in lieu of COBRA and may not be elected while on COBRA or after it ends. You must apply for an Extension of Benefits for Disabling Condition Only within 90

days of the Total Disability beginning. If elected, an Extension of Benefits for Disabling Condition Only is in lieu of COBRA.

You must make an application for this benefit. For more information about these benefits, contact the Fund Office.

XIV. Family and Medical Leave Act Rights

The Family and Medical Leave Act (FMLA) requires certain covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" Employees for certain family medical reasons. If You are provided a leave under the FMLA or applicable state law, You will continue to receive health care coverage through this Fund if the required contributions are made on your behalf. You should consult with your employer on the requirements for FMLA leave.

XV. Health Insurance Marketplace Coverage Options and Your Health Coverage

You also have options to seek coverage through the Health Insurance Marketplace. To assist You as You evaluate options for You and your family, this Section XVI provides some basic information about the Marketplace.

A. What is the Health Insurance Marketplace?

The Marketplace is designed to help You find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

B. Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your Employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

C. Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If You have an offer of health coverage from your employer that meets certain standards, You will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, You may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to You at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover You (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, You may be eligible for a tax credit.

Note: If You purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then You may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for

Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

The Marketplace can help You evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

D. Information About Health Coverage Offered by Your Employer

This Subsection XIV.D. contains information about any health coverage offered by your employer. If You decide to complete an application for coverage in the Marketplace, You will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Fund Name: Teamsters Joint Council 32-Employers Health and Welfare Fund
4. Employer Identification Number (EIN): 41-0855601
5. Fund Address: 3001 Metro Drive—Suite 500
6. Fund Telephone: 952-854-0795 or 1-800-535-6373
7. City: Bloomington
8. State: Minnesota
9. Zip Code: 55425

The Fund covers active Employees and Retirees and eligible Dependents, as described beginning on page 10. Your coverage meets the minimum value standard, and constitutes minimum essential coverage.

MEDICAL BENEFITS

Page

PART TWO
MEDICAL BENEFITS

The following sections of Part Two describe the medical benefits covered under the Plan, subject to the Plan's terms, conditions, and exclusions. Throughout Part Two this booklet uses defined terms, which are capitalized. The definitions of these terms are found in the section titled "Medical Plan Definitions," which begins on page 54. The Fund would pay these benefits if the charges described in this Part are incurred while the Participant is covered for the benefit and Fund claim filing requirements are met. The medical coverage is subject to the Exclusions and Limitations described in this document. A Covered Charge is incurred at the time the service is rendered or the item is provided. Benefits for a Covered Charge will not be paid more than once under this Plan or under more than one coverage Section unless a Section states otherwise.

I. Prior Authorization and Pre-Admission Notification

Prior authorization is required for certain benefits to be covered. All prior authorization requests apply to both In-Network and Out-of-Network Providers. Services or supplies which require pre-authorization are in-patient hospitalizations (including maternity stays over 48 hours for normal delivery and 96 hours for C-section, in-patient behavioral health, skilled nursing facility and residential treatment), home health care, transplants and transplant-related services, partial hospitalizations, durable medical equipment over certain cost thresholds ($500 for rental, $1,500 for purchase; $1,000 for prosthetics, clinical trials, bariatric surgery, chemotherapy, dialysis, medical specialty injectables/ medication program and other services or supplies which may be designated by the Plan. If You or your provider have questions about what services must be preauthorized, call the Fund Office at (952-854-0795 or 1-800-535-6373.

Prior authorization only certifies services as Medically Necessary; it does not guarantee eligibility when the services are provided, payment, or the amount of payment. Eligibility for, and payment of, benefits are subject to the terms of the Plan and your eligibility when the services are provided.

For non-emergency Hospital admissions, the Fund requires pre-admission approval. You must inform Hospital administration in advance that the Fund participates in a Pre-Admission Notification Program. Your provider can contact the Fund Office.

Exclusion – Friday and Saturday admissions for non-emergency Monday surgery or admissions more than 24 hours prior to elective or non-emergency surgery will not be covered.

II. Agreements with In-Network Providers and Facilities

The Plan has agreements with In-Network Providers and Facilities where they agree to accept a negotiated amount as full payment for a covered service when your claim is processed. The amount the Plan pays to In-Network Providers and Facilities, and the amount You pay in the form of Co-insurance, Co-payments and Deductibles will be based on the negotiated payment amount the Plan has established with them. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed.

The negotiated amount of payment with In-Network Provider or Facility for certain covered services may not be based on a specified charge for each service, and the Plan may use a reasonable allowance to establish a per service allowed amount for such covered service. In some cases, after a claim is processed, that negotiated payment amount may be adjusted if the agreement with the provider so provides. Co-insurance, Co-payment and Deductible calculations will not be changed by subsequent adjustments or any subsequent reimbursements the Plan may receive from other parties.

Transplants must be received from an In-Network Provider. Bariatric surgery must be received from an In-Network Provider that is designated as eligible to provide services. For further information contact the Trust Office.

III. Out-of-Network Providers and Facilities

A facility or provider with which the Plan does not have a negotiated agreement is an Out-of-Network Provider or Facility.

In certain limited cases, the Plan covers services a Participant elects to receive them from an Out-of-Network provider at the same level of coverage the Plan provides when a Participant elects to receive the services from an In-Network Provider or Facility. These situations are:

1. Voluntary family planning of the conception and bearing of children.
2. Testing and treatment of sexually transmitted diseases (other than HIV).
3. Testing for AIDS and other HIV-related conditions.
4. Medically Necessary emergency room services

The Plan provides no benefit for services provided by an Out-of-Network Facility unless the Services qualify as Emergency Care, is considered Continuity of Care, or You or your Dependent are residing or traveling in an area where an in-network facility not available and the in-patient services are medically necessary.

In all cases where services are provided by an Out-of-Network Provider or Facility and are Covered Charges, Out-of-Network claims will be calculated based on UMR Benchmark pricing. This determination is not intended to represent a “usual, customary and reasonable charge.”

Benefits for any Covered Charges received from an Out-of-Network Provider will usually be paid directly to the Participant. An assignment of benefits from a Participant to an Out-of-Network Provider or Facility generally will not be recognized by the Fund.

IV. Medical Benefits

Annual Deductible:

	In-Network	Out-of-Network
Individual	$500/calendar year	$500/calendar year
Family	$1,500/calendar year	$1,500/calendar year

The per person Deductible applies separately to each Participant (Employee or Retiree or Dependent) during each calendar year and must be met during the calendar year. The per family Deductible applies to all Participants (Employee or Retiree or Dependent) in the family during each calendar year and must be met during the calendar year. The Deductibles for In-Network and Out-of-Network services are combined and determined annually on a calendar-year basis.

Percentage Payable:

The percentage payable of the covered medical charges You or your Dependent incur in excess of the Deductible for most covered medical charges is stated below.

	In-Network	Out-of-Network
General rule for medical services, except as specified below	85%, after Deductible is met	75%, after Deductible is met
Autism Treatment	85%, Deductible does not apply	75%, after Deductible is Met
Bariatric Surgery	85% after Deductible is met; Must use a Designated Provider	No coverage
Chiropractic Services	85%, after Deductible is met	No coverage
Convenience Clinics	100%, Deductible does not apply	75%, after Deductible is met
Hospice Care	85% after Deductible is met	No coverage
Inpatient Hospital Services, including:		
Facility fees	85%, Deductible does not apply	No coverage except in limited situations **
Professional fees *Out-of-Network professional fees will be paid at In-Network benefit level if patient admitted to In-Network facility through Emergency Room*	85%, after Deductible is met	75%, after Deductible is met
Inpatient Mental Health and Chemical Dependency Services, including inpatient hospital/ residential treatment facilities for adults and children and psychiatric treatment for emotionally disabled children	85%, Deductible does not apply	No coverage except in limited situations **

	In-Network	Out-of-Network
Medically Necessary hospitalization and anesthesia for dental care, including:		
Facility fees	85%, Deductible does not apply	No coverage except in limited situations **
Professional fees	85%, after Deductible is met	75%, Deductible does not apply

**** Coverage provided for services qualifying as Emergency Care, care that is considered Continuity of Care, or care received when You or a Dependent are residing in or traveling in an area where an In-Network Provider is not available, and the inpatient services are Medically Necessary. When covered, Emergency Care benefit is 85% and 75% for non-emergency services.

	In-Network	Out-of-Network
Newborn expenses (facility and professional fees)	85%, Deductible does not apply	75%, Deductible does not apply
Outpatient Mental Health and Chemical Dependency Services	85%, Deductible does not apply	75%, after Deductible is met
ACA-Mandated Preventive Care, including routine exams and tests, pre- and post-natal care, cancer screenings, women preventive services and recommended immunizations	100%, Deductible does not apply Flu shots and Covid-19 Vaccines received at In-Network Pharmacies covered at 100%	No coverage
Telemedicine visits	100%, Deductible does not apply if Doctor on Demand used	75%, after Deductible is met
Transplant Services, including:		
Facility Fees	85%, Deductible does not apply. Must use Designated Facility	No Coverage
Professional fees	85%, after Deductible is met	

** Coverage provided for services qualifying as Emergency Care, care that is considered Continuity of Care, or care received when You or a Dependent are residing in or traveling

in an area where an In-Network Provider is not available, and the inpatient services are Medically Necessary. When covered benefit is 85% for Emergency Care and 75% for non-emergency services.

A medical benefit is calculated by subtracting the amount of the applicable Deductible which has not been satisfied from the covered medical charges incurred and then by multiplying the remaining amount of such charges by the percentage payable.

Co-Payment:

Emergency Room - Facility	$200 Co-payment then 85%
Urgent Care	$25 Co-payment then 85%

Emergency room co-payment is waived if there is an inpatient admission for the same condition withing 48 hours.

These Co-payment amounts are the Participant's responsibility and are generally paid at the time of service. These Co-payment amounts do not count toward satisfaction of the Deductible, but do count toward the Annual Medical Out-of-Pocket Maximum.

Annual Medical Out-of-Pocket Maximum:

	In-Network	Out-of-Network
Individual	$2,500/calendar year	$2,500/calendar year
Family	$5,000/calendar year	$5,000/calendar year

Co-payments and Co-insurance all count towards the Annual Medical Out-of-Pocket Maximum. Deductibles, Out-of-network expenses, expenses for non-covered items or services, and prescription drug expenses do not count towards the Annual Medical Out-of-Pocket Maximum. Prescription drugs have their own annual Out-of-Pocket maximum.

In no event, however, will the annual Out-of-Pocket expenses for Covered Charges for medical and prescription drugs exceed $7,350 per individual or $14,700 per family.

V. Eligible Expenses

Necessary and reasonable charges for medical care rendered while under the care of a licensed Physician are covered under this Medical Benefit, including:

A. Ambulance. Charges for air or ground emergency ambulance services to the nearest facility equipped to treat the illness or Injury, and prearranged or scheduled air or ground ambulance transportation requested by an attending Physician or nurse.

B. Bariatric Surgery. Weight loss surgery or bariatric surgery, which meets Medical Necessity requirements. Bariatric surgery must be pre-authorized and be received from an In-Network Provider who is designated to provide such services. To obtain pre-approval, contact the Fund Office (see page iii for contact information). There is no coverage for weight loss or bariatric surgery performed Out-of-Network.

C. Casts, Splints, and Surgical Dressings. Charges for casts, splints, and surgical dressings.

D. Chiropractic Services. Services of a chiropractor rendered to diagnose and treat acute neuromuscular-skeletal conditions as the result of a non-occupational accident or illness, subject to the 20-visit per calendar year limit in the Schedule of Benefits. All manipulations, therapies, office visits, x-rays and any other procedures performed by a chiropractor are paid under this benefit. There is no Plan coverage for maintenance chiropractic treatment. There is no coverage for chiropractic services provided by an Out-of-Network Provider.

E. Clinical Trials. Routine care costs for clinical trials covered as required by the Affordable Care Act.

F. Dental Accident Benefits. A "Dental Accident" is Injury or damage to the teeth as a result of unnatural force or objects applied to the teeth.

Dental Accident Benefits for an examination and diagnosis by the treating dentist, dental treatment, oral surgery, and dental x-rays resulting from Dental Accidents shall be paid by the Plan at 100% of the Reasonable Expense of a participating dentist or the fee actually charged, whichever is less, provided such dental services are reported to the Plan within 180 days from the date of the dental accident. Dental Accident services provided by a non-participating dentist shall be paid at 100% of the prevailing 51st percentile of Reasonable Expense or the fees actually charged, whichever is less.

Benefits shall be subject to a $5,000 maximum amount payable for dental treatment relating to any incident of accidental Injury and the services must be completed within 24 months.

Dental services provided that are not covered or included as benefits under the Dental Accident benefit under the medical plan may be covered as a payable benefit under the standard Dental benefit, subject to any applicable Co-Payment, Deductible and annual maximum (see Dental Benefits beginning on page 79).

G. Dental – Hospitalization and Anesthesia. Eligible expenses for necessary hospitalization and anesthesia charges incurred in conjunction with dental care for eligible Dependent Children five years of age and under will be considered for payment if the primary reason for such confinement is deemed to be an underlying serious and hazardous medical condition, and subject to the limitations stated in the Schedule of Benefits. Out-of-Network professional services for medically necessary hospitalization and anesthesia for dental care are covered at 75% after the deductible is met.

H. Dental Services or Supplies. When extraction of one or more teeth is Medically Necessary for partially or completely impacted teeth, extractions prior to radiation treatment for an underlying serious medical condition, and excision of tumors of the jaw and mouth area when the condition requires pathological exams. Such services are subject to the limitations stated in the Schedule of Benefits. For Medically Necessary extractions of wisdom teeth, the Medical Plan shall pay secondary to a Dental Plan.

I. Diagnostic Imaging and Laboratory Tests. Charges for diagnostic x-ray examinations and laboratory tests. To be covered, Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) exams must be performed at designated facilities. For information about designated facilities contact the Fund Office. The Fund will pay for laboratory tests or x-ray examinations authorized by the attending Physician and made

solely for diagnostic purposes of a Participant's Injury or illness, and subject to the limitations stated in the Schedule of Benefits.

No benefits will be paid under this provision for the following:

1. Any dental x-ray, except under the supervision of an oral surgeon for use in the treatment by an oral surgeon for any Injury produced by accidental means.

2. Any charge for diagnostic x-ray or laboratory test as part of a physical exam for occupation, school, travel, or the purchase of insurance.

J. Durable Medical Equipment. Charges for a limited selection of Durable Medical Equipment, including the initial purchase price, or the rental up to the maximum benefit available (not to exceed the purchase price) for eligible Durable Medical Equipment.

Durable Medical Equipment includes equipment that:

- is prescribed by the attending Physician;
- is Medically Necessary;
- is primarily and customarily used only for a medical purpose;
- is designed for prolonged use; and,
- serves a specific therapeutic purpose in the treatment of an illness or Injury that is a covered expense under this benefit.

Items ordered by your Physician, even if Medically Necessary, will not be covered if they do not meet all of the above criteria.

The Fund will pay for the repair and/or replacement of Durable Medical Equipment only when:

1. The repairs, including the replacement of essential accessories, such as hoses, tubes, mouthpieces, etc. are necessary to continue to make the item/device serviceable.

2. Routine wear on the equipment renders it non-functional and the Participant still requires the equipment. The Fund does not cover the upgrade or replacement of Durable Medical Equipment when the existing equipment is still functional or can be made functional through repair.

3. The Physician documents that the condition of the Participant changes. (e.g., impaired function necessitates an upgrade to an electrical wheelchair from a manual wheelchair.)

The Fund covers special feeding supplements for treatment of Phenylketonuria (PKU) if it meets Medical Necessity requirement.

K. Durable Medical Equipment. Durable Medical Equipment must be preauthorized if the cost exceeds the following amounts:

- Rentals $500
- Purchase $1,500
- Prosthetic $1,000

L. Emergency Room Visits. Emergency room visits, subject to the specific Co-payment amount stated in the Schedule of Benefits. The emergency room Co-payment stated in the Schedule of Benefits is waived if the Participant is admitted to the hospital for the same illness or Injury within 24 hours after the emergency room visit. The Fund will provide benefits for Emergency Care without regard to whether the Provider is an In-Network or Out-of-Network Facility or Provider. For Medically Necessary Emergency Care received from Out-of-Network Providers or Facilities, benefits will be provided on the same terms as for In-Network Providers except that Out-of-Network Providers and Facilities may bill You for amounts that exceed the Reasonable Expense, as determined in the sole discretion of the Fund. Amounts in excess of the Reasonable Expense are not taken into account in the Plan's Out-of-Pocket limit.

M. Extended Care Benefits. Extended Care Benefits for services such as skilled nursing, convalescent or sub-acute facilities are covered. The services must begin within thirty days of discharge from the hospital for the same or related illness when the confinement was for at least 3 days. Services for respite care are limited to 5 days per episode and respite care and continuous care combined are limited to 30 days.

N. Genetic Counseling. Genetic Counseling that meets the Plan's Medical Necessity requirements is covered.

O. Gender Reassignment. The Plan covers services related to gender reassignment subject to Plan guidelines and Medical Necessity determinations.

P. Hearing Aid. Evaluation for the need for a hearing aid and Medically Necessary hearing aids arranged through and authorized by an In-Network Physician, up to a maximum benefit of $1,000 per ear for each Participant every three years. The hearing aid limits are combined under In-Network and Out-of-Network benefits. A hearing aid appliance is limited to one of the following types:

- In-the-ear;
- Behind-the-ear (air or bone conduction);
- Conventional (on the body); or
- Eye glass frame hearing appliance

The appliance must be prescribed by an In-Network Physician.

Q. Hospice. In-Network Hospice care is covered. There is no coverage for Out-of-Network Hospice care. Respite care is limited to five (5) days per episode and respite care and continuous care combined are limited to 30 days.

R. Hospital – Extra Charges. The Fund will pay extra charges for any one confinement for days when room and board charges are paid under this Plan, or where

hospital charges are incurred in connection with an outpatient Surgical Procedure. (See Prior Authorization on page 30.) Extra charges are defined as:

1. Charges by an In-Network hospital for medical care and treatment (other than room and board charges, other professional charges, and charges made by a radiologist or a pathologist); and,

2. Charges by a Physician, or professional anesthetist for the cost and administration of anesthetics.

S. Hospital – Inpatient Room Charges. The Fund will pay the percentage payable of the hospital's average Semi-Private room and board charges (including special care units) for an inpatient stay during a period of confinement. (See Prior Authorization on page 30.) NOTE: Inpatient services at an Out-of-Network facility are not covered unless services qualify as emergency care; care that is considered continuity of care or received when You or a Dependent are residing in or traveling in an area where an In-Network provider is not available, and the services are medically necessary.

T. Hospital – Nursery Care. Hospital charges for up to five days of routine nursery care provided to a newborn well baby while the mother is hospital confined; the requirement that benefits are payable only for charges made for treatment or diagnosis of bodily Injury or disease shall not apply to this benefit. NOTE: Inpatient services at an Out-of-Network facility are not covered except in limited situations defined in Section S above.

U. Hospital – Nursing Services. Regular charges for nursing services rendered in the hospital. NOTE: Inpatient services at an Out-of-Network facility are not covered except in limited situations defined in Section S above. Private-duty nursing is excluded.

V. Hospital – Surgery Services. Hospital charges for medical services and supplies provided during confinement as a registered inpatient and during outpatient surgery. (See Prior Authorization on page 30.) NOTE: Hospital charges for confinement as a registered inpatient at an Out-of-Network facility are not covered except in limited situations as defined in Section S above.

W. Intensive Care Charges.

X. Massage Therapy. Massage therapy is covered. There is an annual maximum of 20 visits.

Y. Mental and Behavioral Health Benefit Coverage Parity – This Plan provides mental health and substance use disorder benefits and coverage in full parity with medical/surgical benefits provided by the Plan for medically-necessary treatment of any other illness or injury covered under the Plan, including any and all medical management services related thereto. Any exceptions, exclusions, or limitations related to the Plan's benefits and coverage, where applicable, are described in the Exclusions section of this document.

Z. Mental Health and Chemical Dependency Treatment. Charges for Mental Health and Chemical Dependency treatment, subject to the limitations set forth in the Schedule of Benefits, including charges incurred for such services rendered by a Physician or, under a Physician's direction, a licensed psychologist, or a licensed social worker. Charges incurred for treatment received from a licensed social worker are

payable only if a Physician has previously diagnosed and referred the Participant, in writing, to the licensed social worker for treatment and the treatment takes place in a licensed facility except for services qualifying as Emergency Care or Continuity of Care.

The Plan does not cover charges for any treatment not provided at a licensed facility; any confinement or treatment not recommended by a Doctor of Medicine; temporary confinement unless determined to be Medically Necessary and ordered by a Physician; any charge which represents an admitting fee or deposit; involving the family of the person eligible for whom a claim is submitted when they are made part of the therapy; or, educational material.

NOTE: Charges for Inpatient services provided at an Out-of-Network facility are not covered except for services qualifying as Emergency Care, Continuity of Care, or You or a Dependent are residing or traveling in an area where an in-network provider is not available and the inpatient services are Medically Necessary.

AA. Non-Acute Care Facility, Skilled Nursing, Home Health Care. Regular charges for a Non-Acute Care Facility, skilled nursing services or home health care subject to the following conditions and limitations:

The Fund will pay for Non-Acute Care Facility charges if:

1. the Fund has approved the use of the facility prior to admittance;

2. the facility is, at all times, being used to replace an otherwise Medically Necessary hospital stay; and

3. before being admitted to the Non-Acute Care Facility the Participant has been in the hospital at least three days in a row (not counting the day of discharge) and is admitted to the facility within 30 days after leaving the hospital.

The Fund will pay for the charge of a registered nurse, home health aide or licensed physiotherapist, other than one who ordinarily resides in the Participant's home or who is the Spouse, child, brother, sister, or parent of either the Participant or his Spouse, for professional nursing or physiotherapy services, under the supervision of a Physician if being used to replace an otherwise Medically Necessary hospital stay. Skilled nursing/home health services include charges for supplies that are Medically Necessary to treat the Participant's illness or Injury, including, but not limited to, IV therapy, injection therapy, medicaments, and life-sustaining nutrients. Services for respite purposes, are limited to five days per episode, and respite care and continuous care combined are limited to 30 days.

Limitation: Total benefits for home health care are limited to a maximum of 12 visits per calendar year if You are eligible to receive palliative care in the home and You are not homebound. For all other home health services, the maximum is 180 visits per calendar year. A "visit" is each 24-hour visit (or shifts of up to 24-hour visits). Any visit that lasts less than 24 hours, regardless of the length of the visit will count as one visit. Routine postnatal well child visits do not count toward the visit limit.

BB. Oral Surgery. Oral surgery when the procedure involves partial and/or complete bony impactions, and subject to medical necessity and the limitations stated in the Schedule of Benefits. The Medical Plan will pay benefits secondary to a Dental Plan.

CC. Orthotics. Medically Necessary orthotics are covered. Custom molded foot orthotics are limited to one pair per calendar year.

DD. Outpatient Surgery Benefits.

EE. Oxygen. The charge for supplying and administering of oxygen.

FF. Physical, Speech, and Occupational Therapy. Physical, speech, and occupational therapy provided the treatment is:

1. Rehabilitative care to correct the effects of illness or Injury.

2. Habilitative care rendered for congenital, developmental, or medical conditions which have significantly limited the successful initiation of normal speech and normal motor development.

Massage therapy must be performed by a Physician (see definition on page 59) and is limited to 20 visits annually.

GG. Physician Visits. Physician office visits (including telemedicine visits), and urgent care visits, subject to the specific Co-payment amount stated in the Schedule of Benefits on page 31.

HH. Physiotherapy. Charges for treatment by a physiotherapist under the supervision of a Physician.

II. Prosthetic Devices. Charges for prosthetic devices. Note: Wigs for hair loss resulting from alopecia areata are subject to $350 maximum benefit per calendar year for In-Network Benefits and Out-of-Network Benefits combined.

JJ. Transplant Services. This is transplantation (including retransplants) of the human organs or tissue listed below, including all related post-surgical treatment, follow-up care and drugs and multiple transplants for a related cause. Transplant Services do not include other organ or tissue transplants or surgical implantation of mechanical devices functioning as a human organ, except surgical implantation of an FDA approved Ventricular Assist Device (VAD) or total artificial heart, functioning as a temporary bridge to heart transplantation. To receive In-Network benefits, Transplant Services must be performed by an In-Network Provider. For information about designated facilities contact the Fund Office.

Transplants that will be considered for coverage are limited to the following:

1. Kidney transplants for end-stage disease.

2. Cornea transplants for end-stage disease.

3. Heart transplants for end-stage disease.

4. Lung transplants or heart/lung transplants for: (a) primary pulmonary hypertension; (b) Eisenmenger's syndrome; (c) end-stage pulmonary fibrosis; (d) alpha 1 antitrypsin disease; (e) cystic fibrosis; and (f) emphysema.

5. Liver transplants for: (a) biliary atresia in children; (b) primary biliary cirrhosis; (c) post-acute viral infection (including hepatitis A, hepatitis B antigen e negative and hepatitis C) causing acute atrophy or post-necrotic cirrhosis; (d) primary sclerosing cholangitis; (e) alcoholic cirrhosis; and (f) hepatocellular carcinoma.

6. Allogeneic bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for: (a) acute myelogenous leukemia; (b) acute lymphocytic leukemia; (c) chronic myelogenous leukemia; (d) severe combined immunodeficiency disease; (e) Wiskott-Aldrich syndrome; (f) aplastic anemia; (g) sickle cell anemia; (h) non-relapsed or relapsed non-Hodgkin's lymphoma; (i) multiple myeloma; and (j) testicular cancer.

7. Autologous bone marrow transplants or peripheral stem cell support associated with high-dose chemotherapy for: (a) acute leukemias; (b) non-Hodgkin's lymphoma; (c) Hodgkin's disease; (d) Burkitt's lymphoma; (e) neuroblastoma; (f) multiple myeloma; (g) chronic myelogenous leukemia; and (h) non-relapsed non-Hodgkin's lymphoma.

8. Pancreas transplants for simultaneous pancreas-kidney transplants for diabetes, pancreas after kidney, living related segmental simultaneous pancreas kidney transplantation and pancreas transplant alone.

The transplant-related treatment provided, including the expenses incurred for directly related donor services, shall be subject to and in accordance with the provisions, limitations, maximums, and other terms of this Plan document.

Medical and hospital expenses of the donor are covered only when the recipient is a Participant and the transplant and directly related donor expenses have been prior authorized for coverage. Treatment of medical complications that may occur to the donor are not covered. Donors are not considered Participants, and are therefore not eligible for the rights afforded to Participants under this Plan Document.

The list of eligible Transplant Services and coverage determinations are based on established medical policies which are subject to periodic review.

VI. Specific Benefits

A. Pregnancy Stays

Group health plans and health insurance issuers offering group insurance coverage (including this Plan) generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean Section, or require that a provider obtain an authorization from the Plan or the insurance issuer for a prescribed length of stay not in excess of the above periods stays beyond the time periods listed above must preauthorized.

Benefits for treatment of Pregnancy are payable on the same basis as benefits for treatment of disease. All the limitations and other conditions and terms of the Plan that apply to benefits payable for disease will apply to benefits payable for Pregnancy.

B. Women's Health and Cancer Rights Act of 1998

If You have had or are going to have a mastectomy, You may be entitled to obtain benefits under the Women's Health and Cancer Rights Acts of 1998 (WHCRA). For Participants receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and,
- Physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

Coverage is subject to the same annual Deductible, Co-insurance, and maximums as other benefits under Your health plan.

WELLNESS/PREVENTIVE CARE BENEFITS

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PART THREE
WELLNESS/PREVENTIVE CARE BENEFITS

Throughout Part Three this booklet uses defined terms, which are capitalized. The definitions of these terms are found in the section titled "Medical Plan Definitions," which begins on page 54.

I. Preventive Care

The Plan covers the preventive care services mandated by the Affordable Care Act ("ACA") without any cost share to you if received from an In-Network Provider. If these services are received from an Out-of-Network Provider, they are subject to the Plan's deductible, co-payment, and co-insurance requirement. What services considered Preventive Care is updated annually by the United States Preventive Services Task Force. It includes the following basic categories; all adults; women; and, children:

- Evidence-based tests or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. Covered procedures include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas;

- Annual physical exams including services and tests described in guidelines from the Health Resources and Screening Administration;

- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individuals involved;

- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

- With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Covered procedures would include items such as well women visits, screening for gestational diabetes, a variety of maternity-related services (contact the Trust Office for details), HPV testing, mammograms and cervical cancer screenings given in accordance with the guidelines. Additionally, the Trust will cover digital mammography, and any screening mammographies) without cost share if received from an In-Network Provider.

If you have questions about what services are covered by the Preventive Care benefit, contact the Trust Office or go to https://www.healthcare.gov/coverage/preventive-care-benefits/.

II. Cost Sharing Rules for Preventive Services

A. If a preventive item or service is billed separately from an office visit, the office visit will be subject to the Physician office visit Co-payment stated in the Schedule of Benefits and thereafter will be paid by the Fund at the percentage payable for Medical Benefits as stated in the Schedule of Benefits, but the preventive item or service will be paid at the percentage payable for Wellness/Preventive Care Benefits as stated in the Schedule of Benefits.

For example, if a Participant has a cholesterol test during an office visit and the Physician bills for the office visit separately for the lab work associated with the cholesterol screening test, the Participant will be responsible for a Co-payment and Co-insurance for the office visit, but not for the lab work.

B. If a preventive item or service is not billed separately from an office visit, whether the Participant is responsible for a Co-payment and Co-insurance for that office visit depends on the primary purpose of the office visit. If the primary purpose is to obtain the preventive item or service the entire bill is paid by the Fund at the percentage payable for Wellness/Preventive Care Benefits as stated in the Schedule of Benefits. If the primary purpose is not the delivery of the preventive item or service, the Participant will be responsible for a Co-payment and Co-insurance for the office visit.

For example, if a Participant sees a Physician to discuss reoccurring abdominal pain and has a blood pressure screening during that visit, the Participant will be responsible for a Co-payment and Co-insurance for the office visit because the blood pressure check was not the primary purpose of the visit.

C. Children receiving an annual physical exam under guidelines recommended by the Affordable Care Act will have the entire office visit paid at the percentage payable for Wellness/Preventive Care Benefits as stated in the Schedule of Benefits even if some non-preventive services also are provided.

MEDICAL PLAN EXCLUSIONS

Page

PART FOUR
MEDICAL PLAN EXCLUSIONS

Throughout Part Four this booklet uses defined terms, which are capitalized. The definitions of these terms are found in the section titled "Medical Plan Definitions," which begins on page 54.

I. Generally

No benefits are payable for any Covered Charge incurred unless:

A. It is for treatment that is generally accepted medical practice;

B. It is for treatment that is Medically Necessary;

C. It is for treatment or diagnosis of a bodily Injury or disease and the service or supply is prescribed by a Physician or other appropriately licensed provider; and,

D. You are obligated to pay for it and You would have been billed for it even if You did not have Fund coverage.

II. Specific Exclusions

No Benefits are payable for the following:

A. **Accident-Related Dental Services.** Accident-related dental services if treatment is (1) provided to teeth which are not sound and natural, (2) to teeth which have been restored, (3) initiated beyond six months from the date of the Injury, (4) received beyond the initial treatment or restoration, or (5) received beyond 24 months from the date of Injury.

B. **Acupuncture.** Acupuncture services.

C. **Administrative Fees.** Non-medical administrative fees and charges including, but not limited to, medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.

D. **Administrative Health Screenings.** Health services and certifications when required by third parties, including for purposes of insurance, legal proceedings, licensure and employment, and when such services are not preventive care or otherwise Medically Necessary, such as custody evaluations, vocational assessments, reports to the court, parenting assessments, risk assessments for sexual offenses, education classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) competency evaluations, and adoption studies.

E. **Autopsies.**

F. **Benefits Subject to Plan Offset.** Any charges, claims or losses incurred by a Participant at a time that the Participant owes payment to the Plan because of benefit payments made in reliance upon incorrect, misleading, or fraudulent statements or representations by the Participant, or where the Participant has failed to honor the Plan's

rules of subrogation and reimbursement or otherwise has failed to cooperate with the Plan, as described in this Plan Document. The Plan can refuse to pay any charges, claims or losses if the Plan has a reasonable basis to believe that the Participant or his or her representative is not cooperating with the Plan or honoring the Plan's subrogation or reimbursement provisions.

G. Biofeedback Therapy.

H. Blood Pressure Kits. Home blood pressure kits.

I. Cannabis. Medical cannabis.

J. Charges in Excess of Reasonable Expense. The portion of a billed charge for an otherwise covered service by a provider, which is in excess of the Reasonable Expense, or which is either a duplicate charge for a service or charges for a duplicate service.

K. Charges Involving Billing Practices. Charges for services (a) for which a charge would not have been made in the absence of insurance or medical plan coverage, or (b) which the Participant is not legally obligated to pay, and (c) from providers who waive Co-payment, Deductible and Co-insurance payments by the Participant.

L. Coordination of Benefits. Services that are rendered to a Participant, who also has other primary insurance coverage for those services and who does not provide the Plan the necessary information to pursue coordination of benefits, as required under the Plan.

M. Cosmetic Surgery. Cosmetic Surgery and services, and treatments primarily for the improvement of the Participant's appearance or self-esteem, including, but not limited to, augmentation procedures, reduction procedures and scar revision. This exclusion does not apply to services for port wine stain removal, and reconstructive surgery and services subject to the Women's Health and Cancer Rights Act.

N. Counseling Services. Religious counseling, marital/relationship counseling, and sex therapy.

O. Court Ordered Treatment. Court ordered treatment, except as described under Mental Health and Chemical Dependency Treatment on page 38 and "Office Visits for Illness and Injury" or as otherwise required by law.

P. Data Collection. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

Q. Dental Treatment. Dental treatment, procedures or services not listed in the medical benefits portion of the Plan document, pages 35-36 and 39.

R. Employment-Related Services or Supplies. Any expense due to an Injury, sickness, condition, disease or mental or nervous disorder sustained while the Participant was performing any act of employment or doing anything related to any occupation or employment. Any expenses due to Injury, sickness, condition, disease, or mental or nervous disorder for which benefits are or may be payable, in whole or in part, under any

Worker's Compensation Act or any Occupational Diseases Act, or any similar law. However, the Plan will consider advancing medical expenses payable under any Worker's Compensation law if the Participant signs a subrogation agreement and agrees to pursue a claim.

S. Failure to Use a Designated Physician or Facility. For In-Network benefits, charges incurred for bariatric services incurred for weight loss surgery provided by a Provider who is not a Designated Provider.

T. Foot Care. Palliative foot care is excluded.

U. Foster Care and Family Childcare. Foster care, adult foster care and any type of family childcare provided or arranged by the local state or county.

V. Governmental Benefits. If a Participant is entitled, or could have been entitled if proper application had been made, to any medical, dental or disability benefit provided under the authority of any governmental agency, such benefit shall discharge the obligation of the Fund as though it had been paid under this Plan.

W. Health Club Memberships. Health club memberships.

X. Home Births. Charges for elective home births and services of doulas.

Y. Infertility Treatments. Reversal of sterilization; assisted reproduction, including, but not limited to gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), intracytoplasmic sperm injection (ICSI) and/or in-vitro fertilization (IVF), and all charges associated with such procedures; diagnosis and treatment of infertility, including drugs for the treatment of infertility; artificial insemination; and sperm, ova or embryo acquisition, retrieval, or storage.

Z. Investigative or Experimental. Procedures, technologies, treatments, facilities, equipment, drugs, and devices which are considered investigative, or otherwise not clinically accepted medical services. The Plan considers vagus nerve stimulator treatment for the treatment of depression and Quantitative Electroencephalogram treatment for the treatment of behavioral health conditions to be investigative and does not cover these services. The Plan considers the following transplants to be investigative and does not cover them: surgical implantation of mechanical devices functioning as a permanent substitute for a human organ, non-human organ implants and/or transplants and other transplants not specifically listed in this Plan Document. While complications related to an excluded transplant are covered, services which would not be performed but for the transplant, are not covered. See page 56 for a definition of Experimental.

AA. Lost Medications or Supplies. Replacement of prescription drugs, medications, equipment and supplies due to loss, damage, or theft.

BB. Massage Therapy. Massage therapy for the purpose of a Participant's comfort or convenience. Massage therapy that meets Plan requirements is limited to 20 visits annually.

CC. Medical Food. Enteral feedings, unless they are the sole source of nutrition used to treat a life-threatening condition, or special dietary treatment for Phenylketonuria (PKU),

nutritional supplements, over-the-counter electrolyte supplements and infant formula, except as specified in this Plan document.

DD. Medication Therapy Consultation. Medication Therapy Disease Management consultation.

EE. Naturopathic Services. Services provided by naturopathic providers.

FF. Neuromusculoskeletal Treatment. Care that is not rehabilitative in nature and Medically Necessary for the diagnosis and/or treatment of acute neuromusculoskeletal conditions.

GG. Non-Covered Providers. Services from non-medically licensed facilities or providers and services outside the scope of practice or license of the individual or facility providing the service.

HH. Non-Covered Services. Services associated with non-covered services, including, but not limited to, diagnostic tests, monitoring, laboratory services, drugs, and supplies.

II. Non-Prescription or Non-Approved Drugs. Non-prescription (over-the-counter) drugs or medications, including, but not limited to, vitamins, supplements, homeopathic remedies, and non-FDA approved drugs.

JJ. Not Medically Necessary. Treatment, procedures, services, or drugs which are not Medically Necessary and/or which are

- Experimental, or
- Primarily educational in nature or for the vocation, comfort, convenience, appearance, or recreation of the Participant, including skills training.

KK. Oral Surgery. Oral surgery to remove wisdom teeth that is not Medically Necessary. For Medically Necessary extractions of wisdom teeth, the Medical Plan will pay benefits secondary to a Dental Plan.

LL. Out-of-Network Facility Charges. Inpatient services received from Out-of-Network facilities except for services qualifying as Emergency Care, care that is considered Continuity of Care or care received when You or a Dependent are residing or traveling in an area where an In-Network Provider is not available and the inpatient services are medically appropriate.

MM. Out-of-Network Inpatient Care. For Inpatient treatment, procedures or services which are not provided by an In-Network facility unless the services represent Emergency Care, Continuity of Care or You or your Dependent are residing or traveling in an area where an In-Network Provider is not available and the treatment is Medically Necessary.

NN. Prescription Drugs. All prescription drugs, medications, or pharmacy items other than those administered in a Physician's office, during an emergency room or urgent care visit, an outpatient hospital visit or an inpatient stay or unless otherwise specified in this Plan document. The Plan has a separate prescription drug benefit which is described beginning on page 63.

OO. Private Duty Nursing. Private duty nursing services, except as specifically described in this Plan document.

PP. Rest, Respite, Custodial Care. Rest and respite services and Custodial Care, including all services, medical equipment and drugs provided for such care that does not qualify for Extended Facility Benefits.

QQ. Services from a Family Member. Services provided by a family member of the Participant, or a resident in the Participant's home.

RR. Services Received When Ineligible. Treatment, procedures, or services or drugs which are provided when You are not covered under this Plan.

SS. Substance Abuse Intervention. Professional services associated with substance abuse intervention. A “substance abuse intervention” is a gathering of family and/or friends to encourage a person covered under this Plan document to seek substance abuse treatment.

TT. Surrogacy Services. Services related to the establishment of surrogate pregnancy and fees for a surrogate.

UU. Taxes. Charges for sales tax.

VV. Third-Party Reimbursement Claims. Any loss, expense or charge incurred as a result of any Injury, occurrence, condition or circumstance for which the injured Participant: (a) has the right to recover payment from a third party; at the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of reimbursement described beginning on page 112; (b) has recovered from a third party and did not disclose to the Plan that future medical services related to the Injury, occurrence or condition would be incurred if the individual knew or reasonably should have known that such future medical services would be required at the time of settlement of the Plan’s subrogation– reimbursement interest; or (c) has not submitted a claim for such loss, expense or charge prior to resolution of the third party claim. At the discretion of the Trustees, losses, expenses and charges excluded by this paragraph may be paid subject to the Plan's right of subrogation and reimbursement; This exclusion applies to any recovery received by a Participant regardless of how it is characterized, including, but not limited to, any apportionment to a Spouse for loss of consortium and applies whether or not the Participant has been made whole. The term "third party" as used in this section includes any individual, insurer, entity, or federal, state or local government agency, who is or may be in any way legally obligated to reimburse, compensate or pay for a Participant’s losses, damages, injuries or claims relating in any way to the Injury, sickness, occurrence, condition or circumstance for which the Plan has paid medical, dental or disability benefits; this includes but is not limited to insurers providing liability, medical expense, wage loss, uninsured motorist or underinsured motorist coverage.

WW. Travel Expenses. Travel and lodging incidental to travel, regardless if it is recommended by a Physician and any travel billed by a provider.

XX. Vision and Hearing Services. Routine eye exams, keratotomy and keratorefractive surgeries, eyeglasses, contact lenses and their fitting, measurement and adjustment, and hearing aids (implantable and external, including osseointegrated or bone

anchored) and their fitting, except as specifically described in this Plan document. This Plan does not cover cochlear implants.

YY. Vocational Rehabilitation. Vocational rehabilitation and recreational or educational therapy.

ZZ. Weight Loss. Commercial weight loss programs and exercise programs. Weight loss/bariatric surgery is only covered if it meets Plan guidelines, is preauthorized and is performed by an In-Network Provider who is designated to provide such services.

MEDICAL PLAN DEFINITIONS

PART FIVE
MEDICAL PLAN DEFINITIONS

Chemical Dependency: Alcohol or drug dependent as defined in the *International Classification of Diseases.* This only includes dependence on these substances:

- Ethyl alcohol;
- Minor tranquilizers;
- Narcotics and narcotic synthetics;
- Sedatives;
- Hypnotics;
- Amphetamines;
- Cocaine;
- Hallucinogens;
- Products containing tetra-hydro-cannabinol; and,
- Volatile inhalants.

Child: Shall include the Employee's natural children, adopted children, stepchildren and eligible foster children under age 26.

The Plan defines Eligible Children as the Employee's:

- Natural or adopted children;
- Children placed in the Employee's home pending adoption;
- Stepchildren;
- Foster children who are placed with the Employee by an authorized placement agency or by a judgment, decree or other order of a court of competent jurisdiction.

The term "Child" does not include any child who is in active-duty military service except for periods of fewer than 31 days.

Continuity of Care: You may request that the Fund provide coverage for your Out-of-Network Provider or Facility for a limited time due to the need for a specific medical condition until your care be safely transferred to an In-Network Provider or Facility. A request for Continuity of Care must be made within 30 days of your Fund coverage beginning or your Provider or Facility ceasing to be In-Network. Request for Continuity of Care are subject to review for Medical Necessity and approval by the Fund.

Cosmetic Surgery: Means surgery which is chiefly intended to improve appearance and does not meet the definition of Medically Necessary as defined in this Plan.

Covered Charge: Shall mean the actual amount billed by the provider of service, less the following: a) any expense specifically excluded under the Plan or that exceeds any Plan limitation; b) any portion of the billed amount that the Participant is not obligated to pay; and c) any Reasonable Expense reduction for charges by an Out-of-Network provider.

Custodial Care: Services that the primary purpose of which is meeting personal needs. These services can be provided by persons without professional skills or training. Custodial Care does not include skilled care. Custodial Care includes:

- Giving of medicine that can usually be taken without help;
- Preparing special foods; and
- Help with walking, getting in and out of bed, dressing, eating, bathing, and using the toilet.

Deductible: The amount of Covered Charges that must be paid by a person before benefits will be paid by the Fund. The Deductible per person and per family are shown in the Schedule of Benefits.

Dependent: Means the Participant's Spouse and eligible Child or Children.

Designated Facility: An In-Network facility that is allowed to provide specified procedures and such.

Designated Physician: An In-Network Physician who is authorized to provide specified procedures and services.

Durable Medical Equipment: Equipment which:

- is prescribed by the attending Physician;
- is Medically Necessary;
- is primarily and customarily used only for a medical purpose;
- is designed for prolonged use; and,
- serves a specific therapeutic purpose in the treatment of an illness or Injury.

Durable Medical Equipment does not include services or supplies of a common household use, such as: waterbeds, hospital beds, air conditioners, heat appliances, dehumidifiers, exercise equipment, air purifiers, water purifiers, allergenic mattresses, blood pressure kits, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a Physician.

Emergency Care: These are services to treat: (1) the sudden, unexpected onset of illness or Injury which, if left untreated or unattended until the next available clinic or office hours, would result in hospitalization; or (2) a condition requiring professional health services immediately necessary to preserve life or stabilize health. When reviewing claims for coverage of Emergency Services, a reasonable lay person's belief that the circumstances required immediate medical

care that could not wait until the next working day or the next available clinic appointment will be taken into consideration. The Fund must be notified within two working days of admission to an Out-of-Network Facility, or as soon as reasonably possible under the circumstances.

Employee: Means all Employees of Employers who are in a job classification covered by a Collective Bargaining Agreement or a Participation Agreement requiring contributions to be made on the Employee's behalf to the Health Fund and who are covered under the Plan.

Employer: An Employer who contributes to the Health Fund in accordance with a Collective Bargaining Agreement or a Participation Agreement and subscribes to the Health Fund's Trust Agreement.

Experimental: Means any procedure that is investigative and limited to research rather than applied to accepted, general clinical practice. Experimental also means any technique that is restricted to use at those centers which are capable of carrying out disciplined clinical efforts and scientific studies. Any procedure that has a lack of objective evidence which suggests therapeutic benefit and proven value, or whose efficacy is medically questionable, is considered Experimental. The Trust has delegated to its PPO Service Provider the authority to utilize its internal policies and protocols to determine what services and supplies are considered to be experimental.

Exceptions: A service or supply will not be considered Experimental if it is part of an approved clinical trial. An approved clinical trial is one that meets the criteria in either Category 1 or 2 below:

Category 1

- The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs, or an approved research center;
- The trial has been reviewed and approved by a qualified institutional review board; and
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies.

Category 2

- The trial is to treat a condition too rare to qualify for approval under Category 1;
- The trial has been reviewed and approved by a qualified institutional review board;
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies;
- The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as non-investigational therapy; and
- There is no therapy that is clearly superior to the trial treatment.

Fund: The Teamsters Joint Council 32-Employers Health and Welfare Fund.

Hospital: Means an institution licensed by the state or jurisdiction in which it operates as an acute care facility (if licensing is required in the area where it is located), staffed by Physicians caring

and treating for sick and injured persons with surgical and diagnostic facilities, and providing 24-hour nursing service for inpatient and outpatient care.

A Hospital shall include (1) for the inpatient hospital treatment of emotionally handicapped children, a residential treatment facility licensed by the appropriate state agency for the treatment of emotionally handicapped children; and (2) a free standing ambulatory surgical facility which has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located and operates under the supervision of a Physician (M.D.).

Other facilities, as identified under Medical Benefits, are recognized as Hospitals with respect to mental health and Chemical Dependency treatment rendered on an outpatient basis.

Injury: Means accidental bodily damage including all related conditions and recurrent symptoms which require treatment by a Physician and which result in loss independently of sickness and other causes.

In-Network Provider: Means a Physician, dentist, registered nurse, physical therapist, or other licensed health care provider who agrees to be compensated for their services and supplies as are covered under this Plan according to the terms of the contract.

In-Network Facility: Means a:

1. Hospital;
2. Alcohol and substance abuse treatment facility;
3. Hospice;
4. Laboratory;
5. Outpatient surgical facility;
6. Pharmacy;
7. Business establishment selling or renting Durable Medical Equipment; or
8. Any other source for services or supplies covered under this Plan who/which alone, or as part of a group, enter into a contract with the Trustees and who/which agree to be compensated for their services and supplies as are covered under this Plan according to the terms of the contract. Such parties are In-Network Facilities while such contract is in effect.

Medically Necessary: Only those services, treatments or supplies provided by a Hospital, a Physician or other qualified provider of medical services or supplies that are required to identify or treat an Eligible Family Member's Injury or Sickness and which:

- Are consistent with the symptoms or diagnosis and treatment of the Participant's condition, disease, ailment, or Injury;
- Are appropriate according to and are consistent with accepted standards of community medical practice;

- Are not solely for the convenience of the Participant (including his or her family or caregiver), Physician or Hospital;
- Are the most appropriate and can be safely provided to the Participant;
- Are not deemed to be Experimental.

The Board of Trustees has delegated its PPO Services Provider the authority to utilize its internal policies and procedures to determine what services and supplies are considered to be Medically Necessary.

Non-Acute Care Facility: A facility which:

1. Operates within its license to provide the following services for people recovering from an illness:
   (a) room and board;
   (b) 24-hour per day nursing service by one or more licensed nurses; and,
   (c) nursing personnel as are needed to provide adequate medical care.
2. Provides such services under the full-time supervision of a proprietor or an eligible person who is either a Physician or a licensed registered nurse.
3. Maintains adequate medical records and has available the services of a Physician under a contract, if not supervised by a Physician.
4. Is approved by Medicare and the Fund to provide the services for which coverage is provided herein.

The term "Non-Acute Care Facility" (also called an extended care facility or a skilled nursing facility) will not include any institution or a part thereof which is used chiefly as a rest home, home for the aged or Custodial Care facility.

Out-of-Network Facility: Is a Facility providing the services listed under the definition of In-Network Facility which does not have a contractual agreement with the Trustees directly or through their agent. Services at Out-of-Network Facilities are not covered except for services qualifying as Emergency Care, care that is considered Continuity of Care or You or a Dependent are residing or traveling in an area where an In-Network Provider is not available and the inpatient services received are medically necessary.

Out-of-Network Provider: Providers consisting of Physicians, clinics, and hospitals, as well as specialists and specialty facilities that do not have a contractual agreement with the Trustees directly or through their agents. Covered Charges for Out-of Network Providers will be reimbursed based on UMR Benchmark pricing. This determination is not intended to represent "usual, customary and reasonable charge.". For most services, in addition to any applicable Co-payments, Co-insurance and Deductibles, Participants must pay the difference between the Reasonable Expense and the Out-of-Network Provider's billed charges. This amount can be significant and does not apply toward the Plan's Out-of-Pocket maximum. Benefits for any Covered Charges received from an Out-of-Network Provider will usually be paid directly to the Participant.

Participant: An Employee, Retiree, and Dependents enrolled and eligible for benefits under the Plan.

Personal Pronoun Usage: Words used in this booklet in the masculine or feminine gender will be considered as the feminine gender or masculine gender, respectively, where appropriate. Words used in the singular or plural will be considered as the plural or singular, respectively, where appropriate.

Physician: Means a person who is licensed to practice medicine by the governmental authority having jurisdiction over such licensor (excluding naturopaths) and who is acting within the usual scope of such practice and includes the services of a Doctor of Medicine, podiatrist, chiropractor, osteopath, optometrist, psychologist, and doctor of dental surgery, provided such individual is licensed and acting within the usual scope of such practice. For the purposes of the Plan payment responsibility, "Physician" shall also mean services performed by a nurse practitioner who is licensed under state law to provide the services rendered and who performs the services under the direction of a Physician. Physician also includes services by a licensed health professional at licensed birth centers including services of certified nurse midwives and licensed traditional midwives and advanced practice nurse services provided by a nurse practitioner, nurse anesthetist, nurse midwife or clinical nurse specialist.

Physician Assistant (PA): Means a registered Physician Assistant (PA) meeting the educational requirements and operating within their scope of practice.

Plan: Means the document adopted by the Board of Trustees, as amended from time to time, which incorporates the provisions, terms and conditions under which benefits are paid and the Schedule of Benefits which are in effect.

Plan Sponsor: Means the Board of Trustees of the Teamsters Joint Council 32-Employers Health and Welfare Fund.

Plan Year: Means the 12 months beginning any January 1st and ending the following December 31st.

Pregnancy: Any pregnancy, a complication thereof, or the termination of a pregnancy.

Reasonable Expense: Means the allowed charge for the covered services rendered and for the covered supplies furnished in the area concerned, provided services and supplies are recommended and approved by a Physician or dentist.

Reasonableness is determined in several ways, including, but not limited to, any of the following: (1) pricing based upon a percentage not less than 100% of the Medicare Advantage allowed amount for the same or similar service; (2) pricing based upon the medical policy standard of the Plan's PPO Service Provider; (3) pricing based upon a percentage of billed charges; and (4) pricing based upon fee negotiations. The allowed amount calculations for these services are not intended to represent a usual, customary and reasonable charge.

Retiree: Means all retired Employees of Employers who were in a job classification covered by a Collective Bargaining Agreement or a Participation Agreement requiring contributions to be made on their behalf to the Health Fund and who are now retired and covered under the Plan pursuant to the Plan's Retiree eligibility rules.

Semi-Private Room: A room with more than one bed.

Services: Health care services, procedures, treatments, Durable Medical Equipment, medical supplies, articles, and prescription drugs.

Sickness: Means a disease, disorder, or condition (including Pregnancy and childbirth and any related conditions) which requires treatment by a Physician.

Skilled Nursing Home: Means an institution that fully meets every one of these requirements:

1. is regularly engaged in providing skilled nursing care for injured and sick persons at the patient's expense;

2. requires that patients be regularly attended by a Physician and that medications be given only on the order of the Physician;

3. maintains a daily medical record of each patient;

4. continuously provides nursing care under 24-hour-a-day supervision by a registered nurse;

5. is not, except incidentally, a facility for the aged, a rest home, or the like;

6. is not, except incidentally, a place for treatment of substance addiction, alcoholism, or mental illness;

7. is currently licensed as a skilled nursing home, if licensing is required in the area where it is located, and is classified as a skilled nursing home under Medicare;

8. has permanent facilities for the care of six or more resident inpatients; and,

9. requires a Physician's certification that confinement is Medically Necessary.

Spouse: A spouse is the person who is legally married to a Participant who is eligible for benefits under this Plan.

Surgical Procedure: Means performance of one or more surgical procedures during a single operation period, including all procedures performed during one continuous period of anesthetization.

Take Home Drugs: Means drugs dispensed from a licensed hospital, sanitarium, rest home, extended care facility, skilled nursing facility, or similar facility which operates on its premises a facility for dispensing pharmaceuticals.

Totally Disabled: Means You have a physical or mental condition occurring because of bodily Injury or disease, or mental disorder that results in your being unable to perform any and every duty of the occupation in which You were engaged when You became disabled, and that You are not engaged in any gainful occupation.

Treatment: Means the management and care of a patient for the purpose of combating illness or Injury. Treatment includes medical advice and the purchase of prescription drugs.

Trust Agreement or Trust Fund: Means the Agreement and Declaration of Trust for the Teamsters Joint Council 32-Employers Health and Welfare Fund effective January 1, 2018, as amended.

Trustees: Means the Board of Trustees of the Fund, as designated in accordance with the Trust Agreement.

Year of Service: means a period of 12 months of earnings under the Trust or a Legacy Health Fund.

You: Means the Employee.

PRESCRIPTION DRUG BENEFITS

(Available to Active, Non-Medicare Retirees and their Dependents)

Page

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PART SIX
PRESCRIPTION DRUG BENEFITS

(Not available for Retirees Age 65 and Over)

I. In General

The Fund provides prescription drug benefits pursuant to a contract with Sav-Rx Prescription Services ("Sav-Rx"). If You are eligible for medical benefits, You are eligible for prescription drug benefits unless You are a Retiree or Dependent or Retiree who is Medicare eligible.

A. Coverage

Prescription drugs are covered when ordered by a health professional authorized by law to prescribe the drug. Prescription drugs are drugs that are required by law to bear the legend: "Caution: Federal Law prohibits dispensing without a prescription." The prescription drug benefit also covers diabetic supplies including test strips, syringes, needles, lancets, lancet devices, glucose meters and other medically necessary diabetic supplies. To receive benefits you must use an In-Network pharmacy. To locate an In-Network pharmacy please contact Sav-Rx at 1-800-228-3108 or utilize the locations feature at . The Schedule of Benefits is reproduced below.

	In-Network	Out-of-Network
Generic Drugs found on Network formulary (1 month supply)	$10 Co-pay or 20% of Cost, whichever is greater, up to a maximum of $50	No Coverage
Brand Name Drugs found on Network formulary (1 month supply)	$25 Co-pay or 30% of Cost, whichever is greater, up to a maximum of $150	No Coverage
Non-formulary Brand Drugs (1 month supply)	$25 Co-pay or 30% of Cost, whichever is greater, up to a maximum of $150	No Coverage
Specialty Drugs* (1 month supply)	$25 Co-pay or 30% of Cost, whichever is greater, up to a maximum of $150	No Coverage
* Generic specialty drugs for HIV or transplant can be filled for 90 days at a time and you will pay the 90-day generic co-pay.		
90-day Retail or Mail Order – Generic	$25 Co-pay or 15% of Cost, whichever is greater, up to a maximum of $125	No Coverage
90-day Retail or Mail Order – Brand Name Formulary	$62.50 Co-pay or 25% of Cost, whichever is greater, up to a maximum of $375	No Coverage

	In-Network	Out-of-Network
90-day Retail or Mail Order – Brand Name Non-Formulary	$62.50 Co-pay or 25% of Cost, whichever is greater, up to a maximum of $375	No Coverage

Step Therapy applies to some drugs, including cholesterol-lowering and proton pump inhibitor (PPI) drugs. This Program uses a "step" approach to select the drugs the Plan will cover to treat your condition. This means You may first need to try a clinically appropriate, cost-effective drug before other, more costly drugs are approved for payment under the Plan.

B. Annual Prescription Drug Out-Of-Pocket Maximum

The Annual Prescription Drug Out-of-Pocket Maximum is stated in the Schedule of Benefits, and reproduced below. The Co-payments and Co-insurance for prescription drug benefits set forth in the Schedule of Benefits apply to the Annual Prescription Drug Out-of-Pocket Maximum; they do not apply toward the Annual Medical Out-of-Pocket Maximum.

	In-Network	Out-of-Network
Individual	$3,000/calendar year	No Coverage
Family	$7,000/calendar year	No Coverage

In no event, however, will the annual out-of-pocket expense for medical and prescription drugs combined exceed $7,350 per individual or $14,700 per family.

C. Mandatory Generic

If You request a brand name drug when the generic equivalent is available, You will pay the difference between the brand cost and the generic cost plus the co-payment for the brand name drug. The amount of the difference You pay between the brand cost and the generic cost does not count towards the Annual Prescription Drug Out-of-Pocket Maximum. If your Physician prescribes a brand name drug to be dispensed as written (DAW) when a generic is available, You will be asked to provide a letter from your physician concerning the Medical Necessity of the brand name drug. If use of the brand name drug rather than the generic is found Medically Necessary You will only pay the co-payment for the applicable brand name drug. You will not be required to pay the difference between the brand name drug and the equivalent generic drug.

D. Compound Drugs

Clinical review will be requested for all compounds over $100 and those with ingredients which are frequently used off-label or which are on Sav-Rx's fraud and abuse list.

E. Participating Pharmacies

A pharmacy network is a group of pharmacies that have contracted with the Fund to provide covered products and services to members. Typically, a pharmacy network will include thousands of pharmacies across the country, including both chain stores and independents. So even when You are traveling, You can find a pharmacy in your network.

When You need to fill a prescription, use one of the pharmacies in that network. When You use a pharmacy not in your plan's network, You incur 100% of the cost of the prescription as it is not covered by the plan.

To obtain a list of pharmacies in your area a pharmacy in the network, You can use the pharmacy finder feature on www.Sav-Rx.com.

F. Coordination of Benefits

If You or a Dependent are covered for prescription drug benefits under more than one plan, and this Plan is the secondary plan under the coordination of benefits language included in this Plan, the applicable Co-payment still applies. See Order of Benefits provision beginning on page 108. When this Plan is secondary it will only consider those amounts which exceed the applicable Co-payment after the primary plan makes its payment. If the primary plan's Co-payment is less than this Plan's Co-payment the Plan will pay nothing.

G. Retirees Age 65 and Over

The Plan does not provide prescription drug coverage to Medicare-eligible Retirees Therefore, if You are a Medicare-eligible Retiree You must enroll in Medicare Part D or a Medicare Prescription Drug Plan when eligible.

II. Retail Benefit

The Co-payments or Co-insurance applicable to Retail drugs are stated in the Schedule of Benefits and reproduced on page 63.

III. Mail Order and Extended Network Plan

The Co-payments or Co-insurance applicable to Mail Order drugs are stated in the Schedule of Benefits and reproduced on page 63.

Participants may use the mail order plan selected by the Fund or the extended Retail network plan for long-term or maintenance drugs. Maintenance medications are generally prescription drugs that are used on only an ongoing or long-term basis and are associated with the treatment of such illnesses as arthritis, diabetes, heart disorders, high blood pressure, high cholesterol, ulcers, and other chronic conditions. Information on how to use the Fund's mail order plan or on locating an extended network pharmacy is available upon request by contacting Sav-Rx at 1-800-228-3108.

IV. Specialty Drugs

The Co-payments or Co-insurance applicable to specialty drugs are stated in the Schedule of Benefits and reproduced on page 65.

Participants are required to use the specialty pharmacy management program for specialty drug purchases. Specialty drugs are generally prescribed to treat complex or ongoing medical conditions and are usually not stocked at retail pharmacies. If your specialty medication is not available through specialty pharmacy management program, your order will be sent to a specialty pharmacy that can provide your medication.

If You decided not to use the Fund's specialty pharmacy management program, You will be responsible for the entire cost of your medication.

Information on how to use the Specialty Drug program is available upon request by contacting Sav-Rx at 1-800-228-3108.

V. Take Home Drugs

Drugs dispensed from a licensed Hospital, sanitarium, rest home, extended care facility, skilled nursing facility or similar facility which operates on its premises a facility for dispensing pharmaceuticals are take home drugs. Take home drugs are payable under the medical benefits provision of the Plan, and are subject to the same exclusions for prescription drugs.

VI. Flu Shots and COVID-19 Vaccines

Effective September 1, 2020, the Plan began covering flu and COVID-19 vaccines at 100% when received from an in-network pharmacy. Flu shots are also covered at 100% under the Medical Benefit if received from an in-network provider.

VII. Preventive Care Prescriptions

Pursuant to the Affordable Care Act, Co-insurance costs will not be imposed on prescription drugs prescribed as a preventive care item and covered under Wellness/Preventive Care Benefits. However, the Fund will continue to charge the Co-insurance amount for brand name drugs which are a preventive care item if a generic version is available, unless Medical Necessity is established under Plan guidelines.

VIII. Exclusions

The Fund will not pay for the following charges under Prescription Drug Benefits:

A. **Administrative Charges.** Administration of prescription legend drugs;

B. **Amounts Above Approved Charges.** Charges that exceed the approved amount for covered drugs;

C. **Contraceptives Not Covered as Preventive Benefits.** Contraceptive prophylactic devices, even if prescribed (contraceptives are covered under Wellness/Preventive Care Benefits);

D. **Cosmetic Aids.** Cosmetic or beauty aids, treatment of hair loss; dietary or food supplements, special formula, and food substitutes;

E. **Drugs Available Without a Prescription.** Drugs that are lawfully obtainable without a prescription except injectable insulin or over-the-counter drugs the Fund has elected to cover;

F. **Drugs Not Dispensed Through a Pharmacy.** Take-home drugs and injectable insulin dispensed from a Physician's office, during inpatient Hospital care or confinement in a rest home, sanitarium, extended care facility, skilled nursing facility, convalescent

hospital, nursing home or similar institution which operates on its premises a facility for dispensing pharmaceuticals. These may be covered under the Plan's medical benefit;

G. **Drugs Provided at No Cost.** Drugs or medicines that are provided without charge (i.e., drug samples);

H. **Drugs Dispensed When Not Eligible.** Any drugs or medicines dispensed before your coverage is effective or after your coverage terminates, even though your illness started or your Injury was incurred while coverage is in force;

I. **Excess Charges.** Charges for a medication in excess of the least of the submitted charge, usual, customary and reasonable charge as determined by the Fund, and the contracted rate;

J. **Experimental or Investigational.** Drugs or medicines that are considered experimental or investigational, including those that are provided in relation to an investigative treatment;

K. **Growth Hormones.** Growth hormones, unless the person has a documented hormone deficiency due to pituitary origin and completes the Fund's prior authorization procedures;

L. **Medical Necessity.** Any drug or medicine that is not Medically Necessary, or is not administered according to generally accepted standards of practice in the medical community, or is determined not to be appropriate to the treatment of an illness or Injury;

M. **Out-of-Network Mail Order Prescriptions.** Mail Order drugs not purchased from an In-Network Provider;

N. **Out-of-Network Specialty Drugs.** Specialty drugs not purchased from an In-Network Provider;

O. **Over the Counter Drugs.** Non-prescription (over-the-counter) drugs or medicines, vitamin therapy or treatment except the Fund will pay for specific over-the-counter drugs in lieu of a prescription drug for the same illness where the specific over-the-counter drug is prescribed by your Physician. Certain over-the-counter drugs may be covered under Wellness/Preventive Care Benefits. Contact Sav-Rx at 1-800-228-3108 for further information on covered over-the-counter drugs. See page iii for additional contact information;

P. **Quantities Greater Than 90-Day Supply.** Mail-Order or Retail Drugs that exceed a 90-day supply at any one time;

Q. **Smoking Cessation Products.** Nicotine patch, nicotine gum or any other smoking cessation product that can be purchased over-the-counter (except for over-the-counter and prescription tobacco cessation products covered under ACA Preventive Care Benefits);

R. **Sexual Dysfunction.** Drugs and medicines to treat sexual dysfunction, including but not limited to Viagra;

S. **Therapeutic Devices.** Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances regardless of their intended use;

T. **Unauthorized Refills.** Refilling of a prescription in excess of the number specified by the prescribing health professional;

U. **Vitamins.** Vitamins, whether prescribed or not prescribed (except as required under the ACA Preventive Care Benefits, including prescribed prenatal vitamins and multivitamins with fluoride);

V. **Weight Management.** Drug prescribed for weight loss or weight gain.

SHORT-TERM DISABILITY BENEFITS

(Available for Employees Only)

Page

PART SEVEN
SHORT-TERM DISABILITY BENEFITS

(Active Employees Only)

If You are an active Employee eligible for medical benefits, You are eligible for Short-Term Disability Benefits. Short-Term Disability Benefits are not available to Dependents, Retirees or Employees on COBRA. The Short-Term Disability Benefits maximum period of disability, and when benefits begin are stated in the Schedule of Benefits and reproduced below:

Weekly Benefit:	$300 or 1/7th of the weekly amount if disabled less than a full week.
Maximum Disability Period:	26 weeks per illness, per Injury in a 12-month period
When Benefits Begin	
Accident/Injury	1st day of total disability
Illness or Pregnancy	8th day after date Physician first finds You to be disabled

I. Short-Term Disability Benefits

To receive the Short-Term Disability Benefit You must be disabled as a result of a non-work-related Injury or illness or unable to work due to pregnancy, You must be under the care of a Physician and you must file a claim within 90 days. You must have been actively employed and covered for this benefit under the Plan when You become injured, ill or unable to work due to pregnancy. You will be paid a Disability Benefit on a weekly basis while You continue to be Totally Disabled but not for longer than the maximum disability period stated above.

No Short-Term Disability Benefits are payable:

- For auto-related injuries;
- When You are not under the care of a Physician;
- If You are eligible for Worker's Compensation benefits;
- If You are under suspension, are terminated for cause or are retired and receiving retirement benefits.

Short-Term Disability Benefits may be advanced in certain otherwise excluded situations subject to the Fund's right to seek reimbursement and your compliance with the Plan's reimbursement requirements (see page 72).

II. When Short-Term Disability Benefits Begin

If You are injured, Short-Term Disability Benefits are payable from the date the Physician first certifies You are disabled if You have received medical treatment within one day before or three days after the date indicated by the Physician. Otherwise, the first date of medical treatment after that date will be used to start your Disability Benefits.

If You are ill or pregnant, Disability Benefits are payable from the eighth day after the date the Physician first certifies You are disabled if You have received medical treatment within one day before or three days after the date indicated by the Physician. Otherwise, Disability Benefits will begin eight days after You receive medical attention.

III. Definition of Totally Disabled

"Totally Disabled" under Disability Benefits means that You have a physical or mental condition occurring because of bodily Injury or disease, or mental disorder that results in your being unable to perform any and every duty of the occupation in which You were engaged when You became disabled, and that You are not engaged in any gainful occupation.

Two periods of Total Disability shall be considered one unless:

(a) You have been at work on a full-time basis for 30 calendar days between the two periods, or

(b) the later period is due to an Injury or disease entirely unrelated to the causes of the previous period and it begins after You have returned to work on a full-time basis.

IV. Health Coverage During Disability

If You are disabled and eligible for Short-Term Disability benefits, You can also extend health coverage for You and Your Dependents without a premium payment for up to a maximum of 26 weeks (less any weeks paid for by your employer during your disability). Your application for Short-Term Disability will also cover this extended health coverage. See page 16 for further information concerning health coverage during your disability.

V. Limitations

Short-Term Disability Benefits shall not be payable for:

(a) any period during which You are not under the care of a Physician;

(b) any disability which results from any disease or bodily Injury for which benefits are payable or could be payable if a claim is or was made under any workers' compensation, employer's liability or similar law;

(c) any total disability which results from any bodily Injury arising out of or in the course of your employment;

(d) any period during which You are off work because of employer discipline and not eligible for wages; or

(e) any period after the retirement date set by You. If a retirement date is retroactive, any weekly benefits that were paid to You after the retirement date must be paid back to the Fund, or the amount paid after the retirement date will be billed and collected and/or deducted from claims submitted in the future. Benefits cannot be continued through self-payment of the premium, nor be assigned.

VI. Rights of Reimbursement and Subrogation

If a Participant receives Short-Term Disability Benefits for an Illness or Injury for which the Participant recovers any payments from any Responsible Third Party (whether through settlement, judgment, or otherwise, and whether or not denominated as medical damages), the Fund has a first priority subrogation and reimbursement claim against the proceeds of any such recovery. For additional details, see page 112.

VII. Information on Taxation of Short-Term Disability

Short-Term Disability benefits are subject to Social Security taxes. You pay half the tax and your employer pays the other half. Pursuant to federal law, the Plan will withhold your share of the taxes from each weekly benefit check paid to You and forward it to the government. Additionally, Short-Term Disability benefits are included in your gross income and subject to federal income tax. Finally, please note your employer will include any Short-Term Disability benefits received on your W-2 for the calendar year in question.

If You have any further questions about the taxation of Short-Term Disability benefits, please contact your tax advisor.

VIII. Filing a Claim

A Covered Employee must file a claim within 90 days of the onset of your disability to be eligible for Short-Term Disability benefits. Claim forms are available from the Fund Office at:

Teamsters Joint Council 32-Employers Health and Welfare Fund
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55245

Untimely claims will be denied.

DEATH AND
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

(Available Only to Active Employees and Their Dependents)

Page

PART EIGHT
DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

(Death and AD&D Benefits Not Available for Retirees)

Death Benefits are available for active Employees and their Dependents. Accidental Death and Dismemberment (AD&D) Benefits are available for active Employees pursuant to a schedule set out below.

AD&D Benefits are not available for Dependents or Retirees.

The Fund's Death and AD&D benefits are self-funded. If you have questions about the Plan's life and accidental death and dismemberment benefits, please contact the Fund Office.

I. Death Benefits

If You or your Dependent(s) should die, in any place and from any cause, while eligible for the Death benefit under this Plan, the Death Benefit set forth in the Schedule of Benefits will be paid to the beneficiary described below.

Employee	$40,000.00
Spouse of Employee	$10,000.00
Children of Employee	
▪ **15 days old but under 6 months**	$300.00
▪ **6 months old but under age 2**	$900.00
▪ **2 years old but under age 26**	$3,000.00
Minimum Child Dependent Death Benefit	$300.00
Maximum Child Dependent Death Benefit	$3,000.00

A. Beneficiary in the Event of Participant's Death

You as a Participant may designate anyone as beneficiary of any benefits payable for the loss of Your life. You can change your beneficiary designation at any time by written request. The consent of your beneficiary is not required.

Your beneficiary designation or change is effective on the date You sign it, but the Fund shall not be held liable for making payment to another person before the change is received by the Fund Administrator. If You designate more than one beneficiary, any benefits will be paid equally to the beneficiaries who survive you, unless You specify otherwise. If You do not designate a beneficiary or if your designated beneficiary does not survive you, benefits will be paid to the following living persons in the following order of preference: Spouse; children; parents; brothers and sisters; or, your estate.

You are the beneficiary for your Spouse's or Child's coverage. A person is not eligible for death benefits if they are convicted of murder or manslaughter regarding the insured's death.

B. Beneficiary in the Event of Dependent(s) Death

Active Employees are automatically the beneficiary of the Death Benefit for a Spouse or Dependent children covered by the Plan. No one else may be named beneficiary for the Death Benefit for an active Employee's Spouse or Dependent children.

C. Accelerated Benefits Option

If you become terminally ill and are diagnosed with 12 months or less to live, you have the option to receive up to 80% of your life insurance proceeds before your death. This can go a long way towards helping your family meet medical and other expenses at a difficult time. Amounts not accelerated will continue under Your plan for as long as You remain eligible per the certificate requirements and the group policy remains in effect.

The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C.Sec 101(g)).10

Accelerated Benefits Option is not the same as long term care insurance (LTC). LTC provides nursing home care, home-health care, personal or adult day care for individuals above age 65 or with chronic or disabling conditions that require constant supervision.

This option is not available for dependent Spouse or dependent Child coverage.

II. Accidental Death and Dismemberment Benefits (Active Employees Only)

Accidental Death and Dismemberment ("AD&D") coverage complements Your Death Benefits coverage and helps protect you 24 hours a day, 365 days a year.

This valuable coverage benefits beyond your disability or Death Benefits for losses due to covered accidents – including while commuting, traveling by public or private transportation and during business trips. AD&D insurance pays you benefits if you suffer a covered accident that results in paralysis or the loss of a limb, speech, hearing or sight, brain damage or coma. If you suffer a covered fatal accident, benefits will be paid to your beneficiary.

A. What is Covered by AD&D?

If You have an accident while covered under this Plan as an active Employee, and it results directly and independently of all other causes and within 90 days after the date of the accident, in any of the losses to You shown in the Schedule of Benefits, an AD&D Benefit will be paid as shown below.

For members who are available for work	$80,000.00
Maximum AD&D	$80,000.00
All amounts are stated as percentages of the Full Amount	
Loss of life	100%

Loss of a hand permanently severed at/above wrist but below elbow	50%
Loss of a foot permanently severed at/above ankle but below knee	50%
Loss of an arm permanently severed at/above the elbow	75%
Loss of a leg permanently severed at/above the knee	75%
Loss of sight in one eye	50%
Loss of any combination of hand, foot, or sight of one eye	100%
Loss of the thumb and index finger of same hand	25%
Loss of speech and loss of hearing	100%
Loss of speech or loss of hearing	50%
Paralysis of both arms and both legs	100%
Paralysis of both legs	75%
Paralysis of the arm and leg on either side of the body	50%
Paralysis of one arm or leg	25%
Brain damage	100%
Coma	1% monthly beginning the 7th day of the coma for the duration of the coma to a maximum of 60 months.

If an accident results in your death, your beneficiary shall receive the amount stated in the Schedule of Benefits in addition to the Death Benefit.

No more than 100% of the maximum benefit amount stated in the Schedule of Benefits will be paid for all losses from one accident.

Standard Additional Benefits Included

Some of the standard additional benefits included in Your coverage that may increase the amounts payable to You and/or defray additional expenses that result from accidental injury or loss of life are:

- Air Bag
- Seat Belt
- Common Carrier
- Repatriation of Remains

B. What is Not Covered by AD&D?

AD&D insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide;

injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or active participation in a riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self-preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

III. Coverage Effective Date

You must be Actively at Work on the date your coverage becomes effective. Your coverage must be in effect in order for your Spouse's and eligible Children's life coverage to take effect. In addition, your Spouse and eligible Child(ren) must not be home or hospital confined or receiving or applying to receive disability benefits from any source when their coverage becomes effective.

DENTAL PLAN BENEFITS

(Available to Active Employees and their Dependents Only. Not all bargaining agreements provide for dental benefits.)

Page

PART NINE
DENTAL PLAN BENEFITS

(These benefits are for Active Employees and their Dependents Only. Not all bargaining agreements provide for dental benefits.))

The following sections of Part Nine describe the dental benefits provided under this Plan to Active Employees and their Dependents. Retirees can elect to receive dental benefits through a separate insured plan through Delta Dental. Retirees should contact the Fund Office for further information.

Payment of dental benefits are subject to the Plan's terms, conditions, and exclusions. The Fund will pay these benefits if the charges described in this Part are incurred while the Participant is covered for the benefit and Fund claim filing requirements are met. The dental coverage is subject to the exclusions and limitations described in this document. A Covered Charge is incurred at the time the service is rendered or the item is provided. Benefits for a Covered Charge will not be paid more than once under this Plan or under more than one coverage Section unless a Section states otherwise.

I. Eligibility

The Dental Plan is available to bargaining units that have negotiated this benefit and to Employees and Dependents in these bargaining units who meets the Fund's eligibility requirements. Not all Collective Bargaining Agreements provide for the Dental Plan. If you want to know if your bargaining agreement provides for dental benefits, contact the Fund Office.

The Dental Plan provides coverage for certain dental expenses for eligible active Employees and their Dependents, who are enrolled in the Plan. Retirees and their Dependents are eligible to participate if they elect in writing to participate in the Dental Plan as a Retiree within 60 days of retirement with an Employer and make timely self-payments in the amount required by the Board of Trustees. Self-payment must be paid to the Fund in advance of the month of coverage.

II. Deductibles

Whether you have a deductible depends on whether you received services from a Delta Dental PPO Provider (no deductible) or other dental providers (deductible). The amount of deductible for each type of dental provider follows:

	Delta Dental PPO	Delta Dental Premier	Non-Participating
Individual	$0	$25/calendar year	$25/calendar year
Family	$0	$75/calendar year	$75/calendar year

Deductible does not apply to Diagnostic and Preventative or Orthodontic Services.

III. Benefit Maximums

Annual	$2,000
Lifetime Orthodontic	$1,000

The Plan pays up to a maximum of $2,000.00 for each Participant per Plan Year subject to the coverage percentages further described beginning on page 80. Orthodontics is subject to a separate limit.

All services (other than orthodontia) must be commenced and completed within one benefit year (January 1 – December 31).

There is no carry-over payment from one benefit year to another.

A benefit will not be paid on a tooth replaced with an implant more than once in a lifetime.

Orthodontic Lifetime Maximum. Orthodontics is subject to a separate lifetime maximum of $1,000.00 per Dependent Child and limited to those orthodontic treatment plans that begin on or after the eligible dependent Child's eighth birthday and prior to the eligible dependent Child's nineteenth birthday. Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Participant must remain eligible under the Plan in order to receive continued benefit payments.

IV. Benefits

After You have satisfied the Deductible, if any, your Dental Plan pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by the Plan is different for Delta Dental PPO dentists, Delta Dental Premier dentists, and non-participating dentists. If You see a non-participating dentist, your Out-of-Pocket expenses may increase. (Unlike the Medical Plan, there is no maximum Out-of-Pocket limit in the Dental Plan.) If a Delta Dental PPO dentist provides dental services, the Deductible will be waived and the payment percentages may increase, resulting in lower Out-of-Pocket costs for You. For information about locating a Delta Dental PPO Provider, visit the Delta Dental website www.deltadentalmn.org/members/.

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Participating Dentist **
Diagnostic & Preventive Services	100%	100%	100%
Basic Service	100%	100%	100%
Endodontics	90%	80%	80%
Periodontics	90%	80%	80%
Oral Surgery	90%	80%	80%
Major Restorative Services	90%	80%	80%
Prosthetic Repairs and Adjustments	90%	80%	80%
Prosthetics	90%	80%	80%
Orthodontics	50%	50%	50%

** Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.

Pretreatment Estimate. It is recommended that a pretreatment estimate be submitted to the Fund Office prior to treatment if your dental treatment involves major restorative, periodontics, prosthetics, or orthodontic care to estimate the amount of payment. The pretreatment estimate is a valuable tool for both the dentist and You as the patient. By submitting a pretreatment estimate, both the dentist and the patient know what benefits are available to the patient before beginning treatment. The pretreatment estimate will outline the patient's responsibility to the dentist with regard to copayments, deductibles, and non-covered services. This should allow You and the dentist to make any necessary financial arrangements before treatment begins. This process does *not* prior authorize the treatment nor determine its dental or Medical Necessity. The estimated Plan payment is based on the patient's current eligibility and available contract benefits. A subsequent submission of other claims, a change in the Plan's coverage or the existence of other coverage may alter the Plan's final benefit payment amount as shown on the pretreatment estimate form.

After the examination, your dentist will establish the dental treatment to be performed. If the dental treatment necessary involves major restorative, periodontics, prosthetics or orthodontic care, a participating dentist should submit a claim form to the Fund Office outlining the proposed treatment.

A pretreatment estimate of benefits statement will be sent to you and your dentist. You will be responsible for payment of any Deductibles, Copayments and Coinsurance amounts or any dental treatment that is not considered a covered service under the Plan.

The Plan covers the following dental procedures when they are performed by a licensed dentist and are necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Plan shall be provided whether the dental procedures are performed by a duly licensed Physician or a duly licensed dentist, if otherwise covered under this Plan, provided that such dental procedures can lawfully be performed within the scope of a duly licensed dentist.

Only those services listed are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections described below.

A. Preventive Care (Diagnostic and Preventive Services)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered two times per calendar year.

NOTE: Comprehensive oral evaluations will be benefited one time per dental office, subject to the one time per six-month period limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the one time per six-month period.

Radiographs (X-rays)

- Bitewings-Covered at one series of bitewings per 12-month period.
- Full Mouth (Complete Series) or Panoramic-Covered one time per 36-month period.
- Periapical(s)-single X-rays.
- Occlusal-Covered at one series per 12-month period.

Dental Cleaning

Prophylaxis or Periodontal Maintenance - Any combination of these procedures is covered two times per calendar year.

Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

NOTE: A prophylaxis performed on a Participant under the age of 14 will be benefited as a child prophylaxis. A prophylaxis performed on a Participant age 14 or older will be benefited as an adult prophylaxis.

Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment (Topical application of fluoride)-Covered one time per 12-month period for Dependent children through the age of 18.

Oral Hygiene Instructions - Instructions which include tooth-brushing techniques, flossing and use of oral hygiene aids are covered one time per lifetime.

Space Maintainers- Covered one time per lifetime on eligible Dependent children through the age of 16 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

Emergency Treatment

Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations- Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth**- Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth-** This service is not covered under Basic Services. Refer to the Complex or Major Restorative Services section of your benefits.

LIMITATION: Coverage for amalgam or composite restorations will be limited to only one service per tooth surface per 24-month period.

Other Basic Services

- **Restorative cast post and core build-up, including pins and posts**. See benefit coverage description under Complex or Major Restorative Services.
- **Pre-fabricated or Stainless Steel Crown**. Covered one time per 24-month period for eligible Dependent children through the age of 18.
- **Sealants.** Covered one time per lifetime for permanent first and second molars of eligible Dependent children through the age of 15.

Adjunctive General Services

- **Nitrous Oxide (Analgesia)**.
- **Intravenous Conscious Sedation and IV Sedation** - Covered when performed in conjunction with complex surgical service.

LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS -Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesic agents, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouthguard, enamel microabraision, and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to whitening agents, tooth bonding and veneers.
5. Placement or removal of sedative filling, base or liner used under a restoration.

B. Basic Endodontic Services (Nerve or Pulp Treatment)

Endodontic Therapy on Primary Teeth

- Pulpal Therapy

- Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Apicoectomy
- Root Amputation on posterior (back) teeth

Complex or other Endodontic Services

- Apexification- For Dependent children through the age of 16.
- Retrograde filling
- Hemisection, includes root removal

LIMITATION: All of the above procedures are covered one time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Plan.
2. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.

C. Periodontics (Gum and Bone Treatment)

Basic Non-Surgical Periodontal Care- Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- Periodontal scaling and root planing - Covered 1 time per 24 months
- Full mouth debridement -- Covered 1 time per lifetime

Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this Plan.

- Gingivectomy/gingivoplasty
- Gingival curettage
- Gingival flap
- Apically positioned flap

- Mucogingival surgery
- Osseous Surgery
- Bone replacement graft
- Pedicle soft tissue graft
- Free soft tissue graft
- Subepithelial connective tissue graft
- Soft tissue allograft
- Combined connective tissue and double pedicle graft
- Distal/proximal wedge
- Crown lengthening

LIMITATION: Only one complex surgical periodontal service is a benefit covered one time per 36-month period per single tooth or multiple teeth in the same quadrant.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures, or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide or therapeutic drug injections, drugs, or medicaments for non-surgical and surgical periodontal care, regardless of the method of administration.

D. Oral Surgery (Tooth, Tissue or Bone Removal)

Basic Extractions

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Oroantral fistula closure
- Tooth reimplantation- accidentally evulsed or displaced tooth
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal or nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis
- Partial ostectomy
- Incision and drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

Temporomandibular Joint Disorder (TMJ) is covered in accordance with Minnesota Statutes Section 62A.043 Subd. 3 -

Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended.

NOTE: If You or your Dependents currently have medical insurance coverage, the claim must first be submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to the Plan for further benefit (see Coordination of Benefits). You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to this Plan.

If You or your Dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this dental

Plan within the noted Plan limitations, maximums, Deductibles, and payment percentages of treatment costs.

LIMITATIONS

1. Reconstructive Surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from Injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician, to the extent as required by Minnesota Statute 62A.25 provided, however, that such procedures are dental reconstructive Surgical Procedures.

2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statute section 62A.042.

If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this Plan shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.

2. Deep sedation/general anesthesia, analgesic agents, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.

3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

4. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.

5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.

6. Surgical repositioning of teeth.

7. Inpatient or outpatient hospital expenses

8. Cytology sample collection -Collection of oral cytology sample via scraping of the oral mucosa.

E. Complex or Major Restorative Services (Services performed to restore lost tooth structure as a result of decay or fracture)

Posterior (back) Teeth Composite (white) Resin Restorations –

- If the posterior (back) tooth requires a restoration due to decay or fracture;
- If no other posterior (back) composite (white) resin restoration for the same or additional tooth surface(s) was performed within the last 24 months.

Gold Foil Restorations – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any Co-insurance for the covered benefit.

Inlays – Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any Co-insurance for the covered benefit.

Onlays – Covered 1 time per 5-year period per tooth.

Permanent Crowns – Covered 1 time per 5-year period per tooth.

Implant Crowns – See Prosthetic Services.

Crown Repair – Covered 1 time per 12-month period per tooth.

Restorative Cast Post and Core Build-up (**including 1 post per tooth and 1 pin per surface) –** Covered 1 time per 5-year period when done in conjunction with covered services.

Canal Preparation and Fitting of Preformed Dowel and Post –

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
3. Services or supplies that have the primary purpose of improving the appearance of your teeth.
4. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
5. Placement or removal of sedative filling, base or liner used under a restoration.
6. Temporary, provisional, or interim crown.

7. Occlusal procedures including occlusal guard and adjustments.

F. Prosthetic Services (Dentures, Partials, and Bridges)

Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) – Covered when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Adjustments – Covered 2 times per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Removable Prosthetic Services (Dentures and Partials) – Covered 1 time per 5-year period;

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) – Covered 1 time per 5-year period;

- for covered persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last 5 years;
- if 5 years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials and Dentures) – A restoration that is retained, supported and stabilized by an implant.

LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally acceptable treatment. The additional fee is the patient's responsibility. For example: A single crown to restore one open space will be given the benefit of a Fixed Partial Denture Pontic (one unit). The optional benefit is subject to all contract limitations on the benefited service.

LIMITATION: A benefit will not be paid on a tooth replaced with an implant more than once in a lifetime.

Restorative Cast Post and Core Build-up (including pins and posts) – Covered one time per five-year period when done in conjunction with covered fixed prosthetic services.

EXCLUSIONS **–** Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Interim removable or fixed prosthetic appliances (dentures, partials, or bridges)
3. Pediatric removable or fixed prosthetic appliances (dentures, partials, or bridges)
4. Additional, elective, or enhanced prosthodontic procedures including but not limited to connector bar(s), stress breakers, and precision attachments.
5. Procedures designed to enable prosthetic or restorative services to be performed.
6. Procedures designed to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
7. Services or supplies that have the primary purpose of improving the appearance of your teeth.
8. Placement or removal of sedative filling, base or liner used under a restoration.
9. Any artificial material implanted or grafted into or onto bone or soft tissue, including implant procedures and associated fixtures, or surgical removal of implants.
10. Coverage shall be limited to the least expensive professionally acceptable treatment.

G. Orthodontics (Treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies)

Limited Treatment – Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment – A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment – Full treatment includes all records, appliances, and visits.

Removable Appliance Therapy – An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy – A component that is cemented or bonded to the teeth

Other Complex Surgical Procedures –

- Surgical exposure of impacted or unerupted tooth for orthodontic reasons
- Surgical repositioning of teeth

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this Plan) will be benefited on a pro-rated basis.

LIMITATION: Covered eligible Dependent children from the age of eight through the age of 19.

EXCLUSIONS: Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses; and
6. Provisional splinting, temporary procedures, or interim stabilization of teeth.

ORTHODONTIC PAYMENTS: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Participant must have continuous eligibility under the Plan in order to receive ongoing orthodontic benefit payments.

Benefit payments are made in equal amounts: (1) when treatment begins (appliances are installed), and (2) at six-month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see Benefit Maximums in this Plan Summary).

Before treatment begins, the treating dentist should submit a Pre-treatment Estimate. An Estimate of Benefits form will be sent to You and your dentist indicating the estimated Plan payment amount. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to You and your dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

EXCLUSIONS to Dental Accident Benefits:

- Routine, preventive and diagnostic dental services not related to a Dental Accident
- Dental illness or disease
- Orthodontic treatment, including movement of teeth, regardless of cause
- All dental services for a Dental Accident in which disease may be a contributing factor in addition to a Dental Accident
- Charges that exceed the participating dentist's Reasonable Expense
- All hospital expenses associated with a Dental Accident
- Injury or damage as a result of natural force or objects applied to teeth (i.e., eating, etc.)

V. Exclusions

Coverage is NOT provided for:

A. Dental services which a Participant would be entitled to receive for a nominal charge or without charge if this Contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Participant receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or Dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.

B. Dental services or health care services not specifically covered under the Group Dental Plan Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

C. New, experimental, or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

D. Dental services performed for cosmetic purposes. NOTE: Dental services are subject to post- payment review of dental records. If services are found to be cosmetic, we reserve the right to recover any payment made and the member is responsible for the full charge.

E. Dental services completed prior to the date the Participant became eligible for coverage.

F. Services of anesthesiologists.

G. Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.

H. Deep sedation/general anesthesia, analgesic agents, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.

NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

I. Dental services performed other than by a licensed dentist, licensed Physician, his or her employees.

J. Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing, or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

K. Artificial material implanted or grafted into or onto bone or soft tissue, including implant services and associated fixtures, or surgical removal of implants.

L. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

M. Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.

N. Case presentations, office visits and consultations.

O. Incomplete, interim, or temporary services.

P. Corrections of congenital conditions during the first 24 months of continuous coverage under this Plan.

Q. Athletic mouth guards, enamel microabraision and odontoplasty.

R. Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Plan.

S. Procedures designed to enable prosthetic or restorative services to be performed.

T. Bacteriologic tests.

U. Cytology sample collection.

V. Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.

W. Pediatric removable or fixed prosthetic appliances (dentures, partials, or bridges).

X. Interim or temporary removable or fixed prosthetic appliances (dentures, partials, or bridges).

Y. The replacement of an existing partial denture with a bridge.

Z. Additional, elective, or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

AA. Provisional splinting, temporary procedures, or interim stabilization.

BB. Placement or removal of sedative filling, base or liner used under a restoration.

CC. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

DD. Occlusal procedures including occlusal guard and adjustments.

VI. Limitations

A. All services (other than orthodontia) must be commenced and completed within one benefit year (January 1 – December 31).

B. There is no carry-over payment from one benefit year to another.

C. Optional Treatment Plans: in all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Participant and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Participant.

D. Reconstructive Surgery: benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from Injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician, to the extent as required by MN Statute 62A.25 provided, however, that such services are dental reconstructive surgical services.

E. Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate as required by Minnesota Statues Section 62A.042. For Programs without orthodontic coverage: Dental orthodontic services not related to the management of the congenital condition of cleft lip and cleft palate is not covered under this dental benefit program. For Programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this Plan shall be primary and the other policy or contract shall be secondary.

The rules governing eligibility, continuation of coverage, coordination of benefits and third-party liability for dental benefits are contained in this Plan booklet.

VISION PLAN BENEFITS

(Available to Active Employees and Their Dependents Only. Not all bargaining agreements provide for Vision benefits.)

Page

PART TEN
VISION PLAN BENEFITS

**(Available to Active Employees and Their Dependents Only.
Not all bargaining agreements provide for Vision Benefits.)**

The following sections of Part Ten describe the vision benefits provided by the Fund to bargaining units that have negotiated this Vision Plan benefit and to individuals in these bargaining units who meet the Vision Plan's eligibility requirements, subject to the Plan's terms, conditions, and exclusions. Not all Bargaining Agreements provide Vision Plan coverage. If you want to know if your Bargaining Agreement provided for Vision Plan coverage, contact the Fund Office. These benefits are self-funded and use a network provided by Vision Service Plan (VSP).

The Plan will pay vision benefits if the charges described in this Part are incurred while the Participant is covered for the benefit and Fund's claim filing requirements are met. The vision coverage is subject to the exclusions and limitations described in this document. A charge is incurred at the time the service is rendered or the item is provided. Benefits for a Covered Charge will not be paid more than once under this Plan or under more than one coverage Section unless a Section states otherwise.

Retirees and their Dependents are not eligible to participate in the Vision Plan.

The Vision Plan provides coverage for certain vision expenses for Eligible Employees and their Dependents who enroll in the Plan.

I. Summary of Benefits and Coverage

If services are provided by a VSP-contracted provider, the following terms apply:

Frequency	Exam, Lenses or Contact Lenses and Frame once every calendar year Contact lenses are in lieu of lenses and frame.
Frame Allowance	$130.00 retail frame allowance
Lens Copayment	$30.00 lens and frame
Elective Contact Lens Allowance	$130.00 elective contact lenses
Covered Lens Enhancements	Anti-reflective coating, UV coating, scratch coating, mirror, tints and photochromic Polycarbonate lenses for children
Exam Copayments	$15.00 vision exam and maximum of $60 contact lens exam

If benefits are not provided by a VSP-contracted provider, the following services are reimbursed at 100% up to the maximums listed below. Contact VSP if you have questions.

Frequency	Same as above.
Frame Reimbursement	$70.00

Lens Reimbursement	
Single Vision	$30.00
Bifocal	$50.00
Trifocal	$65.00
Lenticular	$100.00
Elective Contact Lens Reimbursement	$105.00
Exam Reimbursement	$45.00

II. Vision Services Not Covered

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances indicated in the Plan Document.
- Services/materials not indicated as covered Plan Benefits on the Plan Document.

HEALTH REIMBURSEMENT ARANGEMENT (HRA)

(Available to Employees Under Bargaining Agreements
which have negotiated the HRA benefit)

Page

PART ELEVEN
HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

I. Availability of HRA

The HRA is available to bargaining units that have negotiated this benefit and to individuals in these bargaining units who meet Fund eligibility requirements. Not all Collective Bargaining Agreements provide for the HRA benefit. If You wish to determine if your bargaining unit participates in the HRA contact the Fund Office. Eligible Employees may use amounts contributed to the HRA to reimburse Eligible Health Expenses as outlined below for themselves and their eligible Dependents.

II. Definitions

Following are definitions that will help You better understand this summary of the HRA:

A. Account Balance means the amount in the Participant Account.

B. Benefit means any amount paid to a Participant as reimbursement for an Eligible Health Expense incurred by the Participant or the Participant's eligible Dependent.

C. Claims Administrator means the individual or entity retained by the Plan from time to time to pay claims.

D. Code means the Internal Revenue Code of 1986, as amended from time to time.

E. Contribution means a payment by the Employer and deposited in the Fund pursuant to the terms of the Plan.

F. Dependent is defined in Paragraph VI. below.

G. Eligible Health Expense means those expenses incurred by a Participant or a Participant's eligible Dependent and are reimbursable expenses as defined by Code Section 213(d) and IRS publication 502. An Eligible Health Expense must meet all of the criteria below:

1. The expense was incurred by a Participant or eligible Dependent while he or she is eligible for benefits from the HRA. An expense is "incurred" at the time the medical care or service is furnished. This means expenses incurred when an individual is not covered by the HRA are not Eligible Health Expenses;

2. Prior to January 1, 2020, if an expense was incurred for medicine or drugs (other than insulin), the medicine or drug must have been prescribed even if the medicine or drug is an over-the-counter drug. On or after January 1, 2020, over-the-counter drugs are Eligible Health Expenses with or without a prescription. Items to support general health such as vitamins and supplements, are not covered without a prescription;

3. The expense was not reimbursed (and will not be reimbursed) by any other health plan, insurance, or other source or entity; and

4. The expense was not taken (and will not be taken) as a tax deduction on a Participant's (or the eligible Dependent's) income tax return.

H. Employee means any person employed by an employer which has adopted the HRA Plan; who has group health insurance coverage during the time for which contributions are made to the Fund; and, is entitled to have contributions made to the HRA pursuant to the terms of the Collective Bargaining Agreement or other written document providing for participation in the Fund.

I. Employer means an Employer that has agreed to make contributions to the HRA and which has complied with all participation requirements established by the Fund.

J. Former Employee means an Employee who has severed employment with the Employer but continues to be eligible for reimbursement of Eligible Health Expenses.

K. Participant means an Employee or a Former Employee for whom Employer contributions have been received by the Plan and whose Participant Account has a positive balance.

L. Participant Account refers to the bookkeeping account maintained by this Plan's Claim Administrator in the name of an Employee which reflects all contributions made to the Plan in the name of the Employee, investment earnings and losses, administrative expenses, and distributions made for the purpose of the payment of Eligible Health Expenses.

M. Plan means the Teamsters Joint Council 32-Employers Health and Welfare Fund, as it may be amended from time to time. The Health Reimbursement Arrangement is a component of the Plan and is referred to as the HRA.

N. Severance means a Participant's voluntary or involuntary termination of employment with the Employer.

III. Eligibility and Participation

You as an Employee are eligible to participate in the HRA if:

A. You are covered under a Collective Bargaining Agreement or other written agreement that provides for HRA contributions; and

B. You have group health insurance coverage during the time contributions are made to the Fund; and,

C. You have not elected to opt out or terminate your coverage under the HRA.

IV. HRA Benefits

The Plan has established this HRA to reimburse Participants for Eligible Health Expenses. This HRA is funded by employer contributions that are credited to your Participant Account. Participant contributions are not permitted. You can use this HRA account to

be reimbursed for Eligible Health Expenses that are incurred by You and your eligible Dependents on or after the date the first contribution to the HRA is required. Reimbursements are limited to the Participant's Account Balance.

Unused HRA contributions in a Participant's Account will continue to be available as long as the Participant is eligible for HRA benefits.

V. Expenses That Can Be Reimbursed under the Plan

The Plan will only reimburse Eligible Health Expenses that are incurred on or after the date the first contribution to the HRA on your behalf is required. All claims must be submitted for reimbursement within 15 months of the dates on which an Eligible Health Expense was incurred. Example: You are eligible to enroll for HRA coverage effective January 1, 2022. You can receive reimbursement only for Eligible Health Expenses incurred on or after January 1, 2022.

Examples of Eligible Health Expenses are otherwise unreimbursed claims for medical, prescription drug, dental, vision and qualified long-term care expenses, including the Deductibles, Co-payments, and Co-insurance You are required to pay under your medical, dental and vision coverages.

Under no circumstance will an expense be reimbursed under this HRA if the expense is provided, paid or payable by any other health or accident plan or insurance policy covering You or an eligible Dependent (including Social Security, Medicare, Medicaid), or if You will be reimbursed for the expense from another source. Benefits will always be limited to a maximum of the amount in your Participant Account or for an ineligible expense. If claims are mistakenly paid that exceed the amount in your Participant Account, You will be responsible for reimbursing the HRA for such excess amount. To recover excess payments, the HRA may offset future contributions to your HRA Account. The right to offset does not limit this Plan's right to recover overpayments in any other manner.

When is an Expense "Incurred"? A health care expense is incurred at the time the medical care or service which gave rise to the expense is furnished. The date of billing or payment is irrelevant.

Example: Jones visits his doctor on March 15, 2022, is billed for the services subject to the Deductible on April 5, 2022 and pays the bill on April 14, 2022. Jones incurred the expense when he visited his doctor on March 15, 2022.

VI. Who is an Eligible Dependent under the HRA Plan?

Eligible Dependents are individuals who meet the definitions set forth below and at the time reimbursement is sought for the expenses they have coverage under a group health plan:

Eligible Dependents are an Employee's:

1. Lawful Spouse; and

2. Child(ren) (as defined on page 11 of this Booklet).

VII. How Do I File a HRA Claim for Benefits?

You must deliver a completed claim form to the Claims Administrator. The address is:

Teamsters Joint Council 32-Employers Health and Welfare Fund
c/o Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55245

The IRS requires that expenditures submitted for reimbursement be substantiated. This requires a completed claim form.

The claim form includes information such as:

- The name of the Participant; the name of the person on whose behalf Eligible Health Expenses have been incurred;
- The nature of the expense and the date incurred;
- The amount of the requested reimbursement;
- Other information regarding the claim may be requested by the Claims Administrator.

You must attach a copy of your bill or receipt or other satisfactory documentation of the amount of the expense and the date(s) the expense was incurred (a canceled check is not sufficient). You must also certify that each expense is eligible for reimbursement under this Plan, that it has not been previously reimbursed under this Plan or another health plan, and that it is not reimbursable from any other source (e.g., insurance). After your claim is reviewed, processed, and approved, You will receive a reimbursement. Claims with missing or illegible information will be denied, pending re-submission of complete and/or legible information. Claims are held until at least $25.00 in claims are available to process.

A. How Often are Claims for Reimbursement Paid?

Benefits are paid weekly once eligibility is established.

B. How Long Do I Have to Submit a Claim for Reimbursement?

You have 15 months after an Eligible Health Expense was incurred to submit a correct and complete claim form to the Claims Administrator. Eligible Health Expenses that are incurred prior to the date a Dependent ceases to be an eligible Dependent may also be submitted for reimbursement from available funds within 15 months of the date they were incurred.

Important Note: Please be advised that this HRA contains a 15-month time limit on submitting a claim. The HRA maintained by the Local 346 Teamsters Health Fund previously had no express time limit on when claims must be submitted. Please ensure that You submit claims for reimbursement in a timely manner.

C. Automatic Payment of Out-of-Pocket Expenses

Alternatively, if You have medical coverage through the Trust, You may elect to automatically apply the funds in your HRA account to pay medical, prescription drugs, or dental plan deductibles, co-payments and co-insurance as your claims are processed. You must affirmatively elect for this to be done. Elections can be made when you are initially eligible or by submitting a written election form 30 days in advance of January 1 and July 1. Contact the Fund Office for further information.

VIII. How Long May I Continue to Participate in the HRA?

If You leave employment or terminate your participation in the HRA, any funds remaining in your Participant Account will be available to You for reimbursement as allowed under the terms of the Plan. Your Participant Account is subject to forfeiture in certain situations. Please see section X below. Additionally, if You elect to opt out of the HRA either at the time of termination of employment or on an annual basis any amounts in your account will be forfeited to the Fund as of the date You opt out.

IX. What Happens If I Die?

If You die with a positive HRA account balance, the HRA can be used to reimburse Eligible Health Expenses incurred before Your death. Additionally, Your eligible Dependent(s) (if any) will be entitled to reimbursement of such Eligible Health Expenses they may incur following Your date of death, for a period of 36 months. The balance in the account is available until it is at zero. No further contributions will be made to the HRA account subsequent to Your death. If there are no eligible Dependents, the amount in the HRA will be forfeited to the Fund.

X. Could My Participant Account Balance Ever Be Forfeited?

A. Balance Less than $300, Inactive for Two Calendar Years

If your HRA account has been inactive for two complete calendar years and there is less than $300 in your account, your account will be closed and any remaining amounts will be forfeited to the Fund. Inactive means that no contributions were received and no claims for reimbursement were made for two complete Plan years.

If your HRA Account is subject to this forfeiture provision, a notice will be sent to your last known address 30 days before the forfeiture will occur. You may prevent forfeiture by using the account in the 30-day period or providing written notice that You are aware that You have an HRA Account and intend to use it in the future.

B. Balance is Greater than $300, Inactive for Two Calendar Years

If your HRA account has been inactive for two complete calendar years but You have $300 or more in your account, your account will be closed and any remaining amounts will be forfeited to the Fund on the earlier of the date on which:

1. You die without a surviving eligible Dependent; or

2. Your last eligible Dependent dies.

Important Note: This Plan allows for inactive accounts to have their balances forfeited, under the circumstances described above. Before this happens, the Plan will attempt to provide You with notice and an opportunity to request in writing that your account not be forfeited. Please keep your contact information up-to-date with the Claims Administrator.

C. Opt-out

Your HRA Account will be forfeit if You elect to opt out of the HRA and forfeit your account balance. You may opt-out by providing a written notice to the Claims Administrator. Opting out of the HRA will not result in any additional amounts being payable to you.

D. What Happens to Forfeited Amounts?

Amounts that are forfeited under circumstances outlined in (a) and (b) above are used to pay future administrative expenses. In no case may these forfeitures revert to the Employer or Employees. There is no cash payout of the HRA account, except through the normal claims submission process.

XI. What Happens if Contributions are Made on Behalf of an Ineligible Participant?

If Fund determines that if contributions have been made on behalf of an ineligible participant, the contributions will be returned to the employer without any interest. The Fund reserves the right to seek to recoup any HRA payments made on behalf of an ineligible individual.

XII. Expenses

Your account will be charged a set-up fee and monthly administrative charges. These fees are subject to change at any time, with or without notice.

Important Note: This Plan may charge your account for your share of administrative expenses necessary to operate the Plan. Depending on the nature of the expense, participants may be charged a flat amount or a pro rata amount based on the size of your account.

XIII. How Benefits Are Taxed

The Internal Revenue Code provides that Employer Contributions and any earnings used to pay for Benefits will not be subject to federal or state income taxes or to Social Security taxes. Benefit payments for Eligible Health Expenses will not be reduced by income tax or social security withholding.

XIV. Termination of Employment

If your employment terminates, Employer Contributions will cease unless You elect to make HRA contributions pursuant to COBRA. Any funds remaining in your Participant

Account will be available to You for reimbursement as allowed under the terms of the HRA to reimburse Eligible Health Expenses (see page 99) unless You elect to forfeit your HRA Participant Account.

GENERAL PROVISIONS

Page

PART TWELVE
GENERAL PROVISIONS

I. Plan Administration

A. Plan Administrator

The general administration of the Plan and the discretionary authority to carry out its provisions is vested in the Board of Trustees. The Board of Trustees may delegate such authority or any portion thereof to a named person or entity, including, but not limited to one or more Claims Administrators, and may from time to time revoke such authority and delegate it to another person or entity. Notwithstanding any designation or delegation, the Trustees will have the final discretionary authority to interpret and administer the Plans.

B. Powers and Duties of the Board of Trustees

The Board of Trustees will have the authority to control and manage the operation and administration of the Plan. This will include all rights and powers necessary or convenient to carry out its functions as the Board of Trustees, including the full discretion to amend, construe and interpret the provisions of the Plan or terminate the Plan or any benefit offered under it. The Board of Trustees reserves the discretionary authority to decide all questions of eligibility, and determine the amount, manner, and time of payment of any benefits under this Plan. Regarding any Retiree benefits, they are not vested and there is no long-term funding and the Board reserves the discretion to modify, amend or terminate Retiree benefits as future circumstances may require.

C. Actions of the Board of Trustees

The Board of Trustees may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Board of Trustees shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan. All rules and decisions of the Board of Trustees will be uniformly and consistently applied so that all individuals who are similarly situated will receive substantially the same treatment.

The Board of Trustees may contract with one or more service agents, including the Claims Administrator, to assist in the handling of claims under the Plan and/or to provide advice and assistance in the general administration of the Plan. Such service agent(s) may also be given the authority to make payments of benefits under the Plan on behalf of and subject to the authority of the Board of Trustees. Such service agent(s) may also be given the authority to determine claims in accordance with procedures, policies, interpretations, rules, or practices made, adopted, or approved by the Board of Trustees and their internal policies and guidelines.

D. Termination or Changes to the Plan

No agent can legally change the Plan or waive any of its terms. No statements made by any of the individual Trustees may expand or eliminate Plan benefits or provide eligibility

inconsistent with the terms of the Plan. Plan interpretations and amendments may only be made by appropriate action of the Board of Trustees.

The Board of Trustees reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Internal Revenue Code, ERISA, or other applicable law) to terminate, modify or amend, in whole or in part, any or all provisions of the Plan. Any amendment to this Plan may be affected by a resolution adopted by the Board of Trustees.

E. Fraudulent Misstatements

Coverage will be terminated if a member and/or his/her Dependents falsify information on his/her application for coverage; submit fraudulent, altered, or duplicate billings, or allow another party not covered under this Plan to use their coverage.

F. Funding

Plan funds are provided by Employers and under some bargaining agreements employee contributions. The medical, prescription drug, dental, vision and short-term disability, life and AD&D benefits are self-funded and payments are made from the general funds of the Fund to honor claims which are payable under the terms and provisions of the benefit Plans provided. The Claims Administrator(s) provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The Claims Administrator's payment of claims is contingent upon the Fund having sufficient funds for benefits. Neither the Board of Trustees nor any Employer nor the Local Unions are liable for payment of claims. Liability for claims payment is limited to the Fund assets.

G. Controlling Law

Any questions, claims, disputes, or litigation concerning or arising from the Plan will be governed by federal law, including ERISA.

II. Coordination of Benefits

If You or your Dependents are entitled to benefits under any other group health care plan, the amount of benefits payable by this Plan will be coordinated so that the total amount paid will not exceed 100% of the medical expenses incurred. In no event will this Plan's payment exceed the amount which would have been paid under this Plan if there were no other plan involved. Benefits payable under another plan include the benefits that would have been payable even if no claim actually was filed or was denied for failure to follow that Plan’s requirements for payment.

When another plan provides benefits in the form of services, the reasonable and customary value of each service will be considered both an allowable expense and a benefit paid.

A. Order of Benefit Calculation

If the other group plan does not contain a coordination of benefits or similar provision, then that plan always will calculate and pay its benefits first. When duplicate coverage arises and both plans contain a coordination of benefits or similar provision, the Participant must report such duplicate group health care coverage on the claim form that is submitted to

secure reimbursement of allowable expenses incurred. This Plan has established the following rules to decide which group plan will calculate and pay its benefits first.

1. If a patient is eligible as an employee in one plan and as a Dependent in another, the plan covering the patient as an employee will determine its benefits first.

2. If a patient is eligible as a dependent child in two plans, the plan covering the patient as the dependent of that parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will determine its benefits first.

3. When parents are divorced or separated, the order of benefit determination is:

- The plan of the parent having custody pays first.
- If the parent having custody has remarried, the order is:
  - the plan of the parent having custody;
  - the plan of the Spouse of the parent having custody;
  - the plan of the parent not having custody; then
  - the plan of the Spouse of the parent not having custody.

However, when a Qualified Medical Child Support Order names and directs one of the parents to be responsible for the child's health care expenses, the plan of that parent will pay first and will supersede any order given here.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses OR if the court decree states that both parents will be responsible for the health care needs of the child but gives physical custody of the child to one parent (and the entities obligated to pay or provide the benefits of the respective parent's plans have actual knowledge of those terms), benefits for the Dependent child will be determined according to the prior Subsection II.A.2.

4. If rules 1, 2, and 3 do not determine which plan will calculate and pay its benefits first, then the plan that has covered the patient for the longer period of time will determine its benefits before a plan that has covered the patient for a shorter time.

There is one exception to this rule 4: A plan that covers a person other than as a laid-off or retired employee, or a dependent of such person, will determine its benefits first, even if it has covered the eligible person for the shorter time.

In addition, if a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the benefits of the plan which covers the person as an employee will be determined before the benefits under the continuation coverage.

Benefits of this Plan will be reduced to the extent necessary to prevent the other group plan from refusing to pay benefits available under its policy.

B. Coordination of Benefits with Automobile Insurance

This Plan will coordinate benefits with automobile insurance carriers as follows:

1. Benefits payable under the Plan are not in lieu of those that would be payable under no-fault automobile insurance and do not affect any legal requirement that an individual maintain the minimum no-fault automobile insurance coverage within the jurisdiction in which that individual resides.

2. For any expenses arising from the maintenance or use of a motor vehicle, no-fault automobile insurance will calculate and pay its benefits first and this Plan will calculate and pay benefits second. The amount of benefits payable by this Plan will be coordinated so that the total amount paid will not exceed 100% of the expenses incurred.

3. Benefits that otherwise might be payable under no-fault automobile insurance will not be payable by the Plan merely because no claim for no-fault benefits was filed. If You or a Dependent fails to maintain the legally required amount of no-fault automobile insurance within the jurisdiction where You or your Dependent resides, Plan benefits will not be payable for amounts which the legally required no-fault insurance otherwise would have paid.

4. An individual injured in an automobile accident which is or should be covered by no-fault automobile insurance must timely protest any notice of discontinuance of no-fault insurance, or benefits for those injuries will not be payable under this Plan.

III. Medicare Provisions

Participants who are retired or disabled are required to enroll in Medicare in the event they become entitled to such coverage by reason of attained age, qualifying disability, End Stage Renal Disease (ESRD), or other bases.

In no event will benefits paid by the Plan exceed the applicable amounts stated in the Schedule of Benefits, nor will the combined amounts payable under Part A and Part B of Medicare and the Plan exceed the eligible expenses incurred by the Participant as the result of any one Injury or sickness. Benefits payable by Part A or Part B of Medicare include those which would have been payable if the Participant had properly enrolled when eligible to do so.

For Participants for whom Medicare is the primary source of coverage, the benefits payable under this Plan for services incurred at a Veterans Administration (VA) facility for non-service-connected disabilities will be reduced by the amount that would have been payable by Medicare had the services been rendered by a Medicare-approved facility.

For Participants for whom Medicare is the primary source of coverage, the benefits payable under this Plan for services otherwise covered by Medicare, but which are

privately contracted with a provider, will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

For Participants for whom Medicare is the primary source of coverage and who have enrolled in a Medicare Advantage plan: the benefits payable under this Plan for services otherwise covered by Medicare, but which are not covered under the Medicare Advantage plan because the Participant did not obtain services at a network provider and/or did not comply with that plan's managed care requirements, will be limited to the amount that would have been payable by the Plan had the services been payable by Medicare.

To facilitate Plan payments in the absence of Medicare payments, it may be necessary for the Trustees to estimate Medicare payments.

Neither You nor the Plan will be responsible for paying any charges which exceed legal limits set by the Medicare Physician Payment Reform Act which limits the amount that Physicians can bill Medicare patients above the Medicare allowance for a particular procedure or service unless services are privately contracted.

A. Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (other than ESRD) and Eligible Under the Plan Through Self-Payments

If a person eligible under the Plan solely because of self-payments becomes initially entitled to Part A or Part B of Medicare due to attained age or a qualifying disability (other than ESRD), benefits payable under this Plan will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

If such person subsequently becomes entitled to Medicare due to ESRD, Medicare will continue to be the primary source of coverage.

B. Persons Initially Entitled to Medicare by Reason of Attained Age or Qualifying Disability (other than ESRD) and Eligible Under the Plan Through Employer Contributions

Plan benefits are not reduced for persons eligible through employer contributions even though they also may become initially entitled to Part A or Part B of Medicare due to attained age or a qualifying disability (other than ESRD). In the event such person subsequently becomes entitled to Medicare due to ESRD, the Plan will continue to be the primary source of coverage for the full 30-month coordination period specified in the following Subsection III.C.

However, an active Employee or Dependent Spouse eligible through Employer contributions who becomes initially entitled to Medicare due to attained age will have the right to reject the Plan and retain Medicare as their primary source of coverage. In such case, the Plan is legally prohibited from supplementing Medicare coverage.

C. Persons Initially Entitled to Medicare by Reason of ESRD and Eligible Under the Plan Through Either Self-Payments or Employer Contributions

In the event a Participant becomes initially entitled to Part A or Part B of Medicare because of ESRD (or when ESRD-based Medicare entitlement occurs simultaneously with attained age or other qualifying disability-based entitlement), benefits will be provided subject to

the following terms. The same terms will apply in the event a Participant becomes initially entitled to Medicare due to ESRD and subsequently becomes entitled to Medicare due to attained age or another qualifying disability.

1. The Plan will be the primary source of coverage for Covered Charges incurred for up to 30 consecutive months from the date of ESRD-based Medicare entitlement provided that the individual otherwise remains eligible.

2. Benefits payable under the Plan beginning with the 31st month of ESRD-based Medicare entitlement will be reduced by the amount of benefits paid or payable under Part A or Part B of Medicare.

IV. Third Party Reimbursement Rights

A. Fund's Third-Party Reimbursement Rights

The Plan excludes benefits for a Participant if the Participant incurs an Illness or Injury caused by the act or omission of another party (known as the “third party”).

- If a Participant is pursuing or investigating a claim or lawsuit against a third party or insurer for an Illness or Injury caused by the act or omission of the third party, the Fund may initially advance payment for benefits related to the third-party Illness or Injury. By accepting advance payment for benefits, the Participant agrees that the Plan’s payment related to the Illness or Injury is conditioned on repayment from any recovery from the third party or the third party’s insurer, under an automobile policy, commercial premises policy, homeowners’ policy, medical malpractice policy, renter’s policy, or any other liability policy, including first-party uninsured or underinsured motorist policy.

- The Fund shall be entitled to first dollar priority to 100% reimbursement from the Participant, with respect to any full or partial recovery by the Participant, whether by judgment, settlement, award or otherwise, from any third party, insurer or persons making payments on behalf of a third party. If the Participant and the Participant’s attorney or personal representative recognize the Fund’s right to reimbursement, comply with the terms of the Plan and cooperate fully with the Fund, the Fund will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount.

- The Fund’s right to reimbursement applies without regard to the characterization of the recovery by the Participant and/or any third party or the source of the recovery. The Fund does not recognize the make whole doctrine, which is expressly rejected. The Fund does not otherwise agree to limit its right to reimbursement based on the amount of the Participant’s recovery; however, the Fund’s right to reimbursement will not exceed the amount of the Participant’s recovery, after payment of attorney fees and expenses.

- Before advancing benefits, the Fund may require that the Participant and/or the Participant’s attorney or personal representative execute, in writing, an agreement acknowledging this reimbursement right, the name and address of the party at fault, the name of any insurance company through which coverage

may be available, the name of any other lien holders involved and a factual description of the accident and/or Injury.

- The Participant and/or the Participant's attorney or personal representative also agree that in the event of a dispute as to the amount of the Fund's claimed reimbursement, the Fund's reimbursement amount will be paid into a trust account and held there until the Fund's claim is resolved by mutual agreement or court order. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the Fund. If the funds necessary to satisfy the Fund's reimbursement amount are not placed in trust, the Participant or the individual named to hold the funds in trust shall be liable for any loss the Fund suffers as a result.

- If the Fund is forced to bring a legal action against the Participant to enforce the terms of the Plan, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

- If there is a reasonable basis to believe that this provision or any agreement to reimburse the Fund is not enforceable or that the Participant will not honor the terms of this provision or any agreement to reimburse, the Fund will deny coverage and may seek refunds of previously paid benefits from providers. The Fund may also cease advancing benefits and exclude future expenses incurred after a judgment, settlement, or proposed settlement of the claim, irrespective of the amount of the recovery, if such expenses are related to the third-party recovery.

- If the Participant fails to honor the terms of this provision or any agreement to reimburse, any advanced benefits will be considered overpaid benefits and the Fund may take appropriate action to collect the overpaid benefits, including, but not limited to, seeking refunds from providers, offsetting future benefits, including those of family members, denying future payments, bringing a breach of contract action in state court to enforce the Fund's right to reimbursement under this Plan provision or seeking a constructive trust in federal court under ERISA § 502(a)(3). In addition to the overpaid benefits, the Participant will be liable for interest, and all costs of collection, including reasonable attorney fees and court costs. Interest will be calculated at the prime interest rate then prevailing at any national bank located in Minneapolis Minnesota, on the date of the breach, plus five (5) percentage points, but not to exceed the amount permitted by law.

- The Fund shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Fund on any overpaid or advanced benefits received by the Participant, or a representative of a Participant (including an attorney) that is due to the Fund, and any such amount shall be deemed to be held in trust by the Participant for the benefit of the Fund until paid to the Fund. By accepting Plan benefits from the Fund, the Participant consents and agrees that a constructive trust, lien, and/or equitable lien by agreement in favor of the Fund exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, the Participant agrees to cooperate with the Fund in reimbursing it for all of its costs and expenses related to the collection of those benefits.

- Venue for any enforcement action of the Plan provision will be in the U.S. District Court for the District of Minnesota in Minneapolis unless the Fund elects to pursue a breach of contract action in state court. The Fund may bring an action in an appropriate court to enforce the agreement to reimburse, enforce the requirement that funds be placed in trust or seek other appropriate relief.

B. Right of Recoupment

Whenever the Plan has made unauthorized or erroneous payments or overpayments, the Trustees have the right to recover such unauthorized or erroneous payments or overpayments from one or more of the following sources:

1. any person to whom or on whose behalf such payments were made, including by making deductions from benefits which may be payable to or on behalf of such person in the future;

2. any service provider, insurance company, or other entity to whom such unauthorized or erroneous payment or overpayment was made; or

3. a reduction in any future benefit payments made to or on behalf of that person or another person in his or her family by the amount of the overpayment.

This right does not affect any other right of recovery this Fund may have with respect to this overpayment.

If repayment is not made upon demand by the Fund, and an offset is not available against future benefit payments, the Fund may bring a legal action to recover the overpaid benefit amount.

If benefits are overpaid as a result of the submission of a fraudulent submission of eligibility, the Fund shall have, in addition to the rights set forth above, the right to report the matter for criminal prosecution to the appropriate law enforcement agency.

V. Physical Examinations

The Trustees, through a Physician they may designate, have the right and opportunity to have medically examined any individual whose Injury or sickness is the basis for a claim when and as often as they reasonably may require during the pendency of a claim under the Plan.

VI. Termination of Plan

A. This Plan may be terminated:

1. as to Participants (and their Dependents) in a particular collective bargaining unit, by agreement of the union and employer association (or individual employers, where applicable) which negotiate the labor agreements covering such collective bargaining units; or

2. when the Trustees determine in their sole discretion to terminate the Trust or any group participating in it.

B. In the event of termination, the Trustees will:

1. make provision out of the Trust Fund for the payment of eligible expenses incurred up to the date of termination of the Plan and the expenses incidental to such termination;

2. arrange for a final audit and report of their transactions and accounts, for the purpose of termination of their Trusteeship;

3. apply the Trust Fund to pay any and all obligations of the Plan and distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Plan and the requirements of law; and,

4. give any notices and prepare and file any reports which may be required by law.

CLAIMS AND APPEALS

PART THIRTEEN
CLAIMS AND APPEALS

I. Types of Claims

A. Pre-service Claim. A pre-service claim is any claim for a benefit under the Plan that requires approval of the benefit in advance of obtaining medical care.

B. Post-service Claim. A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim.

C. Urgent Care Claim. An urgent care claim means medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. could seriously jeopardize the life or health of You or your Dependent or the ability of You or your Dependent to regain maximum function; or

2. in the opinion of a Physician with knowledge of You or your Dependent's medical condition, would subject You or your Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

D. Concurrent Care Claim. A concurrent care claim means a claim for benefits related to an ongoing course of treatment to be provided over a period of time or a specific number of treatments.

E. Disability Claim. A claim for Disability Benefits includes short-term disability, waiver of premium or coverage of a disabled child after age 25.

II. Filing a Claim

You or your Dependent must file a claim with the Fund Office within 90 days from the date the service was provided, materials were obtained, or covered medical expense was incurred. An authorized representative may pursue a claim on behalf of You or your Dependent. The Fund will not pay any claims filed more than 15 months from the date the service was provided, materials were obtained, or a covered medical expense was incurred.

III. Claim Determination

A. Notice of Claim Determination. The Trustees or their designee, shall give written notice to You or your Dependent or your authorized or legal representatives as may be appropriate, whenever there has been denied in whole or in part You or your Dependent's claim with respect to your eligibility for, or amount of, your benefits. Such notice shall be given within 90 days (or within 180 days if notified of extension of time because of special circumstances) after the receipt of the claim and shall include the following:

1. the specific reason(s) for the denial;

2. reference the specific Plan provision(s) on which the denial is based;

3. a description of any additional materials or information needed to perfect the claim and an explanation of why such added information is necessary;

4. an explanation of the Plan's appeal procedures along with time limits;

5. a statement that the claimant has the right to bring a civil action under ERISA Section 502(a) following an appeal;

6. if the denial was based on an internal rule, guideline, protocol or similar criteria, a statement that such rule, guideline, protocol or criteria will be provided free of charge, upon request;

7. if the denial was based on a medical judgment (Medical Necessity, Experimental or Investigational), a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request; and,

8. if the claim is denied and your or your Dependent disagrees with that decision, your or your Dependent's authorized representative may make an appeal request that the Fund Office review its decision. You or your Dependent will have 180 calendar days following receipt of an initial denial to request this review. The Fund Office will not accept appeals filed after this 180-day period.

B. Pre-Service Claim. You or your Dependent shall be notified of the benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Fund Office. If the Trustees or their designee require an extension of time due to matters beyond the control of the Fund, the Trustees or their designee will notify You or your Dependent, prior to the expiration of the initial 15-day period, of the circumstances requiring an extension of time and the date by which the Trustees or their designee expect to render a decision. If such an extension is necessary due to a failure of You or your Dependent to submit the information necessary to decide the claim, the notice of extension shall describe the required information, and You or your Dependent shall be afforded at least 45 days from the receipt of the notice within which to provide the information.

C. Post-Service Claim. If a post-service claim is wholly or partially denied, You or your Dependent shall be given notice in writing within 90 days after receipt of the claim. If the Trustees or their designee requires an extension of time in which to make a determination, the Trustees or their designee will notify You or your Dependent, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Trustees or their designee expect to render a decision. If such an extension is necessary due to a failure of You or your Dependent to submit the information necessary to decide the claim, the notice of extension shall describe the required information, and You or your Dependent shall be afforded at least 45 days from receipt of the notice within which to provide the information.

D. Urgent Care Claims. The Trustees or their designee shall notify You or your Dependent of the benefit determination, whether adverse or not, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of

the claim by the Plan. If You or your Dependent fails to provide sufficient information to determine whether, or to what extent, the benefits are covered or payable under the Plan, the Trustees or their designee shall notify You or your Dependent as soon as possible, but not later than 24 hours after receipt of the claim by the Fund Office, of the specific information necessary to complete the claim. You or your Dependent shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Trustees or their designee shall notify You or your Dependent of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

1. the Fund Office's receipt of the specified information, or

2. the end of the period afforded You or your Dependent to provide the specified additional information.

In the case of an adverse benefit determination concerning an urgent care claim, the determination may be provided to You or your Dependent orally within the applicable time frames with written notice furnished to You or your Dependent not later than 3 days after the oral notification.

E. Concurrent Claims. If the Trustees or their designee determine to reduce or terminate an ongoing course of treatment before the end of such period of time or number of treatments, the Trustees or their designee shall notify You or your Dependents of such decision sufficiently in advance of the reduction or termination to allow You or your Dependent to appeal and obtain a determination on review of that decision before the benefit is reduced or terminated.

Any request by You or your Dependent to extend the course of treatment beyond the period of time or number of treatments that involves an urgent care claim shall be decided as soon as possible, taking into account the medical exigencies, and the Trustees or their designee shall notify You or your Dependents of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Fund Office, provided that any such claim is made to the Fund Office at least 24 hours prior to expiration of the prescribed period of time or number of treatments.

F. Disability Claims. The Trustees or their designee shall notify You or your Dependents of an adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Fund Office. Such notification will include an explanation of the basis for the determination and why such determination disagrees with any other determination (if any) made by (1) the Social Security Administration, and (2) your or your Dependent's treating Physician or a vocational professional who has made an evaluation.

You will be provided with any information that is obtained by the Trustees with respect to your condition, regardless of whether it is used to make the Fund Office's determination. This will include information as to the specific internal rules, guidelines, protocols, standards, or other criteria that the Fund Office relied upon in making its determination.

The 45-day determination period may be extended by the Trustees or their designee for up to 30 days, provided that the Trustees or their designee both determine that such an extension is necessary due to matters beyond the control of the Fund and notifies You or your Dependents, prior to the expiration of the initial 45-day period, of the circumstances

requiring the extension of time and the date by which the Trustees or their designee expect to render a decision. If, prior to the end of the 30-day extension period, the Trustees or their designee determines that, due to matters beyond the control of the Fund, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Trustees or their designee notifies You or your Dependents, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Trustees or their designee expect to render a decision. Any extension notice shall explain the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You or your Dependents shall be afforded at least 45 days within which to provide the specified information.

G. Calculation of Time Periods for Claim Determinations. The time period within which a claim determination is required to be made shall begin at the time a claim is filed in accordance with Plan procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing. However, in the event a period of time is extended due to You or your Dependents' failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to You or your Dependents until the date on which You or your Dependents respond to the request for additional information.

IV. Appeals

A. In General

1. In accordance with Federal law, the Plan provides for a two-step appeal. The first step is an internal appeal to the Board of Trustees or their designee. And the second step is an external appeal to an Independent Review Organization ("IRO").

2. The Plan has engaged IROs on behalf of the Fund and any external appeal shall be assigned to such IROs in accordance with Federal law.

B. First Level Appeal (Internal Appeal)

1. You have 180 days following the receipt of a notification of an adverse benefit determination from the Fund Office to appeal such determination pursuant to the rules regarding the Internal Appeal provided in this Section.

2. You shall submit the Internal Appeal in writing to the Fund Office.

3. You shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

4. You shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. In the case of a claim related to disability, You will be provided with any medical reports and the opportunity to provide any new or additional evidence in response to such reports.

5. A de novo review of your Internal Appeal shall be conducted by the Board of Trustees or a committee of the full Board. Such review shall take into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

6. In deciding an Internal Appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, investigational, or not Medically Necessary or appropriate, the Board of Trustees or a committee of the Board shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any such health care professional consulted shall not be an individual who was consulted in connection with the adverse benefit determination at issue nor the subordinate of any such individual.

7. The identification of all medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided.

C. Time for Decision and Notification of Appeal Rights.

1. Except as hereinafter provided, the Board of Trustees or a committee of the Board shall make a decision on the Internal Appeal no later than the date of the next regularly scheduled Trustees' meeting that immediately follows the Fund's receipt of the appeal, unless the Internal Appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made by no later than the date of the second meeting following the Fund's receipt of the Internal Appeal. If special circumstances require further extension of time for processing, a decision on the Internal Appeal shall be rendered not later than the third meeting of the Trustees following a receipt of the appeal. If such an extension is required, the Board of Trustees or a committee of the Board shall provide You with written notice of the extension which describes the special circumstances and the date as of which the decision will be made, prior to the commencement of the extension. The Board of Trustees or a designated fiduciary shall notify You as soon as possible but no later than five days after a decision is made.

2. Expedited Internal Appeals for Urgent Care Claims. In the case of the Internal Appeal of an urgent care claim, the Board of Trustees or a designated fiduciary shall notify You of the decision on the Internal Appeal as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of your Internal Appeal.

   In the event You receive an adverse benefit determination that involves a medical condition for which the timeframe for completion of an Expedited Internal Appeal would seriously jeopardize the life or health of You or your Dependents or would jeopardize You or your Dependents ability to regain maximum function and You have filed a request for an Expedited Internal

Appeal, the Fund shall waive the Internal Appeal determination and proceed to an Expedited External Review.

3. Pre-service Claims. In the case of a pre-service claim, the Board of Trustees or a committee of the Board shall notify You of the decision on the Internal Appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your Internal Appeal.

4. Calculation of Time Periods. The time period within which a decision on the Internal Appeal is required to be made shall begin at the time an appeal is filed in accordance with the procedures provided in the Plan, without regard to whether all the information necessary to make a decision on the appeal accompanies the filing. However, in the event a period of time is extended due to your failure to submit information necessary to decide an appeal, the period for making a decision on appeal shall be tolled from the date on which the notification of the extension is sent to You until the earlier of the date on which You respond to the request for additional information, or 30 days following the request for additional information.

5. Notification of Internal Appeal Decision. The Board of Trustees or a committee of the Board shall provide You with written notification of the Internal Appeal decision. In the case of an adverse decision, such notice shall include:

   (i) the specific reason(s) for the adverse Internal Appeal decision;

   (ii) reference to the specific Plan provision(s) on which the denial is based;

   (iii) a statement that You are entitled to receive upon request, free access to and copies of documents relevant to the claim;

   (iv) a statement that You have the right to bring a civil action under ERISA Section 502(a) following External Review;

   (v) if the denial was based on an internal rule, guideline, protocol or similar criteria, a statement that such rule, guideline, protocol, or criteria will be provided free of charge, upon request; and

   (vi) if the denial was based on a medical judgment (Medical Necessity, Experimental or investigational), a statement that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request.

D. Second Level Appeal (External Review)

1. Deadline for External Review. You may file a request for External Review with the Fund Office within four months after the date of receipt of the adverse Internal Appeal decision. If there is no corresponding date four months after the date of receipt, i.e., received on October 30th and there is not a February 30th, the request must be filed by the first day of the fifth

month following the receipt of the notice. If the last date falls on a Saturday, Sunday, or a Federal holiday, the filing deadline is extended to the next business day.

2. Preliminary Review. Within five business days following the date of receipt of your External Review request the Trustees, or the Fund Office as its designee, must complete a preliminary review of the request to determine whether it is eligible for External Review. In order to be eligible for External Review the following factors must be met:

   (a) You were or are covered under the Plan at the time the health care item, service or other benefit was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item, service, or other benefit was provided;

   (b) The adverse benefit determination or the adverse Internal Appeal determination involves a medical judgment or a recission of coverage;

   (c) You have exhausted the Plan's Internal Appeal process unless You are not required to exhaust the Internal Appeals process under Federal regulations or this Part.

   (d) You have provided all of the information and forms required to process an External Review.

3. Notice of Preliminary Review. Within one business day after completion of the preliminary review, the Trustees, or the Fund Office as their designee, will issue a notice in writing to you. If the request for External Review is complete, but not eligible for External Review, such notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notice will describe the information or materials needed to make the request complete and the Plan shall allow You to perfect the request for External Review within the later of the four-month filing period or within 48 hours following the receipt of the notice of preliminary review.

4. In accordance with Federal law, the Trustees, or the Fund Office as their designee, shall assign an accredited Independent Review Organization ("IRO") to conduct the External Review. The IRO shall be assigned in accordance with the Fund's rules, which provide an assignment or rotation method that ensures independence and protection against a bias towards the Fund.

5. Upon receipt of the External Review, the IRO will timely notify You in writing of the request's eligibility and acceptance for External Review and this notice will include a statement that You may submit in writing to the assigned IRO within 10 business days following the date You received this notice any additional information that the IRO must consider when conducting the External Review. The IRO may, but is not required, accept, and consider additional information submitted after 10 business days.

6. Within five business days after the date of assignment to the IRO, the Trustees, or the Fund Office as their designee, must provide to the IRO any documents and any information considered in making the adverse benefit determination or the adverse Internal Appeal determination. Failure by the Fund (or the Fund Office) to provide documents must not delay the External Review. If the Fund or the Fund Office fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the adverse benefit determination or the adverse Internal Appeal determination. Within one business day after making such decision, the IRO must notify You and the Trustees.

7. Upon receipt of any information submitted by You in accordance with paragraph e) above, the IRO must within one business day forward such information to the Trustees. Upon receipt of any such information, the Trustees may reconsider its adverse benefit determination or adverse Internal Appeal determination that is the subject of the External Review. Any reconsideration by the Trustees must not delay the External Review. External Review may be terminated if the Trustees determine during reconsideration to reverse the previous determination and provide coverage or payment as requested by you. The Trustees will provide written notice to the IRO and You of its reversal of the previous determination within one business day of such reversal. Thereafter, the IRO will terminate the External Review proceedings.

8. The IRO will review all information and documents timely received and review the claim and all evidence de novo. The IRO is not bound by any decisions or conclusions reached during the initial benefit determination or the Internal Appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, in reaching an External Review decision:

   (a) your medical records;

   (b) the attending health care professional's recommendation;

   (c) reports from appropriate health care professionals and other documents submitted by the Plan, You or your treating provider;

   (d) the terms of the Plan (unless contrary to applicable law);

   (e) appropriate medical practice guidelines, including evidence-based standards;

   (f) any applicable clinical review criteria developed and used by the Plan (unless contrary to the Plan or applicable law);

   (g) the opinion of the IRO's clinical review;

9. The IRO will provide written notice of the final External Review decision to You and the Trustees within 45 days after the IRO receives the request for External Review.

The IRO's final External Review decision notice will contain:

(a) a general description of the reason for the request for External Review, including sufficient information to identify the claim (date or dates of service, provider, claim amount, diagnosis code and corresponding meaning, treatment code and corresponding meaning, and reason for previous denial);

(b) the date the IRO received the assignment to conduct the External Review;

(c) the date of the IRO's final External Review decision;

10. references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;

11. an explanation of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;

12. a statement that the determination is binding except to the extent that other remedies may be available under federal law to either the Plan or you;

13. a statement that judicial review may be available to you; and

14. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

E. Expedited External Review

1. Expedited External Review shall be undertaken when You have a medical condition that necessitates Expedited External Review because the timeframe for completion of the standard External Review would seriously jeopardize the life or health of You or would jeopardize your ability to regain maximum function, or if the adverse Internal Appeal determination concerns an admission, availability of care, continued stay, or health care item, service, or other benefit for which You received emergency services, but have not been discharged from a provider's facility, or such other factors that You qualify for under this Part.

2. The Trustees, or the Fund Office as their designee, shall immediately upon receipt of the request for the Expedited External Review perform the preliminary review and shall complete such review as soon as possible. Upon its determination of the preliminary review, the Trustees, or the Fund Office as their designee, will immediately send the notice of preliminary review.

3. Upon a determination that the request is eligible for External Review, the Trustees or Fund Office as their designee, shall assign an IRO and transmit

or provide all documents and information required electronically or by telephone or facsimile or by any other available expeditious method.

4. The IRO must provide its final External Review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an Expedited External Review. If the notice of the Expedited External Review decision is provided by the IRO other than in writing, then within 48 hours of the date such notice is provided the IRO will provide written confirmation of the decision to You and the Trustees.

F. Reversal of Adverse Determination

In the event the adverse benefit determination or the adverse Internal Appeal determination is reversed by the Trustees or the IRO, the Plan will provide coverage or payment for the claim in accordance with applicable law and regulations, but reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law and regulations.

V. Limitations on Actions Against Fund

No lawsuit shall be brought to recover benefits under this Plan unless:

1. You have exhausted the appeal procedure provided by the Plan; and

2. Such lawsuit is filed within **one year** from the date of Review decision or the Board of Trustees' final decision after your appeal or the External Review decision, if later.

ADDITIONAL PROVISIONS AND NOTICES

SUMMARY PLAN DESCRIPTION

The Name and Address of Plan Administrator

The Plan is administered and maintained by the Board of Trustees.

The Fund Office is located at:

Teamsters Joint Council 32-Employers Health and Welfare Fund
3001 Metro Drive, Suite 500
Bloomington, Minnesota 55425
Telephone: 952-854-0795 or 1-800-535-6373
Fax: 952-854-1632

Type of Plan

The Fund is a multiemployer group health plan. It is maintained for the exclusive benefit of Employees, Retirees and Dependents and it provides Medical, Prescription Drug, Dental, Vision, Short-Term Disability, Life, AD&D and HRA benefits. This Plan is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Plan Sponsor

The Plan Sponsor, Plan Administrator and named fiduciary of the Fund is the Board of Trustees of the Teamsters Joint Council 32-Employers Health and Welfare Fund. This Fund is maintained by Employers and one or more employee organizations, and is administered by a joint labor-management Board of Trustees. A complete list of the Employers and employee organizations sponsoring the Plan may be obtained by Participants upon written request to the Plan Administrator, and is available for examination by Participants at the Fund Office.

Type of Plan Administration

Although the Trustees are legally designated as the Plan Administrator, they have delegated certain administrative responsibilities to an Administrative Manager.

The Administrative Manager (Wilson-McShane Corporation) maintains the eligibility records, accounts for the employer contributions, answers Participant inquiries about benefits, files required government reports, handles other routine administrative functions, and is primarily responsible for the processing of claims and benefit payments.

ADDITIONAL PROVISIONS AND NOTICES

The Names and Addresses of the Trustees

UNION TRUSTEES	EMPLOYER TRUSTEES
Larry Yoswa, Chair Teamsters Local 792 3001 University Avenue SE Minneapolis, MN 55414	William R. Seehafer, Secretary 1270 Northland Drive, Suite 150 Mendota Heights, MN 55120
Richard (Tom) Erickson, Vice Chair Teamsters Local No. 120 9422 Ulysses Street N. E. Blaine, MN 55434	Jeff Taylor, Assistant Secretary Rahr Corporation 800 First Ave. West Shakopee, MN 55379
Rod Alstead General Drivers Local 346 PO Box 16208 Duluth, MN 55816	Rod Fournier Duluth Transit Authority 2402 W. Michigan St. Duluth, MN 55806
Brian Barlage Teamsters Local 792 3001 University Avenue SE, Suite 408 Minneapolis, MN 55414	Melanie Jones Sysco Minnesota 2400 County Road J St Paul, MN 55112
Jeff Oveson General Drivers Local 346 PO Box 16208 Duluth, MN 55816	Kathy McCabe Reyes Holding EVP 6250 N. River Road, Suite 9000 Rosemont, IL 60018
Bill Wedebrand Teamsters Local No. 120 9422 Ulysses Street N. E. Blaine, MN 55434	Kendra Winham (Alternate) Sysco Minnesota 2400 County Road J St Paul, MN 55112
Troy Gustafson (Alternate) Teamsters Local No. 120 9422 Ulysses Street N. E. Blaine, MN 55434	
Kris Knight (Alternate) Teamsters Local 792 3001 University Avenue SE Minneapolis, MN 55414	
Zachary Radzak (Alternate) General Drivers Local 346 PO Box 16208 Duluth, MN 55816	

UNION TRUSTEES	EMPLOYER TRUSTEES
Chris Riley (Alternate) Teamsters Local No. 120 9422 Ulysses Street N. E. Blaine, MN 55434	

Parties to Collective Bargaining Agreements

The Plan is maintained pursuant to one or more Collective Bargaining Agreements between your Employer and Locals 120, 320, 346, and 792, and other local unions affiliated with the International Brotherhood of Teamsters. A copy of any such agreement may be obtained by Participants upon written request to the Plan Administrator, and is available for examination by Participants at the Fund Office during normal business hours.

Internal Revenue Service Employer and Plan Identification Numbers

The Employer Identification Number (EIN) issued to the Board of Trustees is 41-0855601 and the Plan Number is 501.

Name and Address of the Persons Designated as Agents for Service of Legal Process

Fund Administrative Agent
Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, Minnesota 55425

Service of legal process also may be made upon any Plan Trustee.

Eligibility Requirements

The Plan's requirements with respect to eligibility for benefits are shown in the Eligibility Rules in this booklet beginning on page 1. Circumstances which may cause the Participant to lose eligibility are explained in the Eligibility Rules.

Sources of Fund Income

Sources of Fund income include Employer contributions, self-payments, and investment earnings.

All employer contributions are paid to the Fund subject to provisions in the Collective Bargaining Agreements between the Union and Employers, as well as participation agreements between the Trustees and Employers to permit participation by non-bargained employees. The Collective Bargaining Agreements specify the amount of contribution, due date of the contributions, type of work for which contributions are payable, and the geographic area covered by the Collective Bargaining Agreement or participation agreement.

Method of Funding Benefits

The Fund is funded by Employer and, where applicable Employee contributions. Medical, Prescription Drug, Dental, Vision, Life, Accidental Death and Dismemberment, and Short-Term

Disability benefits are self-funded and paid from accumulated assets held in the Fund. The Fund purchases stop-loss insurance for the Medical and Prescription Drug benefits to mitigate the impact of large dollar claims. Benefits are paid from Plan assets and income from investments.

Health Reimbursement Arrangement (HRA) benefits are paid from Employer contributions designated to provide these benefits. Until distributed, these amounts are also held in the Fund.

Fiscal Year of the Plan

The Plan's fiscal year begins January 1st and ends the following December 31st.

Interpretation of the Plan

The Board of Trustees is the named fiduciary of the Fund and reserves the discretionary authority to interpret the terms of the Plan, to establish contribution and self-payment rates necessary to participate in the Fund and determine who is eligible to participate in the Plan. In administering the Plan the Board of Trustees has authorized its claim administrative agents and any medical review organization engaged to utilize their internal protocols and medical guidelines in determining whether or not specific services or supplies are covered under the terms of the Plan.

Future of the Plan and Trust Fund

The Board of Trustees has the authority to terminate the Fund. The Fund will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the Trust Fund. The eligibility for and the benefits provided by the Fund are not vested and are subject to modification, reduction or termination by the Board of Trustees. In the event of termination of the Fund, any and all monies and assets remaining in the Trust Fund, after the payment of expenses, will be used for the continuance of benefits by the then existing plans, until such monies and assets have been exhausted.

Procedures to Be Followed in Presenting Claims for Benefits Under the Plan

The procedures for filing for benefits are described on pages 102 (HRA benefits), 117 (generally). If a Participant wishes to appeal a denial of a claim in whole or in part, certain procedures for this purpose are also found in page 120**.**

This booklet provides you with the most important information about your Plan and your rights under ERISA.

If you have any questions about your Plan, contact the Trustees as follows:

The Board of Trustees
Teamsters Joint Council 32-Employers Health and Welfare Fund
3001 Metro Drive, Suite 500
Bloomington, MN 55425
Phone: 952-854-0795 or 1-800-535-6373
Fax: 952-854-1632

Or, if you have questions about this statement or your rights under ERISA, You may contact the nearest office of the Employee Benefits Security Administration (EBSA) at the Kansas City Regional Office, 2300 Main Street, Suite 1100, Kansas City, MO 64108, telephone number 1-

816-285-1800. You also may obtain certain publications about your rights and responsibilities under ERISA by contacting the EBSA at 1-866-444-EBSA (3272).

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Pursuant to regulations issued by the federal government, the Teamsters Joint Council 32-Employers Health and Welfare Fund is providing You this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

As required by law, the Fund has established a policy to guard against unnecessary disclosure of your health information. The Fund is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured health information.

This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights with regard to such information.

I. Use and Disclosure of Health Information

Your health information may be used and disclosed without an authorization in the following situations:

A. To Make or Obtain Payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care You receive, to determine benefit responsibility under the Fund's Plan or to coordinate Plan coverage. For example, the Fund may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Fund may also share your protected health information with another entity to assist in the adjudication or reimbursement of your health claims.

B. To Facilitate Treatment. The Fund may disclose information to facilitate treatment which involves providing, coordinating, or managing health care or related services. For example, the Fund may disclose the name of your treating Physician to another Physician so that the Physician may ask for your x-rays.

C. To Conduct Health Care Operations. The Fund may use or disclose health information for its own operations, to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants. Health care operations includes: making eligibility determinations; contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general

administrative activities of the Fund (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Fund may use your health information to conduct case management of ongoing care or to resolve a claim appeal You file.

If the Fund discloses protected health information for underwriting purposes, the Fund is prohibited from using or disclosing protected health information that is genetic information of an individual for such purposes.

D. For Disclosure to the Plan Trustees. The Fund may disclose your health information to the Board of Trustees (which is the Plan sponsor), or any insurer or HMO with which the Fund contracts, and to necessary advisors which assist the Board of Trustees in performing plan administration functions, such as handling claim appeals. The Fund also may provide summary health information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary health information is information that summarizes participants' claims information but from which names and other identifying information have been removed. The Fund may also disclose information about whether You are participating in the Fund or one of its available options.

E. For Disclosure to You or Your Personal Representative. When You request, the Fund is required to disclose to You or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by You in writing as your personal representative, attorney-in-fact. The Fund may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Fund will send all mail from the Fund to the individual's address on file with the Fund Administration Office. You are responsible for ensuring that your address with the Fund Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Fund cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

F. Disclosure Where Required By Law. In addition, the Fund will disclose your health information where applicable law requires. This includes:

1. In Connection With Judicial and Administrative Proceedings

The Fund will in response to an order from a court or administrative tribunal disclose protected health information in accordance with the express terms of such an order. The Fund may also disclose protected health information in response to a subpoena or other lawful process if the Fund receives satisfactory documentation that You have received notice of the subpoena or legal process, the notice provided sufficient information to allow You to raise an objection and the time for raising an objection has passed and either no objections were filed or were resolved by the court or administrative tribunal. Alternatively, the party requesting disclosure may provide satisfactory documentation You have agreed to the disclosure or that it has obtained a qualified protective order which meets the

requirements of the Privacy Rules and which allows for disclosure. For example, if the Fund receives a court order requiring it to disclose certain information, it will respond to the court order.

2. When Legally Required And For Law Enforcement Purposes

The Fund will disclose your protected health information when it is required to do so for law enforcement purposes. This may include compliance with laws which require reporting certain types of injuries, pursuant to court issued legal process; or a grand jury subpoena or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate law enforcement purpose and de-identified individual cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Fund premises. For example, the Fund could upon request of a law enforcement agency provide information concerning the address of a fugitive.

3. To Conduct Public Health and Health Oversight Activities

The Fund may disclose your health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure, or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Fund, however, may not disclose your health information if You are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

4. In the Event of a Serious Threat to Health or Safety

The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Fund may disclose evidence of a threat to harm another person to the appropriate authority.

5. For Specified Government Functions

In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

6. For Workers Compensation

The Fund may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

II. Authorization to Use or Disclose Health Information

Other than as stated above, the Fund will not disclose your health information without your written authorization. Generally, You will need to submit an Authorization if You wish the Fund to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below. If You have authorized the Fund to use or disclose your health information, You may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Fund will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. They do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Fund may use and disclose psychotherapy notes when needed to defend against litigation filed by You or in other limited situations.

Your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Fund.

III. Your Rights With Respect To Your Health Information

You have the following rights regarding your health information that the Fund maintains:

A. Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in payment for your care. The Fund is not required to agree to your request unless the protected health information pertains solely to a health care item or service for which you, or a person on your behalf, has paid the provider or Plan in full, and the disclosure at issue is for the purpose of carrying out payment or health care operations.

B. Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal, or administrative proceeding. The Fund may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If You request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic form shall not be greater than the labor costs in responding to the request.

C. Right to Receive Confidential Communications. You have the right to request that the Fund communicate with You in a certain way if You feel the disclosure of your health information through regular procedures could endanger you. For example, You may ask that the Fund only communicate with You at a certain telephone number or by e-mail. If You wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Fund will attempt to honor reasonable requests for confidential communications.

D. Right to Amend Your Health Information. If You believe that your health information records are inaccurate or incomplete, You may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to the Fund's Privacy Contact Person listed above. The Fund may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information You are requesting to amend is not part of the Fund's records, if the health information You wish to amend falls within an exception to the health information You are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

E. Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Fund. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which You are requesting the information. No accounting will be given of disclosures made: to you; for Treatment, Payment or Health Care Operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; pursuant to an authorization; or in other limited situations. The Fund will provide the first accounting You request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform You in advance of the fee, if applicable.

F. Right to Opt Out of Fundraising Communications. In the event that the Fund engages in a fundraising activity, You have the right to opt out of any fundraising communications.

G. Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if You have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the individual listed below. If this Notice is modified, You will be mailed a new copy.

H. Privacy Contact Person/Privacy Official. To exercise any of these rights related to your health information You should contact:

Privacy Contact Person	Privacy Official
Paige Brosseth Teamsters Joint Council 32-Employers Health and Welfare Fund c/o Wilson-McShane Corporation 3001 Metro Drive, Suite 500 Bloomington, MN 55425 Phone: 952-851- 5902 Fax: 952-851-1632	Paige Brosseth Teamsters Joint Council 32-Employers Health and Welfare Fund c/o Wilson-McShane Corporation 3001 Metro Drive, Suite 500 Bloomington, MN 55425 Phone: 952-851-5902 Fax: 952-851-5632

IV. Duties of the Fund

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice summarizing its privacy practices and duties, and to notify you following a breach of unsecured protected health information. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice and to make the new Notice

provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide you a copy of the revised Notice within 60 days of the change. You have the right to request a written copy of the Notice at any time.

You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to the Privacy Official identified above. The Fund encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for inquiring about or filing a complaint about privacy matters.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and You are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs (https://www.medicaid.gov/chip/index.html). If you or your children are not eligible for Medicaid or CHIP, you would not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	**FLORIDA – Medicaid** Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	**GEORGIA – Medicaid** Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid Website: https://www.myarhipp.com/ Phone: 1-855-MyARHIPP 1-855-692-7447)	**INDIANA – Medicaid** Healthy Indiana Plan for low-income adults 19-64 Website: https://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-403-0864

ADDITIONAL PROVISIONS AND NOTICES

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991 State Relay 711	**IOWA – Medicaid** Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid Website: https://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	**NEW HAMPSHIRE – Medicaid** Website: https://www.dhhs.nh.gov/dfa/medical/children.htm Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid Website: https://chfs.ky.gov/agencies/dms/Pages/default.aspx Phone: 1-502-564-4321	**NEW JERSEY – Medicaid and CHIP** Medicaid Website: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	**NEW YORK – Medicaid** Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid Website: https://www.maine.gov/dhhs/ofi/programs-services/health-care-assistance Phone: 1-855-797-4357- TTY: Maine relay 711	**NORTH CAROLINA – Medicaid** Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-841-2900	**NORTH DAKOTA – Medicaid** Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MINNESOTA – Medicaid Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	**OKLAHOMA – Medicaid and CHIP** Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	**OREGON – Medicaid** Website: https://healthcare.oregon.gov/Pages/index.aspx https://www.oregon.gov/OHA/HSD/OHP/Pages/index.aspx Phone: 1-800-699-9075

ADDITIONAL PROVISIONS AND NOTICES

MONTANA – Medicaid Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	**PENNSYLVANIA – Medicaid** Website: https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx Phone: 1-866-550-4355
NEBRASKA – Medicaid Website: https://dhhs.ne.gov/pages/accessnebraska.aspx Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	**RHODE ISLAND – Medicaid** Website: http://www.eohhs.ri.gov/Consumer/ConsumerInformation/Healthcare/HealthcareOverview.aspx Phone: 1-855-840-4774
NEVADA – Medicaid Medicaid Website: https://dwss.nv.gov/Medical/1_0_Apply_for_Assistance/ Medicaid Phone: 1-800-992-0900	**SOUTH CAROLINA – Medicaid** Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid Website: https://dss.sd.gov/medicaid/ Phone: 1-888-828-0059	**WASHINGTON – Medicaid (Apple Health)** Website: https://www.hca.wa.gov/about-hca/apple-health-medicaid Phone Premium Payment Unit: 1-800-562-3022, ext. 15473 Apple Health Hotline: 1-877-543-7669
TEXAS – Medicaid Website: https://hhs.texas.gov/services/health/medicaid-chip Phone: 1-800-252-8263 Phone CHIP Call Center: 1-877-543-7669 or 1-800-647-6558	**WEST VIRGINIA – Medicaid** Website: https://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: https://health.utah.gov/chip Phone CHIP: 1-877-543-7669 Phone Medicaid: 1-801-538-6155	**WISCONSIN – Medicaid and CHIP** Website: https://www.dhs.wisconsin.gov/medicaid/index.htm Website CHIP: https://www.dhs.wisconsin.gov/medicaid/children.htm Phone: 1-800-362-3002
VERMONT– Medicaid Website: https://www.greenmountaincare.org/ Phone: 1-800-250-8427	**WYOMING – Medicaid** Website: https://wymedicaid.portal.conduent.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and FAMIS Medicaid Website: https://coverva.org/programs/ Medicaid Phone: 1-800-432-5924 Medicaid for Children (FAMIS/FAMIS Plus) Website: https://coverva.org/medicaid/#famp Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

STATEMENT OF PARTICIPANTS' RIGHTS UNDER ERISA

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA. ERISA sets forth certain minimum standards for the design and operation of privately-sponsored welfare plans. The law also spells out certain rights and protections to which you are entitled as a Participant. The Trustees of the Teamsters Joint Council 32-Employers Health and Welfare Fund want you to be fully aware of your rights, and for this reason, a statement of your rights follows.

As a Participant in the Teamsters Joint Council 32-Employers Health and Welfare Fund:

A. You will automatically receive a Summary Plan Description (this booklet). The purpose of this booklet is to describe all pertinent information about the Plan.

B. If any substantial changes are made in the Plan, you will be notified within the time limits required by ERISA or other Federal laws or regulations.

C. Each year you will automatically receive a summary of the Plan's latest annual financial report. A copy of the full report also is available upon written request.

D. You may examine, without charge, all documents relating to the operation of this Plan. These documents include: Summary Plan Description, insurance contracts, Collective Bargaining Agreements, and copies of all documents filed by the Plan with the Department of Labor or the Internal Revenue Service, such as annual reports (Form 5500 Series) and Plan descriptions.

Such documents may be examined at the Fund Office (or at other required locations such as work sites or union halls) during normal business hours.

In order to ensure that your request is handled promptly and that you are given the information you want, the Trustees have adopted certain procedures that you should follow:

1. your request should be in writing;

2. it should specify what materials you wish to look at; and,

3. it should be received at the Fund Office at least three days before you want to review the materials at the Fund Office.

Although all pertinent Plan documents are on file at the Fund Office, arrangements can be made upon written request to make the documents you want available at any work site or union location at which 50 or more Participants report to work. Allow 10 days for delivery.

E. You may obtain copies of any Plan document upon written request to the Trustees, addressed to the Fund Office. ERISA provides that the Trustees may make a reasonable charge for the actual cost of reproducing any document you request. However, you are entitled to know what the charge will be in advance. Just ask the Fund Office.

F. You have the right to continue health care coverage for yourself, your Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan

Description and the documents governing the Plan on the rules governing your COBRA continuation of coverage rights.

G. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit exercising your rights under ERISA.

H. In accordance with Section 503 of ERISA and related regulations, the Trustees have adopted certain procedures to protect your rights if you are not satisfied with the action taken on your claim. These procedures appear in on page 120 of this booklet. Basically, they provide that:

1. If your claim for a health care benefit is denied, in whole or in part, you will receive a written explanation of the reasons(s) for the denial.

2. Then, if you still are not satisfied with the action on your claim, you have the right to have your claim reviewed and reconsidered in accordance with the Plan's appeals procedures.

These procedures are designed to give you a full and fair review and to provide maximum opportunity for all the pertinent facts to be presented on your behalf.

I. In addition to creating rights for Participants, ERISA also defines the obligations of people involved in operating employee benefit plans. These persons are known as "fiduciaries." They have the duty to operate your Plan with reasonable care and to look out for your best interests as a Participant under the Plan.

The duties of a fiduciary are complex and are constantly changing as new laws and regulations applicable to employee benefit plans are adopted. Be assured that the Trustees of this Plan will do their best to know what is required of them as fiduciaries and to take whatever actions are necessary to ensure full compliance with all state and Federal laws.

J. Under ERISA, you may take certain actions to enforce the rights previously listed.

1. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in Federal court.

Of course, before taking such action, you will no doubt want to check again with the Fund Office to make sure that:

- the request was actually received;
- the material was mailed to the right address; or,
- the failure to send the material was not due to circumstances beyond the Trustees' control.

If you still are not able to get the information you want, you may wish to take legal action. The court may require the Trustees to provide the materials promptly or pay you a fine of up to $110 for each day's delay until you actually receive the materials (unless the delay was caused by reasons beyond the Trustees' control).

2. Although the Trustees will make every effort to settle any disputed claims with Participants fairly and promptly, there always is the possibility that differences cannot be resolved satisfactorily.

For this reason, you may file suit in a state or Federal court if you feel that you have been improperly denied a benefit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. However, before exercising this right, you must take advantage of all the appeals procedures provided under the Plan at no cost.

3. If it should happen that Plan fiduciaries misuse the Plan's money or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in 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 are not successful, the court may order you to pay these costs and fees. For example, if the court finds your claim is frivolous, you may be expected to pay legal costs and fees.

If you have any questions about your Plan, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, (Kansas City Regional Office, 2300 Main Street, Suite 1100, Kansas City, MO 64108, telephone number 1-816-285-1800), or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

FUND ADMINISTRATIVE MANAGER CONTACT INFORMATION

Wilson-McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

Bloomington Office: 952-854-0795 or 1-800-535-6373
Fax: 952-854-1632

Duluth Office: 218-727-0824 or 1-800-570-1012
Fax: 218-278-4773