TEAMSTERS

Hagerstown Teamsters and Motor Carriers Health and Welfare Fund

10312 Remington Drive
Hagerstown, MD 21704
(301) 733-2602

General Teamsters and allied Workers Local 992

Summary Plan Description 2019 Edition

SUMMARY PLAN DESCRIPTION

2019 Edition

HAGERSTOWN TEAMSTERS
AND MOTOR CARRIERS
HEALTH AND WELFARE FUND

HAGERSTOWN, MARYLAND

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General Teamsters and Allied Workers Local 992
International Brotherhood of Teamsters

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10312 Remington Drive
Hagerstown, MD 21740
(301) 733-2602

Dear Participant:

This 2019 Summary Plan Description ("SPD") for the Hagerstown Teamsters and Motor Carriers Health & Welfare Fund incorporates the changes that have been made to the Plan since the last SPD was issued in 2013.

Please consult this SPD whenever you have a question about your benefits. If this SPD does not answer your question, the Fund Office is always available to respond to your inquiries. Only the full Board of Trustees is authorized to interpret this SPD. No Employer or Union, nor any representative of any Employer or Union, is authorized to interpret the SPD. Nor is any such person authorized to act as an agent of the Board of Trustees.

Sincerely,
Board of Trustees

Tom W. Krause, Chairman
Daniel Craytor
Daryl Jamison, Alternate

Tom Ventura, Secretary
Dennie Gandee

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HOW TO USE THIS BOOKLET

This booklet, known as a Summary Plan Description ("SPD"), describes your rights under the Hagerstown Teamsters and Motor Carriers Health and Welfare Fund ("Health Fund"), and, except as otherwise indicated, serves as the Fund's official plan document. This booklet explains your coverage under the Health Fund, the benefits to which you are entitled, and the methods and procedures for claiming those benefits.

The Health Fund has two different plans of benefits, one covering active employees and their eligible dependents and the other covering retirees and their eligible spouses. Part A of this booklet explains your eligibility under the Health Fund. It also tells you what happens if you are covered by other insurance, or if someone in addition to the Health Fund is obligated to pay for your covered expenses. Part B contains the Schedules of Benefits for each of the Plans. Part C explains in detail the types of benefits offered in the Plans and listed in the Schedules of Benefits. Part D tells you how to file a claim and your rights if that claim is denied. Part E provides other important information concerning the Health Fund. It also sets out other rights accorded you under the law. Part F is the HIPAA Privacy Notice.

This Health Fund was created for the benefit of you and your family. If you do not understand what it offers, or if any part of this booklet is not clear to you, please contact the Fund Office. Only the full Board of Trustees is authorized to interpret the SPD. No Employer or Union, nor any representative of any Employer or Union, is authorized to interpret the SPD. Nor is any such person authorized to act as an agent of the Board of Trustees to interpret the SPD.

PART A: ELIGIBILITY

PERSONAL COVERAGE

INITIAL ELIGIBILITY OF AN EMPLOYEE – In order to be eligible to participate in the Fund, you must either (a) be a regular, full-time employee working in a job classification that makes you eligible for membership in General Teamsters and Allied Workers, Local Union No. 992 and for which your employer is obligated to make contributions to the Fund on your behalf, or (b) your employer must be obligated to contribute to the Plan on your behalf under the terms of a written agreement that has been approved by the Board of Trustees. If you begin to work in such employment, you will become eligible for benefits under the Health Fund on the first day of the calendar month following the calendar month in which contributions are due and paid by your employer.

Example: If you work a full month in January, your employer will make a contribution to the Fund on your behalf in February, and your eligibility for benefits will begin March 1.

CONTINUED ELIGIBILITY OF AN EMPLOYEE – Once you become eligible to participate in the Fund, your eligibility will continue as long as you continue to work in employment for which your employer is obligated to contribute to the Fund on your behalf, and your employer continues to make those contributions to the Fund. Your employer is required to make contributions to the Fund in the month following the month worked. Those contributions provide continued eligibility for the month following the month in which the contributions are due.

Example: You work during the month of February, your employer is obligated to contribute, and contributes, to the Fund on your behalf during March. You therefore have eligibility for the month of April.

DEPENDENT COVERAGE

Your eligible Dependents are eligible for benefits on the same day you become eligible for benefits.

Eligible Dependents include your Spouse and your Dependent child or children.[1] A Spouse is only a "Dependent" if you can claim the Spouse as a Dependent on your Federal and State tax returns. A Dependent child is one who is under 26 years of age, regardless of the adult child's marital status, financial dependency on the participant, residency with the participant, student status, or any other dependency test.

The term "child" includes a natural or legally adopted child. The term "child" also includes a stepchild, foster child or grandchild, if dependent on you and living in your household. A foster child or grandchild is not considered a Dependent unless you have court-ordered custody of the foster child or grandchild.

[1] Dependent children do not qualify as "eligible Dependents" for eligible retirees and are not entitled to benefits.

While your Dependent Coverage is in effect, newly acquired Dependents automatically become eligible for benefits on the date they meet this definition of "Dependent." You should contact the Fund Office upon acquiring a new Dependent so your family's enrollment records can be updated.

Notwithstanding the above, a Dependent child who, upon reaching age 26, otherwise continues to qualify as a Dependent child, and who is physically or mentally incapable of earning a living, will continue to be considered a Dependent child. Proof of such incapacity and its continuance must be furnished to the Fund Office within thirty-one days after the child's attainment of age 26 and whenever thereafter required. Examination of the child by the Fund's designated doctors may also be required at any time during the first two years coverage is continued under this paragraph and as often as once each year thereafter. Continuation of a child's status as a Dependent child in accordance with this paragraph will end on the date the incapacity ceases, required proof of incapacity is not furnished, or medical examination is refused.

SURVIVOR COVERAGE

If you should die while a covered participant, medical coverage for your eligible Dependents (including unborn children when they become eligible Dependents) will continue without change until the earlier of:

1. One year from the date coverage would otherwise have terminated had you terminated employment;

2. Your Spouse's remarriage;

3. In the case of Retiree coverage, the date your spouse becomes eligible for Medicare; or

4. With respect to a particular individual, when that individual no longer qualifies as an eligible Dependent.

At the close of the one-year period, a surviving Spouse, and other eligible Dependents, if applicable, who is receiving survivor coverage may elect to continue receiving health benefits by making self-payments for individual or family coverage (subject to the rules regarding "General Self-Pay" beginning on p. 6) until the first to occur of the following:

1. The surviving Spouse or Dependent reaches age 65 or becomes eligible to receive Medicare;

2. The surviving Spouse remarries; or

3. The surviving Spouse or Dependent obtains other health coverage.

The termination of survivor coverage will be subject to any Extended Benefit or self-pay coverage that may be available for any particular benefit.

RETIREE COVERAGE

ELIGIBILITY – An eligible retired employee, who is under age 65 and is not eligible for Medicare, who was last covered for benefits as an active employee and his or her Spouse will be eligible for benefits under the Retiree Plan of Benefits. An eligible retired employee is:

1. A present or retired employee eligible for benefits under the Health Fund on or after February 1, 1985 who ceases work in the industry after working in covered employment for a Contributing Employer for a total of 15 years of service. For purposes of this Paragraph, an employee will be considered to have worked for 15 years if he or she has worked a total of at least 180 months; or

2. A present or retired employee eligible for benefits under the Fund on or before June 1, 1985, who has been employed by a Contributing Employer for at least 6 of 12 months or 9 of 18 months immediately prior to attainment of age 57, or actual retirement age if later; or

3. Retired employees of specifically designated newly-participating employer groups who are under age 65, are not Medicare eligible, have at least five years of employment while represented by Teamsters Local 992, and receive early or normal retirement benefits from their company Pension Plan or the Hagerstown Motor Carriers and Teamsters Pension Plan will be permitted to pay for retiree coverage for themselves and their Spouses under the Retiree Plan for a monthly premium equal to their company's monthly contribution. The monthly premium will change as the company's contribution rate changes. In addition, the employee must elect to receive retiree coverage at the time of retirement. Coverage for the retiree will terminate when the retiree, and eligible Spouse, if applicable, become eligible for Medicare.

The Spouse of a Medicare eligible retiree who is not yet eligible for Medicare may participate until the Spouse is Medicare eligible.

For purposes of this section, months (up to 12) for which contributions are made for full Self-Pay Extended Coverage under the Active Plan will be treated as if you were employed by a Contributing Employer.

If each of the following conditions is met, months of employment for which contributions are made to another Teamsters health plan will count toward the 15-year eligibility requirement:

(a) During the months for which contributions were paid to the other health plan, the Employee must have earned service credit under a pension plan that has entered into a reciprocity agreement with the Hagerstown Motor Carriers and Teamsters Pension Plan or must have earned service in the Hagerstown Motor Carriers and Teamsters Pension Plan (but not this Health Plan) as the result of a change in operations; and

(b) The Employee must have worked at least five years (60 months) for which contributions were made to this Health Plan; and

(c) The Employee must be eligible for benefits from this Health Plan at the time he retires.

RETIREMENT BEFORE AGE 60 – An Employee who retires and is eligible for retiree coverage may elect to receive health benefits upon retirement. A retiree who refuses coverage or who allows coverage to lapse will not be given another chance to elect coverage until reaching age 60.

ONE-TIME ELECTION AT AGE 60 – An Employee who retires after age 60 or a retiree upon reaching age 60 will have a one-time option to elect retiree coverage. The election of retiree coverage must be made within 60 days after retirement or within 60 days of reaching age 60, whichever is later. If coverage is not elected, or if it is later dropped, all rights to retiree coverage will be permanently forfeited.

REQUIRED PREMIUM – A monthly premium is required for retiree health benefits. Premiums must be received in the Fund Office by the first day of the month for which coverage is provided. In the alternative, a retiree receiving pension benefits from the Hagerstown Motor Carriers and Teamsters Pension Fund may direct that the Pension Fund pay the retiree health premium directly out of each month's pension check. Failure to pay a premium when due will result in the permanent cancellation of retiree health coverage. The Trustees of the Fund may revise the amount of the retiree premium at any time, based upon several considerations, including increases in the cost of retiree health benefits. Please contact the Fund Office for the amount of the premium that is applicable to you.

If you are eligible for Medicare, you are not eligible for Retiree Health coverage.

EMPLOYMENT AFTER RETIREMENT – An individual who otherwise qualifies as an eligible retired employee is not entitled to retiree benefits for any month in which he or she is employed for more than 40 hours by an employer required to make contributions to the Fund on his or her behalf. If an eligible retired employee who is not eligible for Medicare becomes employed and is offered health coverage, the retiree is required to take that coverage, even if the cost of such coverage is greater than the Fund's cost of retiree coverage, and any coverage under this Fund (including coverage for the retiree's Spouse) is automatically secondary to that coverage. (See pages 10 - 12) for an explanation of coordination of benefits.)

If you are a retired Participant who obtains a job that provides health coverage or you are an actively working Spouse of an eligible retiree covered by employer-provided health coverage, you may temporarily suspend your health coverage from the Fund and resume coverage when you terminate your employment, provided you (and your eligible

Spouse) remain continuously covered by the employer's health plan. In order to take advantage of this rule, you must notify the Fund that you have obtained medical coverage from your employer and that you wish to suspend your health coverage. In order to have your coverage under the Fund resume, you must supply the Fund Office with a "Certificate of Creditable Coverage" from your employer that shows that you have been continuously covered. If your coverage has lapsed for more than 31 days, *you will not be permitted to resume your coverage under the Fund.*

FAMILY AND MEDICAL LEAVE

If you have to take a leave of absence from your job because of the birth of a son or daughter in order to care for such son or daughter; because of the placement of a son or daughter with you for adoption; because you must care for your Spouse, child or parent because of a serious health condition or because of your own serious health condition that prevents you from performing the functions of your job, you may be entitled to Family and Medical Leave under the provisions of the Family and Medical Leave Act.[2] If you are entitled to such leave, then your employer is required to continue making contributions to the Fund on your behalf for up to twelve weeks.[3] The Fund will continue to provide benefits during any period for which your Employer makes contributions under the Act.

SELF-PAY EXTENDED COVERAGE - ("COBRA")

GENERAL SELF-PAY – If you become ineligible for benefits for any of the reasons listed below, you have the right to self-pay at the rates set by the Trustees under certain circumstances, and for the periods specified below. This is sometimes called COBRA Continuation Coverage.

If you are an employee, Spouse or Dependent child covered by the Health Fund, you may pay for continued coverage for up to 18 months if you lose your eligibility because of a reduction in hours of employment or the termination of employment (for reasons other than gross misconduct).

If you are the Spouse or other eligible Dependent of a participant covered by the Health Fund, you may self-pay for up to three years if you lose eligibility for any of the following reasons:

1. The death of the covered employee;[4]

2. The covered employee becomes eligible for Medicare;

3. Divorce or legal separation from the covered employee; or

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[2] This Section summarizes some of your rights under the Family and Medical Leave Act. The rules and terms of the FMLA can be found at 29 U.S.C. §2601 *et seq.* and any regulations promulgated under the Act.

[3] You may be required to repay your employer for those contributions if you fail to return to work following the conclusion of your leave period, unless your failure is caused by the continuation, recurrence or onset of a serious health condition that would have entitled you to take leave, or by other circumstances beyond your control.

[4] Under the terms of the Fund's Survivor Coverage, subject to the provisions of that Coverage, your first year will be provided at no cost, and you need self-pay only for the final two years of extended coverage.

4. You cease to qualify as a “Dependent child.”

(Note - if you are a Spouse or child of a participant who has been self-paying, and you lose eligibility for one of the reasons set forth above, you may continue your coverage by making your own self-payments for up to three years from the date the participant began making self-payments.)

If you choose to pay for continued coverage, your coverage will be the same as the coverage provided to similarly situated employees or family members, except that it does not include Life Insurance or Accidental Death and Dismemberment Benefits.

The amount of the required self-payments will be set from time to time by the Trustees, and there will be a separate rate for family and individual coverage. For information on the current rates, please contact the Fund Office.

The participant or a family member has the responsibility to inform the Fund Office within 60 days of the occurrence of a divorce or legal separation, or a child losing Dependent status. Employers have the responsibility to notify the Fund Office of the participant’s death, termination of employment, or reduction in hours, or entitlement to Medicare.

When the Fund Office is notified of one of these events, it will in turn notify you that you have the right to choose to pay for continued coverage. You have 60 days from the date on that notification to inform the Fund Office that you want to self-pay. Payment for coverage must be received by the Fund within a specified time limit in order to maintain continued coverage. In order to qualify for continued health coverage, you must pay for all periods back to the date your coverage lapsed.

However, your right to continue coverage through self-payments may be cut short for any of the following four reasons:

1. The Health Fund ceases to provide health coverage to any employees;

2. You miss a self-payment;

3. You become covered under another group health plan; or

4. You become entitled to Medicare benefits.

The above information is subject to change in order to comply with federal regulations.

DISABILITY SELF-PAY – If you leave covered employment as a result of disability for which you have applied for a Social Security disability award that will entitle you to coverage under Medicare, you may continue to self-pay for an additional 11 months of continued coverage beyond the normal 18-month limitation, even if you are not entitled to Early Retiree Self-Pay Extended Coverage. This program is subject to the following:

1. You may continue to self-pay until the first to occur of the following:

    a. You become eligible for coverage under Medicare;
    b. Your application for Social Security Disability benefits is denied. In the event your application for disability benefits is denied and you appeal that denial, you may continue to self-pay while your appeal is pending before the Social Security Administration for up to two years from the date your coverage from the Fund would have terminated but for your self-payments; or
    c. You cease to be disabled.

2. Subject to the foregoing, the ordinary self-pay rules are applicable (see General Rules above).

CONTINUATION OF COVERAGE FOR ELIGIBLE MILITARY LEAVE

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), if you leave employment with a participating employer to serve in the uniformed services of the United States, and you meet the other requirements of USERRA, you are entitled to continuation health coverage as discussed below.

Under USERRA, if you leave covered employment to serve in the uniformed services of the United States and you meet the other requirements of that Act, you are entitled to elect continuation coverage for yourself and your Dependents. If you continue coverage; however, the Fund's coverage is secondary to the coverage provided by the military. USERRA continuation coverage is governed by the same procedures as are set forth in your Summary Plan Description on pages 6-8, under the Section entitled "SELF-PAY EXTENDED COVERAGE," except as described below:

Duration of Coverage. USERRA continuation coverage will be provided for the lesser of (i) 24 months from the date on which your qualified leave for uniformed service begins or (ii) the period beginning on the date your leave for uniformed service begins and ending on the date you fail to apply for reemployment within the time frames provided in USERRA.

Cost of Coverage. If you are absent from work to perform uniformed service for a period of 30 days of less, your employer will pay contributions on your behalf and the Plan will provide continuation coverage at no cost to you. If you are absent in uniformed service for 31 or more days, the Plan may charge you up to 102% of the full cost of coverage, subject to any contribution obligation of your employer under the collective bargaining agreement.

Notice and Election of Coverage. You are required by USERRA to give advance notice to your employer that you are leaving for a period of uniformed service, unless giving such notice is impossible or unreasonable or barred by the military. You should also notify the Plan in writing that you are leaving to perform uniformed service and that you elect to continue your health coverage. Within 60 days after receipt of that notice, the Fund Office will provide you with specific information regarding the cost of USERRA Continuation

Coverage. The Plan cannot help you ensure the continuation of your health coverage unless the Plan is notified of your leave for uniformed service.

If you **do not** give advance notice of your leave for uniformed service, your coverage will be terminated as of the date you leave employment for uniformed service. If your failure to give advance notice of your uniformed service is excused because it was impossible or unreasonable to do so or because doing so was precluded by military necessity, the Plan will reinstate your health coverage retroactive to the date of departure from employment if you contact the Fund Office to request continuation coverage within 30 days of your departure and return the USERRA Continuation Coverage election form to the Fund Office with your initial payment within 30 days of receiving that form from the Fund Office.

If you give advance notice of your leave for uniformed service to your employer but do not notify the Fund Office that you desire to elect USERRA Continuation Coverage, your coverage will be terminated as of the date you leave employment for uniformed service. The Plan will reinstate your health coverage retroactive to the date of departure from employment, however, if you contact the Fund Office to request continuation coverage within 30 days of your departure and return the USERRA Continuation Coverage election form to the Fund Office with your initial payment within 30 days of receiving that form from the Fund Office.

If your health coverage was terminated as a result of your uniformed service (either because you did not elect USERRA Continuation Coverage or your uniformed service lasted for more than 24 months), your health coverage must be reinstated upon your return to covered employment. At that time, until you satisfy the Plan's eligibility requirements based on hours worked in covered employment and contributed on by your employer, the Plan will charge you for this coverage in an amount up to 102% of the full cost of such coverage until you again become eligible for coverage under the Fund's regular eligibility rules (See Page 2 of your SPD). Alternatively, you may reject coverage until you regain eligibility as a result of your hours worked in covered employment and contributed on by your employer.

DISCONTINUANCE OF BENEFITS

LOSS OF INDIVIDUAL ELIGIBILITY – Your coverage under each type of Personal Coverage and Dependent Coverage will stop on the earliest to occur of the following dates:

1. The date you are no longer eligible for that type of coverage.

2. The last day of the month for which you have made any required contribution toward the cost of that type of coverage.

3. The last day of the calendar month in which your employer ceases contributions on your behalf, subject to Self-Pay Extended Coverage and/or Retiree Coverage, if applicable. (See page 6 for an explanation of Self Pay Extended Coverage, and page 4 for an explanation of Retiree Coverage.)

4. The date of your death, subject to the terms of your survivor coverage. (See page 3 for an explanation of Survivor Coverage.)

Your benefits with respect to each individual covered as your Dependent shall cease on the date the individual no longer qualifies as a "Dependent."

TERMINATION OF BENEFITS UPON EMPLOYER WITHDRAWAL – An Employer will be deemed to have withdrawn from the Fund as of the date it ceases to have an obligation to contribute to the Fund on behalf of its active Employees. The eligibility for benefits (including In-Benefit Continuation and Extended Benefits) of any Employee or Retiree of an Employer that has withdrawn from the Fund but continues to perform bargaining unit work within the jurisdiction of General Teamsters and Allied Workers Local Union No. 992, shall cease immediately upon the date of such withdrawal. A Retiree shall be considered a Retiree of an Employer if his or her last employment covered by the Fund was with such Employer.

EXCEPTION FOR IN-BENEFIT CONTINUATION – If you or your Dependent begins to undergo a course of treatment while covered by the Fund which cannot be stopped without serious medical consequences, that specific course of treatment will continue to be covered for up to twelve additional months even though your Personal and Dependent Coverage under the Health Fund may have been discontinued. In-benefit continuation does not apply, however, if coverage terminates as a result of an employer withdrawal. (See page 10 for an explanation of employer withdrawal.) If you have any question about whether you are or will become eligible for in-benefit continuation, you may submit a written request to the Fund Office for a determination.

TEMPORARY SUSPENSION OF RETIREE COVERAGE WHILE EMPLOYED – If you are a retired Participant who obtains a job that provides health coverage or you are an actively working Spouse covered by employer-provided health coverage, you are permitted to temporarily suspend your health coverage from the Fund and to have it resume when you terminate your employment, provided you (and your eligible Spouse) remain continuously covered by the employer's health plan. In order to take advantage of this rule, you must notify the Fund that you have obtained medical coverage from your employer and that you wish to suspend your health coverage. In order to have your coverage under the Fund resume, you must supply the Fund Office with a "Certificate of Creditable Coverage" from your employer that shows that you have been continuously covered. If your coverage has lapsed for more than 31 days, *you will not be permitted to resume your coverage under the Fund*.

COORDINATION WITH OTHER HEALTH BENEFITS

If you or any of your Dependents are eligible to receive benefits under another plan (as defined below) for goods or services covered under the Health Fund, the benefits

provided for you or your Dependent by this Fund will be coordinated with the benefits from all other such plans so that not more than the total amount of "allowable expenses" incurred by you or your Dependents during a calendar year will be paid jointly by all plans.

A "plan" is considered to be any group insurance coverage or other arrangement of coverage for individuals in a group that provides medical or dental benefits or services on an insured or self-insured basis, and any government program providing benefits or services of a similar nature, including insurance which you are required by law to purchase, *e.g.*, state mandated no-fault auto insurance. An "allowable expense" is any necessary, reasonable and customary item of expense covered in full or in part under any one of the plans involved. A "plan" also includes any individual contract of insurance that covers a participant of this Plan or a Dependent, such as automotive insurance policies and other policies that provide coverage for medical costs in the event of an accident.

The Fund Office may exchange benefit information with other insurance companies, organizations and individuals, and has the right to recover any overpayment made to you if you neglect to report coverage under any other plan. In order to obtain all benefits available to you, a claim should be filed under each plan.

The Fund coordinates benefits with another plan(s) as follows:

With respect to any two plans that provide coverage, one is primary, the other is secondary. The primary plan pays benefits first for a covered service and without consideration of the other plans. The secondary plan or plans, in order of priority, then makes up the difference up to the total allowable expenses. No plan will pay more than it would have paid without this special provision.

A government or tax-supported plan (unless otherwise required by applicable federal law), or a plan that has no coordination of benefits provision, is automatically primary.

A plan that covers medical benefits in case of an accident is automatically primary

A plan is primary if it covers the individual as a present employee, policy holder or primary insured and secondary if it covers the individual as a Dependent or otherwise. However, if the individual is covered as a Dependent or otherwise under two or more plans, the primary coverage is that of the primarily covered or insured person, such as the Dependent's parent, whose birthday is earlier in the calendar year. In the event there is a coordination rule conflict, the Fund will use the rules adopted by the National Association of Insurance Commissioners. Notwithstanding any of the foregoing, coverage under the Retiree Plan is always secondary to any other Plan under which that individual may be covered.

In the event that the Fund is secondary with respect to a particular claim, and the primary plan will not pay as a result of your failure to properly follow the procedures of the primary plan (including the failure to use participating providers, etc.), the Fund will pay no

more than the amount it would have paid had you followed the primary plan's procedures. Information necessary to the administration of this provision will be required at the time a claim is submitted.

MEDICARE COORDINATION FOR RETIREES – When a retired individual (employee or Spouse) becomes eligible for Medicare benefits, coverage under this Plan, including benefits available under the COBRA continuation coverage, is coordinated with Medicare coverage, **whether or not such person is enrolled under Medicare.** This means that if you or a Dependent are entitled to benefits under Medicare Parts A and B, but have not applied for those benefits, this Plan will consider its benefits as if you had. When you retire, it is important that you and your covered Dependent enroll for Medicare as soon as you are eligible.

REIMBURSEMENT AND SUBROGATION (Cases Involving a Third-Party Recovery)

This provision explains what happens if a third party is potentially responsible for causing an illness or injury to you, your Spouse, or Dependent, or for paying monies, damages or benefits related to that illness or injury, and you may or you have filed a claim with the Fund related to that illness or injury. The most common example of when this provision will apply is if you or your Spouse or Dependent is involved in a car accident and then you sue to recover damages from the driver of the other vehicle.

For purposes of this provision: (1) "you" or "yours" refers to the ill or injured person, whether it is you or your Spouse or your Dependent; (2) "third party" means any individual or entity other than you who is liable for expenses relating to the illness or injury suffered by you, including tortfeasors, insured or uninsured motorists programs, workers' compensation programs, or any other insurance programs or benefits plans; and (3) "recovery" (or any variation of that word) refers to any monies, damages or benefits that you receive from a third party through lawsuit, workers' compensation award, judgment, settlement or any other payment that relate to the illness or injury that you have suffered.

If you become ill or are injured and a third party is potentially liable to you for the illness or injury or a third party may be responsible for paying damages or benefits related to the illness or injury, you must promptly notify the Fund. You must also notify the Fund of the filing of any claim or legal action against any third party that is related to such illness or injury. Also, if the Fund requests it, you must promptly provide the Fund with any information and documents that may be related to such third-party recovery, claim or legal action.

If you become ill or injured and a third party is potentially responsible for such illness or injury and/or for the payment of benefits or damages related to such illness or injury, the Fund may advance the payment of benefits for covered medical or dental services rendered in connection with such illness or injury. But if you recover money from a responsible third party, you are required to repay the Fund for the benefits it advanced, up to the amount of the recovery from the third party.

This repayment obligation also applies if the Fund has inadvertently paid for medical or dental benefits rendered in connection with your illness or injury for when a third party is actually responsible for such illness or injury and/or for the payment of benefits or damages related to such illness or injury. In addition, repayment is required even if your only monetary recovery is through your or your Spouse's own insurance company. Regardless of the exact circumstances, the Fund always is fully subrogated to any and all rights of recovery and causes of action that you may have against a responsible third party.

These reimbursement and subrogation rules are in place to assist you – by paying qualified claims while you proceed against the responsible third party. The rules also help ensure that assets are available for all of the Fund's Participants, including Retirees, Spouses, and Dependents.

If you become ill or are injured and a third party is potentially liable to you for the illness or injury or a third party may be responsible for paying damages or benefits related to the illness or injury, the Plan may advance payment of benefits on your behalf, but only under the following conditions:

- You and your attorney (or the attorney of your Spouse or Dependent), if you have one, must sign and return the Fund's Subrogation Agreement. Benefits will not be paid on your or your Spouse's or Dependent's behalf unless the Fund Office receives a copy of the Agreement signed by you and your attorney. Alternatively, if you or your attorney fails or refuses to sign and return the Subrogation Agreement and the Fund still pays your or your Spouse's benefits, your acceptance of those benefits will constitute an agreement by which you acknowledge and consent to the Fund's right to reimbursement and subrogation. By that agreement, you agree that you hold any monies or damages that are recovered from a third party in constructive trust on behalf of the Fund. You also agree and acknowledge that the Fund has an equitable lien by agreement against any monies or damages you recover from a third party.

- If you recover money from a third party related to an illness or injury for which the Fund has paid benefits, you must repay the Fund for the benefits it paid on your behalf, up to the amount of the recovery. (Example: the Fund pays $15,000 in medical claims on your behalf. Later, you recover $25,000 from the third party responsible for your injury. You must reimburse the Fund for the $15,000 of medical benefits paid on your behalf.) In addition, if your third-party recovery is less than the full amount of damages or expenses that you claim, the Fund's share of the recovery will not be reduced and will remain the full amount of the benefits the Fund has paid on your behalf, unless the Fund agrees in writing to a reduced amount

- This repayment obligation applies to any recovery from a third party, regardless of how the recovery is structured and regardless of whether the payment is characterized as compensation for medical expenses, pain and suffering or something else.

- The Fund has a specific and first right of reimbursement out of the proceeds of any recovery to you. That means that your obligation to repay the Fund has priority over other obligations you may have, including any obligation to pay attorneys' fees out of the recovery. You may not reduce the amount you owe the Fund to account for the payment of attorney's fees or other obligations.

- Once Fund benefits are paid, the Fund has a lien on the proceeds of any recovery from a third party received by you or on your behalf. Therefore, you consent and agree that a lien or an equitable lien by agreement in favor of the Fund exists with regard to any recovery from a third party. In addition, you grant the Fund an irrevocable vested future interest in the proceeds of any recovery from a third party that is predicated on an illness or injury for which Fund benefits were paid to you. You also agree that once you receive a recovery, you are responsible for holding and safeguarding the Fund's funds in a constructive trust until those funds are surrendered to the Fund. You will act as the trustee and fiduciary of the Fund's funds, and you may be liable for your failure to safeguard those funds.

- In accordance with the lien described in the paragraph above, you agree to cooperate with the Fund to effect the Fund's reimbursement or subrogation rights, including but not limited to reimbursing the Fund for its costs and expenses. You also agree not to do anything that may impair, prejudice or discharge your right to recover from a third party and/or the Fund's right to reimbursement or subrogation, including but not limited to settling any claim or lawsuit without the written consent of the Fund.

- You will not assign to any other party, including your attorney, any rights or causes of action that you may have against a third party related to the illness or injury for which the Fund may pay, is paying, or has paid benefits without the written consent of the Fund. As such, the Fund's reimbursement will not be reduced by attorneys' fees and expenses.

- The Fund's right to reimbursement and subrogation will not be affected, reduced or eliminated by the make whole doctrine, the comparative fault doctrine, the regulatory diligence doctrine, the collateral source rule, the attorney fund doctrine, the common fund doctrine, or any other defenses or doctrines that may affect the Fund's recovery.

- If you recover money through a third-party recovery, but fail or refuse to repay the Fund, future Plan benefits will <u>not</u> be paid on your, your Spouse's, or your Dependents' behalf until such time as the Fund offsets the full amount due to be reimbursed under these rules plus 10% interest per annum.

- You agree that the Fund may bring an action or claim against a third party in your place to recover the benefits paid by the Fund. If the Fund recovers from a third party an amount that is greater than the amount of benefits the Fund has paid and

the expenses incurred in making the recovery (including the Fund's attorneys' fees), the Fund will pay the excess amount to you.

- The Fund may also choose to bring legal action against you to collect monies due under these reimbursement and subrogation rules. If the Fund prevails, you must also pay interest at the rate of 10% per annum and the Fund's costs and expenses related to the action, including reasonable attorney's fees.

- The Trustees may evaluate the merits of each third-party litigation claim and determine, on a case by case basis, whether to reduce the Fund's claim against any recovery to assist in the payment of your attorneys' fees. To request such relief from the Fund, you must instruct your attorney to discuss the merits of your claim with the Trustees or with Fund counsel, and to provide the Fund with any documents the Fund may request that are related to any settlement or litigation. Unless the Trustees agree in writing to reduce the Fund's demand for full reimbursement in order to share in the payment of your attorneys' fees, the Fund retains its priority over other obligations, including your obligation to pay attorneys' fees out of your recovery.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order is a court order that requires that a health plan provide benefits to the child of a participant. The Fund will honor Qualified Medical Child Support Orders meeting the statutory requirements set forth in ERISA Section 609(a), 29 U.S.C. §1169(a). Participants and Dependents can obtain, without charge, a copy of the Funds' procedures from the Plan Administrator. All such Orders must be submitted to the Fund Office for a determination of whether the Order meets the statutory requirements.

OTHER LIMITATIONS

Benefits are not payable for expenses due to any of the following:

1. Medical care or treatment given by or in any facility owned or operated by the federal government (unless otherwise required under applicable federal law).

2. Disease for which you, your Spouse, or your Dependent are entitled to benefits under any Workers' Compensation Law or Act, or accidental injury arising out of or in the course of employment.

3. Medical procedures that are experimental or not recognized as accepted medical practices.

4. Care or treatment that is not medically necessary.

5. Charges which exceed the regular and customary charge or fair and reasonable value of such services and supplies as determined by the Fund by comparing the charge with prevailing charges for similar services.

The provisions of the Fund are not in lieu of and shall not affect any requirements for coverage by Workers' Compensation Benefits.

WHICH SCHEDULE OF BENEFITS TO USE

Active Employees are covered under the Active Participant Schedule of Benefits. Retirees are covered under the Retiree Plan of Benefits. In addition, some Employees may be covered under a custom plan of benefits, pursuant to an agreement between their Employer and the Union. If you are covered by such a custom plan, you will be provided with a separate schedule showing your level of benefits. The current Schedule of Benefits provided by the Health Fund is contained in Part B of this Summary Plan Description.

If you are an Active Eligible Employee of YRC, you are covered under the Active Participant Schedule of Benefits; however, you are not eligible for Personal Life Insurance, Accidental Death and Dismemberment Insurance or Dependent Life Insurance.

If you are self-paying for coverage, your coverage will not include any life insurance, accidental death and dismemberment, or sickness and accident benefits. If you are self-paying for core-only coverage, your coverage will also not include vision care and dental benefits.

PART B: SCHEDULES OF BENEFITS

ACTIVE PARTICIPANTS & ELIGIBLE DEPENDENTS

PERSONAL LIFE INSURANCE* $40,000

Dependent LIFE INSURANCE*
- For your Spouse .....$ 5,000
- For each Dependent child.....$ 1,000

PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE* $50,000

SICKNESS AND ACCIDENT BENEFIT**

	YRC & ABF Employees	All Other Employees
Weekly Benefit (weeks 1 to 13)	$ 250	$ 300
Weekly Benefit (weeks 14 to 26)	$ 300	$ 350

ADOPTION EXPENSE* .....$ 1,000

DENTAL EXPENSE
- Plan Pays
  - Examinations, Cleanings, Bitewings and Panorex 100%
  - General 80%
    - However, the Plan will pay 100% of actual charges if the actual charges are less than 50% of the usual and customary cost.
  - Orthodontic Treatment 50%
- Maximum benefit per calendar year
  - (Exams, Cleanings & Bitewings limited to two per calendar year and Panorex limited to once every three calendar years) $3,000
- Orthodontic Lifetime Maximum $1,000

Pediatric Dental (children age 17 and under) - No annual cap; however, limited to two exams, cleanings and bite wings per calendar year (Panorex limited to once every three calendar years) and subject to standard medical protocols and reasonable and customary limitations. Orthodontia still subject to $1,000 lifetime maximum

(Note--Expenses over $1000 for children age 17 and younger must be pre-approved. See page 28 for complete explanation.)

* Not available to participants who self-pay for extended coverage.

** Available to participants who self-pay for extended coverage only if the disability payments began while the participant was actively eligible.

VISION CARE EXPENSE

Maximum Covered per Year .....$ 375
(Covered at 80% for a maximum payment of $300)
Pediatric Vision (children age 17 and under) - No annual cap; however, frames and lenses are limited to one per calendar year and contact lenses are limited to one year's supply per calendar year.

PRESCRIPTION DRUG PLAN

Retail (30-day supply): Copayment is 20%, with a minimum payment of $5 for generic drugs, $15 for "preferred" brand-named drugs, and $25 for "non-preferred brand-named drugs."

Mail or CVS Store with Maintenance Choice (90-day supply): Copayment is 20%, with a minimum payment of $15 for generic drugs, $45 for "preferred" brand named drugs, and $75 for "non-preferred brand-named drugs."

Maintenance Medication Purchased at Retail (30-day supply): Copayment is 20%, with a minimum payment of $20 for generic drugs, $45 for "preferred" brand named drugs, and $75 for "non-preferred brand-named drugs."

Maximum Copayment Per Calendar Year: The maximum copayment per person per calendar year is $3,000.

PERSONAL AND DEPENDENT HEALTH COVERAGE

Deductible per Calendar Year

If Enrolled in the Wellness Program
Individual .....$ 200
Family .....$ 400

If Not Enrolled in the Wellness Program
Individual .....$ 500
Family .....$ 1,000

Plan Pays if PPO Provider used ..... 80% of Covered Expenses
Plan Pays if non-PPO Provider used ..... 70% of Covered Expenses

Out of Pocket Maximums

Individual Out of Pocket Maximum[5] .....$ 1,500

Family Out of Pocket Maximum[6] $3,000

If a PPO provider is Not Used, then benefits are paid at 70% even if the Out of Pocket maximums have been reached.

CHIROPRACTIC CARE**

Maximum Covered per Year .....$ 1,000

(Covered at 80% for a maximum payment of $800)

NERVOUS AND MENTAL CARE BENEFITS**

The Plan pays the same as any other illness or injury as described on page 18 under Personal and Dependent Health Coverage.

ANNUAL LIMIT ..... No Annual Limit

[5] Excluding deductible.

[6] Excluding deductible.

**These benefits are also subject to the annual deductibles, copayments, and other terms and conditions for Health Benefits.

RETIREE PARTICIPANTS & ELIGIBLE SPOUSES

PERSONAL LIFE INSURANCE $2,700

PERSONAL ACCIDENTAL DEATH AND
DISMEMBERMENT INSURANCE.....$2,700

PERSONAL AND DEPENDENT HEALTH COVERAGE
Deductible per Calendar Year

If Enrolled in Wellness Program
Individual.....$350
Family $700

If Not Enrolled in the Wellness Program
Individual.....$ 500
Family .....$ 1,000

Plan Pays..... 80%
Individual Out of Pocket Maximum[7] $5,000
Annual Maximum through June 30, 2014 ..... $5 million
Annual Maximum on and after July 1, 2014 .....Unlimited

CHIROPRACTIC CARE*
Maximum Covered per Year.....$1,000
(Covered at 80% for a maximum payment of $800)

NERVOUS AND MENTAL CARE BENEFITS*
The Plan pays the same as any other illness or injury as described on page 18 under Personal and Dependent Health Coverage.

VISION CARE EXPENSE
Maximum Covered Every Three Years.....$200
(Covered at 80% for a maximum payment of $160)

DENTAL EXPENSE[8]
Maximum Covered per Year.....$1,250
(Covered at 80% for a maximum payment of $1000)
However, the Plan will pay 100% of actual charges <u>if</u> the actual charges are less than 50% of the usual and customary cost.

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[7] Excluding deductible.
*These benefits are also subject to the annual deductibles, copayments and other terms and conditions for Health Benefits.

[8]Orthodontic Coverage is not provided.

PRESCRIPTION DRUG PLAN

Retail (30-day supply): Copayment is 30%, with a minimum payment of $10 for generic drugs, $25 for “preferred” brand named drugs, and $35 for “non-preferred brand named drugs.”

Mail or CVS Store with Maintenance Choice (90-day supply): Copayment is 30%, with a minimum payment of $30 for generic drugs, $75 for “preferred” brand named drugs, and $105 for “non-preferred brand named drugs.”

Maintenance Medication Purchased at Retail (30-day supply): Copayment is 30%, with a minimum payment of $30 for generic drugs, $75 for “preferred” brand named drugs, and $105 for “non-preferred brand named drugs.”

Maximum Copayment Per Calendar Year: The maximum copayment per person per calendar year is $3,000.

NEW EMPLOYER RETIREE PLAN

This Plan is only available to eligible Retirees from specifically designated newly-participating employer groups that have not been in the Plan for 15 years. The Plan is only available to participants who have been represented by Local 992 for five years. Existing Retirees will be permitted to continue their coverage under the conditions set forth herein, except as noted.

Retirees Under Age 65 may receive coverage by paying monthly the contribution rate paid by his or her employer. Coverage will be provided for the Retiree and Spouse under the Plan provided by the employer, but without accidental death and dismemberment insurance or sickness and accident benefits. Under the New Employer Retiree Plan, the Spouse of a Retiree can elect to waive coverage; however, once coverage is waived, the Spouse cannot elect coverage, or have coverage reinstated at a later date.

PART C: EXPLANATION OF BENEFITS

PERSONAL LIFE INSURANCE

The insurance benefits described in this section are funded by a premium paid by the Health Fund to Metropolitan Life Insurance Company. The following is a summary description of the policy which is subject to the terms of the policy itself.

BENEFIT – In the event of your death while covered, the Fund Office, upon receipt of a certified death certificate, will submit your claim to the Insurance Company for payment according to the Schedule of Benefits under your Plan. Payment will be made in one sum.

BENEFICIARY – You alone have the right to designate your beneficiary by completing a beneficiary designation form. You may change that designation at any time by completing a change of beneficiary form. The necessary forms are available at the Fund Office. Be sure to clearly identify your beneficiary. If two or more individuals are to share a death benefit, you must specify the portion that is to be paid to each person.

If you have not named a beneficiary, if your beneficiary is no longer living, or if your beneficiary is unable to give a valid release (such as a minor), your coverage will be paid in accordance with the terms of the insurance policy.

WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY – In this section, Total Disability means your disability that is due to an accidental bodily injury or disease, that begins while you are covered and that prevents you from engaging in any occupation for compensation or profit.

If your death should occur within a period of twelve months after the Fund discontinues premium payments for your Personal Life Insurance, and if satisfactory proof is submitted that your death occurred during a period of total disability that began while you were covered and under age sixty, the Insurance Company will pay your beneficiary the amount of Personal Life Insurance provided under your Schedule of Benefits.

If, before or within twelve months following the Fund's discontinuance of premium payments for your Personal Life Insurance, satisfactory proof is submitted to the Insurance Company that you became totally disabled while covered and under age sixty, and that such disability existed continuously for at least nine months, the amount of Personal Life Insurance provided under your Schedule of Benefits will be continued without payment of premiums during the continuance of such disability for a period of one year after receipt of such proof. If your Personal Life Insurance has been continued in accordance with the preceding sentence, such benefit will be continued without payment of premiums during the continuance of your total disability for additional periods of one year each, provided that satisfactory proof of your continued total disability is submitted to the Insurance Company during the three months preceding each date to which coverage has been continued.

The amount of your coverage under this section is the amount of your Personal Life Insurance on the date the Fund discontinued premium payments for that benefit, except

that if the Schedule of Benefits provides for a reduction at a specified age, your coverage under this section will be accordingly reduced at that time.

The Insurance Company may require satisfactory proof of your continued total disability at any time while your coverage is continued under this section. The Insurance Company may also require your examination, by doctors it designates, at any time during the first two years of continuance and not more often than once every year thereafter.

If an individual policy of life insurance has been issued to you in accordance with the Conversion Privilege section of these provisions, you will not be eligible for continuance of coverage under this section unless that individual policy is surrendered without claim except for a refund of the premium paid for it.

No death benefit will be paid under this section unless the Insurance Company receives satisfactory proof of continuous total disability and death within twelve months after your death occurs.

Whenever your total disability ceases, or you do not furnish proof of its continuance, or you refuse to be medically examined as provided in this section, your coverage under this section will terminate. If you attain normal retirement age and retire under the Hagerstown Motor Carriers and Teamsters Pension Fund, your coverage will cease (unless you are entitled to retiree coverage under the Health Fund, in which case it will be reduced to the amount provided under the Retiree Plan).

If, within thirty-one days after the date your Personal Life Insurance under this section is terminated, you do not again become eligible for benefits as an active employee, you may exercise your Conversion Privilege as though your employment had ceased on that date.

Discontinuance of the Group Policy or the Personal Life Insurance part of the Group Policy after you become totally disabled will not affect your rights under this section.

CONVERSION PRIVILEGE – If your Personal Life Insurance is discontinued because of the termination of your employment (other than as a result of your retirement) or your transfer to a classification ineligible for Personal Life Insurance, you can get an individual policy of life insurance without evidence of insurability by making written application to the Insurance Company within 31 days after your coverage would have terminated. The premium for the individual policy is the premium normally charged for a person of your age and class of risks.

For more information and for the necessary forms, contact the Fund Office.

DEPENDENT LIFE INSURANCE

The insurance benefits described in this section are funded by a premium paid by the Health Fund to the Metropolitan Life Insurance Company. The following is a summary description of the policy which is subject to the terms of the policy itself.

BENEFIT – In the event of the death of a covered Dependent, the Fund Office, upon receipt of a certified death certificate, will submit your claim for payment of Dependent Life Insurance as shown in your Schedule of Benefits. Coverage for Dependent children begins at the age of fourteen days.

EXTENDED BENEFIT FOR DEPENDENT CHILDREN – If coverage on the life of a child is discontinued due to your death, and if the child's death occurs within thirty-one days following the date of your death, the Insurance Company upon receipt of adequate proof, will pay the amount of Dependent Life Insurance in effect on the child's life when your death occurred.

CONVERSION PRIVILEGE – If Dependent Life Insurance is discontinued, you may be able to get an individual policy of life insurance without evidence of insurability by making written application to the Insurance Company within 31 days after your coverage would have terminated. The premium for the individual policy is the premium normally charged for a person of your age and class of risks.

For more information and to determine whether you are eligible for Dependent Life Insurance Conversion, as well as for the necessary forms, contact the Fund Office.

PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The insurance benefits described in this section are funded by a premium paid by the Health Fund to an insurance company, currently Metropolitan Life Insurance Company. The following is a summary description of the policy which is subject to the terms of the policy itself.

BENEFIT – If, as a result of an accidental injury that occurs while you have Personal Coverage, you incur the loss of life, limb or sight within one hundred eighty days following the injury, the Insurance Company will pay the benefit specified in the following Schedule of Losses and Benefits. Benefits are payable to you, except that in the event of loss of life the benefit will be paid to your beneficiary.

Payments will be made for each loss without regard to previous losses, except as provided in this paragraph. The total amount payable for all losses resulting from any single accident will not exceed the Principal Sum shown in your particular Schedule of Benefits (see pages 17 and 20).

Loss of Life..... Principal Sum
Loss of Two Hands ..... Principal Sum
Loss of Two Feet ..... Principal Sum

Loss of Sight of Two Eyes	Principal Sum
Loss of Speech and Hearing in Both Ears	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Sight of One Eye	Principal Sum
Loss of One Foot and Sight of One Eye	Principal Sum
Quadriplegia	Principal Sum
Loss of One Arm or One Leg	75% of the Principle Sum
Paraplegia or Hemiplegia	One-Half the Principal Sum
Loss of One Hand	One-Half the Principal Sum
Loss of One Foot	One-Half the Principal Sum
Loss of Sight of One Eye	One-Half the Principal Sum
Loss of Speech	One-Half the Principal Sum
Hearing in Both Ears	One-Half the Principal Sum
Uniplegia	One-Quarter the Principal Sum
Thumb and Index Finger of Same Hand	One-Quarter the Principal Sum
Coma	1% up to 60 months

Loss of a hand or foot means severance at or above the wrist or ankle joint, respectively, and loss of sight means total and irrecoverable loss of sight.

"Principal Sum" is the amount shown in your Schedule of Benefits for Personal Accidental Death and Dismemberment Insurance. The amount paid under this provision for loss of life is in addition to any amounts that may be payable from your Personal Life Insurance.

BENEFICIARY – You alone have the right to designate your beneficiary by completing a beneficiary designation form. You may change that designation at any time by completing a change of beneficiary form. The necessary forms are available at the Fund Office. Be sure to clearly identify your beneficiary. If two or more individuals are to share a death benefit, you must specify the portion that is to be paid to each person. If you have not named a beneficiary, if your beneficiary is no longer living, or if your beneficiary is unable to give a valid release, your coverage will be paid in accordance with the terms of the insurance policy.

LIMITATIONS – No Personal Accidental Death and Dismemberment Insurance benefit will be payable for a loss resulting from or caused directly wholly or partly by any of the following causes:

1. Disease, or bodily or mental infirmity, or medical or surgical treatment of such conditions.

2. Ptomain, or bacterial infections except pyogenic infections that occur through an accidental wound.

3. Suicide or intentionally self-inflicted injury while sane or insane. Participation in the commission of a felony.

4. Any act of war, whether declared or undeclared.

SICKNESS AND ACCIDENT BENEFIT

If, while you are covered and actively at work, you become unable to work due to accidental bodily injury, disease or pregnancy, the Health Fund will pay you the amount of Sickness and Accident Benefit shown in your Schedule of Benefits each week. Benefits will begin on the first day you are forced to miss work, if due to accidental injury for which you received treatment within 72 hours, or on the earlier of the eighth day you are off work or the day you are first hospitalized, if due to disease or pregnancy, and will continue while you remain unable to return to work for up to 26 weeks, provided you remain eligible by employer contributions or COBRA payments. If you remain unable to return to work as the result of a separate accidental bodily injury, disease or pregnancy occurring while you are off work, your benefits may continue, but not beyond the original 26-week period.

Successive absences from work separated by less than four weeks of continuous full-time active work shall be considered as one period in determining the benefits available to you, unless the subsequent absence is due to an injury or disease entirely unrelated to the causes of the previous absence and commences after you return to full-time active work.

LIMITATIONS – Sickness and Accident Benefits will not be payable for disability due to any of the following causes:

1. Injury, disease or pregnancy for which you are not under treatment by a physician.

2. Disease or injury for which you are entitled to benefits under any Workers' Compensation Law or Act. It is presumed that any injury or disease arising out of or in the course of your employment is covered by Workers' Compensation unless the participant has taken all legally available steps to challenge any contrary determination.

3. Benefits cease to be payable once you have retired under any pension plan maintained wholly or in part by your employer, including the Hagerstown Motor Carriers and Teamsters Pension Plan.

ADOPTION EXPENSE BENEFIT

The Adoption Expense Benefit provides you with a single sum payment to help defray the cost of adopting a minor child. The amount of the benefit is shown in your Schedule of Benefits.

LIMITATIONS – The Adoption Expense Benefit is not payable for the following:

1. Adoption of an individual 18 years of age or older.

2. Adoption of an individual to whom you or your Spouse is related by blood or marriage.

DENTAL EXPENSE BENEFIT

If, while a covered individual, you, your Spouse, or any of your covered Dependents incur Covered Dental Expenses (other than for orthodontics), as defined below, your coverage will pay for such expenses at the rate shown in your Schedule of Benefits, up to the annual maximum and subject to any other limitations (Note: The annual deductible is not applicable to Covered Dental Expenses). Children age 17 and under have no annual cap (except for the $1,000 lifetime cap on orthodontia); however, they are limited to two examinations, cleanings and bite-wings per calendar year and subject to standard medical protocols and reasonable and customary limitation. In addition, any course of treatment for your children age 17 and under that exceeds $1,000 must be pre-approved by the Fund's dental consultant in order to be covered. Pre-approval forms are available from the Fund Office, which should be filled out by your dentist.

The Trustees may approve, on appeal, dental services over $1,000 without pre-certification if the dental services are provided on an emergency basis. Consult page 49 for instructions on how to submit an appeal. Non-emergency dental services over $1,000 will still require prior authorization in order to be covered by the Fund.

If you or any of your Dependents incur the expenses of a dentist's or doctor's fee for orthodontic treatment or services, the Fund will pay 50% of such expenses, subject to the Orthodontic Lifetime Maximum shown in your Schedule of Benefits, and all other applicable limitations. (Note: Retired Employees do not receive coverage for orthodontic treatment.)

The total benefit which will be paid for all of a covered individual's Covered Dental Expenses incurred during a calendar year will not exceed the Maximum Dental Expense benefit shown in your Schedule of Benefits.

COVERED DENTAL EXPENSES – Covered Dental Expenses are reasonable charges made for any necessary dental service.

LIMITATIONS – Expenses due to the following are not Covered Dental Expenses:

1. Expenses for which benefits are payable under any other Health Benefit provisions of the Health Fund or which may otherwise be applied to any co-insurance factor or deductible.

2. Any part of an individual's expense for dental treatment or services that exceeds the reasonable value of such service or treatment as determined by the Trustees.

3. Treatments or services rendered by other than a licensed dentist or physician, except the approved services performed by a licensed dental

hygienist performed under the supervision and direction of a licensed dentist and/or physician.

4. Treatments or services that are partially or wholly performed for cosmetic reasons.

5. Treatments or services for children age 17 and under with a total value exceeding $1,000.00 that have not been submitted for pre-determination of benefits by the Fund Office and approved by the Fund's dental consultant.

6. Provision of dentures more often than once every five years.

7. Treatments or services that do not meet the basic and/or customary standards of dental care as determined by the dental consultant.

8. Topical fluoride application for patients over 16 years of age.

9. Prosthetic appliances and the fitting of such appliances if ordered while the covered individual was not insured.

10. Replacement of a lost or stolen prosthetic device.

11. For active employees and their eligible dependents, panorex in excess of one every three calendar years.

12. Dental examinations, cleanings and bite-wing x-rays in excess of two per calendar year.

VISION CARE BENEFIT

If, while a covered individual, you, your Spouse, or any of your Dependents incur Covered Vision Expenses, as defined below, your coverage will pay a benefit in the amount of such expense, subject to the copayment and maximum benefit limitation shown in your Schedule of Benefits. (Note: The annual deductible is not applicable to Covered Vision Expenses.)

COVERED EXPENSES – Covered Vision Expenses are charges for necessary vision care as listed below:

1. Eye examinations by a licensed ophthalmologist or optometrist.

2. Lenses (including contact lenses) prescribed by a licensed ophthalmologist or optometrist.

3. Frames.

LIMITATIONS – Vision Care provisions are subject to the Health Benefit General Limitations. In addition, expenses due to the following are not Covered Vision Expenses:

1. Examination, lenses or frames received in or from an institution owned or operated by the federal government (unless otherwise required by applicable federal law).

2. Non-prescription glasses or sunglasses.

3. Routine yearly examination required by an employer in connection with your, your Spouse's, or your Dependent's occupation.

4. Expenses in excess of the applicable maximum benefit limitation for the one or three year period, as applicable.

5. Keratotomy.

PRESCRIPTION DRUG PLAN

The prescription drug plan provides prescription drug benefits for all participants in the Fund. In general, this benefit covers all medications which, by federal law, are obtainable only with a prescription, as well as insulin and syringes and needles for insulin injection obtained with a prescription.

The Fund will pay the cost of a prescription drug, subject to the copayment shown in the Schedule of Benefits. In addition, if your prescribed medication is available in a less expensive generic equivalent, and you choose to take a more expensive brand-drug, you will be responsible for paying some or all of the additional cost. See explanation of the Generic Drug program below.

The Fund's prescription benefit is provided through CVS Caremark. CVS Caremark will issue you a Prescription Drug Card, which you can use at any pharmacy that participates in CVS Caremark's network. You should present your Prescription Drug Card to your participating pharmacist at the time you pay for your prescription drugs. Your participating pharmacist will charge you only your copayment for your prescription. You can get a list of pharmacies participating in the CVS Caremark network by calling 1-888-790-8086.

In the event you use a non-participating pharmacy, or if for any reason you do not have with you your valid Prescription Drug Card, you can pay your pharmacist the full price, and submit your claim to the Fund Office within one year of the date the prescription drug was obtained. The prescription will be paid in the same manner as a claim for medical expenses, so that you may not be fully reimbursed for the cost of the drug less the copayment.

The copayment for prescription drugs is 20%, subject to a *minimum* copayment depending upon your Schedule of Benefits. The maximum copayment per person per

calendar year is stated in each Schedule of Benefits. Minimum copayments for each Schedule of Benefits will depend upon whether a drug is a generic drug, a "preferred" brand-named drug or a "non-preferred" brand named drug. The lowest copayment will be charged for generic drugs, and the highest for non-preferred brand-named drugs. You may obtain a list of preferred and non-preferred brand-named drugs from the Fund Office. Notwithstanding any other provisions in the plan, the copayment for prescription proton pump inhibitors and second-generation antihistamines deemed "medically necessary" is 50%.

If you have any problems using your prescription card, you may contact CVS Caremark at 1-888-790-8086. If your problems cannot be resolved please contact the Fund Office.

GENERIC DRUG PROGRAM – If a prescription drug prescribed by your physician is available in a generic version approved by both the federal Food and Drug Administration and the state regulatory agency, the Health Fund will only pay the cost of the generic drug (less the copayment described in the Schedule of Benefits). Although you can still buy the more expensive brand-name drug, you will be responsible for paying the extra cost.

If you use a brand-named drug when a chemically identical, generic equivalent is available, you will be required to pay the additional cost of the brand-named drug, *unless* you can establish that use of the brand-named drug is medically necessary.

FLU SHOTS - You and your eligible dependents (age 18 and over) can get the **Injectable Seasonal Flu Vaccine (Quadrivalent)** *at no cost to you*. Just present your Health & Welfare prescription card at any participating pharmacy. There is no copay.

Flu shots are available at pharmacies only during certain periods of the year. Consult your physician to determine when to obtain your flu shot each year.

Applicable law in certain states restrict whether pharmacists may administer flu shots to children under the age of 18. Therefore, if you wish to have your eligible minor children receive the flu shot, you have several options:

- ✓ Visit a participating pharmacy with a medical professional – nurse or doctor – such as a Minute Clinic.

- ✓ If your state allows administration of flu vaccines by a pharmacist to children under 18, visit a participating pharmacy and obtain a flu vaccine from a pharmacist.

- ✓ Visit your child's doctor and pay for the visit and vaccine. You can then file a claim with the Fund Office for reimbursement of the vaccines and associated office visit. *The office visit will be paid in full up to the allowable amount (PPO allowable or UCR).*

You may also get your shots/vaccines at your physician's office and file a claim for reimbursement. If you have any questions, please contact the Fund Office at (301) 733-2602 or toll free at (800) 962-3972.

LIMITATIONS – The Prescription Drug Plan does not pay for the following:

1. Over-the-counter drugs or drugs that may otherwise be obtained without a prescription.

2. Injectable drugs, syringes or needles (except for insulin and syringes and needles to be used for insulin injection, obtained with a prescription). Coverage of injectable drugs (other than insulin and pre-approved life-sustaining drugs) will only be provided through the Plan's major medical provisions, and not through the prescription card. Insulin and other life-sustaining drugs that are pre-approved by the Fund will continue to be covered through the prescription card.

3. Immunological (allergy) agents.

4. Appliances.

5. Drugs prescribed for a use other than that for which they have been approved by the United States Food and Drug Administration.

6. Any quantity in excess of the amount necessary for 30 days or any quantity in excess of a 90-day supply of Maintenance medications by Mail or CVS Store with Maintenance Choice.

7. Medications provided by someone other than a licensed pharmacist.

8. Drugs for impotence or sexual enhancement.

9. Proton pump inhibitors and second-generation antihistamines are not covered, *unless* you can establish that use of the brand-named drug is medically necessary.[9] Notwithstanding any other provisions in the plan, the copayment for such prescription drugs is 50%.

10. Compound Medications - A Compound Medication is one that is made by combining, mixing or altering ingredients to create a customized medication that is not otherwise commercially available.

    Due to the lack of U.S. Food and Drug Administration (FDA) approval for many of the ingredients included in typical Compound Medications and their high cost, Compound Medications are not be covered by the Fund. You will be responsible for the full cost of such medications.

[9] Medical necessity will have to be demonstrated to the Plan's medical consultant, including a demonstration that over-the-counter drugs are ineffective. It is not sufficient for your physician to write "Dispense as Written" on your prescription.

11. Unapproved Topical Analgesics - A Topical Analgesic is a medication applied to the surface of the skin for the temporary relief of minor aches and muscle pains, often the result of:

- Arthritis
- Simple backache
- Strains
- Muscle soreness and stiffness.

The Fund will only cover Topical Analgesics that are approved for that purpose by the FDA. If not FDA approved, **you will be responsible for the full cost of this medication.**

The Prescription Drug Card remains the property of CVS Caremark, and must be surrendered to the Fund Office or to CVS Caremark if your eligibility ceases. You are responsible for any claims made after your eligibility terminates.

HEALTH COVERAGE

Health coverage for Participants and Beneficiaries is self-paid by the Fund using the CareFirst Blue Cross/Blue Shield (BCBS) Preferred Provider Organization.

The Fund has joined in the CareFirst Blue Cross/Blue Shield Preferred Provider Organization. This PPO is a network of hospitals, physicians and other medical providers who meet CareFirst Blue Cross/Blue Shield standard of excellence and who have agreed to limit the fees that they charge. By using a PPO provider, you can ensure that you receive the finest medical care, while helping both you and the Fund save money.

To find a participating provider visit the CareFirst website at www.carefirst.com for the most up-to-date listing and to determine if your provider is in the CareFirst BCBS network. If you are in Maryland, DC or Northern Virginia you may also contact CareFirst at (800) 235-5160.

Participants outside the Local area CareFirst network (considered "FlexLink") should call 888-444-8115 for assistance is locating a doctor or to verify if your provider is in the Blue Cross/Blue Shield network. You may also access this information on-line by going to www.carefirst.com, click on "Members", then "Find Providers". You can then search by provider type (medical or facilities) depending on your needs.

WELLNESS PROGRAM

All eligible participants are required to enroll in the Wellness Program that is designed to help employees and their family members improve their overall health and access all of the healthcare services they need. The Fund has partnered with Healthcare Strategies (HCS), an independent company, to make their *HealthReach* program available to plan participants. *HealthReach* provides ongoing education, support, and mentoring to employees and their covered dependents that live with challenging medical conditions such as diabetes, heart disease, cancer and others.

The goal of the Fund's Wellness Program is to improve the overall health of participants and their dependents, thus achieving a favorable impact on the cost of our medical plan — which will enable the Fund to continue to provide competitive benefits at an affordable cost.

All Plan participants are required to enroll in this program. For Participants who do not enroll the deductible for the current calendar year and any future calendar years that you do not enroll will be $500 individual/$1000 family. If you enroll but do not cooperate with HCS, then your calendar year deductible will be $500 individual/$1000 family for the calendar year that you do not cooperate and the next calendar year.

If you are selected by HCS to participate in the program, a *HealthReach* Registered Nurse Care Manager will contact you to schedule a phone appointment and offer program services to you. Your participation is completely confidential.

DEDUCTIBLE AMOUNTS

For Each Covered Individual – The Individual Deductible Amount shown in your Schedule of Benefit is the amount of Covered Medical Expenses that must be incurred by a covered individual within a calendar year before a benefit is payable for subsequent expenses incurred that year.

Deductible Amount Carryover – Covered Medical Expenses incurred in the last three months of a calendar year and applied to a covered individual's Deductible Amount requirement for that year will also be applied to that individual's Deductible Amount requirement for the following calendar year.

Family Members in One Accident – If two or more members of a family (you, your Spouse, and your covered Dependents) incur Covered Medical Expenses in a calendar year as a result of injuries sustained in the same accident, and if the amount of such expenses applied toward Individual Deductible Amounts equals the Individual Deductible Amount shown in your Schedule of Benefit, each family member will be deemed to have met his Individual Deductible Amount requirement with respect to Covered Medical Expenses due to the accident and incurred in that or the next calendar year.

Family Deductible Amount Limit – If two or more members of a family (you, your Spouse, and your insured Dependents) incur Covered Medical Expenses in a calendar year (not including Deductible Amount Carryover from a prior year), and if the portion of such expenses applied toward Individual Deductible Amounts requirements equals the Family Deductible Amount shown in your Schedule of Benefits, all of your family members shall be deemed to have met the Individual Deductible Amount requirement with respect to Covered Medical Expenses incurred in that year.

HOSPITAL PRE-ADMISSION CERTIFICATION

The Trustees have retained American Health Holdings to administer the Fund's hospital pre-admission certification program. The purpose of this program is to protect your health and the financial integrity of the Fund by preventing unnecessary and potentially harmful medical treatment.

Procedures – When you need to be admitted to the hospital for:

1. Scheduled Admission
   Call the American Health Holdings office before your admission at (800) 641-5566.

2. Emergency Admission
   Call the American Health Holdings office within two (2) business days of your admission at (800) 641-5566.

Penalties – If you fail to notify American Health Holdings as required, the Fund will only pay sixty percent (60%) of what it would otherwise have paid toward your hospital stay. This penalty applies to all bills and charges associated with your admission.

COVERED MEDICAL EXPENSES

HOSPITAL EXPENSES : If, while a covered individual, you, your Spouse, or any of your Dependents incur expenses due to confinement in a hospital either:

1. as an inpatient due to accidental bodily injury or disease, or

2. as other than an inpatient for a surgical operation or for emergency treatment within seventy-two hours following accidental bodily injury;

your coverage will pay the following benefits for any one period of confinement:

1. Room and Board Daily Benefit -- the amount of room and board charges for a semi-private room, except that daily room and board charges for private accommodations will be covered up to $5 in excess of the hospital's average charge for a semi-private room; and

2. Miscellaneous Medical Charges -- charges for medical care and treatment provided by the hospital for other than room and board, including regularly provided nursing care, medications and lab fees, up to the maximum shown for such charges in your Schedule of Benefits. Such charges incurred while an inpatient shall, however, be considered for this benefit only if incurred during a period for which room and board benefits are payable. Also included are charges for ambulance transportation and an anesthetist's fees for administration of anesthesia.

HOME HEALTH CARE AND OTHER ALTERNATIVE CARE

Benefits will be provided for home health care, hospice care, or other forms of care that is in lieu of hospitalization, where approved in advance by the Fund Office.

SURGEON'S FEES

If, while a covered individual, you, your Spouse, or any of your Dependents incur expenses due to a doctor's fee for a surgical procedure performed because of accidental bodily injury or disease, the Health Fund will pay a benefit in the amount of such expense.

A "Surgical Procedure" is considered to be any medical service in the following categories:

1. the incision, excision or electro cauterization of any organ or part of the body;

2. the manipulative reduction of a fracture or dislocation;

3. the suturing of a wound; and

4. the removal by endoscopic means of a stone or other foreign object from the larynx, bronchus, trachea, esophagus, stomach, urinary bladder or ureter.

VOLUNTARY SECOND SURGICAL OPINION

If your physician has recommended surgery, the Fund will cover a visit to another qualified physician to determine whether the recommended surgery is necessary. The purpose of this benefit is to provide you with the means of preventing unnecessary surgery.

Benefits will not be provided for the following:

1. Consultation with a physician who has any financial affiliation or association with the physician who has recommended or who performs the surgery.

2. Consultation with a physician who is not qualified in the specialty necessary to properly evaluate the need for the recommended procedure.

3. Consultation with the physician who performs the surgery.

IN-HOSPITAL DOCTOR'S VISITS

The Fund will pay costs up to your Plan maximum benefit limitation incurred due to confinement in a hospital if you, your Spouse, or your Dependent was confined either:

1. as an inpatient due to accidental bodily injury or disease, or

2. as other than an inpatient for emergency treatment within seventy-two hours following accidental bodily injury.

IN-HOSPITAL CONSULTATION BENEFIT

Coverage is provided if the physician in charge of a case requests the assistance of a physician, other than an intern, a resident or an employee of the hospital, in the diagnosis or treatment of a condition which requires special skill or knowledge. Such benefit is provided only as an inpatient in a hospital or approved facility for convalescent or long-term illness care, provided such confinement is covered under the Plans' Hospital Expense or Extended Convalescent Care Expense Benefits.

PREGNANCY AND MATERNITY EXPENSES

In general, expenses related to pregnancy are treated in the same manner as expenses related to illness or injury. In addition, with respect to pregnancy, the word "Hospital" includes alternative birthing facilities under the supervision of a doctor or a licensed nurse-midwife.

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

EXTENDED CONVALESCENT EXPENSE BENEFIT

If while a covered individual and during a period of confinement in an "extended care facility" that began within fourteen days following at least three consecutive days of hospital confinement, you, your Spouse, or any of your Dependents incurred Covered Extended Convalescent Care Expenses, the Fund will pay benefits for the following:

1. Room and board, except private room charges in excess of the extended care facility's average charge for semi-private accommodations.

2. Routine nursing care provided by the extended care facility on other than a private duty basis.

3. Physical or speech therapy provided by the extended care facility or others under arrangements with the extended care facility.

4. Medical social services provided by the extended care facility.

5. Such drugs, biologicals, supplies, appliances and equipment as are normally provided by the extended care facility for the care and treatment of its inpatients.

6. Diagnostic and therapeutic services furnished the extended care facility's inpatients by a hospital, including medical services of a hospital intern or resident-in-training under the teaching program of a hospital with which the extended care facility has a transfer agreement, but not including any other medical care or treatment by a doctor, resident or intern.

7. Such other services necessary to the health of patients as are generally provided by the extended care facility.

PREVENTIVE CARE

All preventive care, as required by the Affordable Care Act will be covered at 100% if in-network and at 70% if out of network. To obtain a list of the services covered under this provision, please contact the Fund Office.

CHIROPRACTIC CARE BENEFIT

If you receive chiropractic care, including spinal manipulation and related services, whether that care is provided by a chiropractor, a physician, or any other qualified service provider, the Fund will provide payment up to the limitations set forth in your Schedule of Benefits. Benefits will not be provided in excess of the maximum limitations.

NERVOUS AND MENTAL DISORDERS

Treatment of nervous and mental disorders (including drug and alcohol treatment) is a covered medical expense. Such treatment is payable at the levels shown in the Schedule of Benefits. Remember; however, all inpatient admissions, including inpatient admissions for treatment of nervous and mental disorders, must be precertified. See pages 35 and 36 for an explanation of the precertification requirements.

MISCELLANEOUS MEDICAL EXPENSES

Covered Miscellaneous Expenses are expenses incurred in connection with the diagnosis and treatment of an illness or injury for the following medical services and supplies:

1. Treatment by a doctor.

2. Care and treatment furnished by a hospital, except daily room and board charges for private accommodations in excess of $5 above the hospital's average charge for a semi-private room.

3. Attendance of a registered graduate nurse who is not a member of your, or your Dependent's, immediate family or ordinary household. Nursing care where not provided by a registered graduate nurse will be a covered medical expense where provided by an appropriately trained and skilled nurse or other care provider and where approved in advance by the Fund Office.

4. Drugs and medicines obtainable only by a doctor's written prescription.

5. Diagnostic x-ray and laboratory service.

6. Oxygen and rental of equipment for its administration.

7. X-ray, radium and radioactive isotopes therapy.

8. Rental of durable medical equipment required for temporary therapeutic use. Under certain circumstances, the Fund may buy such equipment and lend it to a covered individual rather than rent the equipment.

9. Local transportation to or from a hospital when furnished by a hospital or a professional ambulance service where medically necessary.

10. Casts, splints, crutches, trusses and braces.

11. Prosthetic devices prescribed by a doctor, necessitated by an injury or disease occurring while covered by the Plan, and their replacement, if medically necessary.

12. Treatment by a physiotherapist under the supervision of a doctor.

13. Treatment for mental illness or functional nervous disorder by a psychiatrist or other psychotherapist licensed to offer such treatment.

14. Childhood immunizations required by state or federal law or by the educational institution for attendance by the child at school in the United States, and the associated cost of the physician's visit required to receive the covered immunization.[10]

15. Hearing aids when prescribed by a physician, no more often than once every five years. The Plans will pay no more than $850 per aid ($1,700 per pair). Batteries and expenses of maintenance are not covered.

16. Coverage of injectable drugs (other than insulin and pre-approved life-sustaining drugs).

[10] Unlike other Miscellaneous Medical Expenses, this benefit is available even though the expenses are not incurred in connection with the diagnosis and treatment of an illness or injury.

17. Coverage of a Hair Prosthesis at 80% of charges once per lifetime up to a maximum amount of $200.00 for a Member or eligible Dependent whose hair loss results from chemotherapy or radiation treatment for cancer when prescribed by the oncologist in attendance.

MEDICAL EXPENSE LIMITATIONS

Expenses due to the following are not Covered Medical Expenses:

1. Any part of the expense for medical services and supplies that exceeds the regular and customary charge or fair and reasonable value of such services and supplies as determined by the Fund.

2. Dental treatment, except oral surgery performed while a hospital inpatient, or necessary repair of natural teeth as a consequence of accidental injury that occurs while covered, or gingivectomy, apicoectomy, or surgical removal of impacted teeth.

3. Treatment for temporomandibular joint ("TMJ"), including all related expenses. Treatment for TMJ shall be covered only as a dental expense.

4. Prescription drugs dispensed by someone other than a licensed pharmacist.

5. Prescription drug copayments and deductibles (including extra expenses caused by the use of a brand-named drug), or any other prescription drug expense excluded from coverage under the Prescription Drug Benefit.

6. Health examinations (unless otherwise specifically covered), normal eye and ear examinations, and the fitting of glasses.

7. Any illness, medical care, or treatment resulting from war, whether declared or undeclared.

8. Charges for chiropractic care (including spinal manipulation and all related services), whether performed by a chiropractor, a physician, or any other service provider, in excess of the Chiropractic Care limits. (See page 39 for additional explanation.)

9. Medical services or supplies not certified by a doctor as being necessary.

10. Expenses resulting from hospital confinement that is not recommended and approved by a doctor.

11. Personal expenses, such as telephone, television, guest meals, etc.

12. Treatment or surgery for cosmetic purposes, except repair of disfigurement as a consequence of disease or accidental injury that occurs while covered, or to restore a symmetrical appearance following a covered mastectomy.

13. Examinations that are not made or recommended by a doctor.

14. Emergency Room Charges for non-emergency services, or services for which emergency treatment was not required.

15. TENs units and other similar types of equipment.

16. Purchase or rental of equipment that is not primarily medical in nature, such as hot tubs, spas, tanning beds, sun lamps, air conditioners, humidifiers, treadmills, etc.

17. Custodial care, or care received in a nursing home, which is primarily custodial in nature.

18. Medical services or supplies primarily for dietary control or weight loss.

19. Treatment to reverse voluntary surgically induced infertility.

20. In vitro fertilization procedures or any care or services associated with such procedures.

21. Services administered by certified massage therapists.

EXTENDED BENEFIT

If you or any of your Dependents are totally disabled because of accidental bodily injury or disease on the date of discontinuance of coverage, expenses incurred during the continuance of total disability and within twelve months following such discontinuance of coverage due to that injury or disease will be considered for benefits as though such expenses had been incurred before discontinuance of coverage. This provision does not apply if your coverage (or coverage for similarly situated employees) terminates as a result of your employer's withdrawal from the Fund.

DEFINITIONS

For purposes of this booklet the word "doctor" shall include physician, as well as chiropractor[11] and certified nurse-midwife (where licensed under state law to perform the indicated service, unless otherwise indicated by the context), as well as other licensed health care providers as determined by the trustees.

"Total disability" means a disability which commences after the effective date of a covered individual's benefits and which prevents him or her from performing any and all duties of an occupation for compensation or profit.

A "Hospital" is an institution which:

1. provides day and night lodging and is primarily engaged in further providing diagnostic and therapeutic facilities for the diagnosis and treatment of injury or disease under the supervision of doctors,

2. regularly and continuously provides day and night nursing services by or under the supervision of registered graduate nurses,

3. is operated in accordance with the laws of the jurisdiction in which it is located pertaining to hospitals, and

4. is not primarily a place for rest, the aged or the mentally ill, or a nursing or convalescent home.

An "inpatient" is a covered individual who incurs a hospital charge for a day of hospital confinement in other than the outpatient department of the hospital.

"Extended care facility" means an institution, or its distinct part, lawfully operated under the full-time supervision of a doctor or registered graduate nurse, which:

1. is primarily engaged in providing accommodations for skilled nursing care day and night for compensation from patients recovering from injury or disease,

2. admits patients only upon the recommendation of a doctor and has a written transfer agreement in effect with one or more hospitals,

3. has doctor's services available at all times under an established agreement; has established procedures for dispensing and administering drugs and biologicals; and maintains adequate medical records of all patients, and

4. is not, other than incidentally, a place for rest, the aged, or the mentally ill.

[11] See page 39 for special chiropractic limitations.

"Illness" shall mean a bodily disorder, accidental injury or mental infirmity. All such conditions existing concurrently or successively which are due to the same or related causes shall be considered one illness.

PART D: HOW TO FILE YOUR CLAIM
NOTICE, PROOF AND PAYMENT OF CLAIM

HOSPITAL PRE-ADMISSION CERTIFICATION

When you need to be admitted to the hospital for:

1. Scheduled Admission

   Call the American Health Holdings office before your admission at 1-800-641-5566

2. Emergency Admission

   Call the American Health Holdings office within two (2) business days of your admission at 1-800-641-5566

See pages 35-36 for a more complete explanation of the Pre-Admission Certification program, and a statement of the penalties for failure to comply with the certification procedures.

THE CLAIM FORM

Get a claim form from the Fund Office. Instructions for filling it out will be found on the front or back of each form.

A new claim cannot be processed without a FULLY COMPLETED claim form. Unanswered questions will delay benefit consideration until the missing information is obtained.

Forms completed by your doctor or the hospital must go to the Fund Office for processing.

The requirements for proof pertaining to Personal Life Insurance coverage are described elsewhere in this booklet. The following provisions are applicable to the other Benefits provided by the Health Fund.

NOTICE OF CLAIM AND PROOF OF EXPENSE

All claims must be filed and received in the Fund Office within one year of the date upon which the services were performed. In addition, any additional information needed by the Fund in order to complete the processing of the Claim must be submitted within one year of the initial claim. Submission of a claim after expiration of the one-year period will result in denial of the claim. Claims must be submitted on forms acceptable to the Fund. Claim forms are available at the Fund Office.

You must submit with your claim form any other materials necessary for the processing of your claim. This includes the bill for which you seek payment or reimbursement, and any other materials that the Fund Office may request.

The Fund reserves the right and opportunity to examine the individual whose injury or disease is the basis of claim when and as often as it may be reasonably required and, in case of death, the right and opportunity to order an autopsy if not prohibited by law.

PAYMENT OF CLAIM

No action at law or in equity shall be brought to recover from the Health Fund prior to 60 days after proof of expense has been furnished in accordance with these provisions, and until the administrative remedies provided under the Fund have been exhausted. Nor shall such action be brought at all unless brought within 3 years following the time within which proof of expense is required by these provisions.

If any time limitation specified above is less than that permitted by federal law, such limitation is hereby extended to agree with the minimum period permitted by such law.

All benefits for other than loss of life will be paid to you or the provider, and benefits for loss of life will be paid to your beneficiary. In the event you are a minor, or otherwise unable to give a valid release, benefits will be paid in accordance with the terms of the Fund or, if applicable, the insurance policy.

All accrued benefits will be paid upon receipt of satisfactory proof of expense. Payment of benefits for a continuing loss will be paid at regular intervals occurring at least as often as once each month after receipt of satisfactory proof of expense and during the period for which the Fund is liable, and any balance remaining unpaid at the end of such a period will be paid at that time.

PROHIBITION OF ASSIGNMENT OF BENEFITS

No benefit under the Fund or right under ERISA may be assigned or transferred to another party by a participant or beneficiary. No attempted assignment will be recognized by the Fund. Nothing in this SPD, or the Fund's Trust Agreement shall be construed to make the Fund, the Trustees, Local 992, or any Employer liable to any third-party to whom a participant or beneficiary may be liable for medical care, treatment, or services. The Fund may make direct payments to a medical provider. A direct payment by the Fund to a medical provider does not make the provider an assignee, and in no way confers upon the provider any rights that a participant has under the Plan or ERISA.

MEDICAL BILLS

Your doctor will generally show his charges on the claim form. For other medical charges which do not appear on the claim form you should submit THE ACTUAL BILLS.

Those bills must be itemized to show:

1. Person or firm making the charge.

2. The qualifications and or certifications of the provider to offer the services charged for.

3. Name of patient.

4. Dates of treatment.

5. Services rendered and amount of charge.

6. Diagnosis.

DON'T send canceled checks or cash register receipts. These cannot be accepted.

DON'T submit a list of expenses prepared by yourself. The actual bills will be needed.

DON'T submit bills covering several members of your family. Separate bills are required for each patient.

DON'T accumulate your bills for submission at the end of the year. Submit your bills periodically if your medical treatment covers a long period of time.

Address of Fund Office and Trustees:

Hagerstown Teamsters and Motor
Carriers Health and Welfare Fund
10312 Remington Drive
Hagerstown, MD 21740

CLAIM REVIEW PROCEDURE

THE FUND OFFICE'S INITIAL DECISION - If a claim is denied or partly denied, you will be notified in writing and given the opportunity for a review. Depending upon the type of claim you incur, your claim will be addressed and you will be notified of how the Fund treated your claim within the following time frame.

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Medical, Prescription Drug, Dental, Vision, Mental Health Benefits or similar benefit		
- Urgent Claims (as medically determined)	72 hours	None
- Pre-Service Claims	15 days	15 days
- Post-Service Claims	30 days	15 days
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Life Insurance, Accidental Death and Dismemberment	90 days	90 days
Short Term Disability Benefits	45 days	Two 30-day extensions

If the Fund Office needs more information to complete processing of your claim, you will be notified within a reasonable period of time. Extensions are permitted if the Fund Office determines that special circumstances beyond its control require an extension of time for processing the claim. In such a case, you will be provided with written notice of the extension prior to the time noted in the "Extension Permitted" column above.

If your claim is processed such that all or a portion of your claim is denied (called an "Adverse Benefit Determination"), your explanation of benefits form will contain the following information.

1. An explanation as to why the claim was denied or reduced;

2. The plan provision for which the denial or reduction was based;

3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

4. A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after you have exhausted the appeals process;

5. The identity of any medical or vocational expert(s) whose advice was obtained on behalf of the Plan in cases where the benefit was denied partially or fully;

6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and

7. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

APPEALING A CLAIM

If your claim is denied in a manner in which you deem inappropriate, you or your duly authorized representative may appeal the denial to the Board of Trustees. If your claim involves medical or other health benefits or Weekly Sickness and Accident benefits, your written appeal must be submitted within 180 days of receiving the denial notice. If your claim is for Accidental Death and Dismemberment benefits, your appeal must be submitted within 60 days of the denial.

You may submit written comments, documents, records, and other information relating to the claim for benefits. In addition, upon request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits and a listing of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the benefit determination.

DETERMINATION ON APPEAL

The Board will determine your appeal within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Claim Denial	Extension Permitted
Medical, Prescription Drug, Dental, Vision, Mental Health		
- Urgent Claims	72 hours	None
- Pre-Service Claims	30 days	None
- Post-Service Claims	Board meeting (if appeal received 30 days prior)	Next Board meeting
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Life Insurance, Accidental Death and Dismemberment	Board meeting (if claim received 30 days prior)	Next Board meeting

Short Term Disability	Board meeting (if claim received 30 days prior)	Next Board meeting

You will be notified of the results of an appeal review as soon as possible but no later than five days after the Trustees complete their review.

If the denial of a claim for medical, dental, or vision benefits was based in full or in part on a medical judgment, the Board will discuss the matter with a health care professional who was not consulted when the original claim denial decision was reached, is not the subordinate of anyone who was consulted, and who has the appropriate training and experience in the field of medicine involved in the medical judgment. (i.e. cardiologist for heart related matters). In making the determination on appeal, the Board will not allow the outcome of the original denial decision to impact their appeal review.

On behalf of the Trustees, the Fund Office will send you a letter advising you of the Trustee decision. If the decision still results in a part or all of your claim being denied, the letter will contain the following information:

1. An explanation as to why the appeal was denied;

2. The plan provision for which the appeal result was based;

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

4. An internal rule, guideline, protocol, or other similar criterion if one was relied upon in making the adverse determination, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

5. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

6. A statement of your right to sue under ERISA Section 502(a).

INDEPENDENT REVIEW OF DENIED APPEAL

Once your appeal rights as described above are exhausted, you can ask for an independent external review unless the denial, reduction, termination, or a failure to provide payment for a benefit was based on a determination that you or your Dependent or Beneficiary failed to meet the requirements for eligibility under the Plan. The following procedure will apply:

1. If the Trustees deny your claim, you may file a request for external review within four months of the claim denial.

2. Within five business days of receiving the request for external review, the Fund Office will complete a preliminary review regarding your eligibility for coverage, exhaustion of internal appeals, and completion of forms required for an external review. If your request does not satisfy the preliminary review elements, the Fund Office must notify you within one business day after the preliminary review. If the request is incomplete, you will have at least 48 hours or up to the initial four-month period, to perfect the request for external review. If the request for external review is expedited, the Fund Office must respond immediately.

3. The Fund has contracted with an unbiased accredited Independent Review Organization (IRO), which is required to

    a. Use legal experts when appropriate.
    b. Timely contact you in writing with information about the review, including how to submit additional information.
    c. To consider documentation provided by the Fund Office relevant to your claim. The Fund Office must submit this material within five business days of the request for external review or, for an expedited review, as soon as possible.
    d. To review your claim de novo, considering all relevant available information, including applicable practice standards and opinion from the IRO's own clinical reviewers. The IRO must send written notice of its decision to you and to the Fund Office within 45 days of the request for external review. Notice of the decision must explain the potential for judicial review.

4. If the IRO reverses a claim denial, the Fund must immediately cover the claim. The IRO's decision is binding on the Fund.

STATUTE OF LIMITATIONS

Any legal action brought against the Fund or the Trustees under Section 502 of ERISA must be filed no later than 1 year from the date of the Fund's final determination on appeal.

OVERPAYMENTS

If the Fund pays a claim in error or overpays a claim to, for, or on behalf of a Participant, the Trustees shall have the authority to recover such overpayment or erroneous payment from the Participant to or for or on whose behalf the claim was paid or from any medical provider, plan or insurance company to whom the payment was made by any means appropriate, entirely at the Trustees' discretion. In addition, the Trustees shall have the right to offset any amounts reimbursable on behalf of the Employee or his Dependents from any future benefits payable to or for the Employee or his Dependents. The Fund shall have a constructive trust and/or an equitable lien upon any amounts that the Fund may overpay, and the Participant, medical provider, or insurance company is deemed to hold any such overpayment in trust for the benefit of the Fund until paid to the Fund. If the Trustees are required to file suit in order to recover any such amounts, and should they prevail in such action, they shall have the right to recover from the defendants therein all reasonable legal and other professional fees and costs incurred.

PART E: IMPORTANT INFORMATION REQUIRED BY ERISA

The Employee Retirement Income Security Act of 1974 ("ERISA") requires that certain information be furnished to each participant in an Employee Benefit Plan. The Hagerstown Teamsters and Motor Carriers Health and Welfare Fund is a group health plan within the meaning of ERISA. This booklet is your Summary Plan Description.

The purpose of the Hagerstown Teamsters and Motor Carriers Health and Welfare Fund is to collect contributions from numerous employers that contribute to the Fund through collective bargaining agreements and participation agreements. Contributions to these Plans are made by the Participating Employers and, under certain circumstances, by the participant only. Contributions are based on negotiated contribution rates as set forth in the Collective Bargaining Agreements or Participation Agreements. The contributions received are invested and used to provide benefits to those persons meeting the eligibility requirements previously set forth.

Benefits provided by the Fund are determined by the Board of Trustees. The Board is empowered to amend the Plan at any time, and to impose any conditions, fees, or co-payments on eligibility or on the provision of benefits, as they deem advisable. All determinations by the Board of Trustees are final and binding on all parties.

The Fund may be terminated either by the Trustees or by the Employers and the Union in accordance with the terms of the Fund's Agreement and Declaration of Trust. The Trustees are authorized to terminate the Fund when there is no longer in force and effect any Collective Bargaining Agreements between an Employer and the Union requiring contributions to the Fund. The Employers and the Union may collectively terminate the Fund at least 30 days prior to the Funds' anniversary date. Upon termination, all assets of a Fund must be used to pay the expenses and obligations of the Fund; any remainder must be used to provide for the continuance of health benefits until assets are exhausted. No Fund asset may be used for purposes other than the exclusive benefit of Participants and Dependents.

This booklet also serves as the Plan Document, subject to the following:

1. Amendments adopted after this booklet was prepared are set forth in resolutions by the Board of Trustees and/or summaries of material modifications.

2. Certain benefits (including life insurance and accidental injury and dismemberment benefits) are provided through insurance policies and/or contracts.

This booklet is effective January 1, 2019, and replaces all prior booklets and notices.

PLAN IDENTIFICATION NUMBER
E.I.N. 52-0629995 Plan No. 501

This Plan is provided through the Board of Trustees of the Hagerstown Teamsters and Motor Carriers Health and Welfare Fund whose address is:

10312 Remington Drive
Hagerstown, MD 21740
(301) 733-2602

The Administrator for the Health Fund is (as defined by ERISA Section 3(16)) the Board of Trustees of the Hagerstown Teamsters and Motor Carriers Health and Welfare Fund. The Board of Trustees of the Plan are:

UNION TRUSTEES

Tom Krause, Chairman
Teamsters Local Union No. 992
10312 Remington Drive
Hagerstown, Maryland 21740

Daniel Craytor
Teamsters Local Union No. 992
10312 Remington Drive
Hagerstown, Maryland 21740

Daryl Jamison, Alternate
Teamsters Local Union No. 992
10312 Remington Drive
Hagerstown, Maryland 21740

EMPLOYER TRUSTEES

Tom Ventura, Secretary
c/o Fund Office
10312 Remington Drive
Hagerstown, Maryland 21740

Dennie Gandee
c/o Fund Office
10312 Remington Drive
Hagerstown, Maryland 21740

The service of legal process may be made upon a Fund Trustee or upon the Plan Administrator. Service should be addressed to the office of the Board of Trustees at 10312 Remington Drive, Hagerstown, Maryland 21740. The Plan Year starts on July 1 and ends June 30 and consists of an entire twelve-month period for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

The Fund is maintained pursuant to one or more Collective Bargaining Agreements between the General Teamsters and Allied Workers, Local Union No. 992 and the various Employers that have entered into labor contracts with the Union. The Collective Bargaining Agreements, the names of the parties thereto and the expiration dates may be reviewed at the Fund Office; a copy of any such Agreement may be obtained upon written request to the Board of Trustees.

Upon written request, the Administrator will furnish you with information as to whether a particular Employer participates in the Health Fund and, if so, its address.

CONTRACT ADMINISTRATOR:
Carday Associates, Inc.
Now a part of Benesys, Inc.
10312 Remington Drive
Hagerstown, Maryland 21740
301-733-2602

ATTORNEYS:
Mooney, Green, Saindon, Murphy & Welch
1920 L Street, NW
Washington, DC 20036

Morgan Lewis and Bockius, LLP
1111 Pennsylvania Avenue, NW
Washington, DC 20004

INDEPENDENT AUDITOR:
Novak Francella, LLC
7226 Lee Deforest Drive, Suite 201
Columbia, MD 21046

ACTUARY:
The McKeogh Company
Four Tower Bridge, Suite 225
West Conshohocken, PA 19428

PREFERRED PROVIDER ORGANIZATIONS:
CareFirst Blue Cross/Blue Shield
10455 Mill Run Circle
Owings Mills, MD 21117
(800) 235-5160

HOSPITAL PRE-CERTIFICATION ORGANIZATION:
American Health Holdings, Inc.
100 West Old Wilson Bridge Road, Third Floor
Worthington, Ohio 53085
(800) 641-5566

PHARMACY BENEFIT MANAGER:
CVS/Caremark
One CVS Drive
Woonsocket, RI 02895
(888) 790-8086

LIFE INSURANCE COMPANY:
Metropolitan Life Insurance Company
200 Park Avenue
New York, New York 10166
(800) 638-6420

WELLNESS PROGRAM PROVIDER:
Healthcare Strategies, Inc.
9841 Brokenland Parkway, Suite 315
Columbia, MD 21046
(800) 582-1535

RIGHTS AND PROTECTION UNDER ERISA

As a participant in the Hagerstown Teamsters and Motor Carriers Health and Welfare Fund, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits and Security Administration.

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your Spouse, or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART F: Privacy Notice

The Fund makes every attempt to comply with the Department of Health and Human Services' Privacy Regulations, which were effective April 14, 2003. The following describes how the Fund Office may lawfully use or disclose your protected health information.

As part of its operations, the Hagerstown Teamsters and Motor Carriers Health and Welfare Fund (the group health plan, hereinafter referred to as "the Fund") creates or receives certain information about you relating to your physical or mental health, the provision of healthcare to you, and the past, present, or future payments for the provision of healthcare to you. The privacy practices and procedures below often refer to "protected health information." Protected health information is information that is identifiable to an individual.

The Fund is required by law to maintain the privacy of your health information.

The Fund protects your information from inappropriate use or disclosure. Our employees, and those of companies that provide certain services on our behalf, are required to comply with our requirements that protect the confidentiality of your protected health information. They may use or disclose your information only as permitted, such as to administer claims.

We will not use your information, or disclose your information to other companies for marketing or fundraising. However, we will use or disclose your information to another company or person for other reasons required or permitted by law. The following provisions describe how we may lawfully use or disclose your protected health information.

I. Uses and disclosures of your protected health information

A. Treatment, payment or healthcare operations

The Fund is permitted to use and disclose your protected health information for treatment, payment or healthcare operations, or to the Board of Trustees, as follows:

(1) Treatment. The Fund may make disclosures of your protected health information to a healthcare provider for the healthcare

provider's treatment purposes. For example, we may disclose the identity of an individual seeking approval of the drug Retin-A if over 26 years of age to ensure that it is not prescribed for cosmetic reasons.

(2) Payment. The Fund may use or disclose protected health information to any person or entity for the purposes of carrying out the Fund's payment activities. The Fund receives or discloses your health information to doctors or other healthcare providers, other insurance carriers and occasionally other third parties for payment purposes. For example, the Fund receives information from your doctor's office about your visit to the office and the diagnosis in order to make payment to the doctor on your behalf. The Fund may also disclose your information to a healthcare provider, another health plan, or health care clearinghouse for the payment activities of the entity that receives the information. We may disclose your information to another health plan, for example, for the purpose of coordinating their and our benefits.

(3) Health Care Operations. The Fund may disclose your protected health information for its health care operations. Health care operations include underwriting, contribution establishment and other activities relating to health insurance, arranging for legal services and compliance programs, business planning and business management. For example, as part of the Fund's health care operations, it may receive information from its care management company about an inpatient hospital stay. The Fund may also disclose protected health information to another health plan, health care clearinghouse or health care provider for the health care operations activities of the entity that receives the information, if both the Fund and the other entity either has or had a relationship with you, the protected health information pertains to such relationship, and the disclosure is

- for the purpose of conducting quality assessment and improvement activities; or
- for the purpose of health care fraud and abuse detection or compliance.

(4) Board of Trustees. The Fund may disclose your protected health information to the Board of Trustees (the plan sponsor) in order to manage and administer the Fund, including for payment and health care operations purposes. For example, the Board of Trustees participates in underwriting, contribution establishment, arranging for legal services and auditing, business planning, conducting cost-management and planning related analysis for managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies. The Board of Trustees has certified that it will not use or disclose

your protected health information other than as provided for in this Document or as required by law.

B. Other uses and disclosures required or permitted by law

(1) Secretary of Health and Human Services. The Fund will disclose your protected health information when required to do so by the Secretary of Health and Human Services or any other officer or employee of HHS to whom the authority involved has been delegated.

(2) Communications with You and Your Family. The Fund may disclose your information to you, or to your family members or close friends. If you are available, the Fund will ask for your oral agreement before it discloses information to family or friends, or, if you are unavailable, it will exercise its professional judgment in deciding whether it is in your best interest to discuss your information with family or friends. The Fund will only disclose information to family or friends to the extent of their involvement with your care.

(3) Disclosures Required by Other Law. The Fund may use or disclose your protected health information to the extent that such use or disclosure is required by law. For example, we may disclose your information in the course of a worker's compensation claim in which you are involved.

(4) Incidental Uses or Disclosures. The Fund may use or disclose protected health information as incident to a use or disclosure otherwise permitted or required by the HIPAA Privacy Standards.

(5) De-Identified Information. The Fund may use protected health information to create information that is not individually identifiable health information or to create information that is only identifiable in a limited way, or it may disclose protected health information only to a business associate for such purposes, whether or not such information is to be used by the Fund. If the information is identifiable in a limited way, such limited information will only be used for the purpose of research, public health, or health care operations.

(6) Business Associates. The Fund may disclose your protected health information to a business associate (such as the Fund's actuary, pharmacy benefit manager, and others) and may allow a business associate to create or receive your protected health information on its behalf, if the Fund has satisfactory assurance that the business associate will appropriately safeguard the information.

(7) Disclosures to Law Enforcement Officials. The Fund may disclose your information to a law enforcement official under the following circumstances:

- if a member of the Fund's workforce is a victim of a criminal act;

- in response to a court order;
- as evidence of criminal conduct;
- for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;
- if you are a victim of a crime (if possible, the Fund will obtain your permission to use or disclose your information);
- in compliance with laws requiring reporting of certain types of wounds or physical injuries.

(8) Judicial or Administrative Proceedings. The Fund may also disclose information in the course of any judicial or administrative proceedings so long as it has satisfactory assurance that you have notice that your information is being sought.

(9) Deceased Individuals. The Fund will protect your information even after you are deceased. The Fund may disclose your protected health information to a coroner or medical examiner, funeral director, or to an organ procurement organization in the event of your death.

(10) Serious Threat to Health or Safety. The Fund may use or disclose your protected health information, if the Fund, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or is necessary for law enforcement authorities to identify or apprehend you. The Fund may not disclose your information if they learn about the threat to health or safety through a request by you to initiate or to be referred for treatment, counseling, or therapy;

(11) Military. The Fund may use and disclose your protected health information if you are Armed Forces personnel or foreign military personnel for activities deemed necessary by appropriate military command authorities as published by notice in the Federal Register.

(12) National Security and Heads of State. The Fund may disclose your protected health information to authorized federal officials for the conduct of lawful intelligence, counterintelligence, and other national security activities authorized by the National Security Act (50 U.S.C. §401 *et seq.*) and implementing authority (e.g., Executive Order 12333) and to authorized federal officials for the provision of protective services to the President or other persons authorized by 18 U.S.C. §3056, or to foreign heads of state or other persons authorized by 22 U.S.C. §2709(a)(3), or for the conduct of investigations authorized by 18 U.S.C. §§871 and 879.

(13) Correctional Institutions and Inmates. The Fund may disclose your protected health information to a correctional institution or

a law enforcement official having lawful custody of you, if the correctional institution or such law enforcement official represents that such protected health information is necessary for the provision of health care to you, the health and safety of you or other inmates, or the health and safety of the officers or employees involved with you while in lawful custody.

(14) Disaster Relief. The Fund may disclose your protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. If you are present for, or otherwise available prior to, a use or disclosure for disaster relief and it does not interfere with the ability to respond to emergency situations, the Fund will give you the opportunity to agree or object to the use of your information.

(15) Public Health and Other Government Authorities. The Fund may disclose your health information to proper public health authorities and other government authorities in the following circumstances:

- a member of the Fund's workforce or a business associate may make a disclosure of protected health information to report unlawful conduct by the Fund;
- for reports of child abuse or neglect;
- if the Fund believes you to be a victim of domestic violence (if appropriate, the Fund will notify you before it reports this information);
- for public health activities or health oversight activities such as those regarding an FDA regulated product, or for the oversight of government benefit programs, such as Medicare.

II. Rights of the Participant, spouse and dependents 18 or over

(A) Inspect and Copy. You have the right to inspect and copy protected health information about yourself in a designated record set, except for psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding. The request for access to copy or inspect must be in writing. The Fund must act on a request for access no later than 30 days after receipt of the request (or 60 days if the information is kept off-site). If the Fund denies your request, we will provide information on your review rights and other information. If you agree in advance, the Fund may respond to your request by providing you a summary of the health information requested. If you request a copy of your protected health information or agree to a summary or explanation of such information, the Fund may impose a reasonable, cost-based fee to include the cost of copying (and labor), postage when you have requested the copies or summary or explanation be mailed, and the cost of preparing an explanation or summary of the protected health information. If the Fund does not maintain the protected health information that is the subject of your request for access, and the Fund knows where the requested information is maintained, the Fund will inform you where to direct the request for access. All requests should

be addressed to the Privacy Officer at the Fund Office. The address is located on the last page of this Notice.

(B) Amendment. You have the right to amend your protected health information if you make the request in writing and provide a reason to support a requested amendment. The Fund must act on your request no later than 60 days after receipt of such request by either amending the information or denying your request for amendment. If the Fund amends the information as you request, it will forward the amended information to persons or entities it knows have the protected health information and that may have relied on such information to your detriment. The Fund may deny your request if it determines that the protected health information or record that is the subject of your request (I) was not created by the Fund, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment; (ii) is not part of the designated record set; (iii) would not be available for inspection or copying under the provisions set out in paragraph (1) Inspect and Copy above; or (iv) is accurate and complete. If the Fund denies your requested amendment, in whole or in part, it will provide you with a written denial containing the basis for the denial and an explanation about your rights to disagree with the denial. All requests must be in writing and should be addressed to the Privacy Officer at the Fund Office. The address is located on the last page of this Notice.

(C) Accounting. You have the right to receive an accounting of disclosures of protected health information made by the Fund within the previous six years prior to the date on which the accounting is requested. You do not have the right to accounting of disclosures made (I) to carry out treatment, payment and health care operations, (ii) to you, (iii) incident to a use or disclosure otherwise permitted or required by this Notice or the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164), (iv) pursuant to an authorization, (v) to persons involved in your care, (vi) for national security or intelligence purposes, (vii) to correctional institutions or law enforcement officials, (viii) as part of a limited data set in accordance with 45 C.F.R. § 164.514(e) , or (ix) that occurred prior to April 14, 2003. The Fund will act on your request for an accounting no later than 60 days after receipt of such a request. The Fund will provide the first accounting to you in any 12 month period without charge. The Fund may impose a reasonable, cost-based fee for each subsequent request for an accounting within the 12 month period. e will inform you in advance of the fee and provide you an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee. our requests for an accounting must be in writing and should be addressed to the Privacy Officer at the Fund Office;

(D) Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information when the Fund uses or discloses protected health information to carry out payment or health care operations or when the Fund discloses protected health

information to your family members and friends involved in your care. The Fund is not required to agree to your request. However, if the Fund agrees to a restriction, it may not use or disclose information in violation of such restriction, unless you are in need of emergency treatment and the restricted protected health information is needed to provide the emergency treatment. Once the Fund has agreed to a restriction, it may only terminate its agreement to a restriction if:

- you agree to or request the termination in writing;
- you orally agree to the termination and the Fund documents your agreement; or
- the Fund informs you that it is terminating its agreement to a restriction. Such termination is only effective with respect to health information received after it has so informed you.

(E) Receipt of Confidential Communications. You also have the right to receive confidential communications of your health information upon request. The Fund must accommodate your requests to receive confidential communications, if you clearly state that the disclosure of all or part of your information could endanger you. Furthermore, you must provide information as to how payment, if any, will be handled, and you must specify an alternative address or other method of contact. You should address your requests in writing to the Privacy Officer at the Fund Office. The address is located on the last page of this Notice.

III. Other Information

(A) Authorizations. Except for the uses and disclosures described in Sections I(A) and (B), or as otherwise permitted by law, the Fund will make no uses or disclosures of your protected health information unless you have given your written authorization to the Fund permitting it to use or disclose the information. Furthermore, you may revoke the written authorization given to the Fund at any time, provided that the revocation is also in writing. There are certain circumstances under which you may not revoke the written authorization. Those circumstances are:

- if the Fund has taken action in reliance on the authorization; or
- if the authorization was obtained as a condition of your obtaining insurance coverage, and other law provides the Fund with the right to contest a claim under the policy or the policy itself.

(B) Complaints. If you believe your privacy rights have been violated you may file a complaint with the Privacy Officer at the Fund, or you may file a complaint with the Secretary of Health and Human Services. The address and phone number for the Privacy Officer are located below. You will not be retaliated against for filing such a complaint.

(C) Reservation of Rights. The Fund is required to abide by the terms of the Notice currently in effect. The Fund reserves its right to change the terms of its Notice and to make the new Notice provision effective for all protected health information that it maintains prior to issuing a

revised Notice. The Board of Trustees further reserves the right to modify this Notice in accordance with its practices and policies at any time. The Fund will provide individuals with any revised Notice by mail.

(D) How to Contact Us. If you wish to exercise any of your rights, or if you have any other questions or complaints about our privacy practices, please contact the Privacy Officer, Hagerstown Teamsters and Motor Carriers Health and Welfare Fund, 10312 Remington Drive, Hagerstown, MD 21740 or 301-733-2602.
Email: corporate.compliance@benesys.com