



UPDATE

BULLETIN FROM ROAD CARRIERS LOCAL 707 WELFARE & PENSION FUNDS

ROAD CARRIERS LOCAL 707 WELFARE FUND SUMMARY MATERIAL MODIFICATION NOTICE

Effective September 1, 2007 the following changes will be made to the various welfare plans offered by the Road Carriers Local 707 Welfare Fund:

- 1) *The Fund's agreement with the Magnacare PPO network will be terminated Aug 31, 2007. The Fund's participation agreements with Central States and IBT 671 will also be cancelled. All participants will be enrolled in Empire BCBS's PPO with the exception of retirees residing within Empire's HMO region. Retirees in Empire's HMO region will be enrolled in their HMO as noted below.*
- 2) *The copays for office visits for all participants enrolled in the Empire PPO will increase by \$5.00 per visit. The copays effective September 1, 2007 will be as follows:*

Plan A	\$15	Plan G	\$20
Plan B	\$15	Plan H	\$20
Plan C	\$20	Plan RA	\$20

The copays for the Retiree HMO will remain the same (\$10). The copays for eligible retirees who live outside the area covered by Empire Blue Cross Blue Shield's HMO will remain in Plan RA and will be subject to the \$20 copay noted above (see change below for more information about the retiree HMO coverage).

- 2) *All eligible retirees who reside in the area covered by Empire Blue Cross Blue Shield's HMO (southern New York and parts of adjacent New Jersey) will be enrolled in Empire's HMO plan. The self-insured plan offered in the past will no longer be an option for retirees in this area.*

A separate mailing will be sent to retirees affected by this change and will provide further details regarding this change. Note: All eligible retirees affected by this change must elect a Primary Care Physician (PCP) before August 22, 2007.

New ID cards will be mailed to all participants under separate cover. Participants coming from the Central States and IBT 671 plans, as well as retirees moving to the HMO will need to obtain new prescriptions for refills from your physician as you will be accessing a new Prescription Drug Benefit Manager (PMB).

• Welfare SPD •

Dear Plan Participant:

This booklet is provided to you so that you may familiarize yourself with your health and welfare benefits in the Road Carriers Local 707 Welfare Fund. Please add this to the blue binder previously provided with your Pension SPD.

This booklet contains the official description of the benefits in the Welfare Fund. Please read this booklet carefully and familiarize yourself and your dependents with the contents. We have made an effort to avoid legal and medical language in hopes that the booklet will be easily read and understood.

This booklet contains three sections:

1. The “Welfare SPD” section describes the health and welfare benefits provided through Plan RA, excluding in-network hospital and medical benefits administered by Empire BlueCross BlueShield.
2. The “Empire Hospital” section describes the in-network hospital benefits administered by Empire BlueCross BlueShield (for those participants who are not enrolled in the in-network medical benefits administered by Empire).
3. The “Empire EPO” section describes the in-network hospital and medical benefits administered by Empire BlueCross BlueShield (for those participants who are enrolled in both the in-network hospital and medical benefits administered by Empire).

Please be careful to refer to the section that applies to you.

The Trustees reserve the right to amend, modify, or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.

Sincerely,
The Board of Trustees



ROAD CARRIERS
LOCAL 707

WELFARE PLAN

PLAN RA

SUMMARY PLAN DESCRIPTION
EFFECTIVE AS OF SEPTEMBER 1, 2004

ROAD CARRIERS LOCAL 707 WELFARE PLAN

BOARD OF TRUSTEES

Appointed by Union

Kevin McCaffrey
Vincent Cangelosi

Appointed by Employers

Peter Hassler
Tom J. Ventura

FUND MANAGER

David B. Stewart, CEBS

FUND OFFICE

14 Front Street, Ste. 301
Hempstead, NY 11550-3602
Phone (516) 486-7100 ~ 1-800-366-3707
Fax (516) 486-7375
www.roadcarriers707.com

PLAN CO-COUNSEL

Morgan, Lewis & Bockius, LLP
Cary Kane, LLP

PLAN AUDITOR

Berdon, LLP

PLAN ACTUARY

O'Sullivan Associates

INTRODUCTION

We are pleased to provide you with this updated booklet describing the benefits available to you and your Spouse under the Road Carriers Local 707 Welfare Fund's plan of benefits for retirees (the "Plan"). This booklet replaces and supersedes all previous booklets that you may have received in the past. Please be sure that this book matches the plan in which you are enrolled. Because the Road Carriers Local 707 Welfare Fund (the "Fund") benefits you and your Spouse, we urge you to read this booklet carefully and share it with your Spouse so that you will understand the Plan, the eligibility rules and the procedures for filing claims.

The Fund, which holds the assets of the Plan, is a self-insured, jointly administered labor-management trust, established pursuant to the Taft-Hartley Act and the Employee Retirement Income Security Act ("ERISA"). The Board of Trustees, half of which are designated by employer representatives and half by Local 707, serves as Plan Administrator.

Changing economic conditions require constant assessment of the Plan to maintain its financial stability. Our goal is to continue to make those changes which benefit the membership and which contribute to the security, health and well being of the membership. Many of the rules and limitations incorporated into this booklet are required because of changes in the Federal laws and regulations.

Although this Plan is intended to be maintained for an indefinite period of time, we specifically reserve the right to change, eliminate, add to or delete from the schedule of benefits provided to Participants and to the Spouses of such Participants. The Trustees have the exclusive power to verify claims for the payment of benefits and to determine whether the conditions for payment of benefits have been fulfilled. The Trustees also have the discretionary authority to determine eligibility for benefits and to construe and interpret the terms of the Plan.

Nothing in this booklet or elsewhere should be construed to mean that the Fund's benefits are guaranteed. We will, of course, notify you when we make significant changes in the rules, regulations or the schedule of benefits.

Only the Board of Trustees is authorized to interpret the rules and regulations set forth herein. No representative of any Employer or union has authority to speak on behalf of the Board of Trustees, nor can

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any person act as an agent for the Trustees with respect to questions of interpretation.

You are encouraged to contact the Fund Office with any questions you may have concerning the Plan or its administration. Fund Office personnel will help you understand the rules of the Plan and will refer you to pertinent provisions in this booklet. Matters that require interpretations will be referred to the Board of Trustees.

Sincerely,

BOARD OF TRUSTEES

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PART A. QUESTIONS & ANSWERS

PLAN ADMINISTRATION

1. Who pays for the Plan?

Benefits are paid from the general assets of the Fund. However, in order to receive benefits under the Plan, you must pay a monthly copayment according to the schedule below. The rate for couples will be twice that of an individual.

If you retired prior to September 1, 2004

Participant's Age	% of Cost Paid by Participant
Less than 55	75%
55-57	50%
58-59	40%
60-61	25%
62-64	20%

If you retire on or after September 1, 2004

Participant's Age	% of Cost Paid by Participant
Less than 55	100%
55-57	50%
58-59	40%
60-61	25%
62-64	20%

The schedule is based on a percentage of the Fund's actual cost and the Participant's age. Copayments will be adjusted each year based on the change in the Fund's cost. Copayments will also be adjusted when the Participant reaches the next age category. The new rate will become effective the first of the month following the month the Participant attains the qualifying age for the next tier. In cases where the Participant ceases to receive Fund benefits (due to the attainment of age 65 or death) and the Participant's Spouse continues to receive Fund benefits, the copayment will be determined by:

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- if the Participant dies before age 65, the Participant's age (as if the retiree were still alive) through age 65 and then reverting to the Spouse's age, or
- if the Participant attains age 65, the Spouse's age.

However, the Spouse's monthly copayment will be capped at the greater of the amount paid for coverage for the Participant and Spouse immediately prior to the Participant ceasing to receive Fund benefits or \$216. The Participant must authorize the Pension Fund to withhold the monthly copayment from his or her monthly pension benefit in order to maintain coverage.

2. How are the Plan funds managed?

The Trustees of the Plan hold all of the Plan funds in trust for the Participants in the Plan and their Spouses. The Trustees have the ultimate responsibility for the management of Plan funds.

3. Who is responsible for interpreting the Plan and for making determinations under the Plan?

The Trustees are responsible for interpreting the Plan and making all determinations under the Plan. In order to carry out their responsibility, the Trustees, or their designee, shall have the sole discretion and exclusive authority to determine whether an individual is eligible for any benefits under the Plan, determine the amount of benefits (if any) an individual is entitled to from the Plan, interpret all of the provisions of this booklet, and interpret all of the terms used in this booklet.

All such determinations and interpretations made by the Trustees, or their designee, shall be final and binding upon any individual claiming benefits under the Plan, be given deference in all courts of law to the greatest extent allowed by applicable law, and not be overturned or set aside by any court of law unless found to be arbitrary and capricious.

4. May I pledge the claim money owed me for the purposes of obtaining a loan?

Plan Participants and their Spouses may not assign or transfer any of their benefits under the Plan. The only exception is that of an assignment made to the provider of health services giving rise to the claim.

5. If the Plan is discontinued, what will happen to the assets of the Plan?

The assets of the Plan must be used only for the benefits of Plan Participants and their Spouses. Under no circumstances may money, which has been properly contributed to the Plan ever, be returned to any Employer or to the Union.

COVERAGE AND ELIGIBILITY

6. Who is eligible to participate in the Plan?

You are eligible to participate in the Plan if you meet all of the following criteria:

- you are receiving a pension from the Road Carriers Local 707 Pension Fund (the “Pension Fund”);
- upon your retirement, you had at least 25 years of combined service credit in the Pension Fund, at least 18 years of which was service credit earned under the Pension Fund (and not a related fund);
- upon your retirement, you met one of the following:
 - you were covered by the Fund during the eight consecutive Coverage Periods immediately prior to your retirement effective date (if the quarterly eligibility method applies for your Employer), or during the 24 months immediately prior to your retirement effective date (if the monthly eligibility method applies for your Employer) ; or
 - you had at least 18 years of service credit earned under the Pension Fund (and not a related fund) on or before November 1, 2002; and
- upon your retirement, you did not elect to receive the \$2,500 Life Insurance Benefit from the Pension Fund instead of retiree health coverage.

Your Spouse is also eligible for retiree benefits. For purposes of retiree benefits, your Spouse is determined at the effective date of the commencement of your pension benefit from the Pension Fund. Effective November 1, 2002, the Fund will not provide retiree healthcare coverage to Spouses who remarry after a participant’s death.

No other Dependents are eligible for any benefits from the Fund if you are a retiree.

Eligibility for benefits will be determined by the Trustees. The Trustees shall be the sole judge of the standards of proof required in any case and shall have the full and exclusive power and authority, in their sole discretion, to determine all questions of coverage and eligibility for benefits.

7. When will my coverage end?

Retiree coverage under the Plan terminates upon the last day of the calendar month prior to your 65th birthday. If you chose the Husband and Wife Option in the Pension Fund when you retired, your Spouse will continue to be covered until the earlier of (i) his or her 65th birthday, or (ii) if you predecease your Spouse, the last day of the calendar month in which your Spouse remarries. If you did not choose the Husband and Wife Option in the Pension Fund when you retired, your Spouse will continue to be covered until the earlier of (i) his or her 65th birthday, or (ii) if you predecease your Spouse, the earlier of the fifth anniversary of the effective date of your retirement or the last day of the calendar month in which your Spouse remarries.

The Fund will allow certain Participants to opt out of retiree coverage and reinstate coverage on behalf of himself and/or his Spouse at a later date. This option to reinstate is only available to Participants who had other, substantially comparable medical coverage at all times during the opt out period. In order to opt out of coverage, you must complete a Retiree Medical Coverage Opt Out Election Form. During the opt out period, you will not be required to make the monthly copayment for the person who opted out and that person will not be eligible for any medical coverage under the Plan. Upon return to the Plan, you will be required to make the required copayment at the applicable rate then in effect for all persons receiving medical coverage under the Plan. In addition, you will be required to provide proof of substantially comparable coverage during the opt out period for the person who opted out. Plan coverage resumes the month after the Fund receives a written request to reinstate coverage and verifies eligibility for reinstatement.

IMPORTANT NOTICE REGARDING TERMINATION OR MODIFICATION OF RETIREE COVERAGE

The Trustees reserve the right to amend, modify, or terminate retiree coverage at any time. No Participant or pensioner has a vested interest in the benefits provided for eligible pensioners and their Spouses. In addition, there shall not be any vested right to any pensioner or Spouse or any other beneficiary nor contractual rights after the disposition of all Plan assets and the termination of the Plan. Pensioners and their Spouses shall have no priority with respect to the disposition of Plan assets in connection with the termination of this Plan.

If you are covered by the Plan as a pensioner, and you are covered by another health plan as an active employee or Spouse of an active employee, the Fund will be secondary to your other health plan coverage under the Coordination of Benefits provisions. In other words, the other plan will pay your claims first and the Plan will supplement the payments made by the other plan.

DEPENDENTS

8. Are my dependents eligible for coverage under this Plan?

Only you and your Spouse are eligible for coverage under this Plan. Aside from you and your Spouse, no one else is entitled to benefits. A detailed explanation of who is considered a Spouse is provided in the Definitions section. If you submit claims or you allow someone to submit claims for a person who is not entitled to benefits, you will be held accountable for any losses the Plan sustains.

ANNUAL ENROLLMENT

9. Do I have to enroll?

Yes. The Plan offers a choice between HMO and PPO health benefits. Each Participant who is eligible for benefits under the Plan (see Question 6 above for information on eligibility) must fill out an enrollment card and select either the HMO or PPO option upon retirement. This enrollment card must be sent to the Fund Office as quickly as possible. After you select an option, you may not change to another option until the following September 1st. If you wish to change your medical benefit

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option effective the next September 1st, you must notify the Fund Office in writing of your desire to do so in the month of June. If you do not wish to change your medical benefit option, you do not need to take any action.

PART B.
DESCRIPTION OF BENEFITS IN THE PLAN

When reviewing the benefits provided under the Plan, please note that each benefit in the Plan may have different conditions and maximum amounts associated with the particular benefit.

SCHEDULE OF BENEFITS

The following is a summary of the benefits provided by the Plan. There are two options available to Plan Participants with respect to health benefits: a PPO option and a HMO option. See Question 9 for information on electing an option.

Under the PPO option, all in-network Hospital benefits are provided through Empire Blue Cross/Blue Shield (“Empire”) and in-network Medical Benefits are provided through either Empire or MagnaCare. Participants are automatically enrolled in one of these networks based on each Participant’s zip code. The description of benefits in this section covers only PPO Medical Benefits obtained through MagnaCare and out-of-network benefits. **BOOKLETS DESCRIBING PPO MEDICAL BENEFITS AND PPO HOSPITAL BENEFITS PROVIDED BY EMPIRE ARE INCLUDED AS SUPPLEMENTS TO THIS BOOKLET.** Please refer to the booklets provided by Empire for a description of the Hospital and/or Medical Benefits applicable to you. To the extent the booklets provided by Empire conflict with this booklet, this booklet controls.

Under the HMO option, all in-network benefits are provided to Plan Participants through Empire. There are no out-of-network benefits under the HMO option. The description of benefits in this section does not apply to any HMO benefits. **INFORMATION REGARDING ALL HMO BENEFITS WILL BE PROVIDED SEPARATELY BY EMPIRE.** Please refer to the information provided separately by Empire for a description of all HMO benefits. To the extent the information provided separately by Empire conflicts with the information in this booklet, this booklet controls. As you review the information provided by Empire please remember that only you and your spouse are eligible for benefits under the Plan.

The payment of benefits from the Plan is subject to the conditions and exclusions of the Plan as set forth in this booklet. Please refer to

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the specific provisions of this booklet for details regarding a particular benefit.

<i>Type of Benefit</i>	<i>Benefit</i>	
Medical Benefits	In Network Coverage	Out of Network Coverage
Hospital	See Empire Hospital Booklet	100% of UCR
Emergency Room	\$50 copayment then 100%	\$50 copayment then 100% of Medically Necessary charges
Office Visits	\$15 copayment then 100%	\$250 deductible per individual \$500 family; then 70% of UCR
Rehabilitation Services – Outpatient Therapies	\$15 copayment then 100% Maximum limits on visits may apply.	\$250 deductible per individual, \$500 family; then 70% of UCR Maximum limits on visits may apply.
Specialists	\$15 copayment then 100% Maximum limits on visits may apply.	\$250 deductible per individual, \$500 family; then 70% of UCR Maximum limits on visits may apply.
Inpatient & Ambulatory Surgery	100%	\$250 deductible per individual, \$500 family; then 70% of UCR
Lab/X-Ray	\$15 copayment then 100%	\$250 deductible per individual, \$500 family; then 70% of UCR
MRI	\$25 copayment then 100%	\$250 deductible per individual, \$500 family; then 70% of UCR
CAT Scan	\$25 copayment then 100%	\$250 deductible per individual, \$500 family; then 70% of UCR

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Prescription Drugs Purchased at Pharmacy (30 day supply)	Generic, \$5 copayment Brand Name (no generic available), \$20 copayment Brand Name (generic available), difference in cost between generic and brand name
Prescription Drugs Purchased through Mail Order Pharmacy (90 day supply)	Generic, \$10 Brand Name (no generic available), \$40 No brand name where generic are available
Maximum Out of Pocket expense for medical (excluding deductible)	\$2,500 per person; \$5,000 per family
Lifetime Maximum for Medical Benefits	\$1,000,000 per lifetime (Hospital Expenses incurred prior to September 1, 2004 do not apply towards the Lifetime Maximum)
Vision Benefits	In network: exam, frame, one pair single, standard, bifocal or trifocal lens, 100% Out of network: examination \$15; eyeglasses (frames and/or lenses) \$50; contact lenses \$75

Rather than the Schedule of Benefits above, some Participants may receive benefits through the Teamsters Local 671 or the Central States Health and Welfare Fund. If you have questions regarding who provides your benefits, contact the Fund Office. You may also visit our website at www.roadcarriers707.com.

PPO MEDICAL BENEFITS - MAGNACARE/OUT-OF-NETWORK

This section only describes in-network PPO Medical Benefits provided through MagnaCare and out-of-network PPO Medical Benefits. Please refer to the Empire Supplement in this booklet for information regarding in-network PPO Medical Benefits, all in-network PPO Hospital Benefits. Please refer to the information provided separately by Empire for all HMO benefits.

The Plan provides comprehensive Medical Benefits that cover most Hospital, surgical, and medical expenses. In order to be covered, the medical expenses must be deemed Medically Necessary. The determination of coverage is at the sole discretion of the Trustees. For in-network claims, the Plan generally pays the full cost of the medical expenses, after payment of a copay. For out-of-network claims, the Plan

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covers up to 70% (up to 100% for Hospital Expenses) of the UCR charges for covered medical expenses, after payment of a deductible. For further details regarding coverage, refer below to the applicable booklet sections, or you may call the Fund Office for further information regarding coverage. The maximum out of pocket expense for medical coverage is \$2,500 per person, \$5,000 per family (excluding any applicable deductible).

PPO PROGRAM

A network of physicians and medical service providers is available through the Plan's PPO network and other direct provider arrangements so that you have access to experienced and qualified family doctors, specialists, surgeons, laboratories, x-ray and other medical service providers. It is the sole responsibility of the PPO network to ensure that all physicians and other providers participating in the network are properly credentialed.

IN-NETWORK PROVIDERS

When you use any network provider for covered services, there are no out-of-pocket expenses (other than a copay) for covered services up to the Plan's limitations. There are limitations to certain coverage such as dermatology, physical therapy, podiatry, and chiropractic services. In addition, certain other services may require pre-certification as discussed herein.

The procedure for the use of the Plan's PPO network is as follows: You may locate a provider by calling MagnaCare, one of the Plan's PPO administrators listed in the back of this booklet. The PPO network provides you with a choice of doctors near your home or work. You may then make an appointment with the doctor that you have selected.

- It is recommended that you choose a family Primary Care Physician ("PCP") who will provide routine care and can recommend you to any network specialist or surgeon.
- You do not need a claim form when using an in-network provider. Just show the doctor's office your Road Carriers Local 707 Welfare Plan identification card.
- You will be responsible for the copay associated with your visit or treatment as outlined in the Covered Expenses section below.

NOTE: To obtain maximum utilization of psychiatric benefits, it is recommended that you take advantage of the program administered by

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the Plan's Mental Health and Substance/Alcohol Abuse Administrator listed in the back of this booklet.

OUT-OF-NETWORK PROVIDERS

When you receive out-of-network care, you must pay the first \$250 of covered expenses for yourself and your Spouse until you reach the family deductible limit of \$500. Once the deductible is met, the Plan pays 70% of the UCR charges for covered medical expenses. You only need to meet the deductible limit once in a Plan Year even though you may have several different injuries or diseases. If you have covered charges during the last three months of a Plan Year (June, July, August) that are applied to that Plan Year's deductible, and the deductible is not yet met, these charges will carry over and apply toward meeting the deductible limit for the next Plan Year.

Only in-network benefits are available through MagnaCare. The Plan supplements the in-network coverage with coverage for out-of-network coverage of up to 70% of the UCR charges for covered medical expenses, after payment of a deductible.

OTHER TREATMENT ALTERNATIVES

In certain circumstances, the use of an alternative treatment may be approved by the Trustees, in their sole discretion, to provide cost-effective benefits other than those specifically provided in this booklet, as recommended by the Plan's Medical or Hospital Case Management Organizations or Medical Consultant and agreed to by the patient and/or treating physician.

BASIC MEDICAL EXPENSES

The Plan covers most of your basic medical expenses, subject to the deductibles, copayments, and coinsurance as set forth in this booklet. Covered basic medical expenses include the UCR charges for Medically Necessary services provided by a Physician in connection with the treatment of bodily injury or sickness for the medical services set forth below.

Unless otherwise noted, for in-network providers, a \$15 copay applies for all covered expenses. For out-of-network providers, the Plan covers 70% of the UCR charges once a deductible requirement of \$250 per individual or \$500 per family is met. Covered expenses include the following:

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Allergy and Clinical Immunology;

Anesthesia Expenses – In-network anesthesia claims are paid at 100% of the PPO fee (no copay is required). Out-of-network claims are subject to the normal coinsurance and deductibles. Participants should be aware that the selection of an anesthesiologist generally is at the discretion of the medical facility providing the service and that most anesthesiologists do not choose to participate in the PPO network. Therefore, it is likely that a Participant's anesthesia expenses will be classified as an out-of-network claim;

Annual Physical Diagnostic Screening & Exam – Participants are entitled to a physical exam once a year (to make an appointment, call the Plan's Annual Physical Exam Administrator listed in the back of this booklet);

Central Nervous System Assessments/Tests;

Chemotherapy Administration;

Chiropractic Treatment – In addition to the normal coinsurance and deductibles, the maximum annual benefit for chiropractic treatment is limited to \$500 per Plan Year, including x-rays. Diagnostic tests other than x-rays are not covered. The maximum allowance for the initial visit is \$30 and \$25 for each subsequent visit;

Dermatological Procedures – In addition to the normal copays, coinsurance, and deductibles, dermatological procedures are limited to \$500 per Plan Year (dermatological procedures that exceed \$500 in a Plan Year may be covered under another section of this booklet) (cosmetic procedures are not covered);

Diagnostic Services;

Durable Medical Equipment and Prosthetic Orthotic Supplies (DMEPOS) – The purchase or rental of DMEPOS in-network is paid at 100% of the PPO fee schedule. Out-of-network benefits are subject to the normal coinsurance and deductibles. Coverage for orthotic devices for the feet is limited to two pairs per lifetime with a maximum benefit of \$500. This benefit requires pre-certification prior to receiving services;

Hearing Aids – A Participant may receive a hearing aid from the Plan's Hearing Aid Administrator listed in the back of this booklet. Participants

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and Spouses receive up to \$400 per standard aid or up to \$800 per programmable aid, for a maximum of two aids every 24 months;

Hemodialysis for Kidney Failure – Benefits are provided for hemodialysis or peritoneal dialysis while a registered bedpatient in a Hospital. Benefits are also provided for outpatient dialysis as follows:

- At home – The Plan pays the UCR charges of all appropriate Medically Necessary supplies required for home dialysis treatment, as well as the reasonable rental cost of the required equipment.
- At a Hospital or free-standing facility – The Plan pays the UCR charges of Medically Necessary treatment if the facility's dialysis program is approved by the appropriate governmental authorities.

This benefit is available only until the Participant or Spouse is eligible for Medicare. Benefits are subject to the normal copays, deductibles and coinsurance;

Immunization Injections;

Mammograms – Coverage for routine mammograms is limited to \$175;

MRI – Must be pre-certified if performed at hospital with the Hospital Case Management Organization;

Neurology and Neuromuscular;

Non-Invasive Vascular Diagnostic Studies;

Ophthalmology;

Otorhinolaryngology;

Podiatry – In addition to the normal copays, coinsurance, and deductibles, coverage for podiatry services is limited to a \$500 maximum per Plan Year. Surgical podiatry benefits are subject to the normal copays, coinsurance, and deductibles;

Professional Fees, Office Visits, Hospital Visits, Home Visits;

Pulmonary;

*Therapeutic or Diagnostic Infusions; and
X-Rays.*

OUT-OF-NETWORK PPO HOSPITAL EXPENSES

PRE-CERTIFICATION

Coverage for Hospital expenses requires pre-certification with the Plan's Hospital Case Management Organization (listed in the back of this booklet) prior to incurring any Hospital expenses. If you do not pre-certify with the Hospital Case Management Organization prior to admission, you will be responsible for 50% of expenses up to a maximum of \$2,500. Emergency admission requires certification with the Hospital Case Management Organization within 72 hours of admission or, if later, the first business day following admission.

In addition, pre-approval may be required for certain expenses as specifically provided in this booklet. For example, pre-approval is required for organ transplants, gastric procedures, and mamoplasty. Please refer to the specific provisions of the booklet for details regarding these expenses.

Covered Expenses

The following expenses are covered during a period of hospitalization:

- general nursing care;
- use of extensive or special care facilities;
- x-ray examinations including CAT scans but not dental x-rays;
- use of operating room and related facilities;
- magnetic resonance imaging;
- drugs, medications, biologicals;
- cardiography/encephalography;
- laboratory testing and services;
- casts and dressings;
- pre- and post-operative care;
- special tests;

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- nuclear medicine;
- physical and rehabilitation therapy;
- oxygen and oxygen therapy;
- anesthesia and anesthesia services;
- administration and processing of whole blood, blood plasma and blood derivatives;
- intravenous injections and solutions (in-home infusion therapy is covered for prescribed medical treatment requiring intravenous application, subject to pre-certification by the Plan's Hospital Case Management Organization or Medical Consultant and prior approval);
- surgical, medical and obstetrical services provided by the participating Hospital;
- special duty nursing when certified as such by the participating specialist Physician in concurrence with your or your Spouse's Primary Care Physician ("PCP") and approved and coordinated in advance by the Plan's Hospital Case Management Organization; and
- reasonable ambulance services.

A visit to a Hospital clinic is treated as a basic medical expense, not a Hospital expense, and is subject to a \$50 copay.

EMERGENCY ROOM CARE

The Plan will cover Hospital services and supplies when you are not admitted as a bedpatient but receive care in a Hospital's emergency room or operating room for:

- emergency first aid during the first visit for treatment of an accidental injury within 72 hours following such injury;
- emergency care during the first visit for treatment within 12 hours of the onset of sudden or serious illness; or
- minor surgery.

In order for emergency room treatment to be covered, the following conditions must be met:

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- there must be a sudden, unexpected onset of a serious illness or medical condition, or an accidental injury occurs; and
- immediate medical care must be necessary to prevent what could reasonably be expected to result in either placing the patient's life in jeopardy or causing serious impairment to the patient's bodily functions.

A \$50 copay applies for each covered emergency room treatment, if you are not admitted as a bedpatient. If you are admitted as a bedpatient, you will not have to pay the \$50 copay.

Charges made by an emergency room physician or any other licensed health care professional while you are in the Hospital or emergency room are covered under the major medical portion of your plan and the full amount of the Medically Necessary charges are reimbursable at 100%.

ORGAN TRANSPLANTS

The Plan will cover organ transplants that have been approved as safe and effective by the U.S. Food and Drug Administration ("FDA") and the National Institutes of Health ("NIH") for specific diseases and which the Plan's Hospital Case Management Organization deems Medically Necessary. The Plan will cover the cost of medical and Hospital services, and related organ acquisition costs for approved organ transplants when deemed by the Plan to not be experimental. All transplants must be ordered by the PCP and participating specialist Physician and approved by the Plan's Hospital Case Management Organization in advance of the surgery. The following may also be covered if related to the transplant:

- blood products, except when participation in a volunteer blood replacement program is available to the Participant or Spouse;
- ambulance services;
- tests (laboratory, x-ray, etc.) necessary to confirm a diagnosis prior to Hospital admission, if obtained in a licensed Hospital up to two weeks prior to admission before elective surgery; and
- outpatient surgery charges, if obtained in a licensed Hospital or outpatient surgical center.

The normal copays, deductibles, and coinsurance apply to these expenses.

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The Plan utilizes an organ transplant network of facilities that provide organ transplant services in a cost-effective manner. Please contact the Fund Office for information regarding the organ transplant network.

GASTRIC PROCEDURES

Gastric procedures must be approved by the Plan's Hospital Case Management Organization and Medical Consultant in accordance with the following NIH guidelines: Patients seeking therapy for severe obesity from the Plan for the first time will be considered for treatment in a nonsurgical program integrating components of a dietary regimen, appropriate exercise, and behavioral modification and support. Gastric restrictive or bypass procedures may be considered for well-informed and motivated patients with acceptable operative risks. Candidates for surgical procedures shall be selected carefully and only after evaluation by a multidisciplinary team with medical, surgical, psychiatric, and nutritional expertise. The operation must be performed by a surgeon substantially experienced with the appropriate procedures and in a clinical setting with adequate support for all aspects of management and assessment. The normal copays, deductibles, and coinsurance apply to these procedures.

MASTECTOMY/MAMOPLASTY

The Women's Health and Cancer Act of 1998 requires the Plan to cover the following medical services in connection with coverage for a mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance; and
- prostheses and treatment of physical complications in all stages of mastectomy, including lymphedema.

In addition, the Plan will cover reduction or enhancement mamoplasty that the Plan's Hospital Case Management Organization deems Medically Necessary. Reduction or enhancement mamoplasty (including reconstruction following a mastectomy) must be approved by the Plan's Hospital Case Management Organization and Medical Consultant prior

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to surgery. The normal copays, deductibles, and coinsurance apply to these expenses.

SKILLED NURSING

Treatment at a Skilled Nursing Facility is available when Medically Necessary and prescribed by a Physician for patients who have been Hospitalized in acute inpatient status. Skilled nursing benefits must be precertified by contacting the Hospital Case Management Organization. Skilled nursing benefits are limited to 60 days per calendar year.

HOME AND HOSPICE CARE

Occasionally, necessary services can be arranged in settings other than a Hospital. These include but are not limited to: nursing care, rehabilitation service, intravenous antibiotics, monitors, pain management, oxygen, psychiatric, alcohol and substance abuse treatment. These services must be pre-certified through the Plan's Hospital Case Management Organization prior to receiving these services in order to determine the potential of an alternate setting and/or the potential for cost containment. Failure to do so will result in you being responsible for significant out-of-pocket expenses.

HOME CARE BENEFITS IN LIEU OF HOSPITALIZATION

Home care benefits are available under a Physician-approved plan of treatment when the necessary services are rendered through a state licensed Home Health Agency. Benefits will be provided only if hospitalization or confinement in a Skilled Nursing Facility would otherwise have been required.

When care begins within seven days of discharge from a Hospital, 100% of the UCR charges are covered for up to 100 home care visits per Plan Year. When care is rendered without prior hospitalization or through a non-certified agency (a non-certified agency is one that is not certified by the state or by Medicare), a \$150 deductible must be met, and then the Plan will pay 70% of the UCR charges, up to a maximum of 40 home care visits per Plan Year. In no event will coverage be provided for more than 100 visits in any Plan Year. Nor will the aggregate maximum reimbursement for this benefit exceed \$5,000 per Plan Year.

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Covered services include:

- part-time professional nursing;
- part-time home health aide services (up to four hours of such care is equal to one home care visit);
- physical, occupational or speech therapy;
- medical supplies, drugs and medicines prescribed by a Physician; and
- necessary laboratory services.

When home care begins within seven days following discharge from a Hospital, these additional services are covered following discharge:

- medical social worker visits;
- x-ray and EKG services; and
- ambulance or ambulette to the Hospital.

HOSPICE CARE

In each lifetime, Plan Participants and Spouses have coverage for up to 210 days of inpatient hospice care in a hospice or Hospital, as well as home care and outpatient services provided by the hospice as described below if:

- the patient has been certified by his primary attending physician as having a life expectancy of six months or less; and
- the hospice care is provided by a hospice organization certified under the process required by the State in which the hospice organization is located.

Covered hospice and outpatient services include the following:

- bedpatient care either in a designated hospice unit or in a Hospital and day care services provided by the hospice organization; and
- home care and outpatient services provided by the hospice. The services may include the following:
 - intermittent care by a RN, LPN, or home health aide;
 - physical therapy;

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- speech therapy;
- occupational therapy;
- respiratory therapy;
- social services;
- nutritional services;
- laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of systems;
- medical supplies;
- drugs and medications prescribed by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary (not covered when the drug or medication is experimental in nature);
- medical care provided by the hospice physician;
- a total of five visits for bereavement counseling are available at any time for the family members of the patient;
- durable medical equipment; and
- transportation between home or Hospital and hospice organization when medically necessary.

When the hospice care is provided by a hospice facility or Hospital that has an agreement with the Plan, you will receive full benefits for covered services. When the facility does not have such an agreement with the Plan, coverage is limited to 70% of the facility's charges for services, but in no event will payment to such a facility exceed 70% of the average payment the Plan would make for a like service to a participating facility.

SURGICAL EXPENSES

Inpatient and Ambulatory Surgical coverage is 100% for in-network treatment. Out-of-network treatment is covered at 70% of UCR after the Plan's deductible requirement of \$250 per individual or \$500 per family is met.

PRE-CERTIFICATION

Coverage for inpatient surgical expenses requires pre-certification with the Plan's Hospital Case Management Organization (listed in the back of this booklet) prior to admission for surgery. If you do not pre-certify with

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the Plan's Hospital Case Management Organization prior to admission you will be responsible for 50% of expenses up to a maximum of \$2,500.

In addition, pre-approval may be required for certain expenses as specifically provided in this booklet. For example, pre-approval is required for organ transplants, gastric procedures, and mamoplasty. Please refer to the specific provisions of the booklet for details regarding these expenses.

Mandatory Second Medical Opinion Program for Non-Emergency Surgery Inpatient and Ambulatory Services

All Participants and Spouses must obtain a second opinion as to the need for the elective surgical procedures listed below, whether inpatient or ambulatory. The second opinion must be obtained from a Physician participating in the Second Surgical Opinion Consultation Program. You can obtain an appointment by calling the Fund Office at 800-366-3707 or writing the Fund Office at 14 Front Street, Ste. 301, Hempstead, NY 11550.

The surgical procedures for which you must obtain a second opinion are as follows:

Back Surgery	Disc surgery, including injection therapy, laminectomy and scoliosis surgery
Eye Surgery	Eyelid surgery; Blepharoplasty
Lipectomy	Removal of fatty tissue
Nose Surgery	Rhinoplasty
Scar Revision	All surgeries
Vein Surgery	Sclerotherapy, agent injections

The Plan will pay for a second opinion on any other elective surgical procedure, but it is not mandatory to have one. In all cases, you are free to accept or reject the opinion of the second opinion Physician and the Plan will still pay its regular allowances for the operation.

For further information on the Second Opinion Surgical Consultation Program please contact the Fund Office.

REHABILITATION SERVICES

The Plan covers inpatient and outpatient rehabilitation services as follows:

INPATIENT TREATMENT

The Plan will pay up to 30 days in a rehabilitation facility accredited by the Joint Commission on Accreditation of Health Care Organizations. The patient must notify the Plan prior to transfer to any rehabilitation facility. The attending Physician must send a letter of Medical Necessity and a written treatment plan in order to obtain prior approval from the Plan's Hospital Case Management Organization or Medical Consultant. This benefit is available only for Participants and Spouses who have initially been hospitalized and would be transferred from an acute Hospital to a recognized approved rehabilitation Hospital, or alternative care setting approved by the Medical Consultant or Hospital Case Manager. Coverage includes speech therapy, physical therapy, occupational therapy, cardiac rehabilitation, pulmonary rehabilitation, and cognitive therapy.

OUTPATIENT TREATMENT

The Plan will cover charges incurred for outpatient rehabilitation treatment, subject to the limitations below. Except as set forth below, a \$15 copay applies to in-network covered services and, for out-of-network services, the Plan covers 70% of the UCR charges once the Plan's deductible requirement of \$250 per individual or \$500 per family is met.

SPEECH

The benefit is subject to the following limitations:

- Restore speech function lost through injury or illness - two years maximum treatment limitation, up to a lifetime maximum of \$2,000.
- Correct impairment due to congenital defect for which corrective surgery has been performed - up to a lifetime maximum of \$2,000.

PHYSICAL/OCCUPATIONAL THERAPY.

The benefit is limited to 24 visits per Plan Year per patient per injury. If you receive therapy for an injury and are then re-injured, the therapy for both the original injury and the re-injury will be limited to 24 visits combined in a Plan Year, unless the re-injury occurs at least 60 days after your complete recovery from the initial injury. Therapy for successive injuries due to unrelated causes will count toward your limit of 24 visits per injury unless you were completely recovered from one injury prior to the occurrence of the subsequent injury.

CARDIAC REHABILITATION.

The Plan will cover cardiac rehabilitation services if the services are prescribed by a Physician to restore a maximum level of recovery, and the patient:

- recently had a myocardial infarction (“heart attack”), coronary artery bypass graft surgery (CABG), coronary angioplasty, or coronary stent insertion; or
- has a history of debilitating angina pectoris, or symptomatic left ventricular dysfunction, which has failed to respond to standard medical or surgical treatment.

The Plan will cover one month of treatment with reassessment after that time with the expectation to approve up to an additional month of treatment. The Plan’s Medical Consultant will evaluate approval requests beyond two months prior to the end of the two month treatment period.

MATERNITY

Maternity benefits are provided for expenses incurred in a Hospital for all females covered by the Plan. Regular hospitalization benefits will be provided for Hospital stays involving any pregnancy-related condition, whether or not pregnancy is terminated.

In accordance with Federal law, the Plan does not restrict benefits for any covered Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require

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that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Plan will cover charges by a certified nurse-midwife working under the direction of a Physician in conjunction with an approved Hospital or other approved facility. Benefits are paid on the same basis as if services were performed by a Physician. Charges for a midwife are not subject to the Plan's deductible.

PRESCRIPTION DRUG PROGRAM

RETAIL PHARMACY PROGRAM

The Plan covers the costs of prescription drugs, subject to a copay. Generic prescription drugs are subject to a \$5 copay. Brand-name prescription drugs that have no generic equivalent are subject to a \$20 copay. For brand-name prescription drugs that have a generic equivalent, the copay will be the cost difference between the brand-name drug and its generic equivalent.

Certain narcotic painkillers require pre-authorization for quantities in excess of specified limits (e.g. Hydrocodone, 160 units; Oxycontin, 90 units; Propoxyphene (aka Darvocet), 160 units).

The maximum quantity of prescription drugs filled at a retail pharmacy is 30 days.

The prescription drug benefit includes coverage for prescription oral birth control pills. Nicotine replacement drugs are limited to six months of coverage. Triptans are limited to eight tablets per month.

MAIL-ORDER PROGRAM

In addition to the above coverage, the Plan offers a prescription maintenance drug plan that covers prescriptions used by a patient on a steady year-round basis for up to a 90 day supply maximum. This maintenance program applies to the management of disease and illnesses or any other physical or mental conditions, which would require constant regular medication. The program utilizes a mandatory generic drug substitution and a copay of two times the retail pharmacy copay. Not all prescriptions may be provided through the program.

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The program is administered by the Plan's Prescription Drug Mail Order Administrator listed in the back of this booklet. You can call them to request forms and information or call the Fund Office at 1-800-366-3707. The benefits under this program are limited only to those maintenance drugs available through the Plan's Prescription Drug Mail Order Administrator.

PRESCRIPTION DRUG ABUSE

If the Trustees determine, in their sole discretion, that you are abusing your prescription drug benefits, the Trustees reserve the right to take any actions they deem necessary to end such abuse, including but not limited to the following:

- discontinuing your prescription drug card, thereby requiring you to submit any prescription drug benefits directly to the Fund office for reimbursement; and
- terminating your prescription drug benefits in the Plan.

MENTAL HEALTH AND ALCOHOL SUBSTANCE ABUSE COVERAGE(MH/SA)

The Plan provides coverage for mental health and alcohol/substance abuse to Participants and Spouses. You may obtain information concerning the program and the facilities in which this coverage is offered by calling the Plan's Mental Health/Substance Abuse ("MH/SA") Administrator listed in the back of this booklet.

ASSESSMENT, SHORT-TERM TREATMENT, AND/OR REFERRAL

In order for you to receive mental health benefits, you must first contact the Plan's MH/SA Administrator to certify your treatment. Mental health, alcoholism, and substance abuse treatment services are covered under the Plan as described below.

INPATIENT BENEFITS

Regular Hospital benefits are available for 100% of the cost of up to 30 days in any Plan Year period in an accredited non-governmental general Hospital, non-governmental Psychiatric Hospital, or state-licensed chemical dependency treatment facility through the Plan's

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MH/SA Administrator. This benefit is limited to two inpatient stays in a lifetime. All inpatient care must be precertified by the Plan's MH/SA Administrator.

OUTPATIENT BENEFITS

Claims for out-of-network providers who agree to accept PPO fees as full payment will be subject to the copay only and not subject to the deductible normally applicable to out-of-network claims.

Outpatient benefits are provided in accordance with the following schedule:

	<i>In-Network</i>	<i>Out-of-Network</i>
	100% coverage subject to copay*	
Outpatient Care	Visits (copay per visit) 1-5 \$10 6-10 \$20 11-50 \$30 Maximum visits: 50 per Plan Year	50% covered; \$250 /\$500 deductible per Plan Year; Maximum visits: 30 per Plan Year.

*No copay is required for attendance at group session appointments.

*Participation in an intensive outpatient program applies toward the inpatient limit of two stays in a lifetime.

EXCLUSIONS

The following medical expenses are not covered under the Plan's Medical Benefits:

- all charges not specifically listed as covered expenses;
- charges for services performed on or to the teeth, gingivae or alveolar processes, except to tumors or cysts or except as required because of accidental injury to natural teeth occurring while insured hereunder;
- charges for eye refractions, eyeglasses, or the fittings thereof, except as provided for under the Vision Care Program;
- charges for transportation, except local ambulance service, or as permitted under the Hospital Expenses section;

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- coverage for a donor in a transplant procedure, unless the recipient of the transplant is a Participant or Spouse in the Plan (in the event a Participant or Spouse is the recipient, coverage will be provided under this Plan for a live donor to the extent benefits are unavailable from any other source);
- except as provided in the Hospital Expenses section, all experimental organ transplants and procedures and services associated with the preparation of such transplants;
- expenses in excess of the UCR fee;
- expenses for weight reduction programs or surgical operations or procedures for treatment of obesity, including but not limited to gastric procedures or balloon procedures, unless Medically Necessary as determined by the Plan's Hospital Case Management Organization or Medical Consultant in accordance with NIH guidelines;
- private duty or special nursing care, except as specifically provided in this booklet;
- reversal of voluntary sterilization;
- transsexual surgery or related services;
- in-vitro fertilization procedures, related services, infertility injectables or other supplies;
- immunizations obtained for the sole purpose of travel or immunizations required as conditions of employment;
- breast reduction surgery, unless deemed Medically Necessary or reconstruction after surgery;
- orthopedic shoes or arch supports;
- charges for prescription drugs that the Trustees determine are being abused; and
- any other exclusions listed in General Exclusions.

Determinations regarding the denial of benefits are at the sole discretion of the Trustees.

VISION BENEFITS

You may use a Physician selected by the Plan or the Provider of your choice for your Vision Benefits. Your out-of-pocket expenses will differ depending on your choice. To set up an appointment with a Physician

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selected by the Plan, call the Plan's Vision Care Administrator listed in the back of this booklet.

COVERED EXPENSES

If you choose to receive services outside of the Plan's selected Physicians, you must pay the Physician directly, and submit the completed voucher for reimbursement. The following maximum reimbursement will be paid when services are received from outside of the Plan's selected Physicians:

Benefit	In-Network	Out-of-Network
Eye examination	100%	\$15
Eyeglasses (frames and/or lenses)	100% for basic (see below for other options)	\$50
Contact lenses (exclusive of an examination)	100% for basic (see below for other options)	\$75
Vision Training	See below	

The in-network Providers selected by the Plan will accept your voucher as payment in full for the following annual services:

- a comprehensive eye examination;
- a frame from the Provider's special premier selection of frames;
- one pair of single vision, standard (or blended) bifocal or trifocal lenses, in your choice of either plastic or glass, in any prescription;
- solid, gradient or sun-tinted plastic lenses;
- glass, grey #3 prescription sunglass lenses; and
- post-cataract (lenticular) lenses.

With an additional copay, the following may be selected at an in-network Provider:

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Selection	Additional copay
PGX (sun-sensitive) glass lenses	\$13 (single vision) \$22 (multifocal)
Progressive addition multifocal lenses	\$80
One pair of standard, soft, daily-wear contact lenses (which are available for most prescriptions) in lieu of receiving eyeglasses. A care kit and all necessary visits for proper lens fitting will be provided	\$25
An initial supply (2 multi-packs) of disposable/ planned replacement contact lenses (which are available for most prescriptions), in lieu of eyeglasses.	\$45

You may purchase additional or replacement contact lenses through the LENS 1-2-3 mail-order program by calling 1-800-LENS-123 (1-800-536-7123). A voucher is not required to utilize this service. The Plan does not pay for purchases made through this service.

VISION TRAINING

Vision training will be covered only with prior approval by the Plan's Medical Consultant. In order to receive prior approval the provider must submit, in writing, a treatment plan including diagnosis, estimated number of visits, significant clinical findings and symptomatology.

If approved, payment will be made subject to the following limitations:

Maximum reimbursement for initial work-up	\$35
Maximum reimbursement for training session	\$25
Maximum number of sessions per occurrence	10 sessions
Lifetime maximum for vision training period	\$285

Providers are not obligated to accept these fees as payment in full. Reimbursement will be made to the Participant only. Participants are responsible for expenses not covered under the Plan.

EXCLUSIONS

The following are not covered under the Plan's Vision Benefits:

- vision training without prior approval by the Plan's Medical Consultant; and
- any other exclusions listed in the General Exclusions section.

GENERAL EXCLUSIONS

The Plan does not pay claims for the following:

- Expenses for care which is not Medically Necessary, except as specifically provided in this booklet;
- Expenses incurred during confinement in a Hospital owned or operated by the federal government, unless there is a legal obligation to pay charges without regard to the existence of any insurance;
- Charges for injuries, illness, or losses resulting from war or an act of war, declared or undeclared or participation in a felony, riot or insurrection;
- Charges for injuries, illness, or losses resulting from accidental bodily injury arising out of and in the course of the individual's employment, except as provided for under the Subrogation of Benefits section in this booklet;
- Charges for injuries, illness, or losses which are compensable under any workers' compensation law, occupational disease law, or similar legislation, except as provided for under Subrogation of Benefits;
- Charges for plastic or cosmetic surgery (including, but not limited to, ear piercing, rhinoplasty, gynecomastia and reduction mammoplasty) and surgery or treatment relating to the consequences as a result of plastic surgery, except as specifically provided in this booklet;
- Expenses or losses which are the result of self-inflicted injuries;
- Charges for any loss or portion thereof, for which mandatory automobile no-fault benefits are covered or recoverable;
- Charges for medical treatments or procedures not proven to be safe and efficacious (benefits covered by the Plan are limited

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to scientifically established therapies that have been evaluated and found to have demonstrable benefit for a particular illness or disease; ineffective or experimental surgical or medical treatments or procedures, research studies or other experimental health care procedures under continued scientific testing and research with questions as to safety and efficacy are not covered benefits);

- Charges for benefits for which Medicare or Medicaid is the primary payor (we will pay as secondary payor only for eligible participants under the age of 65);
- Charges for the provision of blood, blood plasma, blood derivative or the cost of receiving the service of professional blood donors (only administration and processing of blood is covered when participation in a volunteer blood replacement program is available to the Member);
- Charges for durable medical equipment and supplies, except as specifically provided in this booklet;
- Expenses for personal convenience items or services such as: telephones, barber services, guest meals, radio and television rentals, and other like items and services;
- Expenses for any type of care where the primary purpose of the total care provided is to attend to daily living activities which do not entail or require attention of trained medical personnel;
- Drugs and medicine, except as specifically provided in this booklet;
- Special medical reports not directly related to treatment of the Participant (e.g., employment physicals);
- Payment for services which are eligible for payment under the provisions of an automobile insurance contract, or pursuant to any federal or state law which mandates indemnification for such service to persons suffering bodily injury from motor vehicle accidents, where permitted by state law;
- Payment for services for an illness or injury to which a contributing cause was the individual's commission of or attempt to commit a felony, or to which a contributing cause was the individual's being engaged in an illegal occupation;
- Chronic alcoholism or drug addiction treatment, except as specifically provided in this booklet;
- Costs related to any court appearance, proceeding or hearing;

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- Speech, physical, occupational or rehabilitation therapies, except as specifically provided in this booklet;
- Orthoptics (a technique of eye exercises designed to correct the visual axes or eyes not properly coordinated for binocular vision), except as specifically provided in this booklet;
- Claims submitted after 12 months from the date the cost was incurred;
- Long-term physical, occupational or speech therapy;
- Cosmetics, dietary supplements, food supplements, health or beauty aids regardless of physician authorization; and
- Over-the-counter medication.

PART C. DEFINITIONS

Coinsurance – A portion of covered benefits required to be paid by a Participant or Spouse in connection with benefits set forth in this Plan.

Copay – An amount required to be paid by a Participant or Spouse in connection with benefits set forth in this Plan.

Coverage Period – The 4-month period beginning on June 1, September 1, December 1, or March 1.

Diagnostic Services – All diagnostic services are covered, including laboratory and x-ray services, laboratory specimen collecting, EKGs, and radiation/chemotherapy.

Durable Medical Equipment Prosthetic Orthotic Supplies (DMEPOS) – Therapeutic apparatuses which are used in the treatment of medical illness or injury or supports that treatment. Normally, “durable medical equipment” includes items, which withstand repeated use, are generally reusable, and serve a specific medical purpose. They generally are not useful to a person in the absence of illness and are appropriate for use in the home. Please call the Fund Office for a list of covered and excluded items.

Employer – A former employer of a Participant that contributed to the Fund on behalf of the Participant.

Home Health Agency – Any organization that is certified as a home health agency under the Medicare laws or is otherwise state licensed.

Hospital – A legally constituted institution, which meets all of the following requirements:

- it is licensed as a hospital (if hospital licensing is required where it is located);
- it is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under the supervision of a staff of legally qualified physicians;
- it continuously provides 24-hour-a-day nursing service by or under the supervision of registered graduate nurses and is

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operated continuously with organized facilities for operative surgery; and

- it is not, other than incidentally, a clinic, a place of rest or convalescence, a place for the aged, a nursing home, or a similar establishment.

The following are not considered Hospitals: ambulatory surgery centers; free-standing diagnostic and treatment centers; nursing homes; Skilled Nursing Facilities; school, college or camp infirmaries, rehabilitation facilities, and places for the care and treatment of alcoholism, substance abuse, mental illness, and tuberculosis.

Hospital Case Management/Hospital Case Manager/Hospital Case Management Organization – Hospital Case Management is a voluntary program administered by the Plan's Hospital Case Management Organization. A Hospital Case Manager is a registered professional nurse that assures you are receiving optimal medical care, obtains information to assist you in making decisions about health care choices, and can discuss alternatives with you on a confidential basis. The Hospital Case Manager can help reduce your confusion and anxiety, can make arrangements for certain services and care and can suggest ways to maximize your coverage

Medicaid – Title XIX of the federal Social Security Act and all amendments and successors thereto.

Medical Case Management/Medical Case Manager/Medical Case Management Organization – Medical Case Management is a voluntary program administered by the Plan's Medical Case Management Organization. A Medical Case Manager is a registered professional nurse that assures you are receiving optimal medical care, obtains information to assist you in making decisions about health care choices, and can discuss alternatives with you on a confidential basis. The Medical Case Manager can help reduce your confusion and anxiety, can make arrangements for certain services and care and can suggest ways to maximize your coverage.

Medical Consultant – A Physician or other qualified or licensed professional employed or contracted by the Plan who is designated as "Medical Consultant."

Medically Necessary or Medical Necessity – Medical Necessity is a need for a particular item or service for the diagnosis or treatment

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of disease, injury or defect. The need for the item or service must be documented in the patient's records. Medically Necessary services or items are: appropriate for the symptoms and diagnosis or treatment of the condition, illness, disease or injury; provided for the diagnosis or the direct care of the condition, illness, disease or injury; in accordance with current standards of good medical practice; not primarily for the convenience of the patient or provider; and the most appropriate supply or level of service that can be safely provided to the patient.

Medicare – Title XVIII of the federal Social Security Act and all amendments and successors thereto.

Outpatient Care – The provision of medical, nursing, counseling or therapeutic services to a Participant or Spouse who does not require an overnight stay in a Hospital or non-Hospital facility on a regular and predetermined schedule, according to an individualized treatment plan.

Participant – An eligible retiree/pensioner who is receiving benefits under the terms and conditions of the Plan.

Physician – A duly licensed member of a medical profession, practicing within the scope of such license.

Plan – The Road Carriers Local 707 Welfare Plan.

Plan Year – September 1st through August 31st.

Primary Care Physician (PCP) – A Physician who supervises, coordinates initial care and basic medical services as a general or family care practitioner, or in some cases, as an internist or a pediatrician to members, initiates their referral for specialist care and maintains continuity of patient care.

Provider – A Physician, Hospital, Skilled Nursing Facility, Home Health Agency, certified nurse midwife who is licensed by the state (if required by law), or other entity or person providing services to this Plan.

Psychiatric Hospital – An acute care general Hospital that is certified or licensed to provide psychiatric services, or a facility that meets the definition of a Psychiatric Hospital as determined by the Trustees.

Skilled Nursing Facility – An institution or a distinct part of an institution that is licensed and approved by Medicare and by appropriate state law,

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regulation or agency or as otherwise determined by the Plan to meet the reasonable standards applied by any of the aforesaid authorities. The institution must be primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care facility, or nursing care facility. It must be: (a) approved by the Joint Commission or Accreditation of Health Care Organization or (b) as a certified skilled nursing facility under Medicare law.

Spouse – In order for an individual to be considered the Participant’s “Spouse,” the Participant and Spouse must be legally married and the marriage must be recognized by the state of New York. The Fund does not cover a Participant’s domestic partner. Marriage between a Participant and his or her Spouse ends on the date that a judgment of divorce is signed. Coverage will terminate for the Spouse at the end of the month in which the divorce occurred. The Participant, however, is responsible for notifying the Fund of the divorce. Until you are divorced, you remain married, even if you marry again. A subsequent marriage is invalid if you have not divorced. Failure to notify the Fund that a former Spouse is no longer eligible for benefits will be considered an act of fraud upon the Fund and the Participant will be responsible for any claims that the Fund pays for the former Spouse.

The Participant’s spouse is determined at the effective date of the pensioner’s commencement of his retirement benefit from the Road Carriers Local 707 Pension Fund.

Effective November 1, 2002, the Fund will no longer provide retiree healthcare coverage to Spouses who remarry after a participant’s death.

Surgical Expenses – Expenses directly associated with the performance of surgical procedures or treatment on behalf of Plan Participants and their Spouses for illness or injury covered by the Plan.

Usual, Customary, and Reasonable (UCR) – That portion of any charge which is not in excess of the charge made for similar services and supplies to individuals of similar age, circumstances, and medical condition in the locality concerned, as determined by the use of a national database at the 75th percentile in the zip code in which the procedure is performed. The UCR charge for specific procedures will be provided upon written request to the Fund Office.

Union – Highway and Local Motor Freight Drivers, Dockmen and Helpers Local Union No. 707.

PART D.
CLAIMS AND APPEAL PROCEDURE

TRUSTEE DISCRETION

The Trustees shall have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply, construe and interpret the provisions of the Plan, this document and the terms used therein, as well as the Trust Agreement and to decide all matters arising in connection with the operation or administration thereof. The authority of the Trustees includes, without limitation, the sole and absolute discretion to:

- take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable;
- formulate, interpret and apply rules, regulations and policies necessary to administer this Plan and the Trust Agreement;
- decide questions, including legal or factual questions, relating to the determination and payment of benefits;
- resolve and clarify any ambiguities, inconsistencies or omissions arising under this Plan and the Trust Agreement; and
- process, and approve or deny, benefit claims and rule on any benefit exclusions or limitations.

All determinations made by the Trustees with respect to any matter shall be final, conclusive and binding upon the Participants and their Spouses. The Trustees shall be the sole judges of the standard of proof required in any matter. Any decision of the Trustees shall only be reversed by a court if such decision is determined to be arbitrary and capricious. Benefits under the Plan will be paid only if the Trustees determine, in their sole discretion, that the applicant is entitled to them.

The Trustees reserve the right to alter the benefit plan design in those instances wherein a cost effective outcome can be achieved by the use of alternative plans of treatment recommended by the Plan's Medical Consultant, and agreed to by the patient, attending and or treating Physician.

The Trustees will have the right and opportunity to examine any claimant (while living) when and so often as it may reasonably require and, also, the right and opportunity to make an autopsy where it is not forbidden by law.

SUBMITTING A CLAIM

Claims must be submitted to the Fund Office, in a format prescribed by the Board of Trustees, within 12 months following the date on which the expense was incurred. Claims submitted after that date will be denied.

CLAIM DENIAL

If a claim is wholly or partially denied, the Fund Office will notify you within a reasonable period of time, but not later than the following:

<i>Type of Claim</i>	<i>Time Limit for Claim Determination</i>	<i>Extension Permitted</i>
Medical, Vision - 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

If your claim lacks information required by the Fund Office to make a determination, 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 case, you will be provided with written notice of the extension prior to the termination of the time for responding.

The Fund Office’s notification of a claim denial will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- 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;
- a description of the Plan’s review 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;

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- 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
- 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, you or your duly authorized representative may appeal the denial to the Board of Trustees within the following timeframe:

<i>Type of Claim</i>	<i>Time Limit for Appealing Denial</i>
Medical, Vision	180 days

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.

DETERMINATION ON APPEAL

The Board will make a determination of your appeal with a reasonable period of time, but not later than the following:

<i>Type of Claim</i>	<i>Time Limit for Appeal Determination</i>	<i>Extension Permitted</i>
Medical, Vision		
- Urgent Claims	72 hours	None
- Pre-Service Claims	30 days	None
- Post-Service Claims	Regularly scheduled Board meeting (if claim received 30 days prior)	Next Board meeting
- Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None

If your claim is determined at a Board meeting, you will be notified of the determination upon review as soon as possible but no later than five days after the determination is made.

If the denial of a claim for Medical or Vision Benefits was based in whole or in part on a medical judgment, the Board will consult with a health care professional who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual and who has appropriate training and experience in the field of medicine involved in the medical judgment. In addition, the determination on appeal will not afford deference to the initial claim denial.

The Board will provide a written notification of the benefit determination on review. In the case of denial, the notification will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- 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;

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- if an internal rule, guideline, protocol, or other similar criterion 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 you upon request;
- 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
- a statement of your right to sue under section 502(a) of ERISA.

INCOMPETENCE

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

COOPERATION

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulae, methods, and procedures as they consider advisable.

MAILING ADDRESS OF CLAIMANT

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last recorded by the Trustees and a letter sent by first class mail to such

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claimant is returned, any payments due the claimant will be held without interest until payment is successfully made.

RECOVERY OF CERTAIN PAYMENTS

The Trustees have the right to recover any overpayment or mistaken payment made to a claimant or to a third party on the claimant's behalf. Such a recovery may be made by reducing other benefit payments made to or on behalf of the claimant, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate.

REIMBURSEMENT AND SUBROGATION OF BENEFITS

If you or your Spouse receives benefits from the Plan for bodily injuries or illnesses sustained from the acts or omissions of any third party, the Plan shall have the right to be reimbursed in the event you or your Spouse recovers all or any portion of the benefits paid by the Plan by legal action, settlement, or otherwise, regardless of whether such benefits were paid by the Plan prior to or after the date of any such recovery, regardless of legal fees, costs or expenses incurred by you or your Spouse. You or your Spouse will not be entitled to receive any benefits for such expenses under the Plan unless you or your Spouse signs the Plan's Subrogation Agreement and agrees to the following conditions:

- To hold in constructive trust any money recovered on your or your Spouse's behalf from a third party, whether by action of law, settlement or otherwise, who is or may be liable for the injury or illness that gave rise to the claim for benefits from the Plan, including an insurance company or a workers' compensation carrier. This money held in constructive trust shall be promptly repaid to the Plan for the benefits extended by the Plan, up to the amount of recovery. You, your Spouse or your or your Spouse's attorney (if the attorney is holding the monetary recovery), shall be fiduciaries with respect to the monies held in constructive trust.
- That the Plan has an equitable lien upon any recovery received by you, your Spouse or your or your Spouse's attorney as a result of compromise or by way of judgment on the claims. The Plan's equitable lien is for the repayment of benefits paid out by the Plan to you or your Spouse or on your or your Spouse's behalf.

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- To irrevocably assign to the Plan all rights to recover monetary compensation from a third party, including the right to bring suit in your or your Spouse's name, or to intervene in any action brought by you or your Spouse to the extent of all benefits paid by the Plan and to give notice of this assignment directly to such third parties, their agents or insurance carriers, or to any agent or attorney who may represent you or your Spouse. The assignment shall entitle the Plan to reimbursement from any sums held or received by the following third parties which are due to you or your Spouse prior to any distribution of benefits to you or your Spouse, and shall provide that such parties shall hold such sums in trust as a fiduciary for the benefit of the Plan. The parties who shall be bound by such assignment are:
 - any party or its insurance carriers making payments to or on behalf of you or your Spouse; or
 - any agent or attorney receiving payments for or on behalf of you or your Spouse.
- To notify the Plan of any claim or legal action asserted against any third party or any insurance carrier(s) for such injuries or illnesses, as well as the name and address of such third parties, insurance carrier(s), any agent or attorney who is representing or acting on behalf of you or your Dependent or the estate of you or your Spouse, or any person claiming a right through you or your Spouse, on a form to be supplied by the Plan.
- To cooperate fully with the Trustees in the exercise of any assignment or right of subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Plan.
- To acknowledge that the Plan shall have the right of recovery by withholding future benefits should you or your Spouse fail to execute an assignment, subrogation agreement or any other documents required herein, or breach any of the terms of this section.
- If there is any reasonable cause to believe that the injuries or illnesses sustained by you or your Spouse were in any way the result of the acts or omissions of one or more third parties, but you or your Spouse disclaims any third party involvements, the Plan shall have the right to require you or your Spouse to sign a declaration, under penalty of perjury, regarding such disclaimer as a pre-condition to the payment of any benefits.

PART E. COBRA COVERAGE

This section contains important information about your Spouse's right to COBRA continuation coverage, which is a temporary extension of your group health coverage (i.e., medical benefits) under the Plan. This section generally explains COBRA continuation coverage, when it may become available to your Spouse, and what he or she needs to do to protect the right to receive it. This notice give only a summary of your Spouse's COBRA continuation coverage rights. For more information about your and your Spouse's rights and obligations under federal law, you should contact the Fund Office.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." For purposes of the Plan, the only applicable qualifying event is divorce, which would result in a loss of coverage for your Spouse. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your Spouse could become qualified beneficiary if coverage under the Plan is lost because of the qualifying event (i.e., divorce). Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred.

You Must Notify The Fund Office About Your Divorce

The Plan requires you or your Spouse to notify the Fund Office within 60 days of your divorce. The notice must contain the name, address, telephone number and Social Security Number of your Spouse, the date on which the divorce occurred and any supporting documents such as a divorce decree. You must send this notice to the Fund Office. Within 30 days after receiving notice of your divorce, the Fund Office will notify you of any right to elect continuation coverage. The Fund Office will also tell you how much the COBRA continuation coverage will cost, and will provide an election form and instructions for electing the coverage.

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To elect COBRA continuation coverage, you must complete the election form and submit it to the Fund Office within 60 days after the later of the

- the qualifying event (the date of your divorce), or
- the date the notice of the right to elect COBRA continuation coverage was sent out by the Fund Office.

If you do not elect COBRA continuation coverage within this time, you will not be eligible for such coverage.

How Is COBRA Coverage Provided?

Once the Fund Office determines or receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to your Spouse if he or she is a qualified beneficiary. If your Spouse elects COBRA continuation coverage, such coverage will apply retroactively to the day on which your Spouse lost coverage under the Plan.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage for divorce lasts up to 36 months. COBRA continuation coverage ends on the earlier of:

- the conclusion of the 36 month period;
- the date on which all coverage offered by the Plan terminates;
- the date on which the Spouse becomes covered by another group health plan that does not contain an exclusion or limitation for a pre-existing condition, provided this occurs on a date after COBRA continuation coverage is elected; or
- the last day of the month preceding the month for which the COBRA premium was not timely paid.

Coverage for a particular benefit may end earlier if you are no longer eligible for that benefit.

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If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

PART F. MISCELLANEOUS

This booklet and the personnel at the Fund Office are authorized sources of Plan information for you. The Trustees of the Plan have not empowered anyone else to speak for them with regard to the Plan. No Employer, Local Union official, business agent, or shop steward is in a position to discuss your rights under the Plan with authority.

Because it is not intended that the Plan duplicate reimbursement that you receive under certain other health care programs, no reimbursement will be made under this Plan for health care costs, if such costs are covered under any workers' compensation or occupational disease law. No benefits will be payable with respect to hospital, surgical, or medical expenses, which are included, or includible in any claim or lawsuit instituted by a Participant or his Spouse against any third party to the extent any award or payment is made in settlement of such claim or lawsuit. Any benefit paid by the Plan prior to such award will be reimbursed to the Plan.

Further, reimbursement for health care costs will be integrated with Medicare, state "no-fault" benefits, and any coverage under any other employer-sponsored health care plans, or health care plans provided under the auspices of an educational institution.

PLAN CONTINUANCE

It is Trustees' intention to maintain this Plan indefinitely. However, the Trustees retain the right to amend or terminate the Plan at any time for any reason, subject to the terms of any collective bargaining agreement. No Participant or Spouse has the right to any benefits from the Plan following its termination.

PRIVACY AND SECURITY OF HEALTH INFORMATION

PRIVACY

Effective April 14, 2003, the receipt, use and disclosure of protected health information ("PHI") by the Fund is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Trustees, certain Fund employees and the Fund's Business Associates may receive, use and disclose PHI in order to carry out payment, treatment and health care operations under the Plan. These entities and individuals may use PHI for such purposes without your consent or written authorization.

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In general, if your PHI is used or disclosed for any other purpose, your written authorization for such use or disclosure will be required. All Plan Participants will receive a Notice of Privacy Practices that explains the Fund's obligation to protect PHI and also describes certain rights you have with regard to your PHI.

Under this new law, the Fund (or health insurance issuer or HMO with the Fund's permission) may disclose PHI, as defined in HIPAA, to the Trustees to carry out administrative functions related to the Plan. The Trustees' administrative functions include the responsibility to control and manage the operation and administration of the Fund, in accordance with ERISA. Such administrative functions include, but are not limited to, the responsibility to determine appeals of benefit claims. The Trustees may use and disclose the PHI provided to it from the Fund (or health insurance issuer or HMO) only for these purposes.

The Trustees are subject to the following limitations and requirements related to their use and disclosure of PHI received from the Fund:

- (1) The Trustees shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to HIPAA.
- (2) The Trustees shall require any agents, including subcontractors, to whom they provide PHI received from the Fund to agree to the same restrictions and conditions that apply to the Trustees with respect to such information.
- (3) The Trustees shall not use PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan.
- (4) The Trustees shall promptly report to the Fund any improper use or disclosure of PHI of which they become aware.
- (5) The Trustees shall provide adequate protection of PHI and separation between the Fund and the Trustees by:
 - (a) ensuring that only the following Fund employees will have access to the PHI provided by the Fund:

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- Fund Manager (Privacy Officer)
- Assistant Fund Manager
- Executive Assistant to the Fund Manager
- Receptionist
- Manager of Information Systems (“MIS”)
- Medical Claims Supervisor (HIPAA Contact Person)
- Hospital Claims Examiner
- Medical Claims Examiners
- Medical Claims Auditor
- Pension Assistant/Back-up for Pre-Audit MagnaCare Auditing Employee
- Member Services Representatives
- Contribution Coordinator
- Eligibility Coordinator
- COBRA Coordinator
- Pension Assistant
- Pension Supervisor

(b) restricting access to and use of PHI to only the employees listed above for limited purposes related to their job responsibilities, and only for the administrative functions performed by the Trustees on behalf of the Fund that are described above; and

(c) using the following procedures to resolve issues of noncompliance by the employees listed above: The Fund has a zero tolerance policy regarding the improper use or disclosure of PHI by any employee. Any employee who violates the Fund’s Policies and Procedures and/or the HIPAA privacy rules will be subject to sanctions at the Fund’s discretion, which may include oral counseling, write-ups, suspension, and/or termination.

(6) The Trustees shall:

(a) make PHI available for access purposes in accordance with 45 C.F.R. § 164.524;

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- (b) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526; and
 - (c) make available the information required to provide an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
- (7) The Trustees shall make their internal practices, books, and records relating to the use and disclosure of PHI received from the Fund available to the Secretary of the Department of Health and Human Services for audit purposes.
- (8) If feasible, the Trustees shall return or destroy all PHI received from the Fund that the Trustees retain in any form when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Trustees shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Fund shall disclose PHI to the Trustees only upon receipt of a certification by the Trustees that the Plan documents have been amended in accordance with 45 C.F.R. § 164.504(f), and that the Trustees shall protect the PHI as described herein.

Please contact the Fund Office if you have any questions regarding your privacy rights or if you need to obtain an authorization form.

SECURITY

Effective April 20, 2005, the Trustees will reasonably and appropriately safeguard the electronic PHI the Trustees receive, create or maintain by, or on behalf of, the Fund in the Trustees' capacity as the sponsor of the Plan. The Trustees shall:

- (1) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the Trustees create, receive, maintain or transmit on behalf of the Fund;

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- (2) implement reasonable and appropriate security measures for the purpose of ensuring that there is adequate separation as described in paragraph (5) of the Privacy section above between the Trustees and the Fund;
- (3) ensure any agent, including a subcontractor, to whom the Trustees provide electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- (4) report to the Fund any security incident of which the Trustees become aware; including attempted or successful unauthorized access, use, disclosure or destruction of information or interference with system operations, that involve electronic PHI provided to the Trustees by, or on behalf of, the Fund.

COORDINATION OF BENEFITS

Under the terms of the Plan, you are not entitled to be paid more than 100% of your covered expenses from this Plan and any other plan combined.

When benefit payments are coordinated between two or more plans, one of the plans is designated as the “primary” plan and all other plans are “secondary.” The Trustees will determine which plan is primary. If a plan has no coordination of benefits provision, it is automatically considered as the primary plan. The primary plan pays full benefits as if there were no other plans.

In instances where this Plan is the secondary plan, it will pay those expenses not covered by the primary plan including co-payments and deductibles, but not more than it would have paid if it were the primary plan. If the primary plan pays benefits equal to or greater than that paid by this Plan, this Plan will not pay any benefits. The total payments from both the primary and secondary plans will never exceed the total allowable expenses under this Plan.

In determining whether this Plan or another plan is primary, the following shall apply:

- (1) The plan covering a person as an employee or in which the person is a participant (regardless of whether such plan deems

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the person covered for the particular benefit) will be the primary plan.

- (2) When rule (1) does not establish an order of benefit determination, the benefits of a plan which has covered the person for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that:
 - (a) The benefits of a plan covering the person as retired employee or as the spouse of such person shall be determined after the benefits of any other plan covering such person as an employee other than as a laid-off or retired employee or a dependent of such person.
 - (b) If either plan does not have a provision regarding laid-off retired employees, and, as a result, each plan determined its benefits after the other, then the provisions of (a) above shall not apply.

If both a husband and wife are eligible for Plan benefits as Participants, the benefit shall be calculated first as if this Plan were the primary plan and then as if the Plan were the secondary plan. This will give them the same coverage as if they had been covered as retirees in two different plans.

If the primary plan denies coverage because of the application of a rule that is unique to the plan and which is not a rule of this Plan, then this Plan will provide only that coverage which it would have provided if the primary plan had granted primary coverage.

Copays required by a primary plan when this Plan is the secondary plan, are eligible for reimbursement under this Plan.

Where not specifically noted, the Plan may utilize NAIC guidelines for Coordination of Benefits.

COORDINATION WITH AUTO NO-FAULT BENEFITS

In some states it is possible for residents to obtain a small savings in their auto insurance premiums by electing a deductible of up to \$2,500 for the

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medical coverage section of their auto insurance policies, the personal injury protection section. If you elect such a deductible, medical expenses up to the amount will not be paid by your auto insurance carrier. This means that deductible amount you select will have to be borne by you unless you have other medical insurance that will cover the deductible amount. If a valid automobile policy is not in force, no benefits will be payable under this Plan.

THIS PLAN WILL CONTINUE TO EXCLUDE THE DEDUCTIBLE FROM ITS SELF-INSURED COVERAGE FOR MEDICAL EXPENSES ARISING FROM OR RELATED TO AUTO ACCIDENTS.

PART G. TECHNICAL DETAILS

PLAN NAME: Road Carriers Local 707 Welfare Plan.

EFFECTIVE DATE: This booklet is effective as of September 1, 2004.

PLAN SPONSOR: Board of Trustees of the Road Carriers Local 707 Welfare Plan.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 11-2159859.

PLAN NUMBER: 501.

TYPE OF PLAN: Welfare Plan.

PLANYEAR ENDS: August 31st.

PLAN ADMINISTRATOR: Board of Trustees – Road Carriers Local 707 Welfare Plan, 14 Front Street, Ste 301,, Hempstead, NY 11550-3602. Phone: (516) 486-7100. The contributing employers and the Union are equally represented on the Board of Trustees.

AGENT FOR SERVICE OF LEGAL PROCESS: David B. Stewart, CEBS, Fund Manager, 14 Front Street, Ste. 301, Hempstead, NY 11550. Phone: (516) 486-7100.

In addition to the person designated as agent for legal process, service of legal process may also be made upon any Plan Trustee.

TYPE OF PLAN ADMINISTRATION: Self-administered by the Board of Trustees.

TYPE OF FUNDING: Insured and Self-Insured.

SOURCES OF CONTRIBUTIONS TO PLAN: Participants are required to contribute to the Road Carriers Local 707 Welfare Plan.

COLLECTIVE BARGAINING AGREEMENTS: This Plan is maintained in accordance with collective bargaining agreements. A copy of these agreements may be obtained by you upon written request to the Fund Manager and are available for examination by you at the Fund Office.

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PARTICIPATING EMPLOYERS: You may receive from the Fund Manager, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. You may also receive the employer's address if the employer is a participating employer.

PLAN BENEFITS PROVIDED BY: All benefits are provided on a self-insured basis. See Part H, Key Contacts, for information regarding insurers and administrators.

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits 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) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself or your Spouse if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse may have to pay for such coverage. Review this booklet and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer,

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your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

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

If you have any questions about the 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 NW, 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.

NO INSURANCE BY THE PBGC: Since this Plan is not a defined benefit pension plan, it is not covered by the Pension Benefit Guaranty Corporation.

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TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the Road Carriers Local 707 Welfare Plan. The following are the individual Trustees that make up the Board. The Union and the Employers who contribute to the Plan are equally represented on the Board of Trustees.

Union Trustees

Kevin McCaffrey
President
I.B.T. Local 707
14 Front Street, Ste 300
Hempstead, NY 11550

Vincent Cangelosi
Secretary/Treasurer
I.B.T. Local 707
14 Front Street, Ste. 300
Hempstead, NY 11550

Employer Trustees

Peter Hassler
Vice President-Labor Relations
Roadway Express
100 Roadway Drive
Carlisle, PA 17013

Tom J. Ventura
Vice President-Contract Administration
Yellow Freight Systems
10990 Roe Avenue
Overland Park, KS 66207

PART H. KEY CONTACTS

(As of September 1, 2004)

Annual Physical Exam Administrator

Professional Evaluation Medical Group (PEMG)
380 South Broadway Hicksville, NY 11801
516-935-4378
www.professionalevaluationmedicalgroup.com

Prescription Drug Program ~ Retail Drug Administrator

Union Labor Life Insurance Co.
USA Health Services
Mail Route 4517
PO Box 169052
Duluth, MN 55816-8220
Pharmacy Hotline 800-287-4505
TDD 800-899-2114

Medical Case Management Organization

Ullicare
111 Massachusetts Ave, NW
Washington, DC 20001
800-848-9200
www.ullicare.com

Hearing Aid Administrator

Crystal Clear Hearing
1919 Middle Country Road
Centereach, NY 11720
516-467-2176

PPO Provider

MagnaCare
825 East Gate Blvd.
Garden City, NY 11530
516-227-6900
www.magnacare.net/ppo.htm

Hospital Case Management Organization

Empire Blue Cross/Blue Shield
P.O. Box 1407
Church Street Station
New York, NY 10008-1407
1-800-553-9603
www.empireblue.com

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Prescription Drug Program ~ Mail Order Administrator

Teamsters Care
552 Main Street/Sullivan Square
Charlestown, MA 02129-1109
800-235-0760

Vision Care Administrator

Davis Vision
Customer Service
PO Box 971
Schenectady, NY 12301
800-999-5431
www.davisvision.com

Mental Health & Substance/Alcohol Abuse Administrator

Teamsters Center Services
Montefiore Medical Center
111 East 210th Street
Bronx, NY 10467
1-800-433-4827

Central States Health & Welfare Fund

P.O. Box 5103
Des Plaines, IL 60017-5103
Claims Processing Dept.
1-800-323-5000

Teamsters Local 671

18 Britton Drive
Bloomfield, CT 06002
1-860-243-0671

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