Central States, Southeast and Southwest Areas Health and Welfare Fund Retiree Plan Document

Restated Retiree Plan Document As Amended Through January 1, 2026

CENTRAL STATES, SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND RETIREE PLAN, a jointly administered, defined benefit retiree employee benefit plan

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PLAN DOCUMENT
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ARTICLE I. DEFINITIONS

The terms used in this Plan shall have the following meanings:

1.01 Accidental Bodily Injury: Physical damage to the body resulting from a sudden and unexpected event, injury or external force occurring without forewarning.

1.02 Active Fund: A Central States-sponsored health and welfare plan covering active participants in existence on the Covered Participant's Date of Retirement or date of selection of the pension benefit deferral.

1.03 Active Plan: Shall have the same meaning as the term "Active Fund."

1.04 Active Plan Coverage: Full entitlement to all benefits of the Active Plan by an Active Plan Participant or Dependent, unless limited or excluded by any provision of the Active Plan.

1.05 Active Plan Covered Participant: A participant who qualifies for Active Plan Coverage in accordance with the provisions of Article III of the Active Plan.

1.06 Alcoholism or Substance Abuse Treatment Facility: A treatment facility or clinic which provides a program of effective medical and therapeutic treatment for either alcoholism and/or substance abuse approved by the attending Physician and the Fund, and which:

(a) Is licensed, certified or approved as an Alcoholism and/or Substance Abuse Treatment Facility by the state or jurisdiction in which it is located, and does not have a license as a "Hospital";

(b) Has or maintains a specific and detailed program requiring full residence or full participation by the patient; and

(c) Provides at least the following basic services:

(1) Room and Board (inpatient);

(2) Evaluation and diagnosis;

(3) Counseling; and

(4) Referral and orientation to specialized community resources.

1.07 Bargaining Unit: A group of Active Plan Covered Participants formed by those categories of employees designated as being represented by the union in the Collective Bargaining Agreement.

1.08 Benefits: Hospital Expense Benefit; Surgical and Obstetrical Expense Benefit; Outpatient Diagnostic X-ray and Laboratory Expense Benefit; Prescription Drug Benefit; Psychiatric, Alcoholism and Drug Abuse-Inpatient Treatment Benefit; Psychiatric, Alcoholism and Drug Abuse-Outpatient Treatment Benefit; Organ Transplant Donor Benefit; Hearing Aid Benefit; Outpatient Cancer Treatment Benefit; Ambulance Service Benefit; Chiropractic Expense Benefit; Women's Health Benefit; Mayo Clinic Treatment; and Miscellaneous Expense Benefit. Benefits are described in detail in Article XI.

1.09 Bone Marrow Transplant: Any care, treatment services or supplies relating to the harvesting and/or transfer of stem cells and/or bone marrow into or back into the patient.

1.10 Chiropractor: A legally qualified and licensed Chiropractor.

1.11 Clinical Psychologist:

(a) A person who is licensed or certified as a Psychologist by the appropriate governmental authority having jurisdiction over such licensure or certification, as the case may be, in the jurisdiction where such person renders service to the Covered Individual; or

(b) A person who is a Member or Fellow of the American Psychological Association, if there is no licensure or certification in the jurisdiction where such person renders service to the Covered Individual.

1.12 Collective Bargaining Agreement: An agreement reached by bargaining as to wages and conditions of work and to which the union is a party.

1.13 Contributory Service: Those periods of time during which contributions were made on behalf of the Covered Participant in order to establish and maintain Coverage under any Active Plan.

1.14 Continuation Coverage: A continuation of the same terms, conditions, limitations and exclusions of Coverage as are provided by the Fund to a Covered Individual on the day before a Qualifying Event upon completion of election procedures pursuant to Section 3.13.

1.15 Core Teamster Industry: Core Teamster Industry means and includes Reemployment in any of the following industries:

(a) trucking and/or freight;

(b) small package and/or parcel delivery;

(c) car haul;

(d) tank haul;

(e) warehouse;

(f) food processing and/or distribution (including grocery, dairy, bakery, brewery, and soft drink); and

(g) building material and/or construction.

1.16 Cosmetic: Care, treatment, services or supplies the primary effect of which is to improve the physical appearance of a Covered Individual. The fact that there may be an incidental medical benefit does not prevent a determination that the care, treatment, services or supplies are cosmetic.

1.17 Coverage: Full entitlement to all benefits of this Plan by a Covered Participant or Covered Dependent, unless limited or excluded by any provision of this Plan.

1.18 Covered Dependent: The Spouse of the Covered Participant who qualifies for Coverage under this Plan in accordance with the provisions of Article III of this Plan.

1.19 Covered Individual: A Covered Participant or a Covered Dependent. See also Section 3.16.

1.20 Covered Participant: A Participant who qualifies for Coverage under this Plan in accordance with the provisions of Article III of this Plan.

1.21	Date of Retirement:	The date a Covered Participant stops working and terminates his employment and chooses to be the effective date of his pension.
1.22	Dentist:	A legally qualified and licensed dentist.
1.23	Dependent:	A Covered Participant's Spouse.
1.24	Early Retirement Pension:	A pension from the Pension Fund or another Teamsters Related Pension Plan requiring the minimum service requirement of 20 years (30 years if Date of Retirement is under age 50) and the appropriate contribution requirement.
1.25	Employer:	Any Employer (including an Association of Employers) who is or becomes a party to a Collective Bargaining Agreement and who, with the acquiescence of the Trustees, agrees to be bound by the Trust Agreement and this Plan and is accepted for participation in the Plan by the Trustees, subject to such rules as the Trustees may in their discretion adopt. The Local Union, the Health and Welfare Fund and the Pension Fund shall be deemed to be Employers of those persons employed and proposed by such organizations and accepted by the Trustees.
1.26	Former Covered Participant:	A person who was a Covered Participant but presently has no Coverage. See also Section 3.16.
1.27	Fund:	The Central States, Southeast and Southwest Areas Health and Welfare Fund Retiree Plan.
1.28	Health Maintenance Organization (HMO):	An organization operating as a Health Maintenance Organization.
1.29	Hospital:	A facility licensed by the State or jurisdiction in which it is located with inpatient beds and medical services, including physician services and continuous nursing services under the supervision of registered nurses, to provide diagnosis and medical or surgical treatment primarily for but not limited to acutely ill patients and accident victims, to provide treatment for patients with mental illness or to provide treatment in special inpatient care facilities.

1.30 Leaving Covered Service: The date on which the Active Fund no longer receives health and welfare contributions for a participant.

1.31 Local Union: Those Local Unions affiliated with the International Brotherhood of Teamsters who have executed Collective Bargaining Agreements which require contributions to be made to the Active Fund on behalf of the covered employees, and such other unions as the Trustees may agree upon.

1.32 Maintenance Care: Maintenance Care is care provided to a person who needs assistance or support for activities of daily living but who is not under a course of treatment which will improve his condition to the extent necessary to enable him to function without such assistance or support, except for care which is necessary to treat a curable illness. A Maintenance Care determination is not precluded by the fact that a patient is under the care of a Physician and that the services are provided at the Physician's request.

1.33 Medicare: The program of accident and health benefits as provided by the Social Security Administration.

1.34 Other Plan: Any group plan, insurance policy or contract which provides benefits for hospital, surgical, dental, psychiatric, chiropractic or other medical treatment, and any plan or insurance coverage hereafter described in subparagraph (f). Other Plan includes a plan providing benefits through:

(a) Group blanket or franchise insurance coverage;

(b) Group Blue Cross, Group Blue Shield, group practice or other prepayment coverage;

(c) Any coverage under labor-management trusteed plans, union welfare plans, employer organizations or employee benefits organization plans;

(d) Any coverage under government programs or any coverage required or provided by statute;

(e) Any other arrangement providing hospital, surgical, dental, psychiatric, chiropractic or other medical treatment for members of a group; and

(f) No fault, personal injury protection or financial responsibility motor vehicle insurance coverage

which provides benefits to or for a Covered Individual for bodily or psychological injury, including but not limited to, benefits for hospital, surgical, dental, psychiatric, chiropractic and other medical treatment.

The term "Other Plan" shall be construed separately with respect to each policy or other provision thereof, sub-plan, contract or other arrangement for benefits or services and separately with respect to that portion of any such policy or other provision thereof, sub-plan, contract or other arrangement (whether a separate plan or not) which reserves the right to take the benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

1.35 Out-of-Pocket Expense Limit: A maximum liability per Covered Individual, per calendar year as set forth in Article XII.

1.36 Pension Fund: The Central States, Southeast and Southwest Areas Pension Fund.

1.37 Physician: A legally qualified and licensed Physician. A Physician does not include a Chiropractor.

1.38 Plan: The Central States, Southeast and Southwest Areas Health and Welfare Fund Retiree Plan as set forth herein and as hereafter amended.

1.39 Plan Deductible: A deductible per calendar year applied to Benefits as set forth in Article XIII.

1.40 Plan Benefit Limit: A maximum payout per calendar year for combined Benefits as set forth in Article XIV.

1.41 Podiatrist: A legally qualified and licensed Podiatrist.

1.42 Prescription Drug: A drug or medicine prescribed by a Physician or Dentist, dispensed by a pharmacist, not available over the counter (except for insulin and insulin syringes) and bearing the Federal or State legend.

1.43	Privacy Rule:	The Standards for Privacy of Individually Identifiable Health Information published at 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subparts A and E.
1.44	Protected Health Information:	Shall have the same meaning as the term "protected health information" as defined at 45 C.F.R. § 164.501.
1.45	Psychiatrist:	A legally qualified and licensed Psychiatrist.
1.46	Psychiatric Treatment Facility:	A facility that is: (a) Engaged in providing, under the supervision of a Physician, psychiatric services for the diagnosis and treatment of mentally ill persons; and (b) Licensed, certified or approved by the state or jurisdiction in which it is located to provide psychiatric services.
1.47	(Reserved)	RESERVED FOR FUTURE USE
1.48	Qualifying Event:	An event, as set forth in Section 3.10, which causes the former Covered Dependent Spouse to become eligible for Coverage under individual Self-Payments provisions.
1.49	Reasonable and Customary:	The usual, Reasonable and Customary charge for the treatment, supply, or service, determined by comparison with the charges customarily made for similar treatments, supplies or services to individuals with similar medical conditions within a given geographical area.
1.50	Reemployment:	Reemployment means and includes any employment, self-employment, occupation or service of any kind and at any time which is a basis for any form of past, present or future wages, salary, commissions, profit or other income (including employment in a managerial or supervisory position, and including any occupation or service in which there is no employer-employee relationship).
1.51	Retiree Contribution Benefit:	The payment of a contribution to the Fund by the Active Fund on behalf of an Active Plan Covered Participant whose Employer has elected to provide for retiree health benefits.

1.52 Self-Payments: Contributions made to the Fund by a Covered Individual on his own behalf.

1.53 Service in the Uniformed Services: Service by a Covered Individual in the Uniformed Services, which means and includes the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency, provided that such services includes the performance of duty by the Covered Participant on a voluntary or involuntary basis in a Uniformed Service under competent authority and also includes any period during which a Covered Participant is absent from employment for the purpose of an examination to determine the Covered Participant's fitness to perform any such duty, and provided further that such service results in the absence of the Covered Participant from continuous funded employment by an Employer.

1.54 Social Security Act: The federal regulations as they pertain to eligibility for coverage under the Medicare programs.

1.55 Spouse: An individual who is married to a Covered Participant in a legally recognized civil or religious ceremony. A Covered Participant's common-law Spouse shall be considered a Spouse for purposes of the Plan, if:

(a) The Covered Participant's state of domicile recognizes common-law marriage; and

(b) The Covered Participant furnishes the Fund with appropriate documentation that the couple has fulfilled all conditions which his state of domicile requires for such a marriage.

1.56 Standard Medical Care, Treatment, Services or Supplies: Care, treatment, services or supplies which are generally accepted by the medical community as Standard Medical Care, Treatment, Services or Supplies.

1.57 Surrogate Mother: A Surrogate Mother is a woman who, before she becomes pregnant, has agreed by contract or other understanding (with or without compensation) to bear a child/children (including when the woman provides the ovum) that will be

given up to another person or persons to raise following birth.

1.58 TeamCare: A registered federal trademark used by the Plan as a tradename.

(a) Network Administrator: a business organization that performs administrative services for TeamCare including negotiating rates with providers, receiving claims, and making payments to providers on behalf of TeamCare.

(b) TeamCare Network: all providers or facilities that have a contract with TeamCare or one of its Network Administrators to provide medical treatment, medical supplies, medical equipment or other services to Covered Individuals at a negotiated rate.

(c) In-network: a Physician, other provider, or facility that has a contract to participate in a TeamCare Network.

1.59 Teamsters: The International Brotherhood of Teamsters and its affiliated Local Unions.

1.60 Teamster Related Pension Plan: A pension plan created as a result of a Collective Bargaining Agreement to which the Teamsters is a party.

1.61 Thirty (30) And Out Pension: The pension payable to an individual who has had 30 years of contributions paid into the Pension Fund.

1.62 Trust Agreement: The Agreement and Declaration of Trust made and entered into on the fourteenth (14th) day of March, 1950, by and between Central Conference of Teamsters, Southern Conference of Teamsters and their affiliated Local Unions, and the Southeastern Area Motor Carriers Labor Relations Association; Southwest Operators Association; and Motor Carriers Employers Conference-Central States, as amended from time to time thereafter by the Trustees.

1.63 Trustees: The Trustees designated and appointed in accordance with the terms of the Trust Agreement.

1.64 Trust Fund: All assets, including principal and interest, of the Retiree Plan Subaccount of the Trust created by the Trust Agreement.

1.65 Twenty-Five (25) And Out Pension: The pension payable to an individual who has had 25 years of contributions paid into the Pension Fund.

1.66 Voluntary Withdrawal: The cessation of an existing contractual obligation of an Employer, pursuant to a Collective Bargaining Agreement, to make employer contributions to the Fund and the Active Fund at published rates established by the Fund and the Active Fund to provide retiree benefits under this Plan, if the cessation of the obligation to contribute results from acts or omissions in which any members of a Bargaining Unit participate, including but not limited to:

(a) decertification or other removal of the union as a bargaining agent;

(b) ratification or other acceptance of a Collective Bargaining Agreement which permits withdrawal of the Bargaining Unit, in whole or in part, from the Active Fund;

(c) failure to submit to the Active Fund a Collective Bargaining Agreement for a renewal of participation in the Active Fund which, in form and substance, complies with participation standards of the Active Fund, and the termination (as a result of that failure) of the Employer as an Employer participating in the Active Fund; and

(d) ratification or acceptance of a collective bargaining agreement which permits the Employer to cease contributions to the Active Fund at a then prevailing published rate established by the Active Fund to provide retiree benefits under this Plan, and the immediate commencement of the Employer's obligation to contribute to the Active Fund pursuant to a Collective Bargaining Agreement, at a published rate established by the Active Fund to provide coverage under the Active Plan without the availability of coverage under this Plan.

If, during or after a temporary work stoppage by Active Plan Covered Participants, their Employer hires replacement workers whose actions later cause or contribute to the withdrawal by that Employer from the Active Fund (and the end of its

obligation to contribute to the Active Fund), this withdrawal will not be considered a “Voluntary Withdrawal” for any Covered Participants except those Covered Participants (if any) who return to work for that Employer during or after the temporary work stoppage.

ARTICLE II. EFFECTIVE DATE OF GENERAL PROVISIONS

2.01 **THE TERMS AND PROVISIONS OF THIS PUBLISHED EDITION OF THIS PLAN DOCUMENT ARE APPLICABLE TO THE COVERAGE OF EVERY COVERED INDIVIDUAL WHO HAS BEEN, IS OR HEREAFTER BECOMES ENTITLED TO COVERAGE BY THE PLAN AS OF ANY DATE ON OR AFTER JANUARY 1, 2026, PROVIDED THAT THE TERMS, PROVISIONS, LIMITATIONS AND EXCLUSIONS OF COVERAGE AS OF ANY DATE PRIOR TO JANUARY 1, 2026, ARE GOVERNED BY THE EARLIER EDITION OF THIS PLAN DOCUMENT THAT WAS IN EFFECT ON THAT DATE (INCLUDING ALL PLAN AMENDMENTS OF THAT EDITION ADOPTED AND IN EFFECT ON THAT DATE), AND PROVIDED FURTHER THAT THE TERMS AND PROVISIONS OF THIS EDITION ALSO INCLUDE ALL PLAN AMENDMENTS ADOPTED AND IN EFFECT AFTER PUBLICATION OF THIS EDITION (EVEN IF THEY ARE YET TO BE INCORPORATED IN THIS EDITION).**

ARTICLE III. PARTICIPATION AND COVERAGE

3.01 QUALIFICATIONS AS A COVERED PARTICIPANT[1]

(a) An individual who retires, subject to the rules set forth in the Pension Fund Plan Document, prior to his 50th birthday will be considered a Covered Participant if:

(1) The individual had Active Plan Coverage under Plan C6 on his Date of Retirement; and

(2) For at least forty (40) of fifty-two (52) weeks in each of the five years immediately before retirement; or at least forty (40) of fifty-two (52) weeks in seven out of the ten years immediately before retirement, the individual was covered by a Central States' plan (a) that provides for retiree health plan benefits and/or (b) under which a Retiree Contribution Benefit was paid on his behalf.

(3) The individual is receiving a 30 and Out Pension based on thirty (30) years of Contributory Service made to the Pension Fund.

If the above requirements are met, the individual will be eligible for this Plan effective on his 50th birthday. For retirement dates subsequent to December 31, 2004, retiree health plan coverage will begin effective the Covered Participant's 57th birthday.

(b) An individual who retires, subject to the rules set forth in the Pension Fund Plan Document, prior to his 55th birthday will be considered a Covered Participant if:

(1) The individual had Active Plan Coverage under Plan C6 on his Date of Retirement; and

(2) For at least forty (40) of fifty-two (52) weeks in each of the five years immediately before retirement; or at least forty (40) of fifty-two (52) weeks in seven out of the ten years immediately before retirement, the individual was covered by a Central States' plan (a) that provides for retiree health plan benefits and/or (b) under which a Retiree Contribution Benefit was paid on his behalf.

(3) The individual is receiving a 25 and Out Pension based on twenty-five (25) years of Contributory Service made to the Pension Fund.

If the above requirements are met, the individual will be eligible for this Plan effective on his 55th birthday. For retirement dates subsequent to December 31, 2004, retiree health plan coverage will begin effective the Covered Participant's 57th birthday.

(c) An individual who retires, as defined in the Pension Fund Plan Document, on or after his 50th birthday, but prior to age 57, will be considered a Covered Participant if:

[1] TForce Participants should refer to Article XVIII

(1) The individual had Active Plan Coverage under Plan C6 on his Date of Retirement; and

(2) For at least forty (40) of fifty-two (52) weeks in each of the five years immediately before retirement; or at least forty (40) of fifty-two (52) weeks in seven out of the ten years immediately before retirement, the individual was covered by a Central States' plan (a) that provides for retiree health plan benefits and/or (b) under which a Retiree Contribution Benefit was paid on his behalf.

(3) The individual is eligible to receive, at minimum, an Early Retirement Pension for twenty years of service (excluding any form of disability or vested pension) from a Teamster Related Pension Plan (including the Pension Fund).

If the above requirements are met, the individual will be eligible for this Plan effective on his 57th birthday (unless 3.01(a) or (b) or (d) applies).

(d) An individual who retires, subject to the rules set forth in the Pension Fund Plan Document, prior to his 57th birthday, will be considered a Covered Participant if:

(1) The individual had Active Plan Coverage under a Plan other than C6 on his Date of Retirement; and

(2) For at least forty (40) of fifty-two (52) weeks in each of the five years immediately before retirement; or at least forty (40) of fifty-two (52) weeks in seven out of the ten years immediately before retirement, the individual was covered by a Central States' plan (a) that provides for retiree health plan benefits and/or (b) under which a Retiree Contribution Benefit was paid on his behalf.

(3) The individual is receiving a 30 and Out Pension at benefit class fifteen or higher, based on thirty years of Contributory Service made to the Pension Fund.

If the above requirements are met, the individual will be eligible for this Plan effective on his 57th birthday.

(e) An individual who retires, as defined in the Pension Fund Plan Document, on or after his 57th birthday, but prior to age 65, will be considered a Covered Participant if:

(1) For at least forty (40) of fifty-two (52) weeks in each of the five years immediately before retirement; or at least forty (40) of fifty-two (52) weeks in seven out of the ten years immediately before retirement, the individual was covered by a Central States' plan (a) that provides for retiree health plan benefits and/or (b) under which a Retiree Contribution Benefit was paid on his behalf.

(2) The individual has worked at least twenty years under the terms of a Collective Bargaining Agreement negotiated by an affiliate of the Teamsters. In the case of a Bargaining Unit joining the Active Fund as a new group, all employment with that employer prior to the date the group joined the Active Fund shall be considered toward the fulfillment of the twenty year requirement provided that the classifications worked in subsequently required that contributions be submitted to the Active Fund.

(f) An individual who is eligible to defer his pension benefit, subject to the rules set forth in the Central States Pension Fund Plan Document, may also be considered a Covered Participant of this Plan under the provisions of 3.01(a), (b), (c) and (d). Eligibility for this Plan shall be determined as follows:

Eligibility rules subject to the provisions of 3.01(a), (b), (c) and (d) will be applied at the time of deferral or when the individual leaves covered employment, whichever is later. Individuals under a Central States plan that provides (a) for retiree health plan benefits and/or (b) for which a Contribution Benefit has been paid on the Participant's behalf, must defer to at least age 57 in order to qualify for this Plan's Benefits. Once eligibility has been established, this Plan's Benefits will begin when pension benefits begin.

(g) If an individual has become unemployed due to the bankruptcy of his employer and returns to work on a part time or casual basis, such individual's eligibility for this Plan shall also be determined at the latest of the following dates:

(1) When the individual was eligible to defer;

(2) When the individual left Health and Welfare covered employment.

If eligibility is established subject to the eligibility rules stated above, this Plan's Benefits will begin according to the provisions of 3.01(a), (b), (c), (d) and (e).

(h) An individual who is not eligible to defer his pension benefit, subject to the rules set forth in the Pension Fund Plan Document, may also be considered a Covered Participant of this Plan under the provisions of 3.01(a), (b), (c) and (d). Eligibility for this Plan shall be determined at the time the individual decides to leave health and welfare covered employment. If eligibility has been established, this Plan's Benefits will begin according to the provisions of 3.01(a), (b), (c), (d) and (e).

(i) The Fund may, at its discretion, waive the requirements set forth in 3.01(a)(2), 3.01(b)(2), and 3.01(c)(2) for individuals who fail to satisfy these requirements solely because of a forced transfer of employment into or out of the geographical jurisdiction of the Fund, a change or dispute over union jurisdiction, or some similar event beyond the control of the individuals involved.

(j) Participants who change employers and become covered by the C6 Active Plan or whose employers change health plans to the C6 Active Plan must have at least forty (40) of fifty two (52) weeks of coverage in the 12 months subsequent to moving to the C6 Active Plan, in addition to meeting all other eligibility requirements, to receive coverage under the C6 Retiree Plan provisions.

(k) Self-payments made to the Central States' Pension Plan subsequent to the participant's employer's termination in the Pension Plan for any reason shall not be included in Contributory Service utilized for determination of retiree eligibility.

(l) No individual shall be qualified as a Covered Participant eligible for Coverage under this Plan if he loses his otherwise available minimum Active Plan Coverage credit (which is described elsewhere in this section as a prerequisite for Coverage under

this Plan) as a result of a Voluntary Withdrawal from the Active Fund, in the following circumstances:

(1) if the date of a Voluntary Withdrawal is prior to September 11, 2002, and if the individual requesting Coverage under this Plan was, on the date of the Voluntary Withdrawal, a member of the withdrawn Bargaining Unit and is still employed by the same Employer ("the withdrawn Employer") six months after the date of the Voluntary Withdrawal, the Fund will exclude all of the individual's credit for Active Plan Coverage based upon his employment at any time by any Employer in determining the individual's eligibility for Coverage under this Plan; and

(2) if the date of a Voluntary Withdrawal is on or after September 11, 2002, the Fund will exclude all of the individual's credit for Active Plan Coverage (to the extent such credit is based upon the individual's employment by the withdrawn Employer at any time before or after September 11, 2002) in determining the individual's eligibility for Coverage under this Plan if:

(A) the individual was employed by the withdrawn Employer on the date of the Voluntary Withdrawal; or

(B) the individual was ever employed by the withdrawn Employer at any time prior to (but not on) the date of the Voluntary Withdrawal (including employment prior to September 11, 2002) and the individual's final Active Plan Coverage as of his Date of Retirement (before or after September 11, 2002) was or is based upon employment by the withdrawn Employer; provided that an individual whose eligibility for Coverage under this Plan is terminable by application of this subsection (l) (2) and who, as of the date of the Voluntary Withdrawal (on or after September 11, 2002), has already been acknowledged by the Fund to be a Covered Participant eligible for Coverage under this Plan will be allowed to provide to the Fund, within a time period established by the Fund, a timely written election for continuation of that Coverage in exchange for a required full Self-Payment in an amount established by the Fund.

3.02 QUALIFICATIONS AS A COVERED DEPENDENT

(a) This Plan provides Coverage only for the Dependent Spouse of a Covered Participant.

(b) Unless otherwise provided herein, an individual shall be considered a Covered Dependent under this Plan when the person to whom he/she is legally married or is considered a Covered Participant under the Plan.

(c) A Covered Dependent will not be eligible for Coverage if the Covered Participant has elected to defer Coverage under the provisions of Section 3.03.

3.03 COMMENCEMENT OF COVERAGE OF A COVERED PARTICIPANT

A Covered Participant shall participate in, and have coverage under, this Plan commencing on the date on which the conditions and qualifications of Section 3.01 are satisfied and on which he or she is

no longer covered by an Active Plan, except that there shall be no Coverage of the Covered Participant under this Plan if, on his or her Date of Retirement, he or she is already 65 years of age and/or is entitled to Medicare benefits(unless the Participant has achieved his first date of entitlement to Medicare benefits solely as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30-month period following the first month in which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this section such period of entitlement to Medicare benefits shall be disregarded.). A Covered Participant whose application for retirement benefits under a Teamster Related Pension Plan is approved, after the date on which he/she is no longer covered by the Active Plan shall, upon such approval, have Coverage under this Plan commencing on the date on which coverage by the Active Plan ended or on his Date of Retirement, whichever is later, except that there shall be no Coverage of the Covered Participant under this Plan if, on his/her Date of Retirement, he or she is already 65 years of age and/or is entitled to Medicare benefits. Coverage of a Covered Participant shall be contingent on compliance with such Self-Payment requirements and procedures as are established by the Fund from time to time.

A Covered Participant may elect on a one-time only basis to defer the start date of his Coverage under this Plan beyond his retirement date or age 57, whichever is later, or to suspend his Coverage once after his Coverage has commenced, provided the following conditions are met:

(1) The Covered Participant has met the eligibility rules stated in Article 3.01 above, and

(2) The Covered Participant provides documentation to the Fund that he has coverage under Other Insurance.

A Covered Participant may start his Coverage again after a deferral period as provided for in this Section 3.03 upon the occurrence of a HIPAA Qualifying Event.

3.04 **COMMENCEMENT OF COVERAGE OF A COVERED DEPENDENT**

The Spouse of a Covered Participant shall be a Covered Dependent and shall participate in, and have Coverage under, this Plan (unless the Spouse is then already 65 years of age and/or entitled to Medicare benefits) commencing on the date on which the Covered Participant to whom he or she is married first has Coverage under this Plan or, if later, the date on which he or she is first married to a Covered Participant (provided written notice is received by the Fund within 60 days from date of marriage. The Spouse of an individual who would have become a Covered Participant on his or her Date of Retirement except that, on such date, he or she is already 65 years of age and/or is entitled to Medicare benefits, shall be a Covered Dependent and shall participate in, and have a maximum of 36 months of Coverage under this Plan (unless the Spouse is then already 65 years of age and/or entitled to Medicare benefit unless the Spouse if entitled to Medicare benefits solely as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30-month period following the first month in which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this section such period of entitlement to Medicare benefits shall be disregarded.) commencing on the date on which the individual (to whom the Spouse is then married would have become a Covered Participant, provided that the Coverage of such a Spouse shall be classified as a Continuation Coverage elected by the Spouse and that the initial date of such Coverage shall be classified as a Qualifying Event, within the meaning and for all purposes of Sections 3.09, 3.10 and 3.12, and provided further that the Continuation Coverage of such a Spouse shall be terminated on the earliest of the termination dates specified in

Section 3.15. Coverage of a Covered Dependent shall be contingent on compliance with such Self-Payment requirements and procedures as are established by the Fund from time to time.

On or after August 1, 2008, a Covered Dependent may elect on a one-time only basis to defer the start date of his or her Coverage under this Plan beyond Covered Participant's effective date Coverage, or to suspend his or her Coverage once after his or her Coverage has commenced, provided the following conditions are met:

(1) The Covered Dependent has met the eligibility rules stated in Article 3.02 above, and

(2) The Covered Dependent provides documentation to the Fund that he or she has coverage under Other Insurance.

A Covered Dependent may start his Coverage again after a deferral period as provided for in this Section 3.04 upon the occurrence of a HIPAA Qualifying Event.

3.05 ELIGIBILITY OF INDIVIDUALS QUALIFYING FOR AN EXTENSION OF BENEFITS UNDER ANOTHER CENTRAL STATES ACTIVE PLAN

(a) If a Covered Participant under this Plan would otherwise qualify for an extension of Basic Benefits under an Active Plan, he shall, as a condition of becoming a Covered Participant under this Plan, lose the eligibility for such extension of benefits.

(b) If a Covered Participant under this Plan would otherwise qualify for an extension of Major Medical Expense Benefits under an Active Plan, he shall, as a condition of becoming a Covered Participant under this Plan, lose the eligibility for such extension of benefits.

3.06 TERMINATION OF COVERAGE OF A COVERED PARTICIPANT

A Covered Participant's Coverage under this Plan shall terminate on the earliest of the following dates:

(a) the date the Covered Participant becomes 65 years of age;

(b) the date such Covered Participant first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. § 1395, et seq.). (Provided however, that Coverage shall not terminate under this Plan solely because the Participant has achieved his first date of entitlement to Medicare benefits as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30 month period following the first month in which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this Subsection (b) such period of entitlement to Medicare benefits shall be disregarded);

(c) the date of the Covered Participant's death;

(d) the date on which this Plan is terminated;

(e) the date on which the Covered Participant again becomes employed by an Employer which is required to make employer contributions to the Active Fund to secure Active Plan Coverage of the Covered Participant, provided that, on his or her future Date of Retirement after such reemployment, he or she may again participate in, and have Coverage under, this Plan if, and on the date on which, the conditions and qualifications of Sections 3.01 and 3.03 are satisfied;

(f) on the date the Covered Participant is engaged in restricted Reemployment as set forth in Section 10.17;

(g) the date the Coverage of the Covered Participant terminates for any reason other than death or commencement of eligibility for Medicare benefits; or

(h) the date of a Voluntary Withdrawal from the Active Fund of a Covered Participant's former Employer and Bargaining Unit on or after September 11, 2002, if

(1) the Covered Participant was ever employed by the withdrawn Employer at any time prior to (but not on) the date of the Voluntary Withdrawal (including employment prior to September 11, 2002) and the Covered Participant's final Active Plan Coverage as of his Date of Retirement (before or after September 11, 2002) was or is based upon employment by the withdrawn Employer; and

(2) the Covered Participant no longer has sufficient Active Plan Coverage credit to satisfy any minimum prerequisite for Coverage under this Plan after the Fund retroactively excludes all of his credit for Active Plan Coverage based upon employment at any time by that withdrawn Employer in re-determining his eligibility for Coverage under this Plan, provided that a Covered Participant whose Coverage under this Plan is terminable by application of this subsection (h) will be allowed to provide to the Fund, within a time period established by the Fund, a timely written election for continuation of that Coverage in exchange for a required full Self-Payment in an amount established by the Fund.

In addition to the above specified events that terminate Coverage, Coverage of a Covered Participant shall be terminated upon an election not to comply, or upon any failure to comply, with such Self-Payment requirements and procedures as are established by the Fund from time to time.

3.07 **TERMINATION OF COVERAGE OF A COVERED DEPENDENT**

A Covered Dependent's Coverage under this Plan shall terminate on the earliest of the following dates:

(a) the date such Covered Dependent attains 65 years of age;

(b) the date such Covered Dependent first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. § 1396 et seq.). (Provided however, that Coverage shall not terminate under this Plan solely because the Dependent has achieved his first date of entitlement to Medicare benefits as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30 month period following the first month in

which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this Subsection (b) such period of entitlement to Medicare benefits shall be disregarded);

(c) a maximum of five years after the Covered Participant's Date of Retirement if such Covered Participant dies prior to his 65th birthday;

(d) the date of such Covered Dependent's death;

(e) the date such Covered Dependent ceases to be legally married to his or her Covered Participant;

(f) the date the Plan is terminated;

(g) the date the Coverage of the Covered Participant terminates for any reason other than death or commencement of eligibility for Medicare benefits;

(h) the date of a Voluntary Withdrawal from the Active Fund of a Covered Participant's former Employer and Bargaining Unit on or after September 11, 2002, if

(1) the Covered Participant was ever employed by the withdrawn Employer at any time prior to (but not on) the date of the Voluntary Withdrawal (including employment prior to September 11, 2002) and the Covered Participant's final Active Plan Coverage as of his Date of Retirement (before or after September 11, 2002) was or is based upon employment by the withdrawn Employer; and

(2) the Covered Participant no longer has sufficient Active Plan Coverage credit to satisfy any minimum prerequisite for Coverage under this Plan after the Fund retroactively excludes all of his credit for Active Plan Coverage based upon employment at any time by that withdrawn Employer in re-determining his eligibility for Coverage under this Plan, provided that a Covered Participant whose Coverage under this Plan is terminable by application of this subsection (h) will be allowed to provide to the Fund, within a time period established by the Fund, a timely written election for continuation of that Coverage in exchange for a required full Self-Payment in an amount established by the Fund.

In addition to the above specified events that terminate Coverage, Coverage of a Covered Dependent shall be terminated upon an election not to comply, or upon any failure to comply, with such Self-Payment requirements and procedures as are established by the Fund from time to time.

3.08 **EXTENDED SPOUSE COVERAGE**

Extended Spouse protection under this Plan provides an additional three years of coverage for the Covered Dependent when the Covered Participant turns age 65. Therefore, in the majority of cases, Covered Dependents will have coverage until the Covered Participant's 68th birthday or, if earlier, the date he/she turns 65, remarries or becomes eligible for early Medicare (unless the Participant has achieved his first date of entitlement to Medicare benefits solely as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30-month period following the first month in which the individual first becomes so entitled to

Medicare benefits on the basis of ESRD; for purposes of this section such period of entitlement to Medicare benefits shall be disregarded.).

There are other events in which the Covered Dependent may also receive the extended coverage as follows. In all cases the extended Spouse coverage ends earlier than three years in the event the Covered Dependent turns 65, becomes eligible for early Medicare or remarries.

(a) In the event the Covered Participant turns age 65:

- Covered Dependent will receive extended coverage for up to three years.

(b) In the event the Covered Participant becomes eligible for early Medicare after retirement:

- Covered Dependent will receive the normal benefit until the retiree's 65th birthday.

- Covered Dependent will also receive up to three years of extended coverage from the Covered Participant's 65th birthday.

- Covered Participants who retire prior to age 57 and whose coverage is scheduled to start at age 57, but who qualify for early Medicare prior to their 57th birthday, are not entitled to coverage. However, the Covered Dependent will be entitled to three years of extended spousal or coverage beyond that date.

(c) In the event the Covered Participant became eligible for Medicare before retirement and met all other qualifying rules:

- Covered Dependent will receive extended coverage for up to three years from the Covered Participant's retirement date.

(d) In the event the Covered Participant retires after his/her 65th birthday and has met all eligibility requirements at retirement date:

- Covered Dependent will receive extended coverage for up to three years from the Covered Participant's retirement date.

(e) In the event the Covered Participant dies prior to age 65:

- Covered Dependent will get the greater of five years from retirement date or three years from death date.

(f) In the event the Covered Participant dies before coverage is in effect:

- Covered Dependent will receive up to three years of extended coverage starting from the Covered Participant's previously anticipated effective date (age 50, 55 or 57).

Termination of the Extended Spouse coverage is not a Qualifying Event to elect Continuation Coverage as described in Sections 3.09 to 3.14.

3.09 SPOUSAL RIGHTS AND REQUIREMENTS IN ELECTING TO CONTINUE INDIVIDUAL COVERAGE UNDER THIS PLAN

A Covered Dependent who would lose Coverage under this Plan as a result of a Qualifying Event, as defined in Section 3.10, is eligible to elect Continuation Coverage, as defined in Section 3.12, upon compliance with notice requirements and election procedures described in Sections 3.11 and 3.13.

3.10 DEFINITION OF QUALIFYING EVENT

For purposes of Sections 3.09 through 3.15 the term "Qualifying Event" means, with respect to a Covered Dependent, the following event which, unless there is an election of Continuation Coverage pursuant to Section 3.14 would result in a loss of Coverage of the Covered Dependent under this Plan:

(a) The divorce or legal separation of a Covered Participant from the Covered Participant's Spouse.

3.11 NOTICE OF QUALIFYING EVENT

With respect to the Qualifying Event defined in Section 3.10, notice shall be provided in accordance with the following requirements:

(a) General notice by the Fund -- at the time of commencement of Coverage of a Covered Participant under this Plan, the Fund shall provide written notice to the Covered Participant and his or her Spouse (if any) of their rights pursuant to Sections 3.09 through 3.15.

(b) Specific notice by Covered Individuals -- within sixty (60) days after a Qualifying Event defined in Section 3.10 either the Covered Participant or the Covered Dependent shall provide written notice of the Qualifying Event to the Fund.

(c) Specific notice by the Fund -- within sixty (60) days after notice of a Qualifying Event has been provided to the Fund in compliance with subsection (b) of this section, the Fund shall provide written notice of the Qualifying Event to the Covered Participant affected by the event (if living) and to his or her Spouse (if any).

3.12 DEFINITION OF CONTINUATION COVERAGE

For purposes of Sections 3.09 through 3.15 the term "Continuation Coverage" means, with respect to any Covered Dependent, a continuation of the same terms, conditions, limitations and exclusions of Coverage as are provided by the Fund to the Covered Dependent on the day before the date of a Qualifying Event, upon election pursuant to Section 3.13 and until termination pursuant to Section 3.15 provided that all modifications of such Coverage during any period of Continuation Coverage which are applicable to Covered Dependents with respect to whom a Qualifying Event has not occurred will be fully and equally applicable to Covered Dependents with respect to whom a Qualifying Event has occurred.

3.13 **PROCEDURES TO ELECT CONTINUATION COVERAGE**

After a Qualifying Event occurs and timely notice of the Qualifying Event is received by the Fund in compliance with Section 3.11(b), a Covered Dependent may elect Continuation Coverage by providing written election of Continuation Coverage to the Fund, in such form as the Fund prescribes, before expiration of the "election period." The "election period" begins on the date of the Qualifying Event and ends on the 60th day after the date of the Qualifying Event or, if later and if the Fund received timely notice of the Qualifying Event pursuant to Section 3.11(b), on the 60th day after notice of the Qualifying Event is provided by the Fund to the Covered Individual pursuant to Section 3.11(c).

3.14 **SELF-PAYMENTS TO MAINTAIN CONTINUATION COVERAGE**

If a written election of Continuation Coverage is provided to the Fund in compliance with Section 3.13, Self-Payments must be remitted to the Fund on behalf of the Covered Dependent on whose behalf the election is made, in order to maintain eligibility for Continuation Coverage. Self-Payments must be remitted for all periods of Continuation Coverage in such amounts, form and manner as the Fund prescribes, except that the Fund will not require any Self-Payments to be remitted prior to the expiration of 45 days after the initial written election of Continuation Coverage is provided to the Fund in compliance with Section 3.13.

3.15 **TERMINATION OF CONTINUATION COVERAGE**

If a written election of Continuation Coverage is provided to the Fund in compliance with Section 3.13, the Covered Dependent on whose behalf the election is made will be eligible for Continuation Coverage throughout the period that begins on the date of the Qualifying Event and ends on the earliest of:

(a) The date, which is 36 months after the date of the Qualifying Event;

(b) The date coverage would have ended if the Qualifying Event occurs while covered under the Extended Spouse Coverage;

(c) The date such Covered Dependent attains 65 years of age;

(d) The date which is 31 days after the date on which Self-Payments pursuant to Section 3.14 and related procedures are owed to the Fund but unpaid (unless such overdue Self-Payments are remitted to the Fund within such 31-day period);

(e) The date on which the Covered Dependent first becomes, after the date of the election, covered (as an employee or otherwise) under any other employee welfare benefit plan providing medical care (as defined in Section 213(d) of Title 26 of the United States Code) to participants and beneficiaries directly or through insurance, reimbursement or otherwise, if such Other Plan does not contain any exclusion or limitation with respect to any preexisting condition of the Covered Dependent;

(f) The date on which the Covered Dependent first becomes, after the date of the election, entitled to Medicare benefits under title XVIII of the Social Security Act (42 U.S.C. § 1396 et seq.); or

(g) The date on which this Plan is terminated.

3.16 RESIDUAL COVERAGE OF FORMER COVERED PARTICIPANTS

In the remaining provisions of the Plan, the term “Covered Participant” shall be extended to include a Former Covered Participant, and the term “Covered Individual” shall be extended to include a Former Covered Participant and/or his Dependent Spouse during the period that such Former Covered Participant and/or his Dependent Spouse were eligible to receive benefits provided according to Plan provisions.

3.17 ELIGIBILITY FOR TEAMCARE SPOUSE PROTECTION PLAN BENEFIT

A Covered Dependent shall be eligible, subject to the conditions described below, for a Spouse protection plan benefit, consisting of the extension of coverage of a Covered Dependent of a Covered Participant who dies, prior to age 65, while residing in an area covered by a TeamCare network or while recorded by the Fund as an enrolled participant of such network, (regardless of residence), for a maximum of five (5) years after the date of death. This benefit shall terminate upon the earlier of the following: acquisition of other health coverage, remarriage, Medicare eligibility (unless the Participant has achieved his first date of entitlement to Medicare benefits solely as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30-month period following the first month in which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this section such period of entitlement to Medicare benefits shall be disregarded.) or age 65. This benefit is subject to the following conditions:

(a) If a different Spouse protection plan benefit has been established and published to Participants in a specific TeamCare area, it shall apply in lieu of the benefit set forth in this provision.

(b) The Spouse protection plan benefit will be lost if, within 24 months prior to the Participant’s death, charges payable by the Fund are incurred by the Participant or Covered Dependent through non-emergency use of a Hospital or Physician outside the Covered Participant’s TeamCare Network.

(c) If eligibility for the Spouse protection plan benefit has been granted, services from TeamCare providers for non-emergency care will be required for benefits to be payable.

3.18 GENDER NEUTRAL PROVISIONS OF PLAN

Whenever used in this Plan Document, the words “he”, “she”, “his” and “her” are interchangeable.

ARTICLE IV. GENERAL CONDITIONS FOR PAYMENT OF CLAIMS

4.01 PAYMENT ONLY FOR COVERED CLAIMS OF COVERED INDIVIDUALS

A Covered Individual shall not be entitled to any payment on a claim for benefits unless the benefits are provided by the Plan, the claimant is a Covered Individual and the claim for benefits is submitted in proper form as determined by the Fund.

4.02 EXCLUSION OF PAYMENT FOR TREATMENT NOT CONSIDERED STANDARD MEDICAL CARE OR MEDICALLY NECESSARY

A Covered Individual shall not be entitled to payment of any charges for care, treatment, services and supplies which are not generally accepted by the medical community as Standard Medical Care, Treatment, Services or Supplies.

4.03 LIMITATION ON PAYMENT OF CLAIMS ARISING FROM WORK-RELATED INJURY OR COVERED BY WORKERS' COMPENSATION

A Covered Individual shall not be entitled to payment on a claim for any charge incurred for any treatment or service for any illness or injury which is sustained as a result of any enterprise or occupation for wage or profit or is an illness or injury of the type covered by any applicable Workers' Compensation act or similar law providing benefits to employees for on-the-job injuries.

In the event that a Covered Individual's claim for Workers' Compensation benefits is denied by the Workers' Compensation carrier, the Covered Individual may be eligible to receive some benefits if the Covered Individual and his/her attorney enter into an agreement with the Fund to provide benefits during the appeal of the denial as set forth in Article 10.15.

After a five (5) year period from the date of disability, any complication arising from the illness or injury shall be deemed payable in accordance with the Plan provisions, unless it is still compensable under Workers' Compensation.

4.04 EXCLUSION OF PAYMENT FOR TREATMENT OF INJURIES SUSTAINED WHILE IN ANY UNIFORMED SERVICE

A Covered Individual shall not be entitled to payment for any charge incurred for treatment or service due to illness or injury sustained while in any Service in the Uniformed Services or for treatment of any complication of such illness or injury. After a five (5) year period from the date of disability, any complication arising from the illness or injury shall be deemed payable in accordance with the Plan provisions.

4.05 EXCLUSION OF PAYMENT FOR TREATMENT DUE TO ILLNESS OR INJURY ARISING OUT OF ANY ACT OF WAR OR CIVIL DISTURBANCE

A Covered Individual shall not be entitled to payment for any charge incurred for treatment or service due to illness or injury arising out of declared or undeclared war or any act of war or civil

disturbance, including riots, demonstrations and marches or for treatment of any complication of such illness or injury. After a five (5) year period from the date of disability, any complication arising from the illness or injury shall be deemed payable in accordance with the Plan provisions, unless it is compensable by an Other Plan or government agency.

4.06 EXCLUSION OF PAYMENT FOR TREATMENT OF INJURIES ARISING AS A RESULT OF PARTICIPATION IN CRIMINAL CONDUCT

(a) A Covered Individual shall not be entitled to payment for any charge incurred for treatment or services due to injury, and any complication thereof, sustained as a result of participation in conduct which results in a conviction for violating any federal, state or local law. The Fund shall have the right to recover the amount of any payment upon discovery that the injury, and any complication thereof, for which payment was made resulted from participation in conduct which results in a conviction for violating any federal or state criminal law.

(b) Notwithstanding the provisions of subsection 4.06(a), a Covered Individual shall not be entitled to payment for any charge incurred for treatment or services due to injury, and any complication thereof, sustained as a result of participation in an illegal act if the Covered Individual dies within 30 days of the date of the illegal act regardless of whether such illegal act results in a conviction for violating any federal, state or local law. The Fund shall have the right to recover the amount of any payment upon discovery that the injury, and any complication thereof, for which payment was made resulted from participation in an illegal act if the Covered Individual dies within 30 days of the date of the illegal act regardless of whether such participation in an illegal act results in a conviction for violating any federal, state or local law.

4.07 LIMITATION ON PAYMENT FOR TREATMENT RECEIVED OUTSIDE THE UNITED STATES

A Covered Individual shall not be entitled to payment for treatment outside the United States if it is not care, treatment, services or supplies that is medically necessary and is generally accepted by the medical community in the United States as Standard Medical Care, Treatment, Services or Supplies. All exclusions and limitations of the Plan shall be fully applicable to all such care, treatment, services and supplies to the same extent as if it were provided within the United States. Interpretations relative to these exclusions and limitations will be resolved by the Fund at its discretion, assisted by the Fund's medical consultants. Benefits will be paid in United States currency.

4.08 EXCLUSION OF PAYMENT FOR TREATMENT CONNECTED WITH SURGERY FOR COSMETIC PURPOSES

A Covered Individual shall not be entitled to payment on a claim for benefits for any charge incurred for treatment or service connected with a cosmetic procedure, even if performed for psychological reasons, unless the treatment or service is medically required as a result of an illness, congenital anomaly or an Accidental Bodily Injury.

This exclusion includes, but is not limited to:

(a) Any surgery primarily for obesity, including lipectomy, suction lipectomy, abdominoplasty and any other surgical procedure, a purpose and result of which is primarily to remove adipose tissue (except to the extent permitted by Section 11.03 Surgical and Obstetrical Expense Benefit);

(b) Augmentation mammoplasty, unless part of reconstructive surgery for the treatment of malignancy of the breast necessitating removal of a portion or all of the breast tissue;

(c) Rhinoplasty, unless the patient has sustained a traumatic fracture of the nasal septum, or unless the patient has chronic nasal obstruction and the procedure is undertaken to relieve this obstruction;

(d) Otoplasty for irregular deformity or macrotia. This is sometimes referred to as plastic surgery for lop ears or cauliflower ears;

(e) Blepharoplasty, or repair of drooping eyelids, unless the droop of the eyelids is such as to restrict the field of vision and the visual field restriction is documented by the ophthalmological consultant;

(f) Radical Keratectomy or Keratotomy, unless the patient has myopia of such a severe degree that it cannot be corrected by lenses;

(g) Rhytidectomy (face lift);

(h) Dyschromia (tattoo removal); and

(i) Genioplasty (chin augmentation).

4.09 EXCLUSION OF PAYMENT FOR TREATMENT OTHERWISE COVERED UNDER THE SOCIAL SECURITY ACT

A Covered Individual shall not be entitled to payment for any charge incurred for treatment or service to the extent that such charge is covered or provided by the Social Security Act as amended, except as provided in Article V.

4.10 EXCLUSION OF PAYMENT FOR TREATMENT NOT RELATED TO ILLNESS, INJURY, CONGENITAL ANOMALY OR PREGNANCY

Except as otherwise provided herein, a Covered Individual shall not be entitled to payment of a claim unless the Covered Individual is ill, injured, has a congenital anomaly, is pregnant or is an organ transplant donor, and receives treatment, compensable under this Plan, related to the illness, injury, congenital anomaly, pregnancy or organ donation.

4.11 EXCLUSION OF PAYMENT FOR TREATMENT OF NON-COMPENSABLE PROCEDURES

A Covered Individual shall not be entitled to payment for any charge incurred for treatment of complications arising from the performance of any procedure not compensable under this Plan.

4.12 RESERVED FOR FUTURE USE

4.13 EXCLUSION OF PAYMENT FOR CERTAIN ITEMS

A Covered Individual shall not be entitled to payment for any charge incurred for sales taxes, surcharges, interest late charges, completion of any claim form or missed appointments.

4.14 EXCLUSION OF PAYMENT FOR MAINTENANCE CARE

A Covered Individual shall not be entitled to payment for any charge incurred for Maintenance Care, as defined in Section 1.32.

4.15 EXCLUSION OF PAYMENT OVER PRESCRIBED MAXIMUMS

A Covered Individual shall not be entitled to payment for any charge which would exceed the stated maximum benefit, maximum allowable fee or stated percentage of covered charges payable as set forth in Article XI of the Plan.

4.16 LIMITATION ON ELIGIBILITY FOR COVERAGE OF ORGAN OR TISSUE TRANSPLANTS

Benefits for organ tissue transplants, including all related services, are payable only if approved on a pre-admission basis. The criteria for patient selection is in agreement with generally accepted medical standards.

The Fund's financial responsibility for Hospital, medical and other expenses incident to, or resulting from, any transplant of any Covered Individual, including expenses incurred in any post-transplant treatment and in any complications arising from the transplant at any time, shall be limited to the following aggregate amounts:

Transplant	Surgical and Follow-up Benefits (Note)
Heart	$350,000
Lung	300,000
Liver	275,000

Pancreas	175,000
Kidney	125,000
Bone Marrow-Autologous	200,000
Allogeneic Related	300,000
Allogeneic Unrelated	400,000

(Note) *Surgical Benefits* include hospital and related facility charges, physician professional fees, ancillary charges and all related expenses associated with the surgical transplant procedure. Organ procurement expenses are included, to the extent they are covered.

Follow-Up Benefits include all professional fees, hospital and related facility charges, prescription drugs, ancillary charges and all expenses which result directly from the transplant procedure and which are incurred after discharge from the hospital stay during which the transplant occurred. Subsequent hospitalizations and outpatient costs resulting directly from the transplant are included in follow-up costs. The above-referenced limitations on Follow-Up Benefits are applicable only to the 12-month period that begins on the date of the transplant.

The benefit payments for human organ transplants under this Plan will not be subject to the overall benefit plan limit.

4.17 EXCLUSION OF PAYMENT FOR INFERTILITY TREATMENT AND SERVING AS A SURROGATE MOTHER

The Plan shall not pay for any charge incurred in connection with the treatment of infertility. This limitation includes but is not limited to:

(a) Charges incurred in connection with in vitro fertilization;

(b) Charges incurred in connection with artificial insemination;

(c) Charges for Prescription Drugs designed to enhance the ability to conceive, used in connection with (a) and (b) above, including but not limited to Clomid, Milophene, Metrodin, Lutrepulse, Pergonal and human chorionic gonaditropin in any form; and

(d) Charges incurred in connection with reversal of prior sterilization procedures.

The Plan shall not pay any charge incurred in connection with serving as a Surrogate Mother (even if the Covered Individual has provided the ovum).

4.18 EXCLUSION OF PAYMENT FOR CHARGES FOR WHICH THE COVERED INDIVIDUAL IS NOT RESPONSIBLE TO PAY

A Covered Individual shall not be entitled to payment for any charge incurred for any Standard Medical Care, Treatment, Services or Supplies if the medical service provider has waived any co-payments due from the Covered Individual or has otherwise relieved the Covered Individual from an obligation to pay for the care, treatment, services or supplies or agrees to accept as full payment whatever amount is payable under this Plan.

In no event will the Fund pay for any care, treatment, services or supplies which have been represented by the person supplying those examinations, services or supplies to be free to the Covered Individual.

4.19 LIMITATION ON PAYMENT OF CLAIMS FOR SERVICES BY PROVIDERS NOT IN A TEAMCARE NETWORK

(a) Benefits otherwise payable shall be reduced by 10% if there exists a TeamCare Network covering the Covered Participant; and

(b) The charges were incurred by the Covered Participant or Covered Dependent through non-emergency use of Hospitals, Physicians or ancillary providers outside of the TeamCare Network.

ARTICLE V. COORDINATION OF BENEFITS

5.01 PRIORITY OF COVERAGE WHERE COVERED INDIVIDUAL IS COVERED BY ANOTHER PLAN

An Other Plan providing no fault, personal injury protection or financial responsibility motor vehicle insurance coverage or benefits shall always have primary responsibility. If the benefits of this Plan duplicate or overlap with benefits for hospital, surgical, dental, psychiatric, chiropractic or other medical treatment provided by an Other Plan, such duplication or overlapping shall be avoided. In this regard, primary responsibility for providing benefits shall be determined in the following order:

(a) A Plan that does not contain a coordination of benefits provision is always primary.

(b) A Plan that covers the person other than as a dependent is the primary Plan and the Plan that covers the person as a dependent is the secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent then the order of benefits between the two Plans is reversed so that the Plan covering the person other than as a dependent is the secondary Plan and the other Plan is the primary Plan.

(c) Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(1) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.

(2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree; or

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (c)(1) above shall determine the order of benefits; or

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (c)(1) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

In the absence of an applicable court decree, the Custodial parent is the parent with whom the dependent child resides more than one half of the calendar year excluding any temporary visitation.

(v) If the dependent child does not reside with either parent, the provisions of Subparagraph (c)(1) above shall determine the order of benefits.

(3) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (c)(1) or (c)(2) above shall determine the order of benefits as if those individuals were the parents of the child.

(d) The Plan that covers a person as an active employee is the primary Plan. The Plan covering that same person as a retired or laid-off employee is the secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled (b) can determine the order of benefits.

(e) If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary Plan and the COBRA or state or other federal continuation coverage is the secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled (b) can determine the order of benefits.

(f) The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary Plan and the Plan that covered the person the shorter period of time is the secondary Plan.

(g) If there is coverage provided by a governmental program, that coverage shall have primary responsibility unless prohibited by federal law.

(h) If both the person and spouse are Covered Participants of this Plan or another Central States Plan, this Plan will be considered an Other Plan.

(i) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan.

5.02 EFFECT OF PRIORITY RULES ON AMOUNT OF PAYMENTS UNDER THE PLAN

Whenever this Plan is determined to have primary responsibility, the Covered Individual shall receive benefits without regard to coverage under the Other Plan. Whenever this Plan is determined not to have primary responsibility, this Plan shall pay, after the Other Plan has paid its maximum allowable benefits, any remaining Covered Charges up to the amount this Plan would have paid if this Plan had primary responsibility and without the payments from the Other Plan being taken into account in applying the specific benefit maximums indicated in this Plan. As used in this section, the term "Covered Charges" means charges by a provider that a Covered Individual is responsible to pay the provider and that entitle a Covered Individual to benefits under the Plan. Covered Charges shall not include payments for charges for which the Covered Individual is not responsible to pay as enumerated in Section 4.18, regardless of whether this Plan is the primary or secondary provider. Maximum allowable benefits will always be construed under this section to mean the amount payable by the Other Plan without regard to coverage under this Plan; that is, the Other Plan's maximum allowable benefits will be computed as if there were no coverage under this Plan.

5.03 RECOVERY OF PAYMENTS

Whenever this Plan has made benefit payments which exceed the amount of benefits payable under the terms of this Plan or which an Other Plan was required to make under Section 5.01, the Fund shall have the right to recover the amount of such payments from any persons receiving such payments or from any Other Plans having primary responsibility for the payment of benefits. The Trustees are authorized to file suit on behalf of the Fund to recover any such payments or to seek a judicial declaration that an Other Plan has primary responsibility for the payment of benefits.

Further, where the Plan has made benefit payments which exceed the amount of benefits payable under the terms of this Plan, and those payments were required to be made by an Other Plan under Section 5.01 (so that the Plan's payment of the Other Plan's obligation has unjustly enriched the Other Plan), the Other Plan shall be liable to make equitable restitution to the Plan, and/or for other appropriate equitable relief to the Plan, in order to enforce the terms of the Plan Document in the amount of benefit payments that were paid by the Plan, but should have been paid by the Other Plan.

5.04 PAYMENTS TO OTHER PLANS

Whenever payments should have been made by this Plan pursuant to the provisions of Article V, but are made by an Other Plan, the Fund shall have the right to pay over to such Other Plan any amounts this Plan should have paid under the provisions of Article V.

5.05 NO FAULT, PERSONAL INJURY PROTECTION OR FINANCIAL RESPONSIBILITY MOTOR VEHICLE INSURANCE COVERAGE

Benefits under no fault, personal injury protection or financial responsibility motor vehicle insurance coverage, as described in Section 1.34(f), shall be primary to benefits under this Plan notwithstanding

state or local law or regulation to the contrary. In the event an Other Plan, as described in Section 1.34(f), fails or refuses to assume primary responsibility for the payment of benefits, the Fund may provide the Covered Individual with benefits under this Plan. Such benefits shall be provided under a reservation of rights and without prejudice to the Fund's right to recover the amount of such benefits from the Other Plan.

A Covered Individual shall cooperate with the Fund in any attempt to recover the amount of benefits paid under a reservation of rights pursuant to this Section. Upon request by the Fund, the Covered Individual shall execute an assignment of rights and any other documents the Fund deems necessary to effect a recovery of the amount of benefits paid under such reservation of rights. A Covered Individual shall do nothing to prejudice the Fund's rights under Article V and is not authorized to subordinate no fault, personal injury protection, financial responsibility or medical reimbursement benefits to benefits under this Plan.

5.06 **COORDINATION OF BENEFITS WITH ANOTHER PLAN**

When a Covered Individual has primary coverage through an Other Plan this Plan will coordinate benefits as described in Section 5.01 provided the Covered Individual is utilizing the Other Plan's network of Hospitals, Physicians and ancillary providers. If the Covered Individual is denied benefits by the Other Plan for using out of network providers or not obtaining proper referrals or authorization, this Plan will deny benefits.

ARTICLE VI. AMENDMENTS AND PLAN TERMINATION

6.01 PROCEDURE FOR AMENDING THE PLAN

This Plan may be amended, from time to time, by majority vote of the Trustees. A copy of each amendment of this Plan shall be adopted and filed by the Trustees as part of the records and minutes of the Trustees.

6.02 TERMINATION OF THE PLAN

This Plan shall be maintained and operated in full force and effect until the occurrence of any of the following events, in which case the Plan shall be terminated:

(a) The Trust Fund, in the opinion of the Trustees, shall be inadequate to effectuate the intent and purposes of the Trust Agreement.

(b) The Trust Fund, in the opinion of the Trustees, shall be inadequate to meet payments due, or to become due, to persons already drawing benefits.

(c) There are no individuals living who can qualify as Covered Participants as defined in Article I of this Plan.

(d) This Plan, in the opinion of the Trustees, shall be a clear and present impediment to effectuating the principal intent and purposes of the Trust Agreement.

In the event of termination, the Trust Fund shall be distributed by the Trustees in accordance with any plan which conforms to the intent and purposes of the Trust Agreement and the “Employee Retirement Income Security Act of 1974”.

ARTICLE VII. PLAN ADMINISTRATION

7.01 TRUSTEE STATUS AS "NAMED FIDUCIARY"

Each Trustee by reason of his position is a "named fiduciary" of this Plan within the meaning of the "Employee Retirement Income Security Act of 1974".

7.02 POWERS OF THE TRUSTEES

The Trustees shall have authority to jointly control and manage the operation and administration of the Fund and of this Plan, in accordance with the terms of the Trust Agreement and of this Plan, including the authority to allocate fiduciary responsibilities among the Trustees and the authority to designate persons other than Trustees to carry out fiduciary responsibilities in the administration of the Fund and this Plan, except that the Trustees may allocate only to a committee of Trustees or one (1) or more "investment managers" (as defined by the "Employee Retirement Income Security Act of 1974") to administer investment and other responsibilities relating to assets of the Fund. All questions or controversies, of whatsoever character, arising in any manner or between any parties or persons in connection with any claim for any benefits preferred by any participant, beneficiary, or any other person, or whether as to the construction of the language or meaning of the rules and regulations contained in this Plan, shall be submitted to the Trustees, or to a committee of the Trustees, and the decision of the Trustees or of such committee thereof shall be binding upon all persons dealing with the Fund or claiming any benefit under the terms of this Plan.

7.03 DECISIONS OF TRUSTEES

All decisions by the Trustees, including all rules and regulations adopted by the Trustees, all amendments of the Trust Agreement and this Plan by the Trustees and all interpretations by the Trustees of any of said documents shall be binding upon all parties to the Trust Agreement, the union, each Employer, all individuals claiming benefits pursuant to this Plan or any amendment thereof and all other individuals engaging in any transaction with the Fund. The Trustees are vested with discretionary and final authority in making all such decisions, including Trustee decisions upon claims for benefits by Covered Participants, Covered Dependents and other claimants, and including Trustee decisions interpreting plan documents of the Fund.

7.04 EFFECT OF ANY MISREPRESENTATION WITH RESPECT TO CLAIMS

Any misrepresentation in any claim or document submitted by a claimant to the Fund shall constitute grounds for rejection of the claim, for the denial of any requested benefits, and for the recovery by the Fund of all benefit payments made in reliance upon said misrepresentation.

7.05 PAYMENTS TO PERSONS WHO HAVE FAILED TO INFORM THE TRUSTEES OF A CHANGE OF ADDRESS

If any person who is entitled to receive payment of benefits, in accordance with this Plan, fails to inform the Trustees in writing and by registered mail of a change of address, and if the Trustees are unable to communicate with such person at the address last recorded by the Fund, and if a letter sent

by registered mail from the Fund to such person is returned because it is not deliverable, all payments due such person shall be held without interest until a claim has been received and approved by the Trustees.

7.06 INFORMATION CONCERNING COVERED INDIVIDUALS

For purposes of implementing the terms of the Plan, the Fund may, without notice to or consent of any Covered Individual, obtain from any person or entity such information concerning the Covered Individual as the Fund deems necessary. Any person claiming benefits under the Plan shall furnish the Fund with such information as the Fund deems necessary to implement the Plan. When any claim for benefits under the terms of this Plan is submitted by a Covered Individual or any medical service provider that provided care, treatment, services or supplies to a Covered Individual then, the furnishing of such claim shall act as a release by the Covered Individual to any medical service provider to allow the Fund, without further notice or consent of any Covered Individual, to obtain any medical records of the Covered Individual from any medical service provider whose claims for treatment of the Covered Individual are submitted for payment.

Failure on the part of any Covered Individual or medical service provider that provided Standard Medical Care, Services, Treatment or Supplies to any Covered Individual to supply or furnish any information requested by the Fund or its agent may result in the rejection of a claim for benefits and/or the recoupment of previously paid benefits.

7.07 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan may make any use and disclosure of Protected Health Information to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended.

Protected Health Information concerning employees of the Fund (including, for purposes of this section 7.07, all former employees of the Fund) may be disclosed to other employees of the Fund to carry out plan administration functions as set forth in this section. The Fund may make any use and disclosure of Protected Health Information concerning employees of the Fund that are required or permitted by law. Protected Health Information concerning employees of the Fund may only be disclosed to other employees of the Fund after the Trustees of the Fund have certified that the Plan document has been amended to incorporate all provisions required by law.

The Trustees agree and hereby certify that:

(a) Protected Health Information concerning employees of the Fund shall not be used or disclosed other than as permitted or required by the Plan documents or as required by law;

(b) Protected Health Information concerning employees of the Fund shall not be used or disclosed to any agents, including a subcontractor, to whom the Fund provides Protected Health Information concerning the employees of the Fund until such agents agree to the same restrictions and conditions that apply to the Plan sponsor with respect to such information;

(c) Protected Health Information shall not be used or disclosed for employment – related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor without a valid authorization;

(d) Any use or disclosure of such information that is inconsistent with the uses or disclosures permitted by the Plan shall be reported to the Fund's Privacy Officer;

(e) Protected Health Information concerning the employees of the Fund will be made available in accordance with 45 C.F.R. Section 164.524;

(f) Protected Health Information concerning the employees of the Fund will be made available for amendment in accordance with 45 C.F.R. Section 164.526;

(g) Any and all Protected Health Information concerning employees of the Fund will be made available to provide an accounting of disclosures in accordance with 45 C.F.R. Section 164.528;

(h) The internal practices, books, and records relating to the use and disclosure of Protected Health Information relating to employees from the Fund that was received from the Plan will be made available to the secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy rule;

(i) That any and all Protected Health Information concerning employees of the Fund received from the Plan will, if feasible, be returned or destroyed and no copies of such information will be retained when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, any further use or disclosure of such information will be limited to the purposes that make the return or destruction of the information infeasible.

The Plan sponsor will ensure that adequate separation between the Plan and the Plan sponsor will be established in accordance with the Privacy Rule. To ensure that adequate separation between the Plan and the Plan sponsor exists, access to the Protected Health Information of the employees of the Fund will be limited to the following classes of employees: (1) Human Resources Group; (2) Health & Welfare Tech Support, Verity Department, and Worker's Compensation; (3) R&C Teamleader, Manager and any other Staff involved in appeals or predetermination of benefits; (4) Law Department attorneys, Subrogation Paralegals, Subrogation Investigation Specialists (and Support), and Subrogation Committee Members; (5) Audit Services: Director, Group Manager, Department Managers, Audit Services Analysts (during audits), and Audit Special Investigations Analysts (during case reviews); (6) HIPAA Privacy Officer, Compliance Specialist, HIPAA Security Officer, Information Security Team, and any other employees when acting under the direction, supervision or approved by of any of the foregoing specifically identified in this class (6); (7) CTS: a limited number of CTS personnel involved in projects, system development, maintenance or trouble shooting and processing reports that require access to Central States employee information; (8) Contributions Receivable, Benefit Disbursements, and Self Payments; (9) Finance; (10) Pension Group Manager and Actuarial Analysis and Pension Department Manager relating to analysis and retiree eligibility, QDRO Certifier, and Retiree Health Analyst; (11) Data Analytics; (12) TeamCare Vendor Services; (13) Digital Communications; (14) Business Communications; (15) Mailroom; and (16) individuals approved by a Group Manager or above for a designated task or special projects under the plan. Such tasks or special projects must be for the purpose of general fund administration but may incidentally involve access of Protected Health Information of the employees of the Fund.

The access to, and use by, such classes of employees shall be limited to the plan administration functions that these employees perform for the Plan. When using protected health information of Fund employees and their dependents, individuals must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR 164.502(b). In order to provide an effective mechanism for resolving any issues of noncompliance by such employees with the Plan document provisions set forth herein, all such employees shall be expressly subject to all of the Fund's Privacy Policies and Procedures. In no event shall Protected Health Information concerning employees of the Fund be used for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

7.08 SAFEGUARDS FOR PROTECTED HEALTH INFORMATION

The Trustees will implement administrative, physical and technological safeguards to reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information that they create, receive, maintain or transmit on behalf of the Plan.

The Trustees will ensure that the "adequate separation" required by the Privacy Rule and by Section 7.07 of the Plan is supported by reasonable and appropriate security measures.

The Trustees will ensure that any agent, including a subcontractor, to whom they provide Protected Health Information agrees to implement reasonable and appropriate security measures to protect the Protected Health Information.

The Plan sponsor will report to the Plan any security incident (within the meaning of 45 C.F.R. § 164.304) of which it becomes aware.

ARTICLE VIII. BENEFIT CLAIMS

8.01 CLAIMS TO BE SUBMITTED IN WRITING ON AUTHORIZED FORMS

Claims for benefits shall be submitted electronically or in writing, within the time limits specified in Section 10.03, in a method or form authorized by the Fund.

8.02 PROCESSING CLAIMS INVOLVING URGENT CARE

(a) The Fund, (or the applicable Network Administrator with respect to claims under Sections 11.06 and 11.07) upon receipt of a claim involving urgent care (as defined in Section 8.02[c]), shall notify the claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim unless the claimant fails to provide sufficient information to determine whether and/or to what extent benefits are covered or payable in accordance with this Plan. If the claimant fails to provide such sufficient information, the Fund (or the applicable Network Administrator with respect to claims under Sections 11.06 and 11.07) shall notify the claimant as soon as possible, but not later than twenty-four (24) hours after the Fund receives the claim, of the specific information necessary to complete the claim. The claimant shall then be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information, and the Fund (or the applicable Network Administrator with respect to claims under Sections 11.06 and 11.07) shall thereafter notify the claimant of the benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

(1) the receipt of the specified information;

(2) the end of the period afforded the claimant to provide the specified additional information.

(b) Notice of any adverse benefit determination pursuant to this Section 8.02 shall be provided in accordance with Section 8.04.

(c) A “claim involving urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (as those periods are specified in Section 8.03):

(1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(2) would, in the opinion of a physician with knowledge of the claimant’s medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Any claim that a Physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care” shall be treated as a “claim involving urgent care”. In the absence of such a Physician’s determination, any question whether or not a claim is a “claim involving urgent care” is to

be determined by an individual acting on behalf of the Fund and applying the judgment of a prudent layperson who has average knowledge of health and medicine.

8.03 PROCESSING CLAIMS FOR BENEFITS (OTHER THAN URGENT CARE CLAIMS)

(a) The Fund, upon its receipt of a claim that is neither a claim involving urgent care nor a claim involving a benefit described in Section 8.03(b) (which relates to benefits requiring the Fund's pre-approval), shall notify the claimant of the Fund's benefit determination (if it is an adverse benefit determination) within a reasonable period of time and not later than 30 days after the Fund receives the claim, provided that this period may be extended for an additional 15 days if the Fund both determines that such an extension is necessary due to matters beyond the control of the Fund and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(b) The Fund, upon its receipt of a claim (not involving urgent care) for a benefit, the receipt of which is conditioned by this Plan upon required approval by the Fund in advance of obtaining the medical care, shall notify the claimant of the Fund's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances but not later than 15 days after the Fund receives the claim, provided that this period may be extended for an additional 15 days if the Fund both determines that such an extension is necessary due to matters beyond the control of the Fund and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(c) In the event that a time period for notice of any benefit determination by the Fund is extended pursuant to this Section 8.03 in order for the claimant to submit information necessary to decide the claim, the time period for making the benefit determination and providing related notice shall be tolled (i.e., not counted) from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(d) Notice of any adverse benefit determination pursuant to this Section 8.03 shall be provided in accordance with Section 8.04.

8.04 NOTICE OF ADVERSE BENEFIT DETERMINATIONS

(a) Whenever an adverse benefit determination (as defined in Section 8.04(c)) is made by the Fund, except upon a claim involving urgent care (in which instance Section

8.04(b) governs the notice), the Fund shall provide the claimant with written (or electronic) notice of the determination that shall include statements, in a manner calculated to be understood by the claimant, of the following:

(1) the specific reason or reasons for each adverse benefit determination;

(2) references to the specific provisions of this Plan on which each adverse benefit determination is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a description of the Fund's appellate review procedures and the time limitations applicable to those procedures, including a statement of the claimant's right to bring a civil action pursuant to Section 502 of the Employee Retirement Income Security Act following an adverse benefit determination at the end of appellate review by the Fund;

(5) in the case of any adverse benefit determination,

(A) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either a statement of the contents of the specific rule, guideline, protocol or other criterion or a statement that the specific rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; and

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

(6) in the case of any adverse benefit determination of a claim involving urgent care, a description of the expedited review process that is applicable to such claims.

(b) Whenever an adverse benefit determination (as defined in Section 8.04[c]) is made by the Fund (or the applicable Network Administrator with respect to claims under Sections 11.06 and 11.07) upon a claim involving urgent care, the Fund (or the applicable Network Administrator with respect to claims under Sections 11.06 and 11.07) may provide the information described in Section 8.04(a) to the claimant by oral notification within the time limitations prescribed in Section 8.02(a), provided that written (or electronic) notice of the determination that includes the information described in Section 8.04(a) is also to be furnished to the claimant not later than three (3) days after the oral notification.

(c) An "adverse benefit determination" means any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) or a recoupment for, a benefit, including any such denial, reduction, termination, recoupment or failure to provide or make payment that is based on a Plan exclusion

of Coverage or a Plan limitation of Coverage as applied to a claim for benefits, or that is based on a determination relative to the question of a Covered Individual's or any other individual's eligibility for Coverage.

8.05 CONCURRENT CARE DECISIONS

(a) If the Fund has approved an ongoing course of treatment to be provided over a period of time and/or to include a number of treatments, any reduction or termination by the Fund of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination for all purposes of this Plan. In such an event, the Fund shall notify the claimant, in accordance with Section 8.04, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and to obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(b) Any request by a claimant to extend such an ongoing course of treatment, previously approved by the Fund, beyond the approved period of time or the approved number of treatments shall, if the course of treatment is a claim involving urgent care, be decided as soon as possible, taking into account the medical exigencies, and the Fund shall notify the claimant of the Fund's benefit determination (whether adverse or not) within 24 hours after receipt of the request by the Fund, provided that any such request is received by the Fund at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(c) Whenever an adverse benefit determination (as defined in Section 8.04[c]) is made by the Fund upon a request by a claimant to extend an ongoing course of treatment, previously approved by the Fund, beyond the approved period of time or the approved number of treatments, whether or not urgent care is involved, notice of the determination shall be provided in accordance with Section 8.04.

8.06 MISCELLANEOUS BENEFIT CLAIMS PROVISIONS

(a) Any time limitation specified in this Article VIII for a determination and/or a notice by the Fund may be waived and/or modified at any time on the basis of a request, agreement or consent by the claimant or by an authorized representative of the claimant, including a retroactive waiver and/or modification of an applicable time limitation after it has expired.

(b) The burden of proof in demonstrating any fact essential to the approval of any claim for benefits, including eligibility for any claimed benefit and the extent to which a claimed benefit is covered or payable in accordance with this Plan, shall at all times be the responsibility of the claimant.

(c) It is a condition precedent to any civil action by a Covered Individual or other individual to recover benefits covered or payable in accordance with this Plan and/or to clarify the individual's rights to past, present or future benefits covered or payable in accordance with this Plan, including any civil action pursuant to Section 502 of the Employee Retirement Income Security Act, that the claimant or other individual files a

benefit claim and initiates and actively pursues appellate review of any adverse benefit determination upon any claim, and secures all related benefit determinations by the Fund, in accordance with Articles VIII and IX of this Plan, prior to the commencement of any civil action.

(d) To the extent that a Hospital, Physician or other provider or person is assigned a claim of a Covered Individual for reimbursement by the Fund of the costs of medical or other services or benefits, any and all rights and authority of such assignee:

(1) are limited by the validity, enforceability and terms of the assignment;

(2) are limited by all exclusions, limitations, terms and provisions of this Plan;

(3) are subordinate to any claims and defenses of the Fund against the Covered Individual; and

(4) are conditioned upon complete compliance by the assignee with all conditions and requirements imposed upon claimants by Articles VIII and IX of this Plan, including the requirement that the assignee (as claimant) files a benefit claim and initiates and actively pursues appellate review of any adverse benefit determination upon any claim, and secures all related benefit determinations by the Fund, in accordance with Articles VIII and IX, prior to the commencement of any civil action.

ARTICLE IX. APPELLATE REVIEW PROCEDURES AND DETERMINATIONS

9.01 PROCEDURES DURING APPELLATE REVIEW OF ADVERSE BENEFITS DETERMINATIONS

(a) Whenever an adverse benefit determination (as defined in Section 8.04[c]) is made by the Fund (or the applicable Network Administrator with respect to claims under Sections 11.06 and 11.07), there are multiple available stages of appellate review of the determination, as follows:

(1) for any Trustee-Reviewable Determination, as defined in Section 9.02, there are two available stages of appellate review of that determination, the first of which is conducted by the Appeals Committee and the second of which is conducted by the Trustee Appellate Review Committee;

(2) for any adverse benefit determination upon a claim involving urgent care (as defined in Section 8.02[c]), there is a single stage of appellate review, which is conducted by the applicable Network Administrator with respect to claims under Sections 11.06 and 11.07 and, in all other cases, is conducted by the Appeals Committee; and

(3) for any other adverse benefit determination ("Other Determination") that is neither a Trustee-Reviewable Determination nor an adverse benefit determination upon a claim involving urgent care, there are two available stages of appellate review of that determination, the first of which is conducted by the Staff Interim-Review Committee and the second of which is conducted by the Staff Final-Review Committee.

The Appeals Committee and the Staff Final-Review Committee each shall be composed of one or more employees of the Fund appointed as members of the committee by the Executive Director of the Fund, provided that the Executive Director retains the authority to terminate any such appointment at any time. The Staff Interim-Review Committee shall be composed of one or more employees of the Fund. If a claimant requests appellate review of multiple adverse benefit determinations, and they consist of both one or more Trustee-Reviewable Determinations and one or more Other Determinations, the Fund in its sole discretion may consolidate all of the determinations into the same appellate review.

(b) All authority and responsibilities of the Board of Trustees with respect to appellate review of adverse benefit determinations is delegated to a committee of Trustees designated as the Trustee Appellate Review Committee.

(c) The following procedures shall govern the operations of the Trustee Appellate Review Committee:

(1) a quorum of the Trustees at any meeting of the Trustee Appellate Review Committee, for the conduct of its business and for all benefit determinations on review by that committee, shall be at least one Employer Trustee and at least one Employee Trustee (all Trustee members of the Board of Trustees are and shall be *de facto* members of the Trustee Appellate Review Committee);

(2) for each matter voted upon at any meeting of the Trustee Appellate Review Committee, the Employee Trustees and the Employer Trustees shall each have the same number of votes based upon the larger number (of Employee Trustees or Employer Trustees) in attendance, provided that each vote shall be cast as the vote of an individual Trustee and not as part of a block, and each determination by the Trustee Appellate Review Committee shall be based upon a majority vote of those present and voting;

(3) the meetings of the Trustee Appellate Review Committee shall be monthly according to a schedule approved by the Trustees;

(4) the Trustees who attend and participate in any meeting of the Trustee Appellate Review Committee shall be vested, relative to all appellate review of adverse benefit determinations, with all authority and responsibilities of the Board of Trustees established by the Fund's benefit plan documents, as heretofore and hereafter amended, including discretionary and final authority in making determinations during all such appellate review; and

(5) the records of monthly meetings of the Trustee Appellate Review Committee, and of its determinations during appellate review, shall be regularly kept and maintained with records of meetings of the Board of Trustees.

(d) At all stages of appellate review of any adverse benefit determination, the following procedures shall be enforced:

(1) the claimant shall be provided an opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(2) the claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information possessed by the Fund and relevant to the claimant's claim for benefits;

(3) the appellate review shall take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(4) the appellate review shall not afford deference to the initial adverse benefit determination by the Fund and shall be conducted by one or more individuals each of whom shall be an appropriate named fiduciary of the Fund who is neither an individual who made the adverse benefit determination that is the subject of the review nor a subordinate of any such individual;

(5) the appellate review shall require that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including any determination whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(6) the appellate review shall require the identification to the claimant of any medical or vocational expert whose advice was obtained on behalf of the Fund in connection with the claimant's adverse benefit determination, whether or not the advice was relied upon in making that determination;

(7) the appellate review shall require that each health care professional engaged by the appropriate named fiduciary for purposes of a consultation during appellate review, pursuant to this Section 9.01, shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the review nor a subordinate of any such individual; and

(8) the appellate review in the case of a claim involving urgent care (as defined in Section 8.02[c]) shall require an expedited review process pursuant to which a request for an expedited appeal from an adverse benefit determination may be submitted orally or in writing by the claimant, and all necessary information, including the benefit determination on review, shall be transmitted to the claimant by telephone, facsimile or other available and similarly expeditious method.

9.02 **DEFINITION OF TRUSTEE-REVIEWABLE DETERMINATIONS**

"Trustee-Reviewable Determinations" are defined to include any adverse benefit determination (as defined in Section 8.04[c]) which is within any of the following classifications (other than a *de minimis* determination which means a single or series of adverse benefit determinations upon monetary claims which involve potential aggregate Fund liability no greater than $5,000: *de minimis* determinations shall be reviewed as Other Determinations):

(a) all adverse benefit determinations based upon Article III (PARTICIPATION AND COVERAGE);

(b) all adverse benefit determinations based upon Article IV (GENERAL CONDITIONS FOR PAYMENT OF CLAIMS);

(c) all adverse benefit determinations based upon Section 10.14 (SUBROGATION), Section 10.17 (Restricted Reemployment) or Section 10.18 (Suspension of Benefits Procedures);

(d) all adverse benefit determinations based upon Article XI (BENEFITS) except determinations upon claims for Prescription Drug Benefits (Section 11.05), Hearing Aid Benefits (Section 11.09) and Chiropractic Expense Benefits (Section 11.12); and

(e) all other types of adverse benefit determinations which the Fund expressly classifies as Trustee-Reviewable Determinations.

9.03 **TIME LIMITATIONS FOR APPELLATE REVIEW OF ADVERSE BENEFIT DETERMINATIONS**

(a) Whenever an adverse benefit determination is made, including a determination affecting a payment amount claimed by a Covered Individual or any medical provider who is an assignee or beneficiary of a Covered Individual, the claimant may initiate appellate review of the determination by submission to the Fund, within 180 days after the claimant's receipt of the notice of such adverse benefit determination, of a request for such appellate review. All requests for appellate review shall be submitted, electronically or in writing, in a method or form authorized by the Fund.

(b) The Fund (or the applicable Network Administrator with respect to claims under Sections 11.06 and 11.07) upon receipt of a claimant's timely request for appellate review of an earlier adverse benefit determination upon a claim involving urgent care (as defined in Section 8.02[c]), shall notify the claimant of the benefit determination by the Appeals Committee as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Fund receives the claimant's request for appellate review.

(c) The Fund, upon its receipt of a claimant's timely request for appellate review of a Trustee-Reviewable Determination, shall perform and complete appellate review, and shall notify the claimant of the determinations upon completion of such review, in accordance with the following time limitations:

(1) all appellate review and benefit determinations by the Appeals Committee shall be completed, and the Fund shall provide written notice to the claimant of those determinations, no later than 30 days after the Fund's receipt of the claimant's timely request for appellate review of a Trustee-Reviewable Determination;

(2) whenever an adverse benefit determination is made by the Appeals Committee at the end of its appellate review, the claimant may initiate appellate review by the Trustee Appellate Review Committee, by request to the Fund within 180 days after the claimant's receipt of the Fund's notice of such determination;

(3) all appellate review and benefit determinations by the Trustee Appellate Review Committee shall be completed within a reasonable time and at the first monthly meeting that takes place on a date 30 or more days after the Fund receives the claimant's timely request for appellate review by the Trustee Appellate Review Committee; and

(4) after appellate review and benefit determinations by the Trustee Appellate Review Committee, the Fund shall provide written notice to the claimant of those determinations by the Trustees no later than 5 days after the determinations are made.

(d) The Fund, upon its receipt of a claimant's timely request for appellate review of an Other Determination, shall perform and complete appellate review, and shall notify the claimant of the determinations upon completion of such review, in accordance with the following time limitations:

(1) all appellate review and benefit determinations by the Staff Interim-Review Committee shall be completed, and the Fund shall provide written notice to the claimant of those determinations, no later than 30 days after the Fund's receipt of the claimant's timely request for appellate review of an Other Determination;

(2) whenever an adverse benefit determination is made by the Staff Interim-Review Committee at the end of its appellate review, the claimant may initiate appellate review by the Staff Final-Review Committee, by written request to the Fund within 180 days after the claimant's receipt of the Fund's notice of such determination; and

(3) all appellate review and benefit determinations by the Staff Final-Review Committee shall be completed, and the Fund shall provide written notice to the claimant of those determinations, no later than 30 days after the Fund's receipt of the claimant's timely request for appellate review by the Staff Final-Review Committee.

(e) The Fund, upon its receipt of a claimant's timely request for appellate review of an adverse benefit determination upon a claim (not involving urgent care) for a benefit, the receipt of which is conditioned by this Plan upon required approval by the Fund in advance of obtaining the medical care, shall arrange a single stage of appellate review within a reasonable period of time appropriate to the medical circumstances, provided that the Appeals Committee shall complete (and send the claimant notice of) the Fund's benefit determination on review no later than 30 days after the Fund receives the claimant's request for appellate review.

(f) Notice of any adverse benefit determination pursuant to this Section 9.03 shall be provided in accordance with Section 9.04.

9.04 **NOTICE OF BENEFIT DETERMINATIONS AFTER APPELLATE REVIEW**

Whenever a benefit determination is made after appellate review, the Fund (or the applicable Network Administrator with respect to claims under Sections 11.06 and 11.07) shall provide the claimant with written (or electronic) notice of the determination that shall include statements, in a manner calculated to be understood by the claimant, of the following:

(a) the specific reason or reasons for each adverse benefit determination;

(b) references to the specific provisions of this Plan on which each adverse benefit determination is based;

(c) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

(d) a description of the Fund's appellate review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action pursuant to Section 502 of the Employee Retirement Income Security Act following an adverse benefit determination at the end of appellate review by the Fund; and

(e) in the case of any adverse benefit determination,

(1) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either a statement of the contents of the specific rule, guideline, protocol or other criterion or a statement that the specific rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy will be provided free of charge to the claimant upon request; and

(2) if the adverse benefit determination is based on a medical necessity requirement or an experimental treatment exclusion or a similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of this Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge to the claimant upon request.

9.05 MISCELLANEOUS APPELLATE REVIEW PROVISIONS

(a) Any time limitation specified in this Article IX for a determination and/or a notice by the Fund may be waived and/or modified at any time on the basis of a request, agreement or consent by the claimant or by an authorized representative of the claimant, including a retroactive waiver and/or modification of an applicable time limitation after it has expired.

(b) In the event that any time period for any appellate review by the Fund of an earlier adverse benefit determination, and of notice of the determinations upon completion of such review, is extended based upon a failure by the claimant to submit information necessary to decide the claim, each time period for the conduct and completion of such appellate review, and for making benefit determinations, and of providing notice of those determinations, relative to the claimant's claim, shall be tolled (i.e., not counted) from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(c) Each individual who is authorized to conduct interim appellate review (as a member of the Appeals Committee or the Staff Interim-Review Committee) is vested with discretionary and final authority in making any determination within the scope of this Article IX, except that, upon further appellate review by the Trustee Appellate Review Committee or the Staff Final-Review Committee, the prior discretionary and final authority of the interim appellate-review agency is displaced by the discretionary and final authority of the final appellate-review agency (the Trustee Appellate Review Committee or the Staff Final-Review Committee), which shall not afford any deference to any determination by the interim appellate-review agency.

(d) The Trustees are vested with discretionary and final authority in making any determination within the scope of this Article IX. The Trustees appoint the applicable Network Administrators as the named fiduciaries authorized to administer the claim and appeal procedures set forth in the Plan with respect to any and all claims for urgent care under Sections 11.06 and 11.07 and any appeals arising out of such claims. Each applicable Network Administrator shall be vested with discretionary and final authority in making any determination concerning such claim and appeal. The

applicable Network Administrators will strictly follow the terms of the Plan and any applicable federal regulations when resolving claim appeal determinations on behalf of the Plan.

(e) The burden of proof in demonstrating any fact essential to the approval of any claim for benefits, including eligibility for any claimed benefit and the extent to which a claimed benefit is covered or payable in accordance with this Plan, shall at all times be the responsibility of the claimant, provided that the Fund will at all times during appellate review of an adverse benefit determination provide to the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information possessed by the Fund and relevant to the claimant's claim for benefits.

(f) It is a condition precedent to any civil action by a Covered Individual or other individual to recover benefits covered or payable in accordance with this Plan and/or to clarify the individual's rights to past, present or future benefits covered or payable in accordance with this Plan, including any civil action pursuant to Section 502 of the Employee Retirement Income Security Act, that the claimant or other individual files a benefit claim and initiates and actively pursues appellate review of any adverse benefit determination upon any claim, and secures all related benefit determinations by the Fund, in accordance with Articles VIII and IX of this Plan, prior to the commencement of any civil action.

ARTICLE X. MISCELLANEOUS PROVISIONS

10.01 VALIDITY OF CHANGES IN THE PLAN

No agent has authority to change the terms of this Plan or to waive any of its provisions. No change in this Plan shall be valid unless adopted by the Trustees of the Fund.

10.02 CLAIM FORMS

The Fund, upon written request of the claimant, will furnish to the claimant such forms as are required for filing a claim.

10.03 TIME WITHIN WHICH CERTAIN CLAIMS ARE TO BE FILED

A claim for any loss must be filed within one (1) year after the date of such loss.

10.04 RECOVERY OF EXCESS PAYMENTS

Whenever this Plan has made benefit payments which exceed the amount of benefits payable under the terms of this Plan, the Fund shall have the right to recover the excess payments from any responsible persons or entities, including the right to deduct the amount of excess payments from any subsequent payable benefits.

10.05 FUND MAY ORDER PHYSICAL EXAMINATION AND/OR AUTOPSY

The Fund shall have the right and opportunity to have a claimant examined by a medical service provider, of the Fund's choosing and at the Fund's expense, when, and so often as it may reasonably require during the pendency of a claim. In the case of death, the Fund shall also have the right to request an autopsy where it is not forbidden by law.

10.06 TO WHOM BENEFITS ARE PAYABLE

All benefits are payable to, or for the benefit of a Covered Individual or his estate, except as otherwise provided in this Plan.

Any provider of medical or healthcare services or goods receiving, or seeking to receive, payment from the Fund will, in the absence of evidence to the contrary, be presumed to have claimed a right to do so pursuant to a valid assignment of benefits under the Plan from a Covered Individual. Any such provider will accordingly be presumed to have presented a claim as a beneficiary under this Plan and will be bound by all provisions of this Plan, including but not limited to, the provisions relating to Amendments and Plan Termination (Article VI), Plan Administration (Article VII), Benefit Claims (Article VIII), Appellate Review Procedures and Determinations (Article IX), and Miscellaneous Provisions (Article X).

10.07 CERTAIN ACTS OF THE FUND DO NOT CONSTITUTE A WAIVER OF RIGHTS

The furnishing of forms by the Fund for filing a claim for benefits, or the acceptance of such filings or the investigation of any claim hereunder, shall not operate as a waiver of any rights of the Fund.

10.08 NO MEDICAL EXAMINATION REQUIRED AS PREREQUISITE TO COVERAGE

In no case shall any individual be required to submit to a medical examination as a prerequisite to Coverage under this Plan.

10.09 ALL MEDICAL BENEFIT PAYMENTS BASED ON ALLOWED AMOUNT FOR THE SERVICE

In all instances, other than when a specific dollar amount is the stated allowance, medical benefits to be paid by the Fund will be based upon the Allowed Amount which is defined as follows:

(a) For providers or facilities which have a written agreement with the Fund or TeamCare Network, the amount specified in such agreement.

(b) For providers that do not have a written agreement with the Fund or TeamCare Network, the lesser of (1) the provider's billed charges; and (2) 200% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s).

(c) For facilities that do not have a written agreement with the Fund or with TeamCare Network, the lesser of (1) the facility's billed charges; and (2) 175% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s).

(d) If there is no base Medicare reimbursement rate for a claim under (b) and (c), then the lesser of (1) the provider's or facility's billed charge; and (2) the rate provided to the Fund by the Network Administrator.

(e) If there is no base Medicare reimbursement rate for a claim under (b) and (c), and no median rate that would be paid for an in-network claim for such claim under (d), then the Reasonable and Customary amount.

(f) In determining the Allowed Amount, all other Plan rules, conditions, exclusions, and limitations apply, including without limitation the specified percentages of the Allowed Amount payable under the Plan.

10.10 PERIOD DURING WHICH BENEFIT PAYMENTS MUST BE CLAIMED

Any benefit amounts payable under this Plan must be claimed by the proper beneficiaries within a period of six (6) years from the date that such amounts become due and payable to such beneficiaries. Benefits unclaimed after this six (6) year period shall be considered the property of the Fund which shall have the immediate right to recover the amount of any unclaimed benefits from any person in possession of said benefit amounts or from any Other Plans having primary responsibility for payment of such benefits.

10.11 **APPLICABLE LAW**

The Trust Agreement was created and accepted in the State of Illinois. All questions pertaining to the validity or construction of the Trust Agreement shall be determined in accordance with the laws of the State of Illinois.

The Fund is a self-funded employee benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1001 et seq. All questions concerning the validity of the terms of the Plan shall be determined under ERISA. Any state law that relates to the operation or administration of the Plan is preempted by ERISA and this Plan. The Fund shall be entitled to assert a lien against third parties, insurers and attorneys when necessary to protect the rights of the beneficiaries of the Plan or when necessary to protect the Fund's rights to recover any reimbursements provided for by the terms of this Plan.

10.12 **SEVERABILITY OF PLAN PROVISIONS**

Should any provision of this Plan be held null and void by a court of competent jurisdiction, such holding shall not adversely affect any other provision of this Plan.

10.13 **RIGHT TO REVIEW ALL CLAIMS**

The Fund reserves the right to question any charge or procedure and to have the same professionally reviewed to determine if it is covered under the Plan. The results of said professional review shall not be binding on the Trustees.

10.14 **SUBROGATION**

(a) The Fund, whenever it makes any payment for any benefits on behalf of a Covered Individual or other person related to any illness, injury or disability (collectively and separately "Disability") of the person, is immediately subrogated, and vested with subrogation rights ("Subrogation Rights"), to all present and future rights of recovery ("Loss Recovery Rights") arising out of the Disability which that person and his/her parents, heirs, guardians, executors, attorneys, agents and other representatives (individually and collectively called the "Covered Individuals") may have. The Fund's Subrogation Rights extend to all Loss Recovery Rights of the Covered Individual. The Loss Recovery Rights of the Covered Individual include, without limitation, all rights based upon any one or more of the following:

(1) Any act or omission by any person or entity, including the Covered Individual; and/or

(2) Any policy, contract, plan or other document creating responsibility for any insurance, indemnity or reimbursement (collectively "insurance") including but not limited to every document within the definition of "Other Plan" in Section 1.34 and also including every other form of no-fault liability insurance, personal-injury-protection insurance, financial responsibility insurance, uninsured and/or underinsured motorist insurance and any casualty liability insurance or medical payments coverage including, but not limited to, homeowners or premises

insurance, school insurance, workers' compensation insurance, athletic team insurance and any other specific risk insurance or coverage; and/or

(3) Any medical reimbursement insurance; and/or

(4) Any government-funded or government-sponsored financial entity which may be a source of payment or reimbursement of Loss Recovery Rights to a Covered Individual.

(b) The Covered Individual shall promptly advise the Fund any time he/she is pursuing any third-party for any Loss Recovery Rights arising out of any Disability. In addition, the Covered Individual shall fully cooperate with the Fund in enforcement of the Fund's Subrogation Rights, shall make prompt, full, accurate and continuous disclosures to the Fund's representatives of all information about all circumstances of his/her Disability and about all other specifics of his/her Loss Recovery Rights (including prompt, full, accurate and continuous disclosures of the specifics of applicable insurance and all other potential sources of recovery), shall upon request by a Fund representative execute whatever documents are appropriate to enforce and preserve the Fund's Subrogation Rights, shall perform whatever acts are requested by a Fund representative to enable the Fund to effectively prosecute a civil action in the name of the Covered Individual and/or the Fund and one or more Trustees if the Fund deems such action necessary or appropriate and shall refrain from any act or omission that would to any extent prejudice or impair the Fund's Subrogation Rights or seek to prejudice or impair the Fund's Subrogation Rights.

(c) The payment by the Fund for any benefits on behalf of a Covered Individual related to his/her Disability, and the simultaneous creation of the Fund's Subrogation Rights to the full extent of present and future payments, shall by itself (without any documentation from, or any act by, the Covered Individual) result in an immediate assignment to the Fund of all right, title and interest of the Covered Individual to and in any and all of his/her Loss Recovery Rights to the extent of such payments, and said payment by the Fund on behalf of a Covered Individual shall be deemed to constitute the Covered Individual's direction to his/her attorneys and other representatives to reimburse the full amount of the Fund's Subrogation Rights, from any settlement proceeds or other proceeds (collectively "Proceeds") which are paid to the attorneys or representatives for or on behalf of the Covered Individual, before the Covered Individual receives any Proceeds in full or partial satisfaction of his/her Loss Recovery Rights, and before any fees or expenses are paid, including attorneys' fees.

(d) No Covered Individual (including his/her attorneys and other representatives) is authorized to act on behalf of the Fund with respect to the Fund's Subrogation Rights, or to receive any payment or reimbursement on behalf of the Fund or to release or impair the Fund's Subrogation Rights to any extent. The Fund is entitled to receive payment and reimbursement in the full amount of the Fund's Subrogation Rights before the Covered Individual receives Proceeds in full or partial satisfaction of his/her Loss Recovery Rights and before any fees or expenses are paid, including attorneys' fees. If the Fund is vested with Subrogation Rights pursuant to this Section 10.14, then, before the Covered Individual receives any Proceeds, the Covered Individual, and every person and entity that provides any recovery of Proceeds to or on behalf of a Covered Individual, are obligated to cause all such Proceeds to be paid primarily

and directly to the Fund until the Fund has received full payment and reimbursement of the Fund's Subrogation Rights.

(e) If at any time, either before or after the Fund becomes vested with Subrogation Rights pursuant to this Section 10.14, a Covered Individual: 1) fails to inform the Fund that he/she is pursuing any third-party for any Loss Recovery Rights arising out of any Disability, 2) fails to cooperate in any way with the Fund in connection with the enforcement of its Subrogation Rights, 3) takes any action which impairs or prejudices the Fund's Subrogation Rights, 4) takes any action which seeks to or has a foreseeable consequence of impairing or prejudicing the Fund's Subrogation Rights, or 5) directly or indirectly receives any Proceeds as full or partial satisfaction of his/her Loss Recovery Rights, including arrangements for an annuity or other similar installment benefit plan, and including any payment or reimbursement of expenses (including attorneys' fees) incurred by or on behalf of the Covered Individual, without prior written approval of an authorized Fund representative, the Fund shall be vested with each of the following mutually independent rights:

(1) The right, at any time, to decline to make any payment for any benefits on behalf of the Covered Individual related to the Disability on which the Loss Recovery Rights were based; and

(2) The right, at any time after the Fund becomes vested with Subrogation Rights, to decline to make any payment for any benefits on behalf of the Covered Individual and his/her Covered Dependents, related to any circumstance or condition for which the Fund otherwise has a Coverage obligation, until the amount of such unpaid Coverage is equal to the unrecovered amount of the Fund's Subrogation Rights;

(3) The right to recoup any payment made for any benefits on behalf of the Covered Individual related to the Disability on which the Loss Recovery Rights were based; and

(4) The right, at any time after the Fund becomes vested with Subrogation Rights, to prosecute a civil action against the Covered Individual and/or against any person and/or any other entity (including any insurance company) which the Fund claims to be responsible, in whole or in part, to provide payment or reimbursement to the Fund of the unrecovered amount of the Fund's Subrogation Rights.

(f) The Fund may assert a lien, for recovery of the Fund's Subrogation Rights, against any person or entity. The fact that the Fund does not initially assert or invoke its Subrogation Rights until a time after a Covered Individual, acting without prior written approval of an authorized Fund representative, has made any settlement or other disposition of, or has received any Proceeds as full or partial satisfaction of, his/her Loss Recovery Rights, shall not relieve the Covered Individual of his/her obligation to reimburse the Fund in the full amount of the Fund's Subrogation Rights.

(g) The Fund shall not be financially responsible for any expenses, including attorneys' fees, incurred by or on behalf of a Covered Individual in the enforcement of his/her Loss Recovery Rights, except to the extent such responsibility is formally accepted by written agreement of an authorized Fund representative.

(h) The Fund is authorized but not required to bring civil actions in enforcement of the Fund's Subrogation Rights, including direct actions (as subrogee or otherwise) against any person, entity, or Responsible Person which the Fund claims to be responsible, in whole or in part, to provide payment or compensation or reimbursement to the Fund of the unrecovered amount of the Fund's Subrogation Rights, and including actions against any person, entity, or Responsible Person to enjoin any act or practice which violates any terms of the Plan, the Fund's Subrogation Rights and/or to obtain other appropriate equitable relief to redress such violations and/or to enforce the Fund's Subrogation Rights. A Responsible Person is any person or entity, including attorneys or other representatives of a Covered Individual in any claim for damages for a Disability suffered by the Covered Individual, resulting from any act or omission of another person or entity, and who receives any Proceeds, by way of settlement or award from said claim for damages. If such a civil action is filed by the Fund and the Fund prevails in any amount on any of its claims, all persons, entities and Responsible Person(s) against whom such action is filed shall jointly and severally be responsible for all costs and expenses, including attorneys' fees, incurred by the Fund in connection with or related to such civil action.

(i) The Trustees are vested with discretionary and final authority in making decisions that interpret plan documents of the Fund that relate to subrogation. Any one or more Trustees and the Executive Director, and any other person authorized by the Trustees or the Executive Director, may, in his/her sole discretion, compromise or settle any Fund claim of Subrogation Rights.

(j) The Fund's entitlement to full payment and reimbursement of its Subrogation Rights is absolute and unqualified, and is not to be reduced or impaired by the relationship of the gross or net amount of the Proceeds to the aggregate monetary damages sustained, or claimed to be sustained, by the Covered Individual in connection with the Disability related to his/her Loss Recovery Rights. The Fund's Subrogation Rights are not in any way subordinate to or affected by any 'make whole' rule. The Fund's Subrogation Rights are not in any way subordinate to or affected by any 'common fund' principle or factor -- sometimes described as the equitable concept of a 'common fund' which governs the allocation of attorney's fees in any case in which a lawyer hired by one party creates through his/her efforts a fund in which others are entitled to share as well. The acceptance of plan benefits from the Fund entirely subordinates the Loss Recovery Rights of the Covered Individual to the Subrogation Rights of the Fund (without any 'common fund' reduction or other reduction of those Subrogation Rights). Every payment and reimbursement to the Fund based upon its Subrogation Rights results in a monetary benefit to all of the Covered Individuals of the Fund.

10.15 **WORKERS' COMPENSATION SUBROGATION**

If any Covered Individual has a claim denied pursuant to Section 4.03 of this Plan and the Covered Individual's claim for Workers' Compensation benefits is denied by the Workers' Compensation carrier, the Fund may, at its discretion, enter into an agreement with the Covered Individual to provide benefits during the appeal of the denial. Such an agreement would be entitled "Agreement to Reimburse Central States Health and Welfare Fund" and is subject to the following conditions:

(a) The Covered Individual and his/her attorney provide proof that a claim is pending before the appropriate Compensation Commission or court;

(b) The Covered Individual and his/her attorney agree to pursue the claim for Workers' Compensation benefits to a final disposition;

(c) The Covered Individual and his/her attorney agree to notify the Fund of the disposition of his claim and to notify the Workers' Compensation carrier of the Agreement;

(d) The Covered Individual and his/her attorney establish sufficient need for the Fund to consider application of this section; and

(e) The Covered Individual and his/her attorney agree to fully reimburse the Fund for benefits paid from the proceeds of any recovery.

The Agreement described in this section is a binding contract between the Covered Individual, his/her attorney and the Fund, and in the event the Covered Individual and/or his/her attorney does not honor this Agreement, the Fund reserves the right to take any necessary step to protect its interest, including a civil action in enforcement of the Fund's rights under this Section, against the Covered Individual, his/her attorney and/or any other person, entity, or Responsible Person which are obligated under this Section to reimburse the Fund.

If such a civil action is filed by the Fund, and the Fund prevails in any amount on any of its claims, all persons, entities and Responsible Person(s) against whom such action is filed shall jointly and severally be responsible for all costs and expenses, including attorneys' fees, incurred by the Fund in connection with or related to such civil action.

10.16 **RIGHT TO PROVIDE ALTERNATIVE CARE**

The Trustees reserve the right to provide benefits for medical care not addressed in this Plan where such alternative care is in the best interest of the Fund and its beneficiaries, and where the Covered Individual or his or her legal guardian agree in writing to such alternative care. Alternative care options will be examined on a case by case basis and subject to the approval of the Trustees.

10.17 **RESTRICTED REEMPLOYMENT**

Restricted Reemployment means and includes any of the following listed in subsections (a) through (e):

(a) Reemployment in a Core Teamster Industry (as defined in section 1.15), except that a Covered Participant that has reached age 65 may work a maximum of 40 hours per month in such a position;

(b) Reemployment by a Contributing Employer[2] (or an employer which was a Contributing Employer at any time after September 25, 1980), except that a Covered Participant

[2] For purposes of Section 10.17, Contributing Employer means any association or individual employer which has agreed or shall agree, in writing, to be bound by the Pension Fund Trust Agreement and

that has reached age 65 may work a maximum of 40 hours per month in such a position;

(c) Reemployment in any position (or supervising any position) that is covered by a Teamster Contract[3] between that employer and any affiliate of the International Brotherhood of Teamsters, except that a Covered Participant that has reached age 65 is not subject to this subsection (c);

(d) Reemployment in any position in the same industry in which the Covered Participant earned contributory service credit with the Pension Fund, except that a Covered Participant that has reached age 60 is not subject to this subsection (d), and except that a Covered Participant that has reached age 57 but has not reached age 60 may work a maximum of 80 hours per month in such a position; or

(e) Reemployment in any position in the same job classification as any other participant in the Pension Fund then employed by a Contributing Employer located within 100 miles of the position, except that a Covered Participant that has reached age 60 is not subject to this subsection (e), and except that a Covered Participant that has reached age 57 but has not reached age 60 may work a maximum of 80 hours per month in such position.

(f) Notwithstanding the provisions of subsections 10.17(a) through 10.17(e), Reemployment with a government agency shall not constitute restricted Reemployment unless such agency is a Contributing Employer (or an employer which was a Contributing Employer at any time after September 25, 1980) to the Pension Fund.

(g) Notwithstanding the provisions of subsection 10.17(c), and only for the purpose of subsection 10.17(c), Reemployment shall not constitute restricted Reemployment if the Reemployment becomes restricted Reemployment because the Covered Participant is in a position (or supervising any position) that becomes covered by a Teamster Contract between that employer and any affiliate of the International Brotherhood of Teamsters subsequent to the beginning of the Covered Participant's Reemployment with that employer.

(h) For purposes of the exception in subsections 10.17(d) and the exception in 10.17(e) which allow a Covered Participant who is at least age 57 but less than age 60 to work a maximum of 80 hours a month in such positions, a Covered Participant shall not be allowed to utilize both the exception in subsection 10.17(d) and the exception in subsection 10.17(e) to exceed a combined total of 80 hours per month in such positions.

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to make Employer Contributions to the Pension Fund according to a Collective Bargaining Agreement, and which has been accepted by the Board of Trustees of the Pension Fund as a Contributing Employer. Contributing Employer also means a union with regard to its Employees, The Pension Fund with regard to its Employees, and the Fund with regard to its Employees.

[3] For purposes of Section 10.17, Teamster Contract means any Collective Bargaining Agreement between an employer and a local union affiliated with the International Brotherhood of Teamsters.

(i) If the application of Section 10.17 results in a Covered Participant being found to be in restricted Reemployment with respect to a position that would not have been covered by the definition of Teamster Industry Reemployment as defined in the Pension Plan prior to January 1, 2004 (as modified for the terminology of the Retiree Plan), then Reemployment in such a position shall not constitute restricted Reemployment.[4]

10.18 **SUSPENSION OF BENEFITS PROCEDURES**

(a) Benefits under this Plan shall be permanently suspended for a Covered individual during all periods of restricted Reemployment by the Covered Participant.

(b) Any failure of a Covered Participant to comply with any disclosure obligation described in subsection 10.18(c), or with any related disclosure request by the Fund, shall, if the Covered Participant has been or is engaged in any Reemployment, create a rebuttable presumption of an existing factual basis, in accordance with this subsection, for a permanent suspension of the Covered Individual's Coverage during all periods of the Covered Participant's Reemployment, provided that such presumption will become inoperative if and to the extent the presumption is rebutted by clear and convincing evidence or is otherwise shown to be unreasonable under the circumstances. Each such permanent suspension of Benefits shall apply not only to the Covered Individual but also to any other potential payee of any part of the Benefits, including a surviving Spouse. Each such permanent suspension of Benefits shall continue in effect until the Fund has received what it determines to be both notice and clear and convincing evidence that the basis for the permanent suspension is no longer applicable, at which time the suspension will be ended and the Benefits will be resumed on a prospective basis only (without any restoration of Benefits for the period prior to that end of the suspension), subject to possible recoupment pursuant to subsection 10.18(f).

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[4] Prior to January 1, 2004, the Pension Plan defined Teamster Industry Reemployment (as modified for the terminology of the Retiree Plan) as follows:

(a) Reemployment in any position by a Contributing Employer (or an employer which was a Contributing Employer at any time after September 25, 1980;

(b) Reemployment by an employer, other than a governmental agency, in any position covered by a Teamster Contract between that employer and any affiliate of the International Brotherhood of Teamsters;

(c) Reemployment (other than governmental employment in any position either in the same industry in which the Covered Participant earned any Contributory Service Credit while covered by the Pension Fund, or in any other industry if the Covered Participant is in the same job classification as are other Covered Participants in the Pension Fund then employed by a Contributing Employer located within the same standard metropolitan statistical area.

(c) Every Covered Participant is obliged, as a prerequisite to any receipt of Benefits, to keep the Fund fully and promptly informed of any employment or any other performance of services in which he was or is engaged during any time period for which he claims or has received Benefits. The Fund may at any time, and as often as is reasonable, require appropriate signed authorizations by any Covered Participant to provide the Fund with access to all information about his past and present circumstances of any employment or any other performance of services, including but not limited to all records of any employers and of the Social Security Administration. The Fund may also at any time, and as often as is reasonable, require appropriate certifications signed by any Covered Participant, and/or appropriate signed responses by any Covered Participant to any requests from the Fund, that relate to a determination whether or not he has been and/or is engaged in Reemployment or restricted Reemployment. Any failure of a Covered Participant to comply with any disclosure obligation described in this subsection (c), or with any related disclosure request by the Fund, shall itself be independent grounds for temporary suspension of the Benefits of the Covered Individual until the Covered Participant complies with his disclosure obligations and/or such request to the satisfaction of the Fund, at which point his Benefits will be resumed (including full restoration of all Benefits that had been temporarily suspended) unless there is then in effect a permanent suspension of his Benefits in accordance with subsection (a). At the time of any temporary suspension of Benefits in accordance with this subsection (c), the Fund shall provide written notice of the suspension to the Covered Participant by first-class mail directed to his last known address on any date prior to the initial effective date of the suspension, and the notice shall describe the specific reasons for the suspension and its initial effective date, and shall inform the Covered Participant of his right to appeal pursuant to subsection (e).

(d) At the time of any permanent suspension of Benefits in accordance with subsection (a), the Fund shall provide written notice of the suspension to the Covered Participant by first-class mail directed to his last known address on any date prior to the initial effective date of the suspension. The notice shall describe the specifics of the Reemployment (including, if applicable, restricted Reemployment) on which the suspension is based, the dates of the Reemployment, the initial effective date of the suspension and the right of the Fund to restitution (pursuant to subsection [f]) including recoupment from post-suspension Benefits, and the notice shall also inform the Covered Participant of his right to appeal pursuant to subsection (e).

(e) The Benefit Claims and Appellate Review Procedures and Determinations of Articles VIII and IX of this Plan shall be applicable to all written requests by a Covered Participant for review of a permanent suspension or a temporary suspension of his Benefits in accordance with subsection (a) or subsection (b), and for review of a status determination in accordance with subsection (g), except that the initial stage of such review shall be conducted by the Benefits Claim Appeals Committee and the second stage (if any) of such review shall be conducted by the Board of Trustees, provided that the Covered Participant must exhaust both stages of review prior to commencement of any legal action with respect to any suspension of his Benefits or any status determination.

(f) The Fund is entitled to restitution of all Benefits paid to or on behalf of a Covered Individual for any period which is determined by the Fund to be a period of Reemployment (including, if applicable, restricted Reemployment) for which the

Covered Individual was not entitled to receive such payments. The Fund may obtain that restitution by recoupment from any future Benefits to which the Covered Individual may be entitled for periods after the end of a suspension. The Fund may also obtain that restitution by any other available remedy at law or at equity.

(g) Every Covered Participant is entitled to submit a written request to the Fund at any time for a determination whether or not specific employment or other specific services constitute Reemployment or restricted Reemployment. Upon receipt of any such request, the Fund shall promptly make a determination whether or not the specific employment or other specific services constitute Reemployment or restricted Reemployment, and shall promptly provide notice of that status determination to the Covered Participant by first-class mail directed to his last known address, which notice shall also inform the Covered Participant of his right to appeal pursuant to subsection (e).

10.19 **MEDICARE ADVANTAGE PLAN**

The Fund provides for a Medicare Advantage Plan ("TeamCare Advantage") available to eligible Covered Individuals for specified time periods, as described in this section.

(a) TeamCare Advantage is initially administered by Humana Inc. ("Humana") or an affiliate of Humana in accordance with an agreement between Humana and the Fund effective August 1, 2008. The Trustees are authorized to modify or terminate the Fund's contractual arrangements with Humana at any time.

(b) Eligibility for TeamCare Advantage is available and limited to each Covered Participant (and to his/her eligible Spouse) whose Date of Retirement is after July 31, 2008, and who on his/her Date of Retirement (1) has Coverage by the Active Fund, as an Active Plan Covered Participant, based on Plan C6 contributions (excluding contributions based on employment by United Parcel Service ["UPS"]), and (2) is then 63 years of age or older, and (3) on that Date of Retirement (excluding contributions from UPS) qualifies for Coverage as a Covered Participant in accordance with Article III of this Plan (or would so qualify except that he/she is then 65 years of age or older), and (4) is then eligible to receive a retirement or disability pension benefit from the Pension Fund. Each individual who satisfies (1), (2), (3) and (4) in the preceding sentence is classified as a Covered Participant for all purposes of this Section 10.19 even if he/she is 65 years of age or older on his/her Date of Retirement.

(c) TeamCare Advantage, administered by Humana, combines Medicare Part A (hospital), Part B (other medical services) and Part D (prescription drug) in one package of benefits. Once the Participant is eligible for Medicare Part A (hospital) and Part B (other medical services), all healthcare claims, including prescription drug claims, will be submitted by medical providers directly to TeamCare Advantage (Humana). No claims need to be filed or coordinated with Medicare. Each eligible Participant and Spouse will be responsible for Medicare Part B payments and for benefit-related co-insurance and co-payments. TeamCare Advantage allows the selection of any doctor, hospital and medical provider that accepts Medicare and agrees to accept the terms of TeamCare Advantage.

(d) The Fund does not participate to any extent in, and is not responsible for, any administration of TeamCare Advantage. The Fund will pay the applicable TeamCare Advantage premiums to Humana on behalf of each eligible Covered Participant who elects TeamCare Advantage (and his/her eligible Spouse), for a period based on the Participant's age at his/her Date of Retirement, to the following extent:

(1) if age 63 on Date of Retirement, for a 2-year period beginning on the Participant's 65th birthday (or on post-retirement date of earlier Medicare entitlement on or after 63rd birthday);

(2) if age 64 on Date of Retirement, for a 4-year period beginning on the Participant's 65th birthday (or on post-retirement date of earlier Medicare entitlement on or after 64th birthday); and

(3) if age 65 or older on Date of Retirement, for a 6-year period beginning on the Participant's Date of Retirement.

The Fund will pay the applicable TeamCare Advantage premiums to Humana on behalf of the eligible Spouse of an eligible Covered Participant who elects TeamCare Advantage, for a period **beginning** on the **later** of (i) the first day of the premium payments applicable to the Covered Participant in accordance with the preceding sentence or (ii) the earlier of the Spouse's 65th birthday or early Medicare entitlement date and **ending** on the final day of the premium payments applicable to the Covered Participant in accordance with the preceding sentence, **provided that** if the Covered Participant dies during that period (in which the Fund is making premium payments for both) the Fund will continue the premium payments for the surviving Spouse until the date the period would have ended if the Covered Participant were still alive on that date, or until the Spouse's earlier remarriage (or until, if earlier than the end of that post-death period, the expiration of a combined total of 3 years of the Spouse's prior extended coverage based upon Section 3.08 and of TeamCare Advantage premiums paid by the Fund for the Spouse).

(e) If any individual dies before his/her Date of Retirement and would have satisfied all TeamCare Advantage eligibility requirements described in (1), (2), (3) and (4) of subsection 10.19(b), *supra*, if his/her date of death had instead been his/her Date of Retirement, the eligibility of his/her surviving Spouse for TeamCare Advantage will be determined as if the individual's date of death had instead been his/her Date of Retirement, **provided that** the Fund will pay the applicable TeamCare Advantage premiums to Humana on behalf of the eligible surviving Spouse for a period **beginning** on the **later** of (i) the deceased individual's date of death or (ii) the earlier of the Spouse's 65th birthday or early Medicare entitlement date and **ending** on the earlier of (1) the end of the entire period applicable to the deceased individual if his/her date of death had been his/her Date of Retirement, (ii) the Spouse's remarriage or (iii) the expiration of 3 years of TeamCare Advantage premiums paid by the Fund for the Spouse.

(f) The Trustees retain full authority to amend or terminate TeamCare Advantage at any time.

10.20 **SPECIAL ARRANGEMENTS FOR BENEFITS**

The Fund enters into agreements with providers from time to time in order to enhance benefits. These providers agree to special arrangements for Fund Participants who patronize them. These agreements are, however, subject to change without prior notice.

10.21 **FORUM SELECTION CLAUSE**

All claims (including without limitation claims under the terms of the Plan, the Trust Agreement, or the Employee Retirement Income Security Act of 1974, as amended) against the Plan (including without limitation claims against the Central States, Southeast and Southwest Areas Health and Welfare Fund, "TeamCare", Trustees, Plan administrator, Plan fiduciaries, or Plan employees) shall be filed and maintained solely in the United States District Court for the Northern District of Illinois, Eastern Division.

ARTICLE XI. BENEFITS

11.01 OUTLINE OF BENEFITS

The specific Benefits and the sections of this Article pertaining to the same are as follows:

	Section
Hospital Expense Benefit	11.02
Surgical and Obstetrical Expense Benefit	11.03
Outpatient Diagnostic X-ray and Laboratory Expense Benefit	11.04
Prescription Drug Benefit	11.05
Psychiatric, Alcoholism and Drug Abuse-Inpatient Treatment Benefit	11.06
Psychiatric, Alcoholism and Drug Abuse-Outpatient Treatment Benefit	11.07
Organ Transplant Donor Benefit	11.08
Hearing Aid Benefit	11.09
Outpatient Cancer Treatment Benefit	11.10
Ambulance Service Benefit	11.11
Chiropractic Expense Benefit	11.12
Women's Health Benefit	11.13
Mayo Clinic Treatment	11.14
Miscellaneous Expense Benefit	11.15

All benefit payments will be at the level of coverage defined in each section of this article, except as modified by Articles XII and XIV, where applicable.

11.02 HOSPITAL EXPENSE BENEFIT

A Covered Individual may receive from the Plan a hospital expense benefit as follows:

(a) Covered Expenses

After Plan Deductible, for an unlimited number of days at 80%, the Plan shall pay for all covered charges incurred in a Hospital by Covered Individuals for services which are required for purposes of treatment. Coverage shall include, but not be limited to: room and board, general nursing care, operating room, administration of anesthesia, X-ray examinations, laboratory analyses, drugs and medicines, unreplaced blood and necessary disposable items. A private room used for isolation purposes will only be covered if the Covered Individual is contagious to other patients.

(b) Non-Covered Expenses

(1) Telephone, television, radio, barber and beauty services, other personal items and replaced blood;

(2) Taxes, surcharges or interest charges; and

(3) Any amount in excess of the Hospital's average semi-private room rate, except as provided in paragraph (b) above.

11.03 SURGICAL AND MATERNITY EXPENSE BENEFIT

A Covered Individual may receive from the Plan a surgical and Maternity Expense Benefit.

Bariatric procedures (including, but not limited to, gastric bypass, gastric stapling and intestinal bypass) if both the procedure and the facility are pre-approved by TeamCare.

(a) Covered Expenses

(1) After Plan Deductible, the Plan shall pay 80% of the Allowed Amount. All payments shall be based upon the Allowed Amount as established by the Fund.

(b) Non-Covered Expenses

(1) Charges for stand-by surgeons and any portion of the surgical expense which exceeds the Allowed Amount.

(2) Charges for Bariatric procedures unless both the procedure and the facility are pre-approved by TeamCare.

11.04 OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY EXPENSE BENEFIT

A Covered Individual may receive from the Plan an outpatient diagnostic x-ray and laboratory expense benefit as follows:

(a) Conditions

(1) Except as otherwise provided in this Plan, the X-ray or laboratory examination must be medically necessary; and

(2) X-ray and laboratory charges will be paid on the basis of the Allowed Amount and/or usage limitations.

(b) Covered Expenses

After Plan Deductible, the Plan shall pay 80 % of the Allowed Amount for outpatient x-ray and laboratory charges.

(c) Non-Covered Expenses

(1) Diagnostic procedures rendered as part of a routine physical examination, except as specified in Section 11.13;

(2) Any portion of the x-ray and laboratory charges that exceed the Allowed Amount and/or usage limitations; and

(3) Dental x-rays or laboratory work.

11.05 **PRESCRIPTION DRUG BENEFIT**

A Covered Individual may receive from the Plan a prescription drug benefit as follows:

(a) Covered Expenses

The Plan will provide benefits only for those covered drugs prescribed by a Physician or Dentist, dispensed by a pharmacist and not available over the counter (except insulin and insulin syringes), including:

(1) Any medicinal substance which bears the legend: “Caution: Federal Law Prohibits Dispensing Without a Prescription”;

(2) Any medicinal substance which may be dispensed by prescription only according to state law;

(3) Any medicinal substance which has at least one ingredient that is a federal or state restricted drug in a therapeutic amount;

(4) Insulin and syringes; and

(5) Nutritional supplements for Covered Individuals with Phenylketonuria (PKU).

(b) Amount Paid

In the TeamCare RX mail order program, the Plan pays 80% of covered charges (20% co-payment), provided that the maximum co-payment is $200 for each filled prescription purchased through the TeamCare RX program. For each prescription drug purchased at a retail pharmacy (TeamCare and non-TeamCare pharmacies), except for non-exempt *maintenance medications* (described in the next sentence) the Plan pays 75% of covered charges (25% co-payment) and, for non-exempt *maintenance medications,* the Plan pays 50% of covered charges (50% co-payment) after a two-fill transition period in which the Plan pays 75% of covered charges (25% co-payment), provided that for each filled prescription purchased from a TeamCare RX retail pharmacy (other than a non-exempt maintenance medication purchased after the above-referenced two-fill transition period) the maximum co-payment is $200. A *maintenance medication* is any prescription drug taken by a Covered Individual over a period exceeding 60 days, other than a drug exempt by the Plan from this classification (exempt drugs include injectable drugs, specialty medications and *antidepressants* as determined by the Plan). If a generic drug equivalent is available to fill a prescription, the Covered Individual must choose the generic drug or pay (in addition to the co-payment) the difference in cost between the generic drug and the brand name drug (if the brand name drug is chosen rather than the available generic drug, the above-stated $200 maximum [for each filled prescription purchased through the TeamCare RX program] is inapplicable and does not limit the amount payable by the Covered Individual).

(c) Non-Covered Expenses

(1) Therapeutic devices or appliances, hypodermic needles, support garments and other non-medicinal substances;

(2) Medications supplied to Covered Individuals in a Hospital or other treatment facility (includes take home drugs);

(3) Drugs or medicines supplied to the Covered Individual by a prescribing Physician or Dentist;

(4) Cosmetic or beauty aids, dietary supplements and vitamins, medications prescribed for weight-loss;

(5) Immunizing agents, blood and blood plasma or medication prescribed for parenteral administration;

(6) Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law or any state or federal agency. Any medication furnished by any other drug or medical service for which no charge is made to the Covered Individual;

(7) Any drug listed on DEA Schedule 1, or labeled: "Caution: Limited by Federal Law to Investigational Use";

(8) Any drug or medication available over the counter;

(9) Any drug or medication for enhancing sexual function, including but not limited to Viagra;

(10) Any drug or medication primarily intended for cosmetic or lifestyle enhancement rather than treatment of an illness or injury; and

(11) Food and/or specialized nutritional products unless approved by the Fund.

11.06 **BEHAVIORAL HEALTH BENEFIT - INPATIENT**

A Covered Individual may receive from the Plan a Behavioral Health Benefit – Inpatient as follows:

(a) Covered Expenses

The Plan will provide benefits for necessary care and treatment including, but not limited to: room at semi-private rate, meals, nursing care, medical supplies and other services as regularly rendered by a qualified Hospital or a licensed Psychiatric Treatment Facility or Alcoholism or Substance Abuse Treatment Facility, as approved by the Fund.

(b) Amount Paid

After Plan Deductible, the Plan will pay 80% of covered expenses for a maximum of 21 inpatient treatment days per calendar year (any partial inpatient treatment day to be calculated as a full day for this purpose), per Covered Individual, up to an aggregate lifetime maximum of 42 inpatient treatment days of such covered expenses incurred on and after January 1, 1998.

(c) Non-Covered Expenses

(1) Maintenance Care;

(2) Treatment not prescribed by a Psychiatrist, Physician or Clinical Psychologist;

(3) Half-way house type facilities;

(4) Legal services;

(5) Recreational, vocational, financial, educational, family or marital counseling;

(6) Services rendered by a federal, state or other facility for which the member is not legally required to pay;

(7) Detoxification or substancer withdrawal programs not rendered by a Hospital, a licensed Psychiatric Treatment Facility or Alcoholism and Substance Abuse Treatment Facility;

(8) Services rendered by an individual who is not licensed or not registered in the state where services are performed; and

(9) Telephone, television, radio, barber, beauty services and other personal comfort items.

11.07 **BEHAVIORAL HEALTH BENEFIT - OUTPATIENT**

A Covered Individual may receive from the Plan a Behavioral Health Benefit - Outpatient as follows:

(a) Covered Expenses

All services rendered on an outpatient basis under the direction of a Psychiatrist, Physician, Clinical Psychologist, or licensed social worker performed for maintenance of a psychiatric condition or chemical abuse program in affiliation with a Hospital, Psychiatric Treatment Facility of Alcoholism or Substance Abuse Treatment Facility.

(b) Amount Paid

After Plan Deductible, the Plan will pay 80% of covered expenses for a maximum of 30 outpatient treatment sessions per calendar year, per Covered Individual.

(c) Non-Covered Expenses

The Plan will not pay charges for:

(1) Educational, vocational, financial, family or marital counseling;

(2) Legal services;

(3) Recreational counseling;

(4) Services rendered by a federal, state or other institution for which the member is not legally required to pay;

(5) Dues or contributions to a supportive organization or facility; and

(6) Services rendered by a social worker or counselor who is not licensed or not registered in the state where services are performed.

(d) Outpatient Treatment Session

For all purposes of Section 11.07, an 'outpatient treatment session' means a separate session at which services covered by Section 11.07 are provided to a Covered Individual, on an outpatient basis, provided that, as is applicable to the medical and surgical benefits provided by the Fund, the amount of benefits to be paid by the Fund, for each outpatient treatment session, will be based upon the Allowed Amount.

11.08 **ORGAN TRANSPLANT DONOR BENEFIT**

A Covered Individual may receive from the Plan an organ transplant donor benefit as follows:

(a) After Plan Deductible, this Plan will provide Coverage for the donor of an organ only in the absence of any other group or individual policy Coverage for the donation of an organ, and only if such donation pertains to a procedure which has met the requirements for Coverage as defined under Section 4.02 or 4.16. The donor's medical expenses will be considered part of, and subject to, the provisions of the recipient's Plan. Donors shall be entitled to hospital and surgical expense benefits as defined under Sections 11.02 and 11.03. Donors shall be entitled to miscellaneous expense benefits as defined under Section 11.15 for services rendered as part of the donation process and for services while hospitalized for the actual donation of the organ and for ninety (90) days after the end of this Hospital confinement; and

(b) If both the recipient and the donor are covered under any Fund Plan, each shall be entitled to the maximum benefits provided and outlined under their respective Plans.

(c) Non-Covered Expenses

(1) Surgical procedures considered to be non-Standard Medical Care; and

(2) Charges covered by any Other Plan.

11.09 **HEARING AID BENEFIT**

A Covered Individual may receive from the Plan a hearing aid benefit as follows:

(a) Covered Expenses

The Plan will provide benefits for all medically necessary services rendered by an audiologist or a certified hearing aid specialist, including fitting, initial batteries and cost of approved hearing aid correction devices.

(b) Amount Paid

After Plan Deductible, the Plan will pay 100% of the Allowed Amount, up to a maximum of $3,000 per hearing aid per ear, once in every thirty-six (36) month period for each Covered Individual.

(c) Non-Covered Expenses

(1) Replacement of lost, missing or stolen appliances;

(2) Repair or replacement of broken appliances;

(3) Replacement of batteries; and

(4) Services and supplies for which the Covered Individual is not required to pay.

11.10 **OUTPATIENT CANCER TREATMENT BENEFIT**

A Covered Individual may receive from the Plan an outpatient cancer treatment benefit as follows:

(a) Covered Expenses

The Plan will provide benefits for medically necessary outpatient nuclear therapy, radiation therapy, chemotherapy, x-ray and laboratory procedures and Physician visits for the treatment of cancer.

(b) Amount Paid

After Plan Deductible, the Plan will pay 80% of the Allowed Amount incurred during the treatment period.

(c) Non-Covered Expenses

(1) Services and supplies for which the Covered Individual is not legally required to pay; and

(2) Services and supplies determined to be follow-up or screening services, occurring during a period when active treatment, such as chemotherapy or radiation therapy is not occurring.

11.11 **AMBULANCE SERVICE BENEFIT**

A Covered Individual may receive from the Plan an ambulance service benefit as follows:

(a) Covered Expenses

(1) The Plan will provide benefits for professional licensed ambulance service charges incurred solely for medical treatment and/or services required during transport, including licensed air ambulance; and

(2) The Fund will provide benefits for transportation by a commercial carrier when it is more economical than a private ambulance service.

(b) Amount Paid

After Plan Deductible, the Plan will pay 80% of the Allowed Amount for each Covered Individual.

(c) Non-Covered Expenses

(1) Transportation in any privately owned vehicle;

(2) Services and supplies for which the Covered Individual is not legally required to pay;

(3) Transportation for reason other than receiving required medical treatment;

(4) Transportation to receive medical treatment which is available at point of origin; and

(5) When an alternative means of transportation other than an ambulance could be utilized without endangering the Covered Individual's health, whether or not such other transportation is available or is a covered benefit.

11.12 **CHIROPRACTIC EXPENSE BENEFIT**

A Covered Individual may receive from the Plan a chiropractic expense benefit as follows:

(a) Conditions and Covered Expenses

(1) The services must be necessitated by illness or injury;

(2) The services can be performed on either an inpatient or an outpatient basis; and

(3) All evaluation, treatment, or physical therapy provided or under the direction of a Chiropractor will be processed solely under this benefit.

(b) Amount Paid

(1) After Plan Deductible, the Plan will pay 70% of the Allowed Amount up to the calendar year maximum of 24 visits per Covered Individual. In no event shall payment exceed the scheduled benefit; and

(2) Each individual charge will be reviewed and only the portion of the charge deemed the Allowed Amount will be considered for payment.

(c) Non-Covered Expenses

(1) Any portion of the Chiropractic expense which exceeds the scheduled benefit; and

(2) Any portion of the Chiropractic expense which exceeds the Allowed Amount as established by the Fund.

11.13 **WOMEN'S HEALTH BENEFIT**

A Covered Individual may receive from the Plan a Women's Health Benefit as follows:

(a) Covered Expenses (services must be provided by an In-network Physician

(1) An annual office visit for women age 18 or older;

(2) An annual Pap test for women; and

(3) An annual mammogram for women age 40 or older.

(b) Amount Paid

The Plan will pay 100% of the Allowed Amount for each Covered Individual.

(c) Non-Covered Expenses

No payment shall be made for any routine laboratory procedures performed in conjunction with annual examination/Pap test/mammogram except as provided in Section 11.18 (a)(2).

11.14 **MAYO CLINIC TREATMENT**

Deductibles shall apply to the cost of covered services provided by Mayo Clinic for Covered Individuals. After Plan Deductible, the Plan will pay covered services at 80%.

Covered Individuals shall not be entitled to payment for travel, lodging and other non-medical costs associated with obtaining medical services at Mayo Clinic.

11.15 **MISCELLANEOUS EXPENSE BENEFIT**

A Covered Individual may receive from the Plan a Miscellaneous Expense Benefit as follows:

(a) Covered Expenses

Covered Expenses shall include the Allowed Amount for medical services, supplies and treatments performed or prescribed by a Physician, including:

(1) Charges by a Physician for professional services, except those related to a routine physical examination;

(2) Charges for services of legally licensed physiotherapists, graduate registered nurses and other allied licensed health professionals, provided such services are not rendered by a member of the person's family;

(3) Charges for rental of braces, crutches, wheelchairs, hospital-type beds and such durable medical equipment as may be approved by the Fund. Purchase of such articles will be approved only if deemed by the Fund to be more economical than rental;

(4) Charges for prosthetics or prosthetic devices;

(5) Charges by a Dentist or dental surgeon for repair of the jaws and for repair or replacement of natural teeth damaged through accidental bodily injury;

(6) Charges for contact lenses and/or glasses prescribed to treat glaucoma, keratoconus or resulting from cataract surgery, once in a lifetime;

(7) Charges for surgical assistance;

(8) Charges for renal dialysis; and

(9) Charges for outpatient cardiac rehabilitation programs which began less than six (6) months after onset of a heart attack, are performed at a qualified hospital, and do not exceed three (3) months in duration.

(b) Amount Paid

After Plan Deductible, the Plan will pay 80% of the Allowed Amount for each Covered Individual.

(c) Non-Covered Expenses

(1) Any charge excluded under Article IV, General Conditions for Payment of Claims, or under Article V, Coordination of Benefits;

(2) Any charge for eye examinations for the correction of vision, fitting of glasses or contact lenses, except as otherwise provided in Section 11.15(a)(6);

(3) Any charge, or any portion of any charge, covered by any benefit of this Plan, other than the Miscellaneous Expense Benefit as set forth under this Section (11.15);

(4) Any portion of a provider charge that exceeds the Reasonable and Customary charge;

(5) Cost of transportation and lodging in connection with medical treatment, transportation equipment, construction modifications, clothing (including undergarments), incontinence supplies (including but not limited to diapers and/or bed liners) and capital asset items;

(6) Specialized furniture and equipment unless approved by the Fund;

(7) Any dental service or appliance, even if performed in conjunction with medical treatment, except as otherwise provided in Section 11.15(a)(5);

(8) Any charge for educational programs or materials;

(9) Any charge for stand by surgeons;

(10) Any charge related to procedures for in-vitro fertilization or artificial insemination; and

(11) Any charge related to reversal of sterilization procedures.

11.16 **WAIVER OF DEDUCTIBLE/CO-PAYMENT REQUIREMENT (OFFICE VISITS)**

Deductibles shall not apply to the cost of covered Physician office visits by Covered Individuals if Physician is an In-network Physician, except for a $20 per visit co-payment, which shall be required.

11.17 **PAYMENT BASED ON PROPRIETY OF PROCEDURES**

If multiple procedures and/or services are performed on the same day or in the same surgical setting or are inclusive with surgery or other services performed, benefits are allowed based on the propriety of the procedures according to accepted medical standards. Reimbursement is based on the Allowed Amount for the appropriate procedure(s).

11.18 **WELLNESS BENEFIT**

A Covered Individual may receive from the Plan a Wellness Benefit as follows:

(a) Covered Expenses—

(1) The Plan shall pay 100% of the Allowed Amount for one routine physical examination per calendar year for a Covered Individual by an In-network Physician;

(2) The Plan shall pay 100% of the Allowed Amount for routine X-ray, laboratory and other diagnostic screening tests, examinations and procedures provided to a Covered Individual in a Hospital or other medical services facility (including a physician's office) to the extent such routine diagnostic services are performed by or under the direction of an In-network Physician (diagnostic services that are covered by this subsection include prostate-specific antigen [PSA] tests, bone density tests, colonoscopies, sigmoidoscopies, complete blood count [CBC] tests, basic metabolic profile or panel [BMP] tests and diabetes screening procedures);

(3) The Plan shall pay 100% of the Allowed Amount for routine immunizations provided by an In-network Physician;

(4) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(5) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

(6) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(7) With respect to women and Women's Preventive Services, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Preventive services include but not limited to well-woman exams, including pap smears, and prenatal care; and

(8) Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are only available if breast pumps are obtained from an In-network.

(b) Non-Covered Expenses— The Plan will not cover as a Wellness Benefit, or pay (as a Wellness Benefit), any charges for:

(1) Any test, examination, procedure, service or product which is not provided by or under the direction of an In-network Physician;

(2) Any test, examination, procedure, service or product which is not generally accepted by the medical community as Standard Medical Care, Treatment, Services or Supplies;

(3) Any amount in excess of the Allowed Amount for the procedure or service provided, as determined by the Fund;

(4) Any charge which is covered by any Other Plan and/or which is paid by any employer, governmental unit or other entity;

(5) Any test, examination, procedure, service or product for which the Covered Individual is not required to pay;

(6) Educational, vocational, recreational, exercise and weight-loss programs, routine hearing tests except as indicated under Section 11.18(a)(6), medications and vitamins that are not covered as Prescription Drugs under Section 11.05, and any test, examination, procedure, service or product that is provided exclusively for the personal and non-medical comfort of a Covered Individual;

(7) Any test, examination, procedure, service or product that is within the scope (and subject to the exclusions and limitations) of the Women's Health Benefit (Section 11.13); and

(8) Any taxes, any surcharges and any charges for late payments, interest, document preparation or missed appointments.

ARTICLE XII. OUT OF POCKET EXPENSE LIMIT

12.01 **OUT-OF-POCKET EXPENSE IS THAT PORTION OF ELIGIBLE EXPENSES INCURRED THAT IS THE COVERED INDIVIDUAL'S RESPONSIBILITY AFTER THE FUND HAS PAID ITS REQUIRED BENEFITS. THE FUND PROVIDES COVERED INDIVIDUALS WITH OUT-OF-POCKET EXPENSE LIMITS. THE OUT-OF-POCKET EXPENSE LIMIT, EXCLUDING THE PLAN DEDUCTIBLE, IS $1,000 PER COVERED INDIVIDUAL PER CALENDAR YEAR.**

(a) Expenses that may be applied to the Out-of-Pocket Expense Limit include:

(1) The balance of eligible Hospital expenses after the Fund has paid its required outpatient Hospital Expense Benefits;

(2) The balance of eligible surgical and obstetrical expenses after the Fund has paid its required Surgical and Obstetrical Expense Benefits;

(3) The balance of eligible outpatient diagnostic x-ray and laboratory expenses after the Fund has paid its required Outpatient Diagnostic X-ray and Laboratory Expense Benefits;

(4) The balance of eligible organ transplant donor expenses after the Fund has paid its required Organ Transplant Donor Benefits;

(5) The balance of eligible outpatient cancer treatment expenses after the Fund has paid its required Outpatient Cancer Treatment Benefits;

(6) The balance of eligible ambulance service expenses after the Fund has paid its required Ambulance Service Benefits;

(7) The balance of eligible women's health expenses that are within the scope of Section 11.13 after the Fund has paid its required Women's Health Benefits;

(8) The balance of eligible Mayo Clinic expenses after the Fund has paid its required Mayo Clinic Treatment Benefits; and

(9) The balance of eligible miscellaneous expense benefits that are within the scope of Section 11.15(a) after the Fund has paid its required Miscellaneous Expense Benefits.

(b) Expenses that may not be applied to the Out-of-Pocket Expense Limit include:

(1) All deductibles;

(2) Any charge or expense which exceeds the Allowed Amount established by the Fund;

(3) Any charge or expense which exceeds any applicable maximum dollar amount payable by the Fund as stated in the Plan;

(4) The balance of any Prescription Drug expenses after the Fund has paid its required Prescription Drug Benefits;

(5) The balance of any psychiatric, alcoholism and drug abuse treatment expenses after the Fund has paid its required Psychiatric, Alcoholism and Drug Abuse-Inpatient Treatment Benefits and/or Psychiatric, Alcoholism and Drug Abuse-Outpatient Treatment Benefits;

(6) The balance of any hearing aid expenses after the Fund has paid its required Hearing Aid Benefits;

(7) The balance of any chiropractic expenses after the Fund has paid its required Chiropractic Expense Benefits;

(8) Any required office visit co-payments to an In-network Provider; and

(9) All other expenses which are not payable by the Fund because of Coverage exclusions and/or limitations, other than eligible expenses that are specified in Section 12.01(a).

(c) After the annual Out-of-Pocket Expense Limit applicable to a Covered Individual has been reached, the Fund is obligated to pay the full Allowed Amount for all expenses described in Section 12.01(a) that are incurred by the Covered Individual during the remainder of that calendar year, provided that this obligation of the Fund does not apply to any expenses described in Section 12.01(b).

ARTICLE XIII. PLAN DEDUCTIBLE

13.01 **TERMS AND CONDITIONS**

The term Plan Deductible is defined as the deductible required in a given calendar year which is applied to any and all Plan benefits paid (except the Prescription Drug Benefit and the TeamCare office visit co-payment) until the stated amount of such deductible is satisfied. The amount of the Plan Deductible is $100 per Covered Individual, per calendar year.

ARTICLE XIV. PLAN BENEFIT LIMIT

14.01 **THE TERM PLAN BENEFIT LIMIT IS DEFINED AS THE MAXIMUM PAYABLE BY THE PLAN IN A GIVEN CALENDAR YEAR UNDER ANY OR ALL PLAN BENEFITS. THE PLAN WILL INCLUDE SUCH PLAN BENEFIT LIMIT AS DESCRIBED. THE AMOUNT OF THE PLAN BENEFIT LIMIT SHALL BE $350,000 PER COVERED INDIVIDUAL PER CALENDAR YEAR.**

ARTICLE XV. TEAMCARE RX INJECTABLE DRUG OUT-OF-POCKET EXPENSE LIMIT

15.01 TEAMCARE RX INJECTABLE DRUG OUT-OF-POCKET EXPENSE LIMIT

Section 11.05 provides for a Prescription Drug Benefit and provides the corresponding payment schedule, including a 'maximum co-payment...[of] $200 for each filled prescription purchased through the TeamCare RX program.' The Prescription Drug Benefit applies to any injectable drug ('Injectable Drug') that is a Prescription Drug as defined in Section 1.42. The Fund provides a separate TeamCare RX Injectable Drug Out-of-Pocket Expense Limit of $1,000 per Covered Individual per calendar year, provided that this separate limit applies only to Covered Individuals who in that year purchase Injectable Drugs through the TeamCare RX program. Each such Covered Individual's share of the cost of all covered Prescription Drugs purchased through the TeamCare RX program (including Injectable Drugs) is applied toward this separate annual $1,000 limit. After this annual $1,000 limit has been reached, the Fund is obligated to pay the full cost of all Injectable Drugs purchased by the Covered Individual through the TeamCare RX program during the remainder of that calendar year.

ARTICLE XVI. DENTAL BENEFITS

16.01 PAYMENT FOR CERTAIN TREATMENT PERFORMED BY A DENTIST

A Covered Individual may receive from the Plan Dental Benefits to help defray the cost of covered dental procedures. The remaining Sections of Article XVI describe policies and procedures applicable to the Dental Benefit and the level of payment, if any, and/or program limitations.

16.02 COVERED DENTAL PROCEDURES AND MAXIMUM AMOUNT PAYABLE

Payments of Dental Benefits are subject to the following:

(a) The Plan shall pay the level of benefits specified below for covered procedures as described by the American Dental Association's current dental terminology (CDT) for a Covered Individual. All payments are subject to Reasonable and Customary charge limits as determined by the Fund:

(1) For Crowns and Bridgework, 70% of the Reasonable and Customary charges subject to a maximum benefit per person per calendar year of $1,500 consisting of any combination of payments for covered services.

(2) For Preventive Services, 100% of the Reasonable and Customary charges for clinical oral evaluations and preventive services as described by ADA codes, subject to a maximum benefit per person per calendar year of $1,500 consisting of any combination of payments for covered services.

(3) For all other ADA Codes (excluding those services listed above and in Section 16.06) 85% of the Reasonable and Customary charges subject to a maximum benefit per person per calendar year of $1,500 consisting of any combination of payments for covered services.

(b) The maximum amount payable for any Covered Individual in a calendar year (January 1st to December 31st) is $1,500; and

(c) If there are alternate treatment procedures available which render effective treatment, the Fund reserves the right to provide benefits for only the least costly of the procedures.

16.03 LIMITATIONS ON PAYMENT OF DENTAL BENEFITS

Dental Benefit payments shall not be made for charges incurred for:

(a) Any amount over the Reasonable and Customary allowance established by the Fund;

(b) Treatment by someone other than a Dentist or doctor, except for cleaning and scaling of teeth and application of fluoride treatment and/or sealants by a licensed

dental hygienist when such services are rendered under the direct supervision and guidance of the Dentist;

(c) Services and/or supplies for cosmetic purposes;

(d) Orthodontic services and/or supplies for a Covered Participant or Spouse including orthodontia in conjunction with TMJ and/or other medical/dental conditions;

(e) Services and/or supplies which do not satisfy Section 4.02 or which are not necessary according to those standards professionally endorsed by the general dental community;

(f) Services and supplies for which the Covered Individual is not legally required to pay;

(g) Precision attachments, specialized techniques and personalization or characterization of dental prostheses;

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

(i) Educational programs, such as plaque control, oral hygiene instruction or nutritional counseling;

(j) Sealants for Participants or Spouses past their fourteenth (14th) birthday;

(k) Sealants more than once in any eighteen (18) month period;

(l) Implantology (except for subperiosteal, mandibular staple bone, osseointegrated biotes or mucosal implants to anchor full dentures only);

(m) Replacement of lost, missing or stolen dental/orthodontic appliances;

(n) Failure to keep a scheduled visit with a Dentist or hygienist;

(o) Completion of any dental claim forms;

(p) Local anesthesia, analgesia or nitrous oxide;

(q) Prescriptions written by the Dentist;

(r) Temporary restorations or sedative fillings on the same day as restorative dentistry;

(s) In connection with restorative dentistry, bases;

(t) In connection with inlays, crowns, bridgework, dentures or prosthetic devices:

(1) Expenses for replacement made less than three (3) years after a preceding placement or replacement which was covered by this Plan;

(2) Expenses for extension of bridges or prosthetic devices previously paid for by this Plan, except for expenses incurred for new extended areas, except as provided in 15.03(pp); and

(3) Expenses for any prosthetic appliance unless the appliance is actually inserted.

(u) Expenses for rebasing of dentures made less than three (3) years after the previous rebasing covered by the Plan;

(v) Expenses for adjustments, tissue conditioning, relining and/or rebasing, less than six (6) months after insertion of denture(s);

(w) Expenses for laboratory relining made less than three (3) years after the previous laboratory relining covered by the Plan;

(x) Expenses for labial veneers/laminate unless due to accident, fracture or birth defect, or within three (3) years of previous labial veneers covered by the Plan;

(y) Full mouth X-rays more than once in any two (2) year period;

(z) Bite-wing X-ray(s) more than once in any six (6) month period;

(aa) Fluoride application more than once in any six (6) month period;

(bb) An oral examination more than once in any six (6) month period;

(cc) Prophylaxis more than once in any six (6) month period;

(dd) Periodontal prophylaxis more than once in any six (6) month period;

(ee) Fluoride application performed on a Participant or Spouse;

(ff) Periodontal scaling and/or root planing more than once in any one (1) year period;

(gg) Crowns without sufficient breakdown or sufficient decay;

(hh) Crowns and/or bridgework without sufficient bone support;

(ii) Crowns and/or bridgework supported by implants;

(jj) Expenses for multiple periodontal procedures performed on the same day;

(kk) Expenses for space maintainer for Participant or Spouse;

(ll) Expenses for home medicaments;

(mm) Any procedure not completed;

(nn) Permanent crowns and/or bridgework on deciduous (baby) teeth;

(oo) Root canal therapy, apicoectomy, root resection and hemisection more than once in a lifetime per tooth (root); and

(pp) General anesthesia; unless administered in conjunction with oral surgery (impacted or surgical extractions), periodontal surgery, fracture, dislocations, apicoectomies, or three (3) or more simple extractions rendered on the same date of service.

16.04 **EXTENSION OF DENTAL BENEFITS**

If, on the date his Coverage under the Plan terminates, a Covered Individual has undergone any of the following dental procedures which require extended treatment, Dental Benefits will be extended to provide coverage for these procedures, providing the work is completed within one (1) year:

(a) Dentures, full or partial, if the impression was taken while a Covered Individual;

(b) Fixed bridgework, gold restorations and crowns, if tooth or teeth were prepared while a Covered Individual; and

(c) Root canal therapy, if the tooth or teeth were opened for treatment while a Covered Individual.

16.05 **COVERAGE FOR SPECIFIC DENTAL PROCEDURES**

The American Dental Association procedure codes D7340 through D7997 will be considered for payment under the Covered Individual's Medical Benefits (refer to Article XI).

ARTICLE XVII. VISION BENEFITS

17.01 COVERED VISION EXPENSES

(a) The Plan provides payments to help defray the cost of eye examinations and materials for Covered Individuals. Article XVII describes policies and procedures applicable to Vision Benefits and the levels of payment, if any, and/or program limitations.

(b) Only procedures intended to improve the otherwise healthy eye by glasses shall be covered under Vision Benefits. However, eye procedures requiring hospitalization, surgery, X-ray or laboratory work may be covered under Medical Expense Benefits.

(c) Only vision procedures performed by an optician, optometrist or ophthalmologist shall be covered.

17.02 COVERED VISION PROCEDURES AND MAXIMUM AMOUNT PAYABLE

The Plan shall pay covered expenses incurred up to the amount listed for the covered procedure or item:

(a) Examination - $50 per Covered Individual once in any twelve (12) month period;

(b) Frames - $75 per Covered Individual once in any twelve (12) month period;

(c) Lenses (per pair) Single Vision - $50 per Covered Individual once in any twelve (12) month period;

(d) Lenses (per pair) Bifocal - $50 per Covered Individual once in any twelve (12) month period;

(e) Lenses (per pair) Tri-Focal - $50 per Covered Individual once in any twelve (12) month period;

(f) Lenses (per pair) Lenticular - $60 per Covered Individual once in any twelve (12) month period; and

(g) Lenses (per pair) Contacts - $80 per Covered Individual once in any twelve (12) month period.

17.03 LIMITATION ON PAYMENT FOR VISION BENEFITS

(a) No Vision Benefit payment shall be made in any one twelve (12) month period for more than:

(1) One (1) complete examination;

(2) One (1) pair of lenses;

(3) One (1) set of frames, or repair of frames;

(4) One (1) pair of contact lenses; or

(5) Either one (1) pair of lenses and frames or one (1) pair of contact lenses.

(b) No Vision Benefit payment shall be made for:

(1) Vision care services or supplies received from a medical department maintained by the Participant's Employer, a mutual benefit association, a labor union, trustee or similar group;

(2) Vision care services or supplies furnished by, or at the direction of, the United States government or any agency thereof;

(3) Medical or surgical treatment of the eye;

(4) Sunglasses, plain or prescription, or safety glasses;

(5) Orthoptics, vision training or aniseikonia;

(6) Replacement due to loss or theft;

(7) Any amount over the Reasonable and Customary allowance established by the Fund; and

(8) Services and/or supplies for cosmetic purposes.

ARTICLE XVIII. TFORCE PARTICIPANTS

18.01 QUALIFICATIONS AS A COVERED PARTICIPANT FOR TFORCE PARTICIPANTS

(a) An individual who retires meeting the requirements set forth in the TForce Freight Plan will be considered a Covered Participant if:

(1) The individual had coverage under the Active Plan Coverage on his Date of Retirement;

(2) For at least forty (40) of fifty-two (52) weeks in each of the five years immediately before retirement; or at least forty (40) of fifty-two (52) weeks in seven out of the ten years immediately before retirement, the individual was covered by an Active Plan (or a previous plan) for which United Parcel Service, Inc or TForce was responsible for making required contributions on his/her behalf or under which a Retiree Contribution Benefit was paid on his behalf;

(3) The individual is eligible to receive, at minimum, a pension benefit based upon:

(A) For retirements January 1, 2025 through December 31, 2025 for TForce Participants, at least ten (10) years of credited service from the UPS Plan and/or TForce Freight Pension Plan or retire with at least twenty (20) years under a recognized union Collective Bargaining Agreement.

(B) For retirements on or after January 1, 2026 for TForce Participants, at least a Twenty Year Service Pension from a pension plan contributed to by UPS or TForce or retire with at least twenty (20) years under a recognized union Collective Bargaining Agreement.

(4) The individual's retirement date as established by the TForce Freight Pension Plan shall be the retirement date established under the TForce Retiree Plan.

(5) If the above requirements are met, the Full-time TForce Participants will be eligible for this Plan effective on his/her 55th birthday.

(b) No individual shall be qualified as a Covered Participant eligible for Coverage under this Plan if he loses his otherwise available minimum Active Plan Coverage credit (which is described elsewhere in this section as a prerequisite for Coverage under this Plan) as a result of a Voluntary Withdrawal from the Fund, in the following circumstances:

(1) The Fund will exclude all of the individual's credit for Active Plan Coverage (to the extent such credit is based upon the individual's employment by the withdrawn Employer at any time) in determining the individual's eligibility for Coverage under this Plan if:

(A) The individual was employed by the withdrawn Employer on the date of the Voluntary Withdrawal; or

(B) The individual was ever employed by the withdrawn Employer at any time prior to (but not on) the date of the Voluntary Withdrawal and the individual's final Active Plan Coverage as of his Date of Retirement was or is based upon employment by the withdrawn Employer; provided that an individual whose eligibility for Coverage under this Plan is terminable by application of this subsection (b) and who, as of the date of the Voluntary Withdrawal, has already been acknowledged by the Fund to be a Covered Participant eligible for Coverage under this Plan will be allowed to provide to the Fund, within a time period established by the Fund, a timely written election for continuation of that Coverage in exchange for a required full Self-Payment in an amount established by the Fund.

18.02 QUALIFICATIONS AS A COVERED DEPENDENT

(a) This Plan provides Coverage only for the Dependent Spouse of a Covered Participant.

(b) Unless otherwise provided herein, an individual shall be considered a Covered Dependent under this Plan when the person to whom he/she is legally married or is considered a Covered Participant under the Plan.

(c) A Covered Dependent will not be eligible for Coverage if the Covered Participant has elected to defer Coverage under the provisions of Section 3.03.

18.03 COMMENCEMENT OF COVERAGE OF A COVERED PARTICIPANT

A Covered Participant shall participate in, and have coverage under, this Plan commencing on the date on which the conditions and qualifications of Section 18.01 are satisfied and on which he or she is no longer covered by an Active Plan, except that there shall be no Coverage of the Covered Participant under this Plan if, on his or her Date of Retirement, he or she is already 65 years of age and/or is entitled to Medicare benefits (unless the Participant has achieved his first date of entitlement to Medicare benefits solely as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30-month period following the first month in which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this section such period of entitlement to Medicare benefits shall be disregarded.). A Covered Participant whose application for retirement benefits under a Teamster Related Pension Plan is approved, after the date on which he/she is no longer covered by the Active Plan shall, upon such approval, have Coverage under this Plan commencing on the date on which coverage by the Active Plan ended or on his Date of Retirement, whichever is later, except that there shall be no Coverage of the Covered Participant under this Plan if, on his/her Date of Retirement, he or she is already 65 years of age and/or is entitled to Medicare benefits. Coverage of a Covered Participant shall be contingent on compliance with such Self-Payment requirements and procedures as are established by the Fund from time to time.

A Covered Participant may elect on a one-time only basis to defer the start date of his Coverage under this Plan beyond his retirement date or age 57, whichever is later, or to suspend his Coverage once after his Coverage has commenced, provided the following conditions are met:

(1) The Covered Participant has met the eligibility rules stated in Article 18.01 above, and

(2) The Covered Participant provides documentation to the Fund that he has coverage under Other Insurance.

A Covered Participant may start his Coverage again after a deferral period as provided for in this Section 18.03 upon the occurrence of a HIPAA Qualifying Event.

18.04 **COMMENCEMENT OF COVERAGE OF A COVERED DEPENDENT**

The Spouse of a Covered Participant shall be a Covered Dependent and shall participate in, and have Coverage under, this Plan (unless the Spouse is then already 65 years of age and/or entitled to Medicare benefits) commencing on the date on which the Covered Participant to whom he or she is married first has Coverage under this Plan or, if later, the date on which he or she is first married to a Covered Participant (provided written notice is received by the Fund within 60 days of the marriage date). The Spouse of an individual who would have become a Covered Participant on his or her Date of Retirement except that, on such date, he or she is already 65 years of age and/or is entitled to Medicare benefits, shall be a Covered Dependent and shall participate in, this Plan (unless the Spouse is then already 65 years of age and/or entitled to Medicare benefit unless the Spouse if entitled to Medicare benefits solely as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30-month period following the first month in which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this section such period of entitlement to Medicare benefits shall be disregarded.) commencing on the date on which the individual (with whom the Spouse is then married) would have become a Covered Participant. Coverage of a Covered Dependent shall be contingent on compliance with such Self-Payment requirements and procedures as are established by the Fund from time to time.

A Covered Dependent may elect on a one-time only basis to defer the start date of his or her Coverage under this Plan beyond Covered Participant's effective date Coverage, or to suspend his or her Coverage once after his or her Coverage has commenced, provided the following conditions are met:

(1) The Covered Dependent has met the eligibility rules stated in Article 3.02 above, and

(2) The Covered Dependent provides documentation to the Fund that he or she has coverage under Other Insurance.

A Covered Dependent may start his Coverage again after a deferral period as provided for in this Section 3.04 upon the occurrence of a HIPAA Qualifying Event.

18.05 ELIGIBILITY OF INDIVIDUALS QUALIFYING FOR AN EXTENSION OF BENEFITS UNDER ANOTHER CENTRAL STATES ACTIVE PLAN

(a) If a Covered Participant under this Plan would otherwise qualify for an extension of Basic Benefits under an Active Plan, he shall, as a condition of becoming a Covered Participant under this Plan, lose the eligibility for such extension of benefits.

(b) If a Covered Participant under this Plan would otherwise qualify for an extension of Major Medical Expense Benefits under an Active Plan, he shall, as a condition of becoming a Covered Participant under this Plan, lose the eligibility for such extension of benefits.

18.06 TERMINATION OF COVERAGE OF A COVERED PARTICIPANT

A Covered Participant's Coverage under this Plan shall terminate on the earliest of the following dates:

(a) the date the Covered Participant becomes 65 years of age;

(b) the date such Covered Participant first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. § 1395, et seq.). (Provided however, that Coverage shall not terminate under this Plan solely because the Participant has achieved his first date of entitlement to Medicare benefits as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30 month period following the first month in which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this Subsection (b) such period of entitlement to Medicare benefits shall be disregarded);

(c) the date of the Covered Participant's death;

(d) the date on which this Plan is terminated;

(e) the date on which the Covered Participant again becomes employed by an Employer which is required to make employer contributions to the Active Fund to secure Active Plan Coverage of the Covered Participant, provided that, on his or her future Date of Retirement after such reemployment, he or she may again participate in, and have Coverage under, this Plan if, and on the date on which, the conditions and qualifications of Sections 3.01 and 3.03 are satisfied;

(f) on the date the Covered Participant is engaged in restricted Reemployment as set forth in Section 10.17;

(g) the date the Coverage of the Covered Participant terminates for any reason other than death or commencement of eligibility for Medicare benefits; or

(h) the date of a Voluntary Withdrawal from the Active Fund of a Covered Participant's former Employer and Bargaining Unit on or after September 11, 2002, if

(1) the Covered Participant was ever employed by the withdrawn Employer at any time prior to (but not on) the date of the Voluntary Withdrawal (including employment prior to September 11, 2002) and the Covered Participant's final Active Plan Coverage as of his Date of Retirement (before or after September 11, 2002) was or is based upon employment by the withdrawn Employer; and

(2) the Covered Participant no longer has sufficient Active Plan Coverage credit to satisfy any minimum prerequisite for Coverage under this Plan after the Fund retroactively excludes all of his credit for Active Plan Coverage based upon employment at any time by that withdrawn Employer in re-determining his eligibility for Coverage under this Plan, provided that a Covered Participant whose Coverage under this Plan is terminable by application of this subsection (h) will be allowed to provide to the Fund, within a time period established by the Fund, a timely written election for continuation of that Coverage in exchange for a required full Self-Payment in an amount established by the Fund.

In addition to the above specified events that terminate Coverage, Coverage of a Covered Participant shall be terminated upon an election not to comply, or upon any failure to comply, with such Self-Payment requirements and procedures as are established by the Fund from time to time.

18.07 **TERMINATION OF COVERAGE OF A COVERED DEPENDENT**

A Covered Participant's Coverage under this Plan shall terminate on the earliest of the following dates:

(a) the date such Covered Dependent attains 65 years of age;

(b) the date such Covered Dependent first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. § 1396 et seq.). (Provided however, that Coverage shall not terminate under this Plan solely because the Dependent has achieved his first date of entitlement to Medicare benefits as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30 month period following the first month in which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this Subsection (b) such period of entitlement to Medicare benefits shall be disregarded);

(c) a maximum of five years after the Covered Participant's Date of Retirement if such Covered Participant dies prior to his 65th birthday;

(d) the date of such Covered Dependent's death;

(e) the date such Covered Dependent ceases to be legally married to his or her Covered Participant;

(f) the date the Plan is terminated;

(g) the date the Coverage of the Covered Participant terminates for any reason other than death or commencement of eligibility for Medicare benefits;

(h) the date of a Voluntary Withdrawal from the Active Fund of a Covered Participant's former Employer and Bargaining Unit on or after September 11, 2002, if

(1) the Covered Participant was ever employed by the withdrawn Employer at any time prior to (but not on) the date of the Voluntary Withdrawal (including employment prior to September 11, 2002) and the Covered Participant's final Active Plan Coverage as of his Date of Retirement (before or after September 11, 2002) was or is based upon employment by the withdrawn Employer; and

(2) the Covered Participant no longer has sufficient Active Plan Coverage credit to satisfy any minimum prerequisite for Coverage under this Plan after the Fund retroactively excludes all of his credit for Active Plan Coverage based upon employment at any time by that withdrawn Employer in re-determining his eligibility for Coverage under this Plan, provided that a Covered Participant whose Coverage under this Plan is terminable by application of this subsection (h) will be allowed to provide to the Fund, within a time period established by the Fund, a timely written election for continuation of that Coverage in exchange for a required full Self-Payment in an amount established by the Fund.

In addition to the above specified events that terminate Coverage, Coverage of a Covered Dependent shall be terminated upon an election not to comply, or upon any failure to comply, with such Self-Payment requirements and procedures as are established by the Fund from time to time.

18.08 **EXTENDED SPOUSE COVERAGE**

Extended Spouse protection under this Plan provides an additional three years of coverage for the Covered Dependent when the Covered Participant turns age 65. Therefore, in the majority of cases, Covered Dependents will have coverage until the Covered Participant's 68th birthday or, if earlier, the date he/she turns 65, remarries or becomes eligible for early Medicare (unless the Participant has achieved his first date of entitlement to Medicare benefits solely as a result of a diagnosis of end stage renal disease (ESRD) under the terms and conditions referenced in 42 U.S.C. § 1395Y(b)(1)(c)(i), or during the 30-month period following the first month in which the individual first becomes so entitled to Medicare benefits on the basis of ESRD; for purposes of this section such period of entitlement to Medicare benefits shall be disregarded.).

There are other events in which the Covered Dependent may also receive the extended coverage as follows. In all cases the extended Spouse coverage ends earlier than three years in the event the Covered Dependent turns 65, becomes eligible for early Medicare or remarries.

(a) In the event the Covered Participant turns age 65:

- Covered Dependent will receive extended coverage for up to three years.

(b) In the event the Covered Participant becomes eligible for early Medicare after retirement:

- Covered Dependent will receive the normal benefit until the retiree's 65th birthday.

- Covered Dependent will also receive up to three years of extended coverage from the Covered Participant's 65th birthday.

- Covered Participants who retire prior to age 57 and whose coverage is scheduled to start at age 57, but who qualify for early Medicare prior to their 57th birthday, are not entitled to coverage. However, the Covered Dependent will be entitled to three years of extended spousal or coverage beyond that date.

(c) In the event the Covered Participant became eligible for Medicare before retirement and met all other qualifying rules:

- Covered Dependent will receive extended coverage for up to three years from the Covered Participant's retirement date.

(d) In the event the Covered Participant retires after his/her 65th birthday and has met all eligibility requirements at retirement date:

- Covered Dependent will receive extended coverage for up to three years from the Covered Participant's retirement date.

(e) In the event the Covered Participant dies prior to age 65:

- Covered Dependent will get the greater of five years from retirement date or three years from death date.

(f) In the event the Covered Participant dies before coverage is in effect:

- Covered Dependent will receive up to three years of extended coverage starting from the Covered Participant's previously anticipated effective date (age 50, 55 or 57).

Termination of the Extended Spouse coverage is not a Qualifying Event to elect Continuation Coverage as described in Sections 3.09 to 3.14.