SUMMARY PLAN DESCRIPTION

TEAMSTERS LOCAL 639— EMPLOYERS HEALTH TRUST

HOW YOUR HEALTH PLAN WORKS

JANUARY 1, 2011

HOW YOUR HEALTH PLAN WORKS

Teamsters Local 639—Employers HealthTrust Fund

3130 Ames Place, NE · Washington, DC 20018

800-983-2699

202-636-8181

January 1, 2011

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

CONTENTS

IS THIS BOOKLET FOR YOU?

This booklet describes the benefits under the Teamsters Local 639 — Employers Health Trust Fund (the "Health Plan") Plan Document as of January 1, 2011. It applies to you if you are an eligible Participant or Dependent on or after January 1, 2011, unless a specific effective date is set forth in the text.

The Trustees have provided this Summary Plan Description to give you the detailed rules of the Health Plan. To make it easier to read, we have tried to write in plain English. This Summary Plan Description serves as the official Plan Document and we refer to it as the Plan throughout this booklet.

If you have questions about your personal benefit entitlement, write or contact the Fund Office for information. Do not rely solely on your Local Union Representative, your employer or others for health benefit information. The detailed rules of the Plan can be complex and the Plan is not bound by their statements or interpretations. Only the full Board of Trustees is authorized to interpret the rules and provisions of the Plan.

You can contact the Fund Office at 202-636-8181 or toll free at 800-983-2699 or in person at 3130 Ames Place, NE, Washington, DC, 20018.

Save this booklet. Put it in a safe place. If you lose your copy, you can ask the Fund Office for another.

Grandfathered Plan

The Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

1 ELIGIBILITY

INITIAL ELIGIBILITY

You become eligible for benefits under the Plan on the first day of the third month after the month in which you first work at least 140 hours for an employer or employers who contribute to the Plan on your behalf. Employer Contributions must be received by the Fund Office before eligibility credit for hours worked is provided.

Here's how the general rule works. If you first worked at least 140 hours in January, you will become eligible on April 1. If you first worked at least 140 hours in February, you will become eligible on May 1. Use the table to determine when you will first become eligible for benefits.

IF YOU WORKED 140 HOURS IN:	YOU ARE ELIGIBLE FOR THE MONTH OF:
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

Employees of New Employers to the Plan

If you work for an employer who does not participate in the Plan and your employer later agrees to start participating in the Plan, you will be eligible for benefits 30 days after the date your employer becomes obligated and makes Contributions to the Plan on your behalf. However, you are eligible in these circumstances only if you have worked for that employer for:

- 840 hours in a job classification now represented by Teamsters Local 639, and
- at least 6 continuous months before the employer begins participating in the Plan.

In addition, your employer must send Contributions for the 30-day period to the Fund Office on your behalf in order for you to be eligible.

MAINTAINING YOUR ELIGIBILITY

You will continue to be eligible for benefits as long as your employer or employers make Contributions on your behalf for at least 140 hours in a month.

If you fail to meet the 140 hour requirement in a month, you can still be eligible if you have Contributions made on your behalf for at least 840 hours in six consecutive months ending with the month in which you failed to work 140 hours. The following chart shows how this works:

Generally speaking, your employer will report to the Fund Office the number of hours you worked for which the employer is required to make Contributions, and will then make Contributions based on the reported hours.

IF YOU WORKED 840 HOURS IN:	YOU ARE ELIGIBLE FOR THE MONTH OF:
January through June	September
February through July	October
March through August	November
April through September	December
May through October	January
June through November	February
July through December	March
August through January	April
September through February	May
October through March	June
November through April	July
December through May	August

Eligibility during Disability

If you are sick or hurt and are getting Weekly Accident & Sickness Benefits or benefits under your employer's workers' compensation program, you will get credit for 7 hours of work for each weekday during the period of your disability, up to the maximum number of weeks. For this provision to apply, you must be actively employed and eligible for benefits on the day before you leave work due to disability. If you are receiving Workers' Compensation, you must submit written proof of that fact to the Fund Office in order to receive disability credits.

Eligibility during a Strike

If you are on strike, and the strike is duly authorized by the Union, you will be credited with 7 hours of work for each weekday you are on strike, up to a maximum of 60 calendar days. You must have been actively employed and eligible for benefits on the day before the strike began.

Eligibility during Vacation

If you are on vacation and your employer is not required to make Contributions on vacation hours, you will receive vacation credits for each vacation hour for which you are paid by your employer up to a maximum of 20 calendar days. You must have been actively employed and eligible for benefits on the day before you leave for vacation and your employer must confirm your vacation hours.

Eligibility after Military Duty

Your rights to health coverage from the Plan during and following any periods of military service are governed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The Plan provides you with the right to elect continuous health coverage for you and your eligible Dependents for up to 24 months beginning on the date your absence begins from employment due to military service, including Reserve and National Guard Duty, as described below. Contact the Fund Office for more information if this may apply to you.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible Dependents under the provisions of USERRA. The period of coverage for you and your eligible Dependents ends on the earlier of:

- the end of the 24-month period beginning on the date on which our absence begins; or
- the day after the date on which you are required but fail to apply under USERRA for or return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must reapply for employment within 90 days of discharge).

After 31 days, you must pay the cost of the coverage. The cost that you must pay to continue benefits will be determined in accordance with the provisions of USERRA by the same method that the Plan uses to determine cost of COBRA continuation coverage.

You must notify the Fund Office that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You also must contact the Fund Office and elect continuation coverage for yourself or your eligible Dependents under the provisions of USERRA within 60 days after your military service begins. Payment of the USERRA promiun, retroactive to the date on which coverage under the Plan termininated, must be made within 45 days after the date of election of your USERRA coverage.

Ongoing payment must be made by the last day of the month for which coverage is to be provided. You will not be billed; it is your responsibility to remit payments to the Fund Office. Late payments can result in termination of coverage. You are responsible for the payment of required premiums.

If you are off work for no more than 30 days, your and your family's coverage will not be affected. If you are off work for more than 30 days and your total time off work from all separate periods of military service is less than five years, in general, your coverage will resume upon your return to employment, as long as you return to work within the period provided by law (generally 14 days if your period of military service is no more than 180 days, and 90 days for longer periods of military service). You should be aware that this is only a general statement of your rights. For more information on your rights as a member of the Armed Forces, contact the Fund Office or the local office of the Veterans' Employment and Training Service of the Department of Labor.

Self-Payments to Maintain Eligibility

If you do not work enough contribution hours (including disability, strike or vacation credit hours) in any calendar month to remain eligible, you may make Self-Payments to maintain eligibility for medical, prescription drug, dental, vision and life insurance benefits.

To maintain your eligibility for a month you will have to pay for 140 hours less your actual credited hours, multiplied by the hourly contribution rate paid by your employer.

The Fund Office will send you a letter advising you that your eligibility is about to end, and how much you must pay to maintain eligibility. Your Self-Payment must be received within 20 days from the date of the Fund Office's letter.

You may make Self-Payments for up to 12 months. If you miss a payment, you will lose eligibility. If that happens, you will have to return to work and re-qualify for benefits.

Self-Payments cannot be made if you quit or are discharged. However, if you are discharged and the Union grieves your discharge, you can self-pay until the resolution of the dispute or for one year, whichever comes first.

Self-Payments are not permitted if you retire. However, you may continue to be eligible under the COBRA Continuation Rules discussed in Section 2 of this booklet. Alternatively, you may be eligible to begin receiving benefits under the Retiree Health Plan offered through the Teamsters Local 639-Employers Pension Trust. This optional retiree health plan is described in a separate Summary Plan Description.

Self-Payments are in lieu of COBRA continuation coverage, discussed later in this

booklet. If you elect to make Self-Payments, you may not later elect COBRA.

WHEN YOUR ELIGIBILITY ENDS

You are no longer eligible for benefits if one or more of the following events occur:

- You fail to work the required number of hours;
- You use the maximum disability, strike or vacation credits described above;
- If the Plan permits you to self-pay and you fail to make Self-Payments when they are due;
- You make the maximum number of Self-Payments permitted;
- You or your eligible Dependent fail to make COBRA payments as described in Section 2; or
- You or your eligible Dependent make the maximum number of COBRA payments permitted by law, as described in Section 2.

Dependent eligibility ends when a person no longer is a qualified Dependent. When your eligibility terminates, all benefits provided by the Plan cease. However, if you (or your eligible Dependent) are confined in a Hospital, eligibility for the individual's medical benefits will continue for the remainder of the confinement, or 30 days, whichever is less.

DEPENDENT COVERAGE

Most of the Plan benefits also apply to your Dependents. Your Dependents are:

Spouse

"Spouse" is defined as your legal husband or wife.

Children

With respect to coverage other than life insurance coverage, eligible dependent Children are Children:

- under the age of 26, provided an adult Child is not a Dependent if he or she is eligible for other employer sponsored coverage; and/or
- who are mentally or physically unable to make a living (coverage will continue for as long as the son or daughter remains disabled).

With respect to life insurance coverage only, eligible dependent Children are unmarried and:

- under the age of 19 (Dependent child must be over 14 days old to be covered);
- full-time students in an accredited school under the age of 25. To maintain coverage for a Dependent who is a full-time student, you must complete the Certification for Dependent Child over Age 19 within 60 days of the student's 19th birthday, which must be renewed each quarter/semester without notice from the Fund Office for coverage to be continued.

"Children" means:

- your biological children,
- stepchildren,
- legally adopted children, or
- children under your legal guardianship.

For retirees, your only Dependent is your legal spouse.

If you die, your Dependents will remain eligible for benefits to the last day you would have remained eligible. Under certain circumstances, Dependents may continue eligibility by making monthly payments to the Plan as described in Section 2, COBRA Continuation Coverage.

Spousal Surcharge

Under the spousal surcharge plan, if your spouse has "adequate alternate coverage" available through an employer, your spouse will be required to take that coverage or pay a monthly spousal "surcharge" of $388 in order to receive coverage from the Plan. The monthly spousal surcharge amount of $388 (in 2011) may be adjusted annually, effective each January 1.

If your spouse is not employed, or does not have "adequate alternate coverage" available through an employer, your spouse

will be covered by the Plan and will not have to pay the spousal surcharge.

"Adequate Alternate Coverage":

Your spouse does ***not*** have "adequate alternate coverage" available through her/his employer if:

1. Your spouse is not employed and therefore does not have any employer sponsored health care coverage;
2. Your spouse is employed, but all of the individual coverage options under your spouse's employer's health benefit plan would require your spouse to pay a monthly contribution of more than $330; or
3. Your spouse is employed, but all of the individual coverage options under your spouse's employer's health benefit plan have individual annual Deductibles of $1,000 or more, individual annual out-of-pocket maximums of more than $3,000 ***and*** coinsurance of more than 25%.

Spousal Health Coverage Information Form

All married Participants and their spouses must complete and sign the Spousal Health Coverage Information Form indicating whether the spouse is employed and whether the spouse has "adequate alternate coverage" and hand deliver or mail it to the Fund Office. Depending on your response, you may also need to provide the following additional information (as indicated on the Form):

- If you file separate tax returns, provide a copy of your spouse's most recent signed Form 1040 and W-2s.
- If you file a joint return, provide a copy of your most recent signed Form 1040 along with a copy of your spouse's W-2s.
- Open enrollment materials or a signed statement from your spouse's employer that confirms your spouse does not have "adequate alternate coverage."

All Form 1040s and W-2s will be kept in confidence by the Fund Office in accordance with government privacy and security regulations.

You may be required to provide the Fund Office with the same Form and supporting information annually in advance of each January 1 plan year. (The Fund Office will mail these to you). Failure to return a completed and signed Spousal Health Coverage Information Form by any required due date will cause your spouse's coverage to be suspended and/or terminated.

If your form is returned to the Fund office **after** the due date:

- And your spouse does not have "adequate alternate coverage", your spouse's coverage will be suspended until such time as a completed and

signed Form is received. Your spouse's coverage will then be reinstated prospectively beginning on the first of the month following the month in which the Form is received. Claims incurred prior to that date and during the suspension will not be paid.

- And your spouse has "adequate alternate coverage" but elects to pay the spousal surcharge and continue spousal coverage under this Plan, your spouse's coverage will be terminated and you will not be able to re-enroll your spouse in the Plan for 12 months.

How the Spousal Surcharge Works For a Spouse Who Has "Adequate Alternate Coverage" Through the Spouse's Employer:

- Your spouse must either enroll in the "adequate alternate coverage" available through your spouse's employer or pay a monthly spousal surcharge to receive spousal coverage under the Plan.
- If you decide to pay the monthly spousal surcharge in order to receive spousal coverage under the Plan, each payment must be received in the Fund Office before the first day of the month for which spousal coverage is requested. If payment is not received on a timely basis, spousal coverage will be terminated and you will not be permitted to re-enroll your spouse in spousal coverage from the Plan for a period of 12 months.
- You will not be required to start paying the monthly spousal surcharge until your spouse has a right to enroll in her/his employer's plan. (Your spouse must ask her/his employer when she/he will be allowed to enroll in the employer's plan. If the employer's plan is a cafeteria plan, your spouse's employer should allow your spouse to enroll immediately. If your spouse, for whatever reason, is not allowed to enroll immediately in the employer's plan, your spouse must do so during the next open enrollment.)
- If your spouse declines the employer sponsored coverage AND you refuse to pay the monthly spousal surcharge, your spouse will lose spousal coverage under the Plan and you will not be allowed to re-enroll your spouse in the Plan for a period of 12 months.
- Coverage is effective as of the first day of the month for which the monthly spouse premium is paid.

Penalty for Providing False Information

If you or your spouse makes a false or incorrect statement to the Plan about your spouse's employment status or the health coverage that is or is not available through your spouse's employer, you and your spouse will be subject to stiff penalties. Those penalties may include suspension

of Plan coverage for a year, in addition to having to repay all benefits paid by the Fund on your spouse's behalf. You should also be aware that making a false statement on the Form provided to the Fund Office is a federal crime in violation of Section 1027 of the United States Criminal Code (18 U.S.C.), which is punishable by a fine of up to $10,000, five years in prison, or both.

Changes in Spousal Surcharge Amount:

The monthly spousal surcharge amount of $388 (in 2011) may be adjusted annually, effective each January 1, to represent the monthly cost of providing the Plan's benefits for an adult. The monthly surcharge will not increase by more than 5% in any year.

OBTAINING BENEFITS

When you first become covered under the Plan, you must fill out an individual enrollment card for the Fund Office providing information about you and your Dependents.

You must also update your enrollment information whenever there is a change in the status of you or your Dependents (for example, a change of address, new baby, removal or addition of a spouse). You will be given a medical card and a prescription drug card for proof of participation in the Plan.

When you need medical benefits, simply make an appointment with a medical care provider. In most instances they will complete and submit any needed claim forms. For some benefits (like the Weekly Accident and Sickness benefit) you will need to get a claim form from the Fund Office. Complete the claim form and return it to the Fund Office.

You must be sure your claim form is filed in the Fund Office within 12 months of the date of service. If you do not file within the time limit, the Plan will not pay your claim.

2 COBRA CONTINUATION COVERAGE

BASIC COBRA PROVISIONS

ELECTING COBRA CONTINUATION

PAYING FOR COBRA CONTINUATION

RELATIONSHIP OF COBRA CONTINUATION TO SELF-PAY

BASIC COBRA PROVISIONS

Under a federal law referred to as COBRA, if you or your Dependent lose your eligibility as a result of a "qualifying event" you may be able to purchase temporary extension coverage at group rates. This is "COBRA continuation coverage."

Benefits Covered

With COBRA continuation coverage you will generally be eligible for the same medical benefits provided under the applicable Schedule of Benefits in effect on the day before the qualifying event occurred. You may elect to continue only Medical and Prescription benefits (Core Benefits). If you are covered under a Schedule of Benefits which provides Dental and/or Vision Care Benefits (Non-Core Benefits), you may also elect those Non-Core Benefits in addition to the Core Benefits. COBRA continuation coverage does not include any non-medical benefits, such as life insurance, accidental death and dismemberment insurance, or Weekly Accident & Sickness benefits.

COBRA Continuation Coverage Begins

You have the right to purchase continuation coverage only if you lose coverage due to a "qualifying event." "Qualifying events" for you and your eligible Dependents include:

- your termination of employment for reasons other than gross misconduct, or
- reduction in your hours of employment.

In addition, "qualifying events" for your spouse and other eligible Dependents include:

- your death,
- your spouse's divorce from you,
- your entitlement to Medicare coverage, or
- your Dependent's loss of Dependent status under the Plan.

How Long Continuation Coverage Runs

You can purchase continuation coverage that extends until the earlier of the end of the "Applicable Continuation Period" or a "Termination Event."

"Applicable Continuation Period" is:

- If your or your eligible Dependents' eligibility ended because of the termination of your employment or a reduction in hours, the applicable continuation period is 18 months from the first day of the month following the qualifying event.
- If the Social Security Administration (SSA) has determined that you are

disabled within the first 60 days of your COBRA continuation period, the applicable continuation period is 29 months, as long as you notify the Fund Office of the Social Security disability award within the 18 months following the qualifying event. If your disability ends, however, you and your Dependents will no longer be eligible to purchase continuation coverage beyond the later of the end of the initial 18 month period or the date that is 30 days after a final determination that you are no longer disabled.

- If you die, the applicable continuation period for your eligible Dependents is 36 months from the date of your death.
- If the qualifying event is due to divorce from you or loss of Dependent status under the Plan, the applicable continuation period is 36 months from the date of the qualifying event.
- If two or more qualifying events occur, the applicable continuation period for your Dependents is 36 months from the date of the first qualifying event. A Dependent who was not eligible to elect continuation coverage at the time of the first qualifying event cannot do so upon a subsequent qualifying event.
- If you become eligible for Medicare benefits, the applicable continuation period for your Dependents is 36 months from the date you become eligible for Medicare.

A "Termination Event" is

- The conclusion of the Applicable Continuation Period;
- The date on which all coverage offered by the Plan terminates;
- The date on which you or your Dependent becomes covered by another group health plan that does not contain an exclusion or limitation for a pre-existing condition, provided this occurs on a date after COBRA continuation coverage is elected;
- The date you or your Dependent become entitled to Medicare coverage, provided this occurs on a date after COBRA continuation coverage is elected; or
- The last day of the month preceding the month for which the COBRA premium was not timely paid.

ELECTING COBRA CONTINUATION COVERAGE

The Fund Office must be notified of any qualifying event that may entitle you or your Dependents to continuation coverage. In the event of divorce or loss of Dependent status, you or your Dependent must notify the Fund Office within 60 days and in writing. For other qualifying events, your employer must notify the Fund Office within 30 days. An employer fulfills this obligation by reporting the qualifying event on its timely filed contribution report to the Fund Office.

If you become disabled within the first 18 months of COBRA continuation coverage, you are obligated to inform the Fund Office within 60 days of the time you receive a Social Security disability award. If the Social Security Administration determines that you are no longer disabled, you must notify the Fund Office within 30 days.

Within 30 days after receiving notice of a qualifying event, the Fund Office will notify you or your Dependent of the right to elect continuation coverage. The Fund Office will also tell you how much such coverage will cost, and will provide an election form and instructions for electing the coverage.

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

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

If you do not elect continuation coverage within this time, you will no longer be eligible for such coverage.

PAYING FOR COBRA CONTINUATION COVERAGE

You must pay the premium for COBRA coverage. The first premium payment must be made to the Fund Office no later than 45 days after the date continuation coverage is elected. Subsequent premiums are due on the first day of the calendar month; however, there is a grace period of 30 days for the payment of the subsequent premiums. If a payment is not made within this 30-day grace period, COBRA continuation coverage will terminate automatically.

The Board of Trustees will determine the amount of the monthly premium for

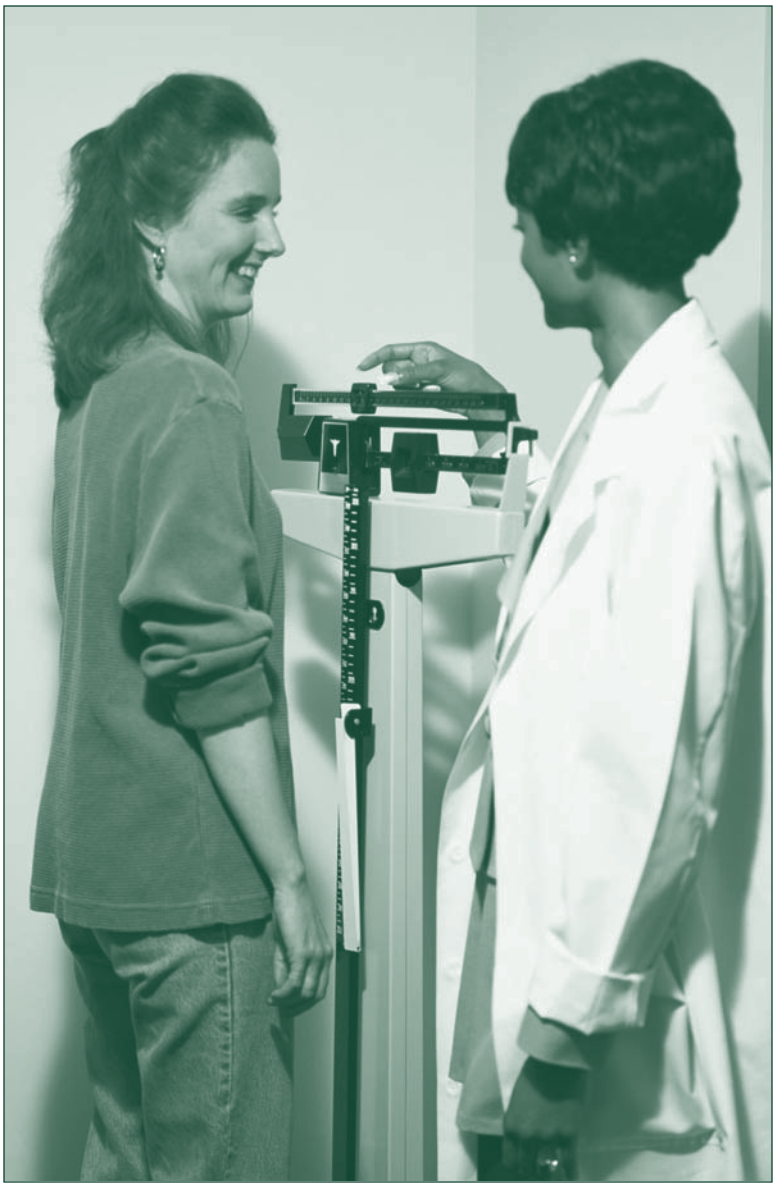
COBRA continuation coverage annually but it will be no more than 102% of the cost of coverage provided to similarly situated Participants and Dependents unless a higher charge is permitted by law.

RELATIONSHIP OF COBRA CONTINUATION COVERAGE TO SELF-PAY

When you lose coverage under the Plan, you may elect to continue coverage under COBRA or under the self-pay provisions of the Plan, if otherwise eligible to do so. If you elect COBRA payments, you may not later elect to make Self-Payments.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

3 MEDICAL



SCHEDULE OF BENEFITS

CIGNA PREFERRED PROVIDER ORGANIZATION

DEDUCTIBLE

MEDICAL COVERED AMOUNT

COVERED EXPENSES - MEDICAL

HOSPITAL ROOM AND BOARD

HOSPITAL SERVICES AND SUPPLIES

PHYSICIAN SERVICES

SURGICAL

INPATIENT DOCTOR VISITS

X-RAY AND LABORATORY

OUTPATIENT SURGICAL EXPENSES

GRADUATE REGISTERED NURSES

TRANSPORTATION

ANESTHETICS

MEDICAL SUPPLIES

SCHEDULE OF BENEFITS (PARTICIPANT & DEPENDENTS)	IN-NETWORK (see page 24)	OUT-OF-NETWORK (see page 24)
DEDUCTIBLE		
Per Person	$150	$700
Per Family	$300	$1,400
COVERED AMOUNT		
First $4,000 of the Usual, Customary and Reasonable (UCR) Charge for Covered Expenses (in excess of the Deductible) Per person for In-Network (For Family, first $8,000 of the UCR Charge for Covered Expenses)	80%	–
First $10,000 of the UCR Charge for Covered Expenses (in excess of the Deductible) Per person for Out-of-Network (For Family, first $20,000 of the UCR Charge for Covered Expenses)	–	60%
Excess over $4,000 of the UCR Charge for Covered Expenses (in excess of the Deductible) Per person for In-Network (For Family, excess of $8,000 of the UCR Charge for Covered Expenses)	100%	–
Excess over $10,000 of the UCR Charge for Covered Expenses (in excess of the Deductible) Per person for Out-of-Network (For Family, excess of $20,000 of the UCR Charge for Covered Expenses)	–	100%
Maximum Annual Out of Pocket Payment (for Covered Expenses, per calendar year, after the Deductible has been satisfied)		
Per Person	$800	$4,000
Per Family	$1,600	$8,000
Maximum Medical, Mental Health, and Drug and Alcohol Dependency Benefit Payable		
Per calendar year	$1,000,000**	
Emergency Room Co-Payment	$100 (waived if admitted)	
WELLNESS BENEFITS (not subject to the Deductible)		
Well Baby Care (For eligible Dependents through age three)		
Routine Physical Examination (For Participants and eligible Dependents age four and above)	Once every year	
Pap test (For female Participants and Dependents age 18 or older)	Once every two years	
Mammogram (For female Participants and Dependents age 40 and older)	Once every other year for ages 40 to 49, and once every year for ages 50 and older	
Proctology screening (For male Participants and Dependents age 40 or older)	Once every other year for ages 40-49 and once each year for ages 50 and older	
Hearing Aids – Maximum payable per ear	$1,000, once every 36 months	
Routine Colonoscopy (starting at age 50)	Once every 10 years	

*Covered expenses are limited to the UCR Charge.

**The annual limit is $1,000,000 for 2011, $1,250,000 for 2012, $2,000,000 for 2013, unlimited for 2014 and thereafter.

HEARING AIDS
CHIROPRACTOR
PHYSIOTHERAPY
VISION THERAPY
SPEECH THERAPY
OCCUPATIONAL THERAPY
AMBULATORY SURGICAL CENTER
SPECIAL RULES RELATING TO PREGNANCY AND CHILDBIRTH
SPECIAL RULES RELATING TO MASTECTOMY COVERAGE
WELLNESS BENEFITS
CASE MANAGEMENT
EXCLUSIONS

THE CIGNA PREFERRED PROVIDER ORGANIZATION

The Board of Trustees has contracted with CIGNA HealthCare to make Preferred Provider Organization ("PPO") services available to Plan Participants through the CIGNA Health Care PPO ("CIGNA PPO"). A PPO is a group of selected physicians, specialists, Hospitals and other Treatment centers that have agreed to provide their services to Plan Participants at a discount. The PPO can be used for regular or emergency medical services. Certain benefits are provided through a CIGNA subsidiary called CareAllies, the nation's leading provider of Participant-friendly, effective care management programs. Please note the following important information:

- **In Network Benefits:** If you live in the CIGNA PPO network area, you must use Hospitals, physicians, and other medical providers that participate in the CIGNA PPO in order to receive the In-Network benefit levels. Currently the CIGNA PPO has over one million locations across the nation and has coverage throughout the District of Columbia and the surrounding suburbs of Maryland and Virginia. To determine the providers in your area, you can request a provider directory from the Fund Office or from CIGNA at 800-768-4695 or you can access the most up-to-date version on the internet at www.cigna.com\SA-PPO2.
- **Out-of-Network Benefits:** If you live in the CIGNA PPO network area but use a physician or Hospital that is not in the CIGNA PPO network, your benefits will be covered at the Out-of-Network benefit levels.

If your Doctor/provider is not in the CIGNA network and you would like CIGNA to reach out to your Doctor/provider, you may obtain a nomination form from the Fund Office.

You are free to choose any service provider you wish. You are encouraged to use the CIGNA PPO because **you will save money**. You pay a percentage of billed charges under the Plan. With the CIGNA PPO, you will be paying a smaller percentage of a smaller amount.

When you first become eligible for benefits under the Plan you will be given a CIGNA PPO I.D. Card. The Fund Office can provide a directory that lists all of the Doctors and Hospitals participating in the PPO. Check to see if your current Doctor participates by using this directory or going to the CIGNA website at www.cignasharedadministration.com. There is a good possibility that you are already using a PPO physician. The directory and website

can also help you if you are looking for a new Doctor.

When you go to a participating Doctor or Hospital, identify yourself as a CIGNA PPO Participant by presenting your I.D. card. Complete and sign the claim form as usual. The physician or Hospital will then submit your claim directly to the CIGNA PPO.

If you choose to use a Doctor or facility that is not in the PPO, submit a completed claim form to your Doctor or the facility. Ask them to forward it to the Fund Office.

DEDUCTIBLE

You must pay the first $150 of the UCR Charge for your personal In-Network (or $700 if Out-of-Network) Covered Expenses. If you have Dependents, you must pay the first $150 of the UCR Charge for In-Network (or $700 if Out-of-Network) Covered Expenses for each of them until you reach the family limit. The family limit is $300 (or $1,400 if Out-of-Network). This is called the Deductible.

The Deductible applies only once in any calendar year. A new Deductible applies each calendar year for each person covered under the Plan.

The requirement to meet the annual Deductible will not apply to the following benefits:

- Routine physical exams (including approved annual screenings);
- Well Baby Care;
- Pap tests;
- Mammogram testing;
- Proctology screenings;
- Routine Colonoscopy (starting at age 50); and
- Hearing Aids.

MEDICAL COVERED AMOUNT

After you pay your Deductible, the Plan will pay 80% of the UCR Charge for In-Network Covered Expenses. The Plan will pay 60% of the UCR Charge for Out-of-Network Covered Expenses. When you have paid the maximum out-of-pocket expense (as shown in the Schedule of Benefits) the Plan will pay 100% of the UCR Charge for additional Covered Expenses for the rest of the year.

The annual Deductible will not count towards satisfying your annual out-of-pocket maximum. For example, if you are a single Participant seeking In-Network benefits, you will be required to pay the $150 annual Deductible and then 20% of

the UCR Charge for the next $4,000 in Covered Expenses until you have satisfied the annual out-of-pocket maximum (the $150 Deductible plus $800 in coinsurance).

All annual Deductibles and maximums are determined on a calendar year. You will be required to satisfy the annual Deductible and meet the out-of-pocket maximum again each calendar year.

For 2011, the Plan has an annual maximum benefit of $1,000,000 per person.

COVERED EXPENSES — MEDICAL

Covered Expenses include the medical services described on the following pages. The Plan will pay only the UCR Charges in accordance with the Schedule of Benefits for Medically Necessary services provided on the recommendation and approval of the attending physician in connection with the Treatment of bodily Injury or Sickness for these medical services. You must pay any expenses that exceed the UCR Charge. UCR Charge is defined on page 121.

Hospital Room and Board — The Plan will pay UCR Charges in accordance with the Schedule of Benefits for a semi-private room, or intensive care unit if needed. Hospital admissions must be pre-certified by the CIGNA CareAllies. Prior to any scheduled Hospital admission, you or your physician must call CIGNA for pre-certification at 800-768-4695. In an emergency or life-threatening situation, you or a family member must notify CIGNA within 24 hours of admission. This requirement applies whether or not your physician participates in the CIGNA PPO. If you incur Hospital expenses that are not certified by CIGNA, the Plan will pay only 80% of the amount which would otherwise be paid by the Plan (i.e., 80% of the 80% of UCR Charges for an In-Network Covered Expense or 80% of the 60% of UCR Charges for an Out-of-Network Covered Expense).

Treatment in an approved Hospice Program, which is approved by CIGNA in lieu of hospitalization, is a covered expense.

Hospital Services and Supplies — UCR Charges in accordance with the Schedule of Benefits for Necessary Hospital services and supplies are also covered. This includes such things as:

- Use of the operating room,
- X-rays and tests, and
- Additional Hospital charges for Medically Necessary services.

Physician Services — The Plan will pay the UCR Charges in accordance with the Schedule of Benefits for performing

surgical procedures and for medical care and Treatment personally rendered in the presence of the patient. Charges for services in connection with Mental Illness, functional nervous disorders; psychiatric or psychoanalytic care are typically not covered under the Medical benefit but may be covered under the Mental Health Benefit (Section 8 of this booklet).

Surgical — All non-emergency ambulatory and out-patient surgical procedures must be pre-certified by CIGNA. Prior to any scheduled ambulatory surgery, you or your physician must call CIGNA for pre-certification at 800-768-4695. This phone number also appears on your CIGNA I.D. card. This requirement applies whether or not your physician participates in the CIGNA PPO. If Treatment is not pre-certified by CIGNA before it is provided, the Plan will pay only 80% of the UCR Charges for Covered Expenses that would otherwise be paid by the Plan (i.e., 80% of the 80% of UCR Charges for an In-Network Covered Expense or 80% of the 60% of UCR Charges for an Out-of-Network Covered Expense).

If your physician has recommended surgery, the Plan will pay for a visit to another qualified Physician to obtain a second surgical opinion. The purpose of this benefit is to help you ensure that the surgery is Necessary and to help avoid unnecessary surgery.

Obtaining a second surgical opinion is easy to do. Contact CIGNA member services at 800-768-4695 and ask for a "Board Certified" surgeon in your area. The member services representative will give you a list of providers to choose from. Make an appointment with the provider and have them contact the Fund Office for benefit information on second surgical opinions.

The Plan will pay UCR Charges in accordance with the Schedule of Benefits for treatment by an oral surgeon for fractures and dislocations of the jaw due to accidental bodily Injury and for cutting procedures in the oral cavity other than for extractions, repair and care of the teeth or gums.

Inpatient Doctor Visits — If you or your Dependents are in the Hospital and receive a Medically Necessary visit from your Doctor, the Plan will pay the UCR Charge in accordance with the Schedule of Benefits. Payments ***will not*** be made for more than one visit per day. Charges for visits by your surgeon are not covered because they are included in the fee for the surgery.

X-Ray and Laboratory Expenses — The Plan will pay UCR Charges in accordance with the Schedule of Benefits for x-ray and laboratory examinations.

- X-ray examinations and microscopy and laboratory tests performed for diagnostic purposes; and

- X-ray, radium and radioactive isotope Treatments.

Outpatient Surgical Expenses The Plan will pay UCR Charges in accordance with the Schedule of Benefits for Hospital expenses incurred at the time of, and in connection with, a surgical operation performed in an ambulatory care center.

Graduate Registered Nurses (RN's) for Necessary private duty nursing services and licensed practical nurses for Necessary private duty nursing services rendered in a Hospital to a registered bed patient (other than a nurse who is related to the patient in any way).

Transportation by ambulance, regularly scheduled airlines or railroad from the city in which the Participant or Dependent becomes disabled to, but not from, the nearest Hospital qualified to provide Treatment for such Injury or Sickness.

Anesthetics and the administration thereof.

Medical Supplies prescribed by a legally qualified physician or surgeon including, but not limited to:

- Drugs and medicines provided during the course of a Hospital stay, which are obtainable only by written prescription and which must be dispensed by a licensed pharmacist, excluding payments under the Prescription Drug Benefit described in Section 4;
- Bandages and surgical dressings;
- Appliances to replace lost limbs or eyes;
- Oxygen and rental of equipment for the administration of oxygen;
- Blood, blood plasma, and other fluids to be injected into the circulatory system;
- Casts, splints, trusses, braces, crutches; and
- Rental of a wheelchair or Hospital type bed and of mechanical equipment for the Treatment of respiratory type Illnesses. Charges for rental of durable medical equipment will be paid up to the purchase price. Charges for purchase of durable medical equipment will be covered only when the required length of rental would result in rental fees which exceed the purchase price of the equipment.

Hearing Aids — The Plan will pay UCR Charges in accordance with the Schedule of Benefits for the purchase and fitting of a hearing aid. The Plan will pay the UCR Charge up to a maximum of $1,000 for each ear. There is no Deductible. The Plan will pay this benefit only once every thirty-six (36) months.

Chiropractor — The Plan will pay up to $1,000 annually of the UCR Charges in

accordance with the Schedule of Benefits for visits and manipulations by a Chiropractor. Your Chiropractor must obtain pre-approval for all chiropractic services for more than eight visits per calendar year. Prior to your ninth Treatment you or your Chiropractor must contact CIGNA for a concurrent review and pre-certification at 800-768-4695. If Treatment is not pre-approved the Plan will pay nothing.

Physiotherapy — The Plan will pay UCR Charges for services by a legally qualified physiotherapist (excluding services rendered by a member of the family or a close relative). Your physiotherapist must obtain pre-approval for all physiotherapy services for more than eight visits per calendar year. Prior to your ninth visit your or your physiotherapist must contact CIGNA for a pre-certification and concurrent review at 800-768-4695. If Treatment is not pre-approved the Plan will pay nothing.

Vision Therapy —Your or your Dependent's attending physician must provide a certificate of medical necessity for any of these services before the Plan will pay for them and must perform periodic evaluations of the patient's progress. In addition, pre-certification is required. If Treatment is not pre-approved, the Plan will pay nothing.

Speech Therapy — Your attending physician or your Dependent's attending physician must provide a certificate of medical necessity for any of these services before the Plan will pay for them and must perform periodic evaluations of the patient's progress. In addition, pre-certification is required. If Treatment is not pre-approved the Plan will pay nothing.

Occupational Therapy — You or your Dependent's attending physician must provide a certificate of medical necessity for any of these services before the Plan will pay for them and must perform periodic evaluations of the patient's progress. In addition, pre-certification is required. If Treatment is not pre-approved the Plan will pay nothing.

Ambulatory Surgical Center — The Plan will pay for charges for services and supplies in connection with a surgical procedure. Pre-certification is required for all non-emergency ambulatory surgeries. If you incur ambulatory surgical center expenses which are not pre-certified by CIGNA, the Plan will pay only 80% of the UCR Charges for Covered Expenses that would otherwise be paid by the Plan (i.e., 80% of the 80% of UCR Charges for an In-Network Covered Expense or 80% of the 60% of UCR Charges for an Out-of-Network Covered Expense).

SPECIAL RULES RELATED TO PREGNANCY AND CHILDBIRTH

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

SPECIAL RULES RELATED TO MASTECTOMY COVERAGE

The Plan covers the following medical services in connection with coverage for a mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications in all states of mastectomy including lymphedemas.

Coverage for these medical services is subject to applicable Deductibles and Co-Insurance amounts under the Plan.

WELLNESS BENEFITS

The Plan provides several additional benefits to encourage you and your Dependents to live healthy, take preventive actions and test for early discovery of conditions that may need Treatment. The Plan pays 100% of UCR Charges for these benefits and they are not subject to the Deductible or Co-Insurance.

Well baby care — Charges for routine Doctor visits, testing and immunizations for Dependent children through the age of three.

Routine physical examinations — once every year for Participants and Dependents age four and older.

Pap test — once every two years for all female Participants and Dependents age 18 or older.

Mammogram — once each year for all female Participants and Dependents age 50 and older, and once every other year for female Participants and Dependents between the ages 40 to 49. All mammography services must be certified by the U.S. Food and Drug Administration.

Proctology Screening — once each year for all male Participants and Dependents age 50 or older, and once every other year for male Participants and Dependents ages 40 to 49.

Routine Colonoscopy — once every 10 years for all Participants and Dependents starting at age 50.

24-Hour NurseLine — This program provides toll-free telephone access to medical care professionals 24 hours a day and 365 days a year. This voluntary, toll free line is perfect for new mothers with lots of questions, for parents looking for home care suggestions so that they can avoid a trip to the emergency room, for Participants with questions on Illnesses or health related news topics like how to treat the flu, treating a fever, etc. The telephone number for NurseLine is 800-768-4695.

Maternity Management — You have access to a voluntary maternity management program that works to achieve a healthy outcome for both mother and baby. As part of this program, Participants receive valuable prenatal guidance and are given access to a toll free 24-hours a day, 365-days a year answer line. A high-risk maternity screening is also conducted through this program and when necessary, maternity, and prenatal care is subsequently coordinated and supported through a CIGNA Case Management nurse to increase the likelihood of a healthy delivery for mother and baby. Participants should call 800-768-4695 to access these services.

Lifesource Organ Transplant Program — Should a covered Participant need an organ transplant, this program provides access to a voluntary Centers of Excellence program. Through this program, care coordination will be provided into transplant centers of excellence across the country and case management will be provided to you and your family.

MyCareAllies.com — There are several other unique services available through myCareAllies.com, a component of CIGNA's care management program, which you are encouraged to use. These services will enable you to:

- Visit an electronic Health Library and learn about a specific disease, your current medical condition(s), how to treat your condition(s), questions to ask your Doctor(s) about your condition(s), etc.
- Take a Health Risk Assessment to help you determine what medical conditions you have a risk of getting over time due to your personal habits and family history, and what to do to reduce the chances of getting these conditions
- Review medications and their potential interactions and alternatives
- Review preventative care tips
- Gain access to tools to quit smoking, lose weight, and live a healthier life.

You may access the myCareAllies.com website. Your Plan specific password is TL639 (password is case sensitive).

CASE MANAGEMENT

The CIGNA PPO includes Case Management, which is a patient-focused program that is intended to provide assistance and care coordination to chronically or critically ill patients (e.g. cancer, serious spinal cord Injury, diabetes, heart disease, etc). You may call CareAllies at 800-768-4695 to speak with a case manager to engage in this helpful program.

Referral Screening — A referral specialist evaluates and assigns the case based on current medical services, the available benefits, and anticipated potential outcomes. Case Management most often focuses on costly, complex and/or long term care needs. Referral to Case Management may result from diagnosis specific triggers such as: traumatic injuries, intensive oncology, stroke, brain Injury, complicated newborn, transplants, amputations and chronic Illnesses with readmission and compliance issues.

Voluntary Program — Case Management is a voluntary program.

Individual Case Manager — Each case manager is a Nurse with expertise in clinical, social, and behavioral health issues who will work with you throughout the life of the case. If you are in the Case Management program, you will have direct access to the assigned Case Manager via an 800 number and direct extension.

Continuous Case Management Process — The nursing process is the structure of the case management workflow. The case manager will assess for needs (Treatment, opportunities and risks) and collaboratively

develop a plan with you to address these needs and mitigate risks. Once the management plan and goals are identified, interventions are implemented and results evaluated. This process is cyclical throughout the life of a case and the case manager will repeatedly assess, plan, implement, coordinate, monitor, and evaluate options and services in order to meet your health needs and promote quality cost effective outcomes.

EXCLUSIONS

Any benefits not specifically identified in the previous paragraphs of this section are not covered by the plan. Examples of such non-covered benefits include:

- All charges not specifically listed as Covered Expenses;
- All charges in excess of UCR Charges;
- Charges for eye refractions or the purchase or fitting of glasses;
- Charges for the fitting of hearing aids except as specifically described above;
- Charges for the care and Treatment of the teeth, gums or alveolar process, and charges for dentures, appliances or supplies used in such care or Treatment, unless such expenses are incurred as a result of, and within 12 months of, an Accident or for the Treatment of Temporal Mandibular Joint Syndrome;
- Charges for, or in connection with, cosmetic surgery, unless such expenses are incurred as a result of an accident;
- Charges for medical services, supplies or medications specifically for diet control;
- Charges for services or supplies not related to Treatment for Illness or Injury, such as routine immunizations, except as expressly allowed;
- Charges for custodial or rest cures;
- Charges for Treatment rendered by the surgeon on the day of any surgical operation or the days of convalescence;
- Any confinement or medical care not recommended and approved by a legally qualified physician;
- Confinement or medical care which is caused by or results from pregnancy, childbirth or miscarriage of a Dependent other than a spouse; and
- Any other general limitations listed in Section 15 of this booklet.

4 PRESCRIPTION DRUGS

SCHEDULE OF BENEFITS

Co-Payment, per prescription	Retail Network	Mail Order
Generic	$5.00	$5.00
If there is no generic available or your Doctor provides a "Brand Name Letter of Medical Necessity"		
Brands on the Primary Drug (Voluntary Formulary) List	$20.00	$30.00
Brands not on the Primary Drug (Voluntary Formulary) List	$35.00	$50.00
Brand name drug without "Brand Name Letter of Medical Necessity"	$5.00 plus the difference in cost between brand name and generic	$5.00 plus the difference in cost between brand name and generic
Days Supply Limit	up to 30 days	up to 90 days
Fill Limit	3 fills only on and after 7/1/2011	none

YRC Worldwide, Inc. Employees: Prescription drug Co-Payments are different for employees of YRC Worldwide, Inc. For drugs purchased through the retail network, Co-Payments are as follows: Generic – $10; Drugs on the Primary Drug List – $25; Drugs not on the Primary Drug List – $40; and for Brand name drugs without a Brand Name Letter of Medical Necessity – $10 plus the difference in cost between brand name and generic. For drugs purchased through the Mail Order program, Co-Payments are as follows; Generic – $10; Drugs on the Primary Drug List – $35; Drugs not on the Primary Drug List – $55; and for Brand name drugs without a Brand Name Letter of Medical Necessity – $10 plus the difference in cost between brand name and generic.

CAREMARK

The Plan provides Prescription Drug Benefits for you and your eligible Dependents through Caremark, a prescription benefit provider under contract with the Plan.

Once you are covered under the Plan, you will receive a prescription drug card. Many pharmacies participate in the Caremark network and will accept the card. You may contact the Fund Office or Caremark at 866-282-8503 for a list of participating pharmacies. You can also check the Caremark website at www.caremark.com. Once the pharmacy has filled your prescription, present the card plus a Co-Payment for each prescription. The Plan

will pay the balance, provided that the prescription was filled with a generic drug, if available.

Caremark will tell you the number of doses or the type of drugs covered under the Plan. This card cannot be used for drugs or other items you can buy without a Doctor's prescription or in connection with on-the-job Illnesses or injuries. These limits are described on the following pages.

PLAN BENEFITS

The Plan recognizes three types of prescription drugs:

1. Brand name drugs are medications that are produced and sold under the original manufacturer's name. These drugs are typically the most expensive.
2. After a brand name drug has been on the market for a number of years federal law allows other companies to copy and sell a medically equivalent drug. A drug that is produced and sold under its chemical name, rather than a brand name, is a generic drug. (e.g. Ibuprofen is the generic version of Advil). Generic drugs are similar to, but less costly than, brand name or formulary drugs.
3. Formulary drugs are those medications that appear on a comprehensive list of preferred generic and branded drugs that are safe and cost effective for patients. Drugs on this list are chosen by a committee of physicians and pharmacists. Formularies have been used in Hospitals for many years to help ensure quality drug use. Caremark has negotiated discount agreements with the pharmaceutical manufacturers of the drugs that are included in the formulary program. The Fund Office publishes a list of prescribed drugs which are included in the Voluntary Formulary (or Primary Drug List). You and the Plan will save money if you use these drugs because they are less expensive than brand name drugs.

If there is a generic drug that can be safely substituted for a brand-name drug, the Plan will only pay for the cost of the generic drug.

If there is no generic equivalent drug available and you obtain a brand name drug, you will be charged the applicable brand name Co-Payment identified above.

If your physician believes that a generic drug will not have the same effect as the brand-name drug, for reasons that are particular to you, he may present relevant medical evidence to the Fund Office, and request that coverage be provided for

the brand-name drug at the brand name rates on the Schedule of Benefits. The Doctor's medical evidence is called a "Brand Name Letter of Medical Necessity". Your Doctor should send the letter to the Fund Office. It must include the patient's name and the specific brand-name drug being prescribed. If a Brand Name Letter of Medical Necessity is presented, you will only be responsible for the Co-Payment identified on the schedule above.

If a generic equivalent is available but you choose to use a brand name drug (without a Brand Name Letter of Necessity from your Doctor) you will be charged the generic drug Co-Payment plus the difference between the cost of the generic equivalent and the cost of the brand name drug.

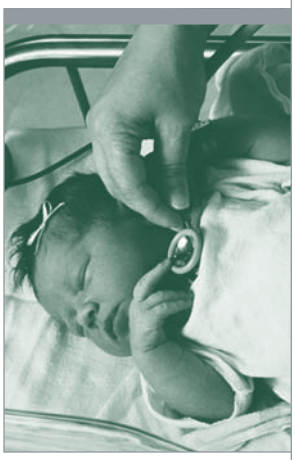
MAIL ORDER PROGRAM FOR MAINTENANCE DRUGS

If you are taking a maintenance drug from a retail Caremark network pharmacy, you should be aware that you will be limited to a 30-day supply. A mail order program is available that provides up to a 90-day supply for only one mail order program Co-Payment. Maintenance drugs include medication for regular use over a long period of time. Such drugs are usually prescribed for heart disease, high blood pressure, asthma, diabetes, ulcers, anemia and other ailments.

Beginning July 1, 2011, the Plan allows no more than three 30-day fills of maintenance drugs at any retail Caremark network pharmacy. After that, the Plan will cover maintenance drugs only if you have a 90-day supply filled through the mail order program. If you continue to have a 30-day supply of maintenance drugs filled at a retail Caremark network pharmacy, after three fills, the Plan will not pay for the maintenance drug refill.

You may use this program by doing one of the following:

- Have your Doctor write a prescription for a 90-day supply of your maintenance medication. Then, complete the mail order form (available from the Fund Office or at www.caremark.com/local639) and send the form to: Caremark, P.O. Box 94467, Palatine, IL 60094-4467.
- Visit the Caremark website at www.caremark.com/local639 and complete the form online. Caremark will contact your Doctor to obtain the prescription for a 90-day supply.
- Call Caremark FastStart at 800-875-0867, provide your prescription card



ID number and prescription information, and Caremark will contact your Doctor to obtain the prescription for a 90-day supply.

- Have your Doctor call Caremark FastStart at 800-378-5697 and provide your prescription ID number and prescription information for a 90-day supply.

You can save money if you use mail order for maintenance medications. For example, three 30-day fills of a generic maintenance medication at a retail pharmacy can cost you $15 ($5 x 3), whereas the 90 day supply through the mail will only cost you $5. This saves $10 every 90 days.

The rules regarding generic substitution apply to the mail order program. If you choose a brand-name drug where a generic can be substituted, you must pay the generic Co-Payment plus the cost difference in cost between the brand name and generic drugs.

COVERED MEDICATIONS

The Plan covers the following medications:

- Charges for drugs and medicines Necessary for the care and Treatment of a non-occupational accidental bodily Injury or Sickness that are prescribed by a legally qualified physician;
- Charges for drugs and medicines that can be obtained only by prescription and bear the legend, "Caution, Federal Law Prohibits Dispensing without a Prescription'" subject to the limitations and exclusions described below; and
- Viagra and other erectile dysfunction drugs, limited to 10 pills per month.

Oral Contraceptives that are prescribed for the Treatment of a disease (with a letter of medical necessity) are covered under the regular prescription drug program with the regular Co-Payments.

LIMITATIONS AND EXCLUSIONS

The *maximum amount* or quantity of prescription drugs that will be considered as eligible charges may not exceed a 30-day supply when taken in accordance with the direction of the prescriber except:

- Maintenance drugs may be dispensed in amounts of not more than 90 units supply (tablets, capsules, etc.) even though, when taken in accordance with the prescriber's directions, such amount would exceed a 30-day supply.

Maintenance drugs include, but are not limited to:

Nitroglycerine
Phenobarbital
Thyroid and Synthetics
Digitalis and Derivatives
Orinase
Diabenese
DBI, DBI-TD
Dymelor
Tolinase

Any benefits not specifically identified in the previous paragraphs of this section are not covered by the plan. For example, Prescription Drug Benefits are not provided for the following:

- Charges that are not listed as covered charges;
- Charges for a non-legend, patent, or proprietary medicine or medication not requiring a prescription;
- Charges for appliances, supports and prosthetic devices such as, but not limited to, canes, crutches, wheelchairs, or any means of conveyance or locomotion; braces, splints, dressings, bandages, sick room equipment or supplies; heat lamps or similar items; hypodermic syringes and/or needles; or oxygen;
- Charges for immunizing agents, biological sera, blood or blood plasma, injectables, or any prescription directing parental administration or use, except insulin;
- Charges for vitamins, vitamin prescriptions, cosmetics, dietary supplements, or health or beauty aids;
- Charges for medication that is to be taken or administered, in whole or in part, to the individual while a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home, or similar institution;
- Charges for drugs or medicines delivered or administered to the eligible individual by the prescriber;
- Charges for any drug labeled "Caution—Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the individual;
- Charges for drugs procured without a physician's prescription;
- Charges for contraceptives (except oral contraceptives as described above), contraceptive material or infertility medications, unless Medically Necessary and such Medical Necessity is certified by the Director of the Prescription Drug Program;
- Depo-Provera and Norplant;
- Charges for drugs prescribed for Injury or Sickness resulting from war or any act of war;
- Drugs obtained after the termination of eligibility for benefits under this Plan;
- Charges for brand name drugs that

exceed the cost of available generic drugs, unless the brand name drug has been specifically determined by the physician as Medically Necessary and evidence of such determination is provided in writing to the Fund Office;

- Injectable Drugs (however, Imitrex, Epipen, and other diabetic injectables such as insulin are covered);
- Diabetic Supplies including Test Strips, Lancets, monitors;
- Retin-A, Renova, and Differen for persons over age 25;
- Drugs used to treat Baldness;
- Growth Hormones; and
- Any other applicable general exclusion listed in Section 15.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

5 DENTAL

SCHEDULE OF BENEFITS

Basic Benefits	**No cost or reduced cost if services are performed by a participating dentist If services cannot be performed by a participating dentist, you will be reimbursed up to the maximums allowed for in-network dentists**
Extended Benefits	**Participant is responsible for 25% of UCR Charges and amounts over $4,000 per family per year**
Emergency care outside of network	**$50 per patient per year**

DENTAL HEALTH CENTER AND ASSOCIATES (DHC)

The Plan has contracted with Dental Health Center and Associates ("DHC") to provide dental benefits to eligible Participants and Dependents. If you live in Maryland, Virginia or the District of Columbia, you must use the Dental Health Center or one of the many participating dentists. The Dental Health Center is located at:

3700 Donnell Drive, Suite 215
Forestville, MD 20747-3901
301-736-1400

Participating dentists will provide the same services at a location more convenient to you. A list of participating dentists can be obtained from the Fund Office. There are nearly 700 participating dentists located in:

District of Columbia
Maryland
- Montgomery County
- Prince George's County
- Baltimore
- Howard County

Virginia
- Alexandria
- Falls Church
- Arlington
- Fairfax
- City of Fairfax

To make an appointment for dental care, call the Dental Health Center or a participating dentist of your choice. You will not have to complete a claim form. If you cancel, notify the dentist at least 24 hours in advance or you will be charged for the broken appointment.

For 24-hour emergency service, please call the Dental Health Center or the participating dentist you last visited. If you are unable to reach and be treated by our Emergency Staff or if you are traveling anywhere in the USA, emergency care will be paid up to $50 per patient per year. A copy of your paid receipt should be mailed to Dr. Robert Cohen, 3700 Donnell Drive, Suite 215, Forestville, MD, 20747-3901, with an explanation of the circumstances.

BENEFITS WITHIN THE DHC NETWORK

Basic Benefits

The Plan provides the following basic services at no cost provided they are performed by a participating dentist:

Routine oral examination, limited to 2 visits per person per year (once every 6 months), plus emergency examinations;

X-rays, including single films, full-mouth series and bite wing x-rays. Full-mouth series are limited to one set per person every 36 months. Bitewing x-rays are limited to one set per person every 6 months. Panoramic x-rays may be substituted for full-mouth x-rays if a set of bitewings are taken at the same time for the initial diagnosis. The time/frequency limitations on full-mouth and bite wing x-rays do not apply to x-rays required due to accident, emergency, or unusual circumstances;

Consultations;

Prophylaxis, including cleaning, cleaning with fluoride paste, and scaling, but no more frequently than once every six months;

Restorative dentistry as follows:

- Deciduous teeth restorations, including pulpotomies, stainless steel crowns and sealants where indicated;
- All silver and composite fillings, unlimited in size and quantity, with local anesthesia;

Gum Treatment of the following nature:

- Treatment for trench mouth, fungal and bacterial infections, bleeding gums, pain, Injury, emergencies and accidents not requiring Hospitalization, canker sores and simple gingivitis;
- Scaling of teeth over and above the routine scaling of a thorough prophylaxis; gum Treatment and/or scaling Treatments are limited to a maximum of 2 Treatments per person per year;

Emergency examinations and Treatments including toothaches, infections, oral pain and accidents that do not require plastic surgery or hospitalization;

Medications are covered under prescription drugs in Section 4 of this SPD.

Anesthetics Local anesthetics and general anesthesia for oral surgery;

Oral surgery, including extractions, impactions, cysts, abscesses, alveolectomy/alveoplasty, biopsies and surgery due to accidents that do not require plastic surgery and/or hospitalization.

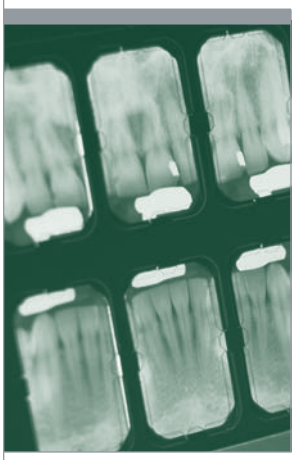
Prosthetics, including the construction of all full and partial dentures and removable bridges of the finest quality materials, repair of dentures, relining of dentures (a new set of dentures may be provided after a period of 5 years, if necessary; and

Emergency dental reimbursement of charges for emergency dental services performed anywhere in the United States and paid for by a Participant, up to the maximum of $50 per person per year, upon presentation of a paid bill.

Extended Benefits

The following extended services are paid for in part by the Plan up to a maximum of $4,000 per year, per family. The Participant is responsible for 25% of the charges for the following services:

- Endodontic Treatment;
- Periodontal Treatment;
- Orthodontics; and
- Crown and Bridge work (maximum of 5 crowns per year, per family).



Discounts For Some Excluded Services

Although the Plan will not pay for any of the services listed in the "Exclusions" list below, participating providers in the DHC Network have agreed to provide a 25% discount on some excluded services for Plan Participants. Please contact your participating provider for more information regarding discounts on excluded services.

BENEFITS OUTSIDE THE DHC NETWORK

If you reside in a state ***other*** than the District of Columbia, Maryland or Virginia ***and*** you are unable to get to the Dental Health Center or any of the participating dentists, you may submit a paid receipt for direct reimbursement and you will be reimbursed up to the maximums allowed for in-network dentists. The bill should be sent to Dr. Robert Cohen, 3700 Donnell Drive, Suite 215, Forestville, MD 20747.

EXCLUSIONS

Any benefits not specifically identified in the previous paragraphs of this section are not covered by the plan. For example, the following are not covered under the Dental Benefit provisions of the Plan:

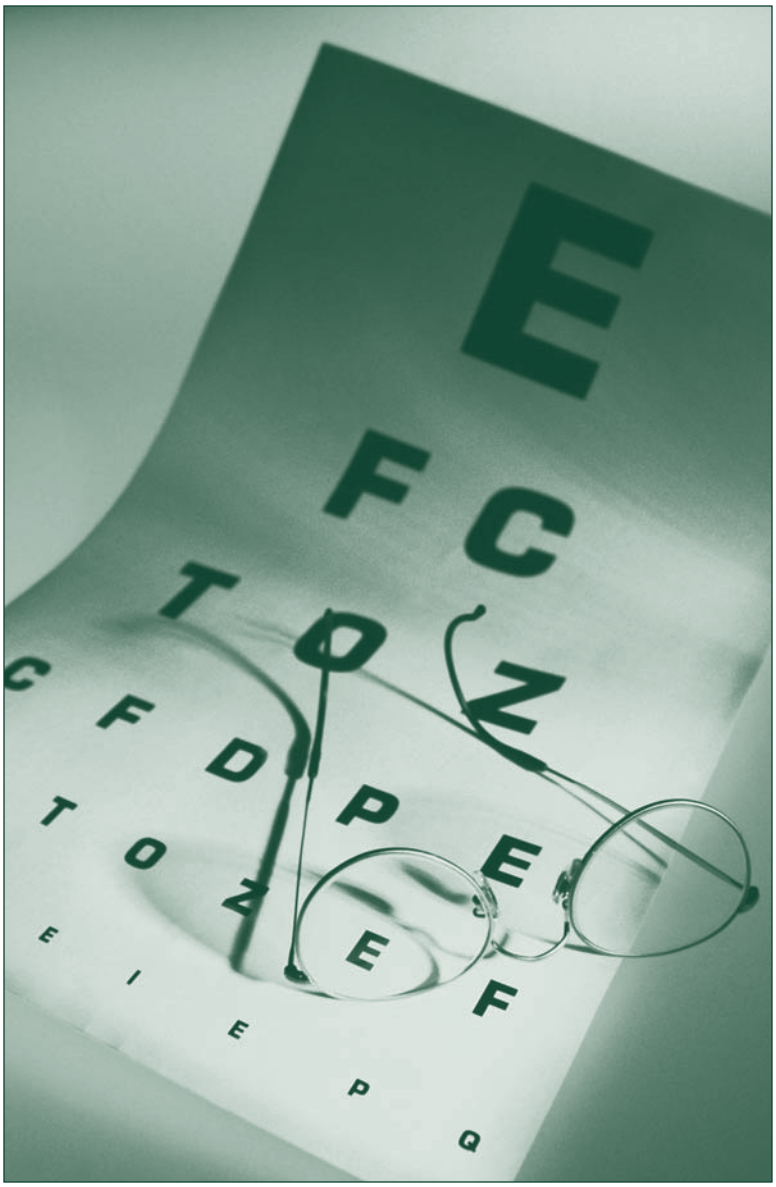
- Expenses incurred after termination of eligibility, except:
- Temporary fillings will be replaced with permanent fillings for a period of 30 days following termination;
- Prosthesis in progress at time of termination will be completed and adjusted, with the person assuming responsibility for payments for adjustments beginning 30 days after termination;
- Any procedure begun while the person was not eligible under this Plan;
- Hospital administered anesthesia or general anesthesia for restorative dentistry procedures or fillings;
- Separate fluoride Treatments;
- Panoramic x-rays, except as substituted for a full-mouth x-ray;
- Implants or temporo-mandibular joint Treatment or diagnosis, including such procedures as bite planes;
- Bedside calls, either home or Hospital;
- Treatment of any person whose medical condition would, in the estimation of the director of dental services, make conduct of dental services in the office unsafe or hazardous to that person's health;
- Any cosmetic, beautifying or elective procedure;
- Recementing of inlays or overlays;
- Services of a dentist or other practitioner of the healing arts not approved by the Plan;
- Experimental procedures, implantation or pharmacological regimens;
- Proprietary drugs, available with or without prescription;
- Convenience and personal items;
- Services for injuries or conditions which are covered under Workers' Compensation or Employer's Liability Law;
- Oral surgery requiring the setting of fractures or dislocations;
- Treatment of malignancies, cysts, neoplasms or congenital malformations;
- Replacement of dentures, crowns or bridgework less than 5 years old;
- Services which, in the opinion of the attending dentist, are not Necessary for the patient's dental health;
- Services provided by or paid for by any governmental agency (whether state, federal or otherwise) or under any governmental plan or law, except as to charges which the person is legally

obligated to pay, unless otherwise required by applicable law, which exclusion extends to any benefits provided under the United States Social Security Act and its amendments;

- Services covered under any other group plan or Employer, union, or association sponsored plan;
- The placement of bone grafts or extra-oral substances in the Treatment of periodontal disorders;
- Treatment of any disease contracted, or injuries sustained as a result of war, declared or undeclared or any Illness or Injury occurring after the effective date of this Plan caused by atomic explosion, whether or not the result of war;
- Prophylaxis more frequently than once every six months;
- Emergency Treatment which entails plastic surgery or hospitalization; and
- Any other applicable general exclusion listed in Section 15 of this booklet.

6

VISION CARE



SCHEDULE OF BENEFITS

VISION SERVICE PLAN (VSP)

BENEFITS WITHIN THE VSP NETWORK

BENEFITS OUTSIDE VSP NETWORK

EXCLUSIONS

SCHEDULE OF BENEFITS

IN-NETWORK PROVIDERS (MAXIMUM ALLOWABLE BENEFITS)	
Examination (annually)	**100%**
Lenses (annually)	**100%**
Frames (every other year)	**$120.00**
Contact Lenses (in lieu of lenses and frames, every other year)	**$120.00**
OUT-OF-NETWORK PROVIDERS (YOU WILL BE REIMBURSED UP TO):	
Examination (annually)	**$30.00**
Lenses (annually)	
Single Vision	**$9.00**
Bifocal	**$15.00**
Trifocal	**$15.00**
Lenticular	**$15.00**
Frames (every other year)	**$32.00**
Contact Lenses (in lieu of examination, lenses and frames, every other year)	**$93.00**

VISION SERVICE PLAN (VSP)

The Plan provides Vision Care Benefits for you and your eligible Dependents through a Policy with Vision Service Plan ("VSP"). VSP is a Preferred Provider Organization specializing in vision care at negotiated rates. The Plan will provide you with a listing of VSP vision specialists, upon request. With VSP, you are able to choose from network private practice providers and retail chain providers.

If you would like to find a network provider, visit VSP's Website — www.vsp.com — and provider locator or call VSP's Provider Locator Service at 800-877-7195 and follow the voice prompts. You will need the unique identification number of the primary insured and the Zip code for the area you wish to check.

Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a VSP Participant. This will assist your provider in obtaining a claim authorization number prior to your visit.

BENEFITS WITHIN THE VSP NETWORK

The following benefits are available though a VSP vision specialist:

Eye Examination A comprehensive vision examination is covered-in-full once every year when provided by a network optometrist or ophthalmologist.

Materials Standard lenses are covered once every year and frames from VSP's selection are covered once every other year or you may select contact lenses in lieu of lenses and frames once every other year.

Pair of Lenses If prescribed, a pair of standard single vision or standard multi-focal lenses is covered–in-full. Standard scratch resistant coating is covered-in-full. Should you choose lens options not covered by the program, such as, but not limited to, progressive lenses, polycarbonate lenses, high index tints, UV, and anti-reflective coating, you may be able to purchase these options at a discount.

Frames Your choice from a wide selection of fashionable frames will be covered. If you select a frame outside of VSP's covered-in-full selection, you will receive a $120 retail ($46 wholesale) frame allowance at private practice providers.

Contact Lenses In lieu of lenses and frames, you may select contact lenses. VSP's covered contact lens benefit includes the fitting/examination fees, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to four boxes (depending on prescription) are included when obtained from a network provider. It is important to note that VSP's covered contact lenses may vary by provider. Should you choose contact lenses outside of the covered selection, a $120 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses once every other year. Toric, gas permeable, and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered-in-full after applicable Co-Payment.

Refractive Eye Surgery This is not a covered benefit under the plan, but VSP Participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit the VSP website at www.vsp.com. This is subject to change by the provider.

You will be responsible for the added cost of:

- Special options such as photosensitive, cosmetic tinted, or over-sized lenses;
- Special type of frames (e.g. a designer frame) which exceed the maximum allowable benefit; and
- A second pair of glasses.

BENEFITS OUTSIDE THE VSP NETWORK

If you elect vision coverage and choose to use an out-of-network provider, you will be reimbursed up to the limits shown in the Vision Care Schedule of Benefits.

If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to: VSP, Attention: Claims, P.O. Box 997105, Sacramento, CA 95899-7105 or fax to 916-851-5152.

Please note: Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement.

EXCLUSIONS

Any benefits not specifically identified in the previous paragraphs of this section are not covered by the plan. The following services and materials are excluded from coverage under the Vision Care Benefits of the Plan:

- Post cataract lenses;
- Non prescription items;
- Medical or surgical Treatment for eye disease that requires the services of a physician;
- Services or materials covered under a Workers Compensation law;
- Services or materials that the patient, without cost, obtains from any governmental organization or program;
- Services or materials that are not specifically covered by the Plan;
- Sunglasses, plain or prescription;
- Replacement or repair of lenses and/or frames that have been lost or broken;
- Cosmetic extras, except as stated in the Policy's Table of Benefits;
- Examinations, lenses, frames, or contacts obtained more frequently than provided by the Plan;
- Safety glasses or goggles or the fitting thereof;
- Visual training, orthoptic, aniseilconia, or reading rate and comprehension studies;
- Expenses incurred prior to the date of eligibility or after termination of eligibility;
- Expenses for which benefits are not payable under the Plan;
- Radial Keratotomy; and
- Any other applicable general exclusion listed in Section 15.

7

MEMBER ASSISTANCE PROGRAM (MAP)

SCHEDULE OF BENEFITS

HOW DOES IT WORK

SCHEDULE OF BENEFITS

Assessment and Referral	**Unlimited telephonic support plus up to 5 visits per condition**

The Mental Assistance Program ("MAP") has been established to help you and your eligible Dependents deal with difficult situations that cause stress and can result in challenges to your mental health and well being. It provides confidential, professional assessment, counseling, education and referral services for personal mental health problems. It is designed to make it as easy as possible for you to get help with personal and family problems.

The Board of Trustees has contracted with MHN to administer this program. Advice given to anyone who uses the program is strictly CONFIDENTIAL. No information can be released without written permission, unless required by court order or subpoena.

HOW DOES IT WORK

MHN provides you with access to free counseling services designed to help you and your family deal with a variety of situations such as:

- Alcohol and substance abuse
- Marital and family problems
- Adolescent and child difficulties
- Divorce and separation adjustment
- Job-related stress
- Stress related to legal and financial difficulty
- Death of a loved one
- Other personal and emotional problems

When you or a family member has a personal problem, you can contact MHN 24 hours a day, 7 days a week by calling 800-327-6517. During the initial call a counselor will discuss the nature of the problem and outline a plan of action for you to consider. The program may include referral to a clinical specialist or facility in your area for an assessment of your Mental and Nervous Condition or drug and alcohol dependency health needs. You may also be referred to appropriate community support services in the case of personal problems such as child care, elder care, financial and legal problems.

MHN also provides work life products to assist with every day life's challenges associated with:

- Child and Elder care resources
- Stress related to financial difficulties
- Stress related to legal difficulties
- Basic Identity Theft Assistance
- Daily Living Assistance — broker and locator of services

MHN does not provide legal advice or financial counseling services.

8 MENTAL HEALTH

SCHEDULE OF BENEFITS

Out-patient visits	**Up to 50 per year**
In-patient days	**Up to 30 per year**
In-Network the Plan pays	**90% of UCR Charges for Covered Expenses used by the Plan** (rates negotiated by MHN)
Out-of-Network the Plan pays	**70% of UCR Charges for Covered Expenses used by the Plan** (non-network providers may bill you for amounts in excess of UCR Charges)
Calendar Year Maximum	**$1,000,000 combined with Medical and Drug and Alcohol Dependency Benefits***

*The annual limit is $1,000,000 for 2011, $1,250,000 for 2012, $2,000,000 for 2013, unlimited for 2014 and thereafter.

MENTAL HEALTH NETWORK (MHN)

The Board of Trustees has contracted with MHN Services, ("MHN") to administer mental health care services available to Plan Participants through the MHN network of preferred providers. The network is a group of selected physicians, specialists, Hospitals and other Treatment centers that have agreed to provide their services to Plan Participants at a discount.

HOW DOES IT WORK

When you need care, you can contact MHN 24 hours a day, 7 days a week by calling 800-327-6517. Many people will find the help they need in the telephonic support and counseling provided through the MAP program described in Section 7. However, if more specialized or extensive Treatment or assistance is needed for a Mental or Nervous Condition, the MHN counselor may suggest a referral to a high quality specialist or inpatient facility for Treatment to meet your specific needs.

You must obtain prior authorization to access the Plan's Mental Health benefits. A Participant or eligible Dependent may call MHN toll free at 800-327-6517, 24 hours a day, 7 days a week. If you do not obtain pre-authorization from MHN, the Plan will pay only 70% of the UCR Charge for Covered Expenses and you are subject to balance billing by the provider.

BENEFITS WITHIN THE MHN NETWORK

The Plan provides:

- Up to 50 outpatient mental health visits per year, such as to a psychiatrist, psychologist, or social worker. A group therapy visit will count as only half a visit.
- Up to 30 in-patient mental health days per year. Days in Treatment in a partial or day hospitalization (a setting that does not require the patient to stay overnight) count as half an in-patient day.

There is a one time exemption for a failure to obtain a preauthorization from MHN for outpatient visits

All claims for treatment of Mental Health and Nervous Conditions must be specifically approved in advance by MHN, otherwise they will be paid at 70% of the UCR Charge for Covered Expenses and you are subject to balance billing by the provider.

Any benefits not specifically identified in the previous paragraphs of this section are not covered by the plan.

Any applicable general exclusion listed in Section 15 of this booklet and the annual $1,000,000 for 2011 combined maximum described in Section 3 of this booklet.*

BENEFITS OUTSIDE OF THE MHN NETWORK

If you use an out-of-network provider for mental health and Nervous Condition care, you may be reimbursed up to the limits shown in the Mental Health Schedule of Benefits. Remember, if you do not obtain pre-authorization from MHN, the Plan will pay only 70% of the UCR Charge for Covered Expenses used by the Plan and you are subject to balance billing by the provider.

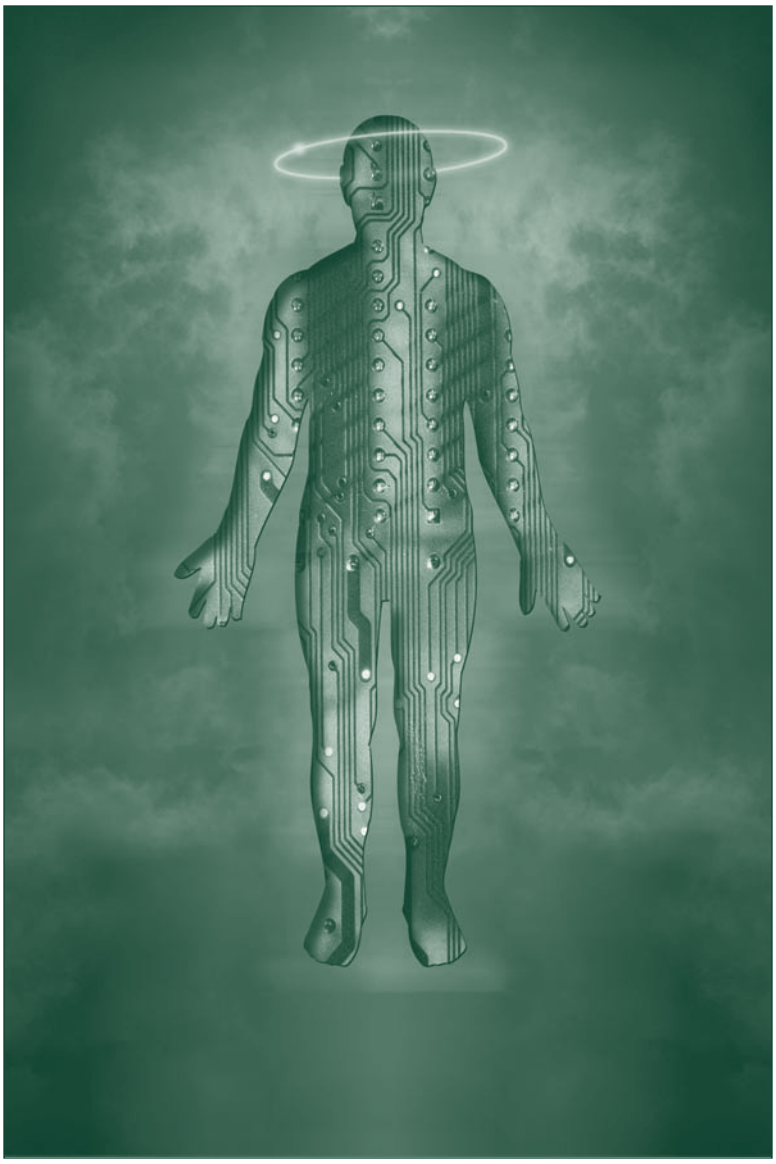
If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to:

Teamsters Local 639 —
Employers Health Trust
3130 Ames Place, NE
Washington, DC 20018-1593

*The annual limit is $1,250,000 for 2012, $2,000,000 for 2013 and unlimited for 2014 and thereafter.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

9 DRUG & ALCOHOL DEPENDENCY



SCHEDULE OF BENEFITS

HOW DOES IT WORK

BENEFITS PROVIDED

LIMITATIONS AND CONDITIONS

SCHEDULE OF BENEFITS

In-Network the Plan pays	**100% of UCR Charges for Covered Expenses** (rates negotiated by MHN)
Out-of-Network the Plan pays	**Nothing**
Calendar Year Maximum	**$1,000,000 combined with Medical and Mental Health***

*The annual limit is $1,000,000 for 2011, $1,250,000 for 2012, $2,000,000 for 2013, unlimited for 2014 and thereafter.

The Board of Trustees has contracted with MHN Services, ("MHN") to administer Drug & Alcohol Dependency health care services available to Plan Participants through the MHN network of preferred providers. The network is a group of selected physicians, specialists, Hospitals and other Treatment centers that have agreed to provide their services to Plan Participants at a discount.

The Board of Trustees has also contracted with Business Health Services, ("BHS") to access American Substance Abuse Professionals ("ASAP") for Department of Transportation ("DOT") and non-DOT United Parcel Service ("UPS") substance abuse referrals. BHS will notify MHN of all new referrals. Upon case closure, BHS will refer members to MHN with recommendations for further treatment as appropriate. You or your supervisor will need to contact BHS at 800-765-3277 for these services.

HOW DOES IT WORK

When you need care, you can contact MHN 24 hours a day, 7 days a week by calling 800-327-6517. Many people will find the help they need in the telephonic support and counseling provided through the MAP program described in Section 7. However, if more specialized or extensive Treatment or assistance is needed for Drug & Alcohol Dependency health problems, the MHN counselor may suggest a referral to a high quality specialist or inpatient facility for Treatment to meet your specific needs.

You must obtain prior authorization to access the Plan's Drug & Alcohol Dependency benefits. A Participant or eligible Dependent may call MHN toll free at 800-327-6517, 24 hours a day, 7 days a week. If you do not obtain pre-authorization from MHN, the Plan will pay only 70% of the UCR Charges for Covered Expenses used by the Plan and you are subject to balance billing by the provider. The Plan does not pay for Covered Expenses for charges incurred outside the MHN network of preferred providers.

BENEFITS PROVIDED

This benefit provides confidential treatment for pre-authorized Drug and Alcohol Dependency in network.

Benefits include:

- Outpatient counseling;
- Inpatient rehabilitation Treatment at an approved Rehabilitation Center;
- Inpatient detoxification at an approved Hospital or Rehabilitation Center; and
- After-care, consisting of outpatient counseling and monitoring of the Participant's or Dependent's progress.

These benefits are provided at no cost to the Participant subject to the combined annual maximum of $1,000,000.

LIMITATIONS AND CONDITIONS

Only expenses incurred at MHN's network of providers are covered by the Plan. There is no coverage for expenses incurred outside the network.

All expenses for treatment of alcohol or drug dependency must be specifically approved in advance by MHN, otherwise they will be paid at 70% of UCR Charges and you are subject to balance billing by the provider.

No Participant or eligible Dependent will be covered for more than one admission for inpatient Treatment unless:

he or she has fully completed the after-care program following discharge from the previous inpatient treatment, or

it is determined by MHN that additional detoxification is Necessary during the course of the after-care treatment.

Any other general limitations listed in Section 15 of this booklet and the annual combined $1,000,000 (for 2011) maximum described in Section 3 of this booklet also apply.*

*The annual limit is $1,250,000 for 2012, $2,000,000 for 2013 and unlimited for 2014 and thereafter.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

DISEASE CASE MANAGEMENT

BENEFITS PROVIDED

BENEFITS PROVIDED

Disease Case Management is offered to Participants identified with one of the following chronic medical conditions; asthma, diabetes, and heart-related conditions. Disease Case Management is provided by CIGNA through a program called CIGNA Well Aware for Better Health. This is a voluntary program.

The goal of the CIGNA Well Aware for Better Health program is to improve your quality of life by reducing future health problems and improving your understanding of your medical condition. Participating in the Well Aware for Better Health program can help you to:

- Understand your conditions and medications.
- Get answers to your questions and concerns.
- Develop a personal plan to better manage your condition.
- Improve your health so it is easier to do the things you want to do.

The Well Aware for Better Health program will first review medical and medication histories to find individuals who may have one or more of the chronic conditions listed above. If you do, the Well Aware For Better Health program will contact you. The Well Aware for Better Health program is voluntary and free. The Well Aware for Better Health program has a proven record of success in helping people with chronic conditions improve their health. For example:

- **Asthma —** Participants in the Well Aware for Asthma program needed 43% fewer emergency room visits for asthma than non-Participants with asthma.
- **Diabetes —** Through the support and education provided by the Well Aware program, 47% of the Participants in the Well Aware for Diabetes program have significantly lowered their blood glucose level to below 7%.
- **Heart Disease —** 84% of Participants in the Well Aware for Heart Disease program have been able to lower their LDL, "bad" cholesterol, to the recommended level and 64% have been able to increase their HDL, "good" cholesterol, to the recommended level.

If you choose to participate in the Well Aware program, a team of registered nurses (RNs) and other clinicians will help you create a self-care plan that supports your Doctor's Treatment plan and helps you avoid triggers, anticipate symptoms, reduce your risk of complications and improve your health.

As a Participant in the Well Aware for Better Health program, you will receive:

- A welcome letter and packet, followed by an initial call and health assessment from a nurse or other clinician.
- Follow-up phone calls from a nurse or clinician. During these phone calls, you can talk with a Well Aware program nurse or clinician about your concerns and get help developing a self-care plan.
- Toll-free access to Well Aware program clinicians, 24 hours a day, 7 days a week.
- A variety of additional educational resources, including workbooks, good-health guidelines, a self-care planning tool to record your goals, quarterly newsletters, annual satisfaction surveys and online access to the Well Aware program materials.
- The Well Aware program encourages you to take what you learn and share it with your Doctor. A Well Aware program does not replace your Doctor's care. In fact, it is designed to help you make the most of your Doctor visits. By supporting your Doctor's Treatment plan, the Well Aware program makes it easier for you to manage your chronic condition.

If you have asthma, diabetes or heart disease and you have not been contacted by the Well Aware program, you may voluntarily enroll in the program by calling CIGNA Well Aware at 1-866-797-5833. The Plan pays for all costs associated with this program. There is no cost to you or your Dependents.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

11

ACCIDENT / SICKNESS

Participant Only

SCHEDULE OF BENEFITS

FILING FOR WEEKLY ACCIDENT AND SICKNESS BENEFITS

EXCLUSIONS

Weekly Accident and Sickness Benefits are provided to replace income lost when you are out of work due to a non-occupational Accident or Sickness that prevents you from performing any and every duty pertaining to employment.

Benefits begin with the first day of an Accident disability and the eighth day of an Illness and continue for the duration of any "one continuous period of disability" up to the maximum shown in your ***Schedule of Benefits***. "One Continuous Period of Disability" includes all Periods of Disability which are due to the same or related cause or causes and which are separated by less than 90 days of continuous full-time, active work. A return to full-time, active work for a period of at least 90 days will qualify a subsequent disability as a new disability irrespective of its cause or causes.

SCHEDULE OF BENEFITS

Maximum weeks for one disability	**52**
First 26 weekly payments	**$225**
Excess over 26 weekly payments	**$275**
Commencement date of payments	
Accident/Injury	Day 1
Illness	Day 8

FILING FOR WEEKLY ACCIDENT AND SICKNESS BENEFITS

To apply for this benefit, contact the Fund Office. You will be given forms and procedures to follow. The claim form has four parts. You, your employer and your physician must each complete a part of the application form. When all parts are completed, mail or take the claim form to the Fund Office for processing.

EXCLUSIONS

You will not be entitled to the Weekly Accident and Sickness Benefit if during any period of disability you:

- Are not under the direct care of a Licensed Physician;
- Are already on vacation and receive vacation pay when the disability commences;
- Are receiving sick pay or any other pay from your employer;
- Are receiving benefits under any Workers' Compensation Act or similar legislation; or
- Are eligible under the Plan but were not actively employed by a contributing employer on the date the disability began.

12

LIFE INSURANCE

SCHEDULE OF BENEFITS

IF YOU BECOME DISABLED

CONVERSION OF LIFE INSURANCE

SCHEDULE OF BENEFITS

Participant Life Insurance	**$50,000**
Payable on death from any cause (Subject to the terms of the Insurance Contract)	
Dependent Life Insurance	
Payable to the Participant only for death of an eligible Dependent from any cause	
Spouse	$6,000
Dependent Child *	$3,000

** A Dependent child must be over 14 days old to be covered by Dependent Life Insurance.*

Life Insurance benefits are provided under a contract with an insurance company and are subject to the terms of that insurance contract.

IF YOU BECOME DISABLED

Life Insurance coverage will be continued if you become permanently and totally disabled while insured and you were not yet age 60 at the time you became disabled. This is called Waiver of Premium. You must furnish proof of your disability to the Fund Office within one year of your disability. Coverage will be extended one year at a time if you furnish proof of continued disability each year within three months of the anniversary of initial proof. Waiver of Premium will terminate at age 60, the date you are no longer disabled, or the date you do not give proof of your total disability, whichever is the earliest. Contact the Fund Office to find out how to get this continuing life insurance coverage. The Waiver of Premium feature is not available for spouse and Dependent life insurance.

CONVERSION OF LIFE INSURANCE

If you cease to be eligible for benefits under the Plan but would like to continue your Life Insurance, conversion to an individual policy of insurance is available. You or your insured Dependent may convert this insurance by applying and paying the first premium for an individual policy within 31 days after the Group Policy stops. Proof of good health is not required. If you are interested, notify the Fund Office and it will provide you with forms. Once you convert the policy, you will be solely responsible for payment of premiums and the relationship will be between you and the insurance company. You do not have to provide evidence of insurability to obtain coverage.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D) Participant Only

SCHEDULE OF BENEFITS	
For accidental loss of life or any two or more members (hands, feet, eyes or any combination)	**$50,000**
For accidental loss of one member (hand, foot or eye)	**$25,000**

Accidental Death and Dismemberment benefits are provided under a contract with an insurance company and are subject to the terms of that insurance contract.

If you have an Accident that results in the loss of your life, your beneficiary will receive a benefit payment in the amount shown in the schedule above. This amount is in addition to your Life Insurance benefit. If you have an Accident that results in the loss of:

- two hands, two feet, the vision in two eyes, or any combination of hands, feet, and eyes

  or

- one hand, one foot or one eye

within 180 days of the Accident, the Plan will pay the applicable amount listed in the schedule above.

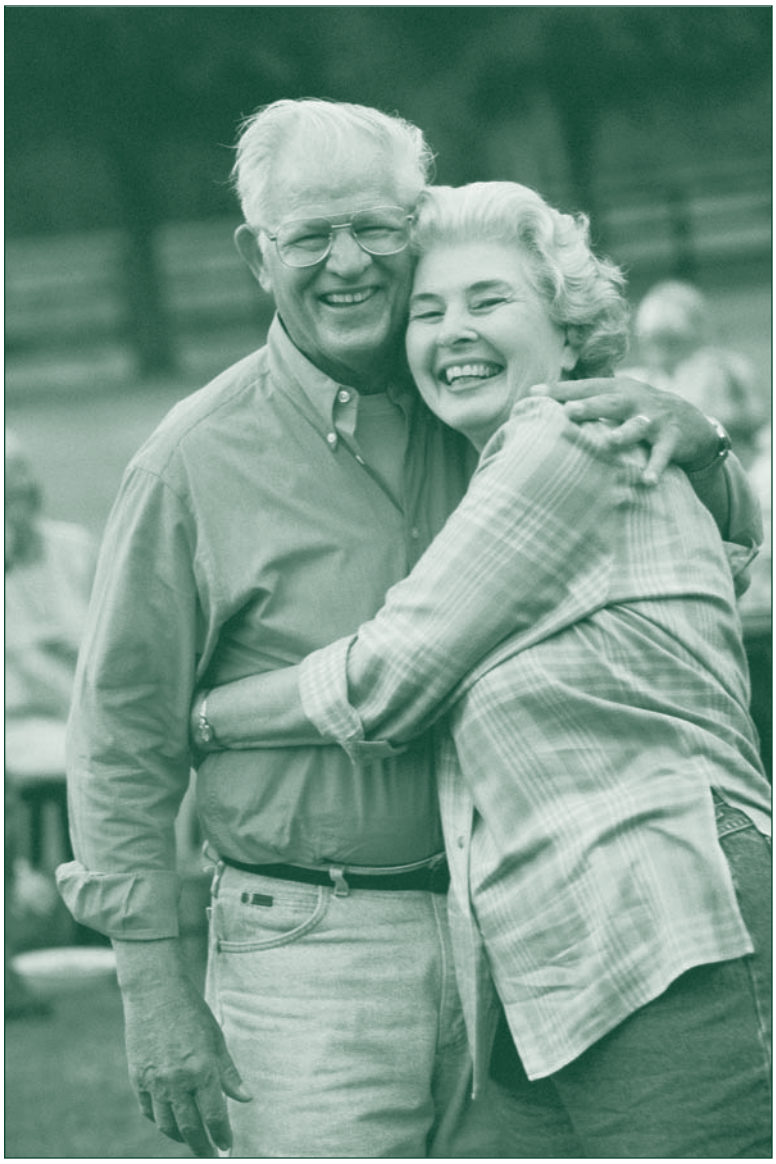
No Accidental Death and Dismemberment benefit will be paid for any loss due to:

- Suicide or intentionally self-inflicted Injury, while sane or insane;
- Physical or mental illness;
- Bacterial infection or bacterial poisoning, except those resulting from a cut or wound caused by an accident;
- Any armed conflict, whether declared as war or not, involving any country or government or service in the military for any country or government;
- Riding in or descending from an aircraft as a pilot or a crew member;
- Injury which occurs when you commit or attempt to commit a felony; or
- Use of any drug, narcotic or hallucinogenic agent, unless prescribed by a Doctor, which is illegal, or not taken as directed by a Doctor or the manufacturer.

No more than the full amount will be paid for all losses from any one accident.

14

RETIRED PARTICIPANTS



ELIGIBILITY FOR RETIREE BENEFITS

SCHEDULE OF BENEFITS

ELIGIBILITY FOR RETIREE BENEFITS

The Retiree benefits in this Plan apply only to Participants who retired prior to January 1, 1980 and elected this coverage. For these retired Participants, your Class of Benefits depends on the coverage level you elected at the time of your retirement. If you retired on or after January 1, 1980, you are not eligible for any benefits from this Plan. You may be eligible for coverage under the medical benefit part of the Teamsters Local 639 — Employers Pension Trust. Ask the Fund Office for information about this other plan.

If you retired on or after December 1, 1977 but prior to January 1, 1980 and satisfied the rules for Retiree eligibility in effect at the time you retired, you continue to be eligible for the benefit corresponding to the "P" category in which you were placed at retirement (i.e., P1, P3, P6, P11, P15 or P21), but only as long as you make the monthly payments required for your particular category of coverage.

If you retired prior to December 1, 1977 and satisfied the rules for Retiree eligibility in effect at the time you retired, you continue to be eligible for the benefits corresponding to the "NP" category in which you were placed at retirement (i.e., NP2, NP3 or NP4).

SCHEDULE OF BENEFITS		
Hospital Expense Benefit (for Retiree categories NP2, NP3, NP4, P15 and P21)		
Daily Room and Board (Maximum of 70 days per confinement for one disability)	**Up to $21**	
Additional Hospital charges	**Up to $550**	
Surgical Expense Benefit (for Retiree categories NP2, NP3, NP4, P15 and P21)		
Subject to the Surgical Procedure Schedule	**Up to $300**	
Pre-certification may be required		
Doctor Visits (for Retiree categories NP2, NP3, NP4, P15 and P21)		
In Hospital only, per visit		
Maximum one visit per day	**$5**	
X-Ray & Laboratory Expense Benefit (for Retiree categories NP2, NP3, NP4, P15 and P21)		
Prescription Drug Benefit (for Retiree categories NP2, NP4, P1, P3, P15 and P21)		
Co-Payment, per prescription, charged to you	Retail	Mail Order*
Generic	**$5**	**$5**
If there is no generic available or your Doctor provides a "Brand Name Letter of Medical Necessity"		
Brands on the Primary Drug (Voluntary Formulary) List	**$20**	**$30**
Brands not on the Primary Drug (Voluntary Formulary) List	**$35**	**$50**
Brand name drug without "Brand Name Letter of Medical Necessity"	**$5 (Retail) or plus the cost difference between brand name and generic**	**$5 (Mail Order)**
(See Section 4 for benefit information)		
Dental (for Retiree categories NP2, NP3, NP4, P6 and P21)	**Provided by Dental Health Center and Associates**	
(See Section 5 for benefit information)		
Vision Care (for Retiree categories NP2, NP3, NP4, P3, P6, P15 and P21)	**Provided through VSP**	
(See Section 6 for benefit information)		
Life Insurance (Participant only)		
Payable on death from any cause:		
Class A—Limited to Retiree categories NP2 and NP3	**$1,000**	
Class B—Limited to Retiree categories NP4, P15 and P21	**$3,000**	

* Beginning July 1, 2011, the Plan allows no more than three 30-day fills of maintenance drugs at any retail Caremark network pharmacy. After that, the Plan will cover maintenance drugs only if you have a 90-day supply filled through the mail order program. If you continue to have a 30-day supply of maintenance drugs filled at a retail Caremark network pharmacy, after three fills, the Plan will not pay for the maintenance drug refill. See Section 4 for details.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

GENERAL LIMITATIONS

TYPES OF SERVICE PROVIDERS

SERVICES NOT COVERED

WORKERS' COMPENSATION

TYPES OF SERVICE PROVIDERS

The Plan will, within the limits set forth in this Summary Plan Description, pay for services provided by the following health professionals:

- Doctor of Medicine (MD),
- Doctor of Chiropractic (DC),
- Doctor of Dental Surgery (DDS),
- Doctor of Dental Medicine (DMD),
- Doctor of Osteopathy (DO),
- Doctor of Podiatry Medicine (DPM),
- Doctor of Psychology (DPs/PsyD),
- Doctor of Optometry (OD),
- Licensed Practical Nurse (LPN),
- Registered Nurse (RN),
- Licensed Clinical Social Worker (LCSW),
- Licensed PhysicalTherapist (LPT), or a
- Licensed Certified Midwife (LCMW)

The Plan will also cover other such providers who are providing care under specific referrals from one of the above-mentioned providers, or who are affiliated with an organization which is under the direct supervision of one of the above-mentioned providers. These other service providers must be licensed under the laws of the state in which Treatment is performed. The services they render must be within the scope of their specific license.

SERVICES NOT COVERED

The Plan does not pay claims for the following:

- All charges not specifically listed as Covered Expenses;
- Expenses for care which is not Medically Necessary, except as previously specified;
- Expenses in excess of the UCR Charge;
- Work-related Injuries or Illnesses (see Workers' Compensation provisions in this section);
- Charges for losses resulting from war or an act of war;
- Charges for an Injury or Sickness contracted while in the Armed Forces;
- Charges for cosmetic, elective or reconstructive surgery except as previously specified;
- Charges incurred in connection with pregnancy, childbirth or miscarriage other than such charges incurred by a Dependent other than a Spouse;
- Expenses for custodial care, except as directed by MHN or the Director of CIGNA PPO, Inc.;
- Charges for services provided by a licensed social worker, or other certified specialist for the Treatment

of Mental and nervous disorders, unless such services are provided under the direction of a psychiatrist or psychologist;

- Expenses you are not required to pay;
- Charges for, or in connection with, services and supplies which are experimental or investigational including any Treatment, drug, or supply which is not recognized as acceptable medical practice, or any items requiring governmental approval which was not granted at the time the services were rendered;
- Charges for education, training, and/or bed and board while a Participant or eligible Dependent is confined in an institution which is primarily a school or institution for training, a place of rest, a place for the aged or a nursing home;
- Charges for which payment is provided under a governmental program, regardless of whether or not the Participant elects to participate in the program;
- Charges for procedures which are not prescribed by a legally qualified physician and/or are not Medically Necessary;
- Charges for the Treatment of obesity;
- Charges for the care of corns, bunions (except capsular or bone surgery therefore), calluses, nails of the feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet except where major surgery is performed;
- Charges for transsexual operations or any care or service associated with this type of operation;
- Charges for the purchase or rental of air conditioners, humidifiers, exercise equipment, whirlpools or similar devices;
- Charges for services for which a claim is filed later than one year from the date the service was rendered; and
- Expenses for educational training.

In Addition

- Multiple Periods of disability or confinement will be considered continuous unless separated by 90 days of active employment. For Dependents, a period of disability will be considered continuous unless separated by 90 days between surgical procedures performed for the same or related causes.
- When two or more surgical procedures are performed at the same time and in the same operative field, payment will be made for only that operation for which the largest amount is scheduled.
- Benefit payments for Treatment related to Mental or nervous disorders are limited to the annual maximum described in the applicable Schedule

of Benefits for Mental Health Benefits (see Section 8 of this booklet). Benefit payments for Treatment related to drug and alcohol dependency are limited to the maximums described in the applicable Schedule of Benefits for Drug and Alcohol Dependency Benefits (see Section 9 of this booklet).

WORKERS' COMPENSATION

These special provisions apply only to you. No benefit payments will be made for Workers' Compensation claims submitted on behalf of your spouse or any Dependents. This Plan has been designed to provide coverage for you and your eligible Dependents for Illnesses or injuries that are not job related. In today's world of rising medical costs, you must be extremely careful not to submit work-related claims for payment by the Plan. You also have to be careful not to use your prescription drug card to obtain medications for a work-related Injury or Illness.

By law, your employer is required to provide you with medical coverage for all work-related Illnesses or Injuries. This also applies to your spouse and Dependent children if they are working full or part time.

The Board of Trustees recognizes, however, that if your employer's insurance carrier denies your initial Workers' Compensation claim, the appeal process may take a long time. Consequently, the Board has adopted provisions with respect to work-related Injuries and Illnesses so that you can, in appropriate cases, get some interim financial relief from the Plan while you go through the Workers' Compensation appeal process.

In accordance with these provisions, you must comply with the following procedures in order to be considered for interim financial relief from the Plan for work-related Injuries or Illnesses:

If you suffer a work-related Injury or Illness, you must file a claim with your employer's Workers' Compensation insurance carrier.

If your employer's Workers' Compensation insurance denies your claim for benefits, you must appeal this decision to the appropriate administrative authority. In Virginia, your appeal would be made to the full Industrial Commission; in Maryland, your appeal would be made to the Workers' Compensation Commission; in the District of Columbia, your appeal would be made to the Hearing Officer of the Department of Employment Services.

You may file a claim for benefits from the Plan once you appeal to the appropriate Workers' Compensation authority. The Trustees will consider the payment of benefits in accordance with Plan provisions provided that you comply with the requirements in Section 16 regarding Reimbursement and Subrogation and complete a Reimbursement and Subrogation Agreement assigning to the Plan any benefits you receive as a result of your Workers' Compensation appeal. The Reimbursement and Subrogation Agreement must be completed by you and the attorney who represents you in your Workers' Compensation appeal. The attorney must also confirm in writing that you are appealing the Workers' Compensation decision and provide the name of the jurisdiction in which the appeal has been filed. Your claim for benefits will be considered only after you and your attorney sign the Reimbursement and Subrogation Agreement and provide the necessary information.

When the Workers' Compensation appeal authority makes its decision, you must forward a copy of this decision to the Fund Office. If the decision is in your favor and grants you Workers' Compensation benefits, you must reimburse the Plan all benefits paid on account of the work-related Injury or Illness, in accordance with the terms of the Reimbursement and Subrogation Agreement both you and your attorney signed.

If the Workers' Compensation appeal authority's decision is not in your favor, you still have the right to appeal the decision to the appropriate court in the jurisdiction involved. If you do so, the Reimbursement and Subrogation Agreement (assignment of benefits) you and your lawyer signed will remain in effect and will continue to be binding. If you do not appeal the decision, the Plan will recognize the claim you filed as a legitimate, non-work-related claim and will not require you or your attorney to reimburse the Plan for benefits that were paid on your behalf.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

16

RULES OF THE PLAN

CLAIM APPEAL

COORDINATION OF BENEFITS

THIRD PARTY LIABILITY AND SUBROGATION

NO ASSIGNMENT OF BENEFITS

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

OVERPAYMENT AND MISTAKEN PAYMENT POLICY

CLAIM APPEAL

Certain claims for insured benefits concerning Life Insurance and Accidental Death and Dismemberment benefits are determined under the terms of insurance contracts. In the event a claim involves such a decision, you will be directed to send all claims and appeals of denial of such claims directly to the insurer and your claims and appeals will be determined in accordance with procedures established by the insurer.

With respect to claims for all other benefits that are not insured, if your claim for benefits from the Plan is denied, in whole or in part, you will be notified within a reasonable period of time, but not later than the following:

If the Fund Office needs more information to make a determination on your claim, you will be notified within a reasonable period of time. Extensions are permitted if the Fund Office determines that special circumstances beyond its control require an extension of time for processing the claim. In such case, you will be provided with written notice of the extension prior to the termination of the time for responding.

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

- The specific reason or reasons for the denial;
- Specific references to pertinent Plan provisions on which the denial is based;

TABLE 16 A

Type of Claim	Time Limit for Claim Determination	Extension Permitted
Medical, Prescription Drug, Dental, Vision, Member Assistance Program, Mental Health, Drug and Alcohol Dependency, Disease Case Management		
Urgent Claims (as medically determined)	72 hours	None
Pre-Service Claims	15 days	15 days
Post-Service Claims	30 days	15 days
Concurrent Claims (claims for ongoing course of Treatment)	Prior to termination of care (if sufficient notice)	None
Life Insurance, Accidental Death and Dismemberment	90 days	90 days
Accident and Sickness	45 days	Two 30-day extensions

- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after you have exhausted the appeals process;
- With respect to a claim for medical, prescription drug, dental, vision, member assistance program, mental health, drug and alcohol dependency, disease case management, and accident and sickness, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination, or a statement that such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- With respect to a claim for medical, prescription drug, dental, vision, member assistance program, mental health, drug and alcohol dependency, disease case management, and accident and sickness, if the denial is based on a medical necessity or experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Appealing a Denied Claim

If your claim is denied, you or your duly authorized representative may appeal the denial of the claim by giving notice in writing to the Board of Trustees within the following timeframe from your receipt of

TABLE 16 B

Type of Claim	Time Limit for Appealing Denial
Medical, Prescription Drug, Dental, Vision, Member Assistance Program, Mental Health, Drug and Alcohol Dependency, Disease Case Management	180 days
Life Insurance, Accidental Death and Dismemberment	60 days
Accident and Sickness	180 days

the claim denial:

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

Determination on Appeal of Denied Claims

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

If your claim is determined at a Board meeting, you will be notified of the determination upon review as soon as possible but no later than 5 days after the determination is made.

If the denial of a claim for medical, dental, vision, member assistance program, mental health, drug and alcohol dependency, disease case management, and accident and sickness benefits was based in whole or in part on a medical judgment, on review, the Board will consult with a health care professional who was not consulted in connection with the denial that is the subject of the appeal, is not the subordinate of anyone who was consulted, and who has appropriate training and experience in the field of medicine involved in the medical

TABLE 16 C

Type of Claim	Time Limit for Appeal Determination	Extension Permitted
Medical, Prescription Drug, Dental, Vision, Member Assistance Program, Mental Health, Drug and Alcohol Dependency, Disease Case Management		
• Urgent Claims	72 hours	None
• Pre-Service Claims	30 days	None
• Post-Service Claims	Board meeting (if claim received 30 days prior)	Next Board meeting
• Concurrent Claims (claims for ongoing course of Treatment)	Prior to termination of care (if sufficient notice)	None
Life Insurance, Accidental Death and Dismemberment	Board meeting (if claim received 30 days prior)	Next Board meeting
Accident and Sickness	Board meeting (if claim received 30 days prior)	Next Board meeting

judgment. In making the determination on appeal, the Board will not afford deference to the initial claim denial.

The Board will notify you in writing of the benefit determination on review. In the case of a claim denial, the notification will set forth the following:

- The specific reason or reasons for the denial;
- Specific references to pertinent Plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A statement of other voluntary appeal procedures and your right to obtain information about such procedures that may be available, and a statement of your right to bring a civil action under section 502(a) of ERISA.
- With respect to a claim for medical, prescription drug, dental, vision, member assistance program, mental health, drug and alcohol dependency, disease case management, and accident and sickness, an internal rule, guideline, protocol, or other similar criterion if one was relied upon in making the adverse determination, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
- With respect to a claim for medical, prescription drug, dental, vision, member assistance program, mental health, drug and alcohol dependency, disease case management, and accident and sickness, if the adverse benefit determination is based on a medical necessity or experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If the time limitations set forth in these claims procedures have not been exceeded, you may not bring an action in a court of law unless the claims review procedure is exhausted and a final determination has been made. Any challenge will be limited to the facts, evidence, and issues presented to the Board of Trustees during the claims review procedure. Issues not raised with the Board of Trustees during the appeal provided will be deemed waived.

COORDINATION OF BENEFITS

Under the terms of your Plan, you are not entitled to be paid more than 100% of your Covered Expenses from this Plan and any other plan combined. Payments you or your Dependents receive from other sources can affect payments from this Plan. The Fund Office will work with you or your Dependent's other health plan to ensure you receive all the benefits to which you are entitled.

When two plans provide the same coverage, one is primary, the other is secondary. The primary plan will pay benefits first and without consideration of the other plan(s). The secondary plan then makes up the difference up to the total allowable expenses. The order in which benefits will be determined is as follows:

1. A plan covering a person as an employee will be the primary plan. A plan covering a person as a dependent will be the secondary plan.
2. If a dependent child is covered under both parents' plans, the plan of the parent whose date of birth (without regard to year of birth) occurs earlier in the calendar year will be the primary, and the plan of the other parent will be secondary.
3. When the rules of paragraphs 1 and 2 do not establish an order of priority, the plan which has covered the person for the longer time will be considered primary.
4. When the parents are unmarried (whether by reason of divorce or otherwise) the order is:

- The plan of the parent with sole legal custody is primary. The plan of the parent without custody is secondary. Where both or neither parent has legal custody, then the rule of paragraph 2 shall apply.
- If a person with custody has remarried, the order of priority is:
  - The plan of the parent with custody,
  - The plan of the step-parent, and
  - The plan of the parent without custody.

5. If there is a court decree, which states that one of the parents is responsible for the child's health care expenses, the plan of that parent will be primary. The court decree will supersede any order given in paragraph 4.
6. If a person is covered under more than one plan, and the rules of paragraphs 1 through 4 do not resolve the order of priority, then the plan he or she was covered under longer will be primary except as follows:

- A group plan that covered a person other than as a laid off or retired

employee, or dependent of such person, will be primary.

- A group plan that covers a person as a laid-off or retired employee, or dependent of such person, will be secondary.

7. A plan that contains no coordination of benefits rule is always primary.
8. A governmental plan is always primary, unless required by statute.
9. If a retired Participant is eligible for Medicare, this Plan will not provide for payment of any of the benefits that are provided under the Medicare Program, regardless of whether the retired Participant elects to enroll in the Medicare Program.

You have the responsibility to fully inform the Plan of any and all health insurance coverage available to you and your eligible dependents. You must disclose this information on the Individual Enrollment Card that you complete at the time you attain eligibility. You are also obligated to inform the Plan at any time that the information regarding other health insurance coverage changes.

THIRD PARTY LIABILITY AND SUBROGATION

If you, or your Dependent's, Injury or Illness was caused by the action or inaction of another person or party, that person or party or another party, including tortfeasors, insured or uninsured motorists programs, workers compensation programs, or any other insurance programs or benefits plans, may be responsible for your Hospital or medical bills. If that is the case and you or your Dependent receive benefits from the Plan, you are required to reimburse the Plan for the benefits or subrogate your recovery rights to the Plan. Automobile accident injuries or personal injury suffered on the job or on another's property are examples.

The repayment rules described in this section, which are also known as reimbursement and subrogation rules, are in place to assist you. Collecting payment for your, or your Dependent's, medical expenses or your Accident and Sickness expenses from another person or party may take a long time, and during that time, the Plan will provide you with covered benefits, but the Plan must be repaid from any recovery related to the Injury or Illness that you or your Dependent may receive, whether through settlement, judgment, worker's compensation or any other insurance or benefits program. These rules also prevent a situation where you are compensated twice for the same Injury or

Illness — once by the Plan when it pays your medical bills or provides Accident and Sickness benefits and a second time by the other person or party when it pays damages for your loss. The bottom line is that the repayment rules help to ensure that the Plan's assets are available to cover all of the Participants and Dependents.

At their core, the repayment rules require that, if you or your Dependent recover money from another person or party related to an Illness or Injury for which the Plan is paying or has paid benefits, you or your Dependent must repay the Plan for the benefits it paid out on your or your Dependent's behalf, up to the amount of the recovery. For example, if the Plan pays out $15,000 in medical claims on your behalf, and you later recover $25,000 from the person who caused your Injury, you must reimburse the Plan for the full $15,000 it paid in medical benefits on your behalf. In addition, if the amount that you or your Dependent recover from the other person or party is less than the full amount of damages or expenses that you claim, the Plan's share of the recovery will not be reduced and will remain the full amount of the benefits that the Plan has paid on your or your Dependent's behalf, unless the Board of Trustees agrees in writing to a reduced amount.

Under the repayment rules, you or your Dependent need to promptly inform the Plan of any potential recovery from another person or party, or the filing of any claim or legal action against another person or party, that is related to an Injury or Illness that may be covered by Plan benefits. You also must promptly provide the Plan with any information and documents that are related to the potential recovery, claim or legal action.

Under the repayment rules, if you or your Dependent have a potential recovery, claim or legal action against another person related to an Injury or Illness that the Plan covers, you and your Dependent will be required to sign a form, called a Reimbursement and Subrogation Agreement, that acknowledges the Plan's right to be reimbursed and verifies that you will help the Plan secure its rights. If you have hired an attorney to help you in your efforts to collect from the other person or party, your attorney will be required to sign the form also. The form must be completed and signed by you and your Dependent (and your attorney if you have one) before the Plan will make payments on your or your Dependent's behalf. If you, your Dependent or your attorney fails to sign the form, the Plan may withhold paying any claims relating to your or your Dependent's Injury or Illness caused by the other person or party, as well as any and all future claims. Even if you or your Dependent do not sign or return the

Plan's forms, the Plan is entitled to recover in accordance with the repayment rules because, by accepting Plan benefits, you and your Dependent are consenting to the repayment rules.

If you or your Dependent bring a liability claim against the other person or party, benefits payable under the Plan must be included in the claim. However, even if you fail to include such a claim, the Plan is still entitled to reimbursement under the repayment rules. When the claim is resolved, you, your Dependent or your attorney (if your attorney is holding the monetary recovery) must hold the monetary recovery in constructive trust and promptly reimburse the Plan for the benefits provided related to the Injury or Illness, up to the amount of the monetary recovery. You, your Dependent and your attorney (if your attorney is holding the monetary recovery) shall be fiduciaries and trustees with respect to the monetary recovery. You and your Dependent may not assign to any other party, including your attorney, any rights or causes of action that you or your Dependent may have against another person or party related to the Illness or Injury for which the Plan is paying or has paid benefits, absent written consent of the Board of Trustees.

You and your Dependent agree that the Plan has an equitable lien, an equitable lien by agreement and/or an irrevocable vested future interest upon, and will have a specific and first priority in, any recovery related to the Injury or Illness caused by the other person or party for which Plan benefits are payable or were paid regardless of the manner in which the recovery is structured or worded. This is the case, regardless of whether you have been made whole by the settlement. The Plan's reimbursement will not be reduced by attorney's fees, absent consent of the Board of Trustees.

In addition to its right to reimbursement, the Plan is fully subrogated to any and all rights of recovery and causes of action that you or your Dependent may have against any other liable person or party. Therefore, the Plan may make a claim or bring any action against such other person or party to recover any benefits paid on you or your Dependent's behalf by the Plan. You and your Dependent agree to cooperate with the Plan to effect the Plan's subrogation rights, including repaying the Plan for its costs and expenses. You and your Dependent are legally obligated to avoid doing anything that would prejudice the Plan's rights of reimbursement and subrogation, including settling any claim or lawsuit without the written consent of the Board of Trustees.

The Plan's right to reimbursement and subrogation will not be affected, reduced or eliminated by the make whole doctrine, the

comparative fault doctrine, the regulatory diligence doctrine, the collateral source rule, the attorney fund doctrine, the common fund doctrine, or any other defenses or doctrines that may affect the Plan's recovery.

Your or your Dependent's failure to comply with the repayment rules and cooperate with the Plan to recover from another responsible party or person may result in your and your Dependent's disqualification from receipt of future benefits from the Plan. In addition, the Plan may offset any future benefits otherwise payable to you or your Dependent with interest of 10% per annum until the outstanding benefit amounts are repaid. If the Plan prevails in a lawsuit to enforce its Reimbursement and Subrogation Agreement and/or these rules, the Plan shall be entitled to recover benefits paid on your or your Dependent's behalf, together with interest at 10% per annum plus costs and expenses, including reasonable attorneys fees. Any amount recovered in excess of the Plan's recovery will be payable to you and your Dependent.

NO ASSIGNMENT OF BENEFITS

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A QMCSO is a court order giving a child who otherwise might not be eligible for medical or dental coverage under the Plan a right to such coverage. Normally, such an order is issued by the court in connection with a divorce or separation. Before the Fund Office will comply with a QMCSO, it must determine that the court order meets the requirements of applicable law pertaining to QMCSOs. You will be notified if a court order relating to you is received by the Fund Office and the procedure used to determine whether the order is a QMCSO. You may get a copy of the Plan's QMCSO procedures from the Fund Office at no charge.

OVERPAYMENT AND MISTAKEN PAYMENT POLICY

If the Plan makes an overpayment or mistaken payment directly to a Participant, Dependent or other person, such payment shall be held in constructive trust by the recipient of the payment. Upon a demand for repayment, the Participant shall promptly reimburse the Plan. If no response is received within 10 days, or if the Participant cannot or will not reimburse the Plan directly, any future claims submitted by the Participant and his or her Dependent will be suspended and offset against the amount overpaid with interest of 10% per annum until it is recovered in full.

If an overpayment or mistaken payment is made to a service provider, such overpayment shall be held in constructive trust by the service provider. The Plan shall seek recoupment from the service provider. If the service provider fails to repay this money a demand for repayment will be made directly to the Participant. If the Plan is still unsuccessful in recovering the overpayment, or if the Participant cannot or will not reimburse the Plan directly, future claims submitted by the Participant and his or her Dependents will be suspended and offset against the amount overpaid with interest of 10% per annum until it is recovered in full.

The Trustees reserve all legal rights, including the right to sue for the full amount of the overpayment.

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

TEAMSTER LOCAL 639 COMMITMENT TO PRIVACY

INFORMATION SUBJECT TO THIS NOTICE

THE FUND'S PRIVACY POLICIES

TEAMSTERS LOCAL 639 – EMPLOYERS HEALTH TRUST FUND'S COMMITMENT TO PRIVACY

The Plan is committed to protecting the privacy of your protected health information. Protected health information, which is referred to as "health information" in this Notice, is information that identifies you and relates to your physical or mental health or to the provision or payment of health services for you. The Plan creates, receives and maintains your health information when it provides medical, dental, vision, and prescription drug benefits to you and your eligible Dependents. The Plan also pledges to provide you with certain rights related to your heath information.

By this Notice of Privacy Practices ("Notice"), the Plan informs you that it has the following legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice of the Plan's legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this Notice currently in effect.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "your" refers to covered Participants and eligible Dependents.

This Notice is effective as of April 14, 2003, and will remain in effect unless and until the Plan issues a revised Notice.

INFORMATION SUBJECT TO THIS NOTICE

The Plan creates, receives, and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and health care professionals, and from reports and data provided to the Plan by health care service providers or other employee benefit plans. The health information the Plan has about you includes, among other things, your name, address, phone number, social security number, and medical and health claims information. This is the information that is subject to the privacy practices described in this Notice.

THE FUND'S PRIVACY POLICIES

The Fund's Uses and Disclosures

Except as described in this Notice, as provided for by federal privacy law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and the processing of health claims. The uses and disclosures that do not require your written authorization are described below.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. **For Treatment.** The Plan may disclose your health information to a health care provider, such as a Hospital or physician, to assist the provider in treating you. The Plan does not anticipate making disclosures "for Treatment." However, if Necessary, the Plan may make such disclosures without your authorization.
2. **For Payment.** The Plan may use and disclose your health information so that your claims for health care services may be paid according to the Plan's terms. For example, the Plan may share your enrollment, eligibility, and claims information so that it may process your claims. The Plan may use or disclose your health information to health care providers to notify them as to whether you are eligible to receive certain medical Treatment or other health benefits. The Plan also may disclose your health information to other insurers or benefit plans to coordinate payment of your health care claims with others who may be responsible for certain costs.
3. **For Health Care Operations.** The Plan may use and disclose your health information to enable it to operate efficiently and in the best interest of its Participants. For example, the Plan may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Plan.

Uses and Disclosures to Business Associates

The Plan may disclose certain of your health information, without your authorization, to its "business associates." Business associates are third parties that assist the Plan in its operations. For example, the Plan discloses your health information so that it may process your claims. The Plan also may disclose your health information to auditors, actuaries, accountants, and attorneys as described above.

The Plan enters into agreements with its business associates, to ensure that they protect the privacy of your health information. Similarly, the Plan's business associates contract with their

subcontractors to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information, without your authorization, to the Plan's Board of Trustees, which is the Plan Sponsor, for fund administration purposes. Plan administration purposes include determining appeals of benefit claims, performing quality assurance functions, and auditing or monitoring the Plan. The Plan Sponsor will certify to the Plan that it will protect the privacy of your health information and that it has amended the Plan's plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

In addition to those described above, the federal health privacy law provides for specific uses or disclosures of your health information that the Plan may make without your authorization, which are described below:

1. **Required By Law.** Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for the following purposes:
   - for judicial and administrative proceedings pursuant to court or administrative orders, legal process and authority;
   - to report information related to victims of abuse, neglect, or domestic violence; and
   - to assist law enforcement officials in their law enforcement duties.
2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person as long as the Plan makes that disclosure in good faith, and consistent with applicable law and standards of ethical conduct. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability.
3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities, and protection of public officials, as required by law. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.
4. **Active Members of the Military and Veterans.** Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.

5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to workers' compensation benefits.
6. **Emergency Situations.** Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.
7. **Others Involved In Your Care.** In limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are involved in your care or payment of your care. For example, the Plan may disclose your health information if you are seriously injured and unable to discuss your case. Also, the Plan may advise a family member or close personal friend about your general condition, location (such as in the Hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.
8. **Personal Representatives.** Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have the right to act on your behalf. Examples of personal representatives are parents for minors and those who have Power of Attorney for adults.
9. **Treatment and Health-Related Benefits Information.** The Plan and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative Treatment, services and medication.
10. **Research.** Under certain circumstances, the Plan may use or disclose your health information for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.
11. **Organ and Tissue Donation.** If you are an organ donor, the Plan may use or disclose your health information to an organ donor or procurement organization to facilitate an organ or tissue donation transplantation.
12. **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan and its business associates do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Written Authorization

Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization in writing. If you do so, the Plan will not use or disclose your health information authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization.

Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or the Plan's knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan creates, receives, and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

HIPAA Privacy Officer
Teamsters Local 639 —
Employers Health Trust
3130 Ames Place, NE
Washington, DC 20018-1593
800-983-2699

Right To Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health information maintained by the Plan. This includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy health information maintained by the Plan, submit a written request to the Privacy Officer named above. The Plan may charge a fee of $0.25 per page for the cost of copying and/or mailing the health information that you have requested. In limited instances, the Plan may deny your request to inspect and copy your health information. If that occurs, the Plan will inform you in writing. In addition, in certain circumstances, if you are denied access to your health information, you may request a review of the denial.

Right to Request That Your Health Information Be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Plan may deny your request if you have asked to amend information that:

- was not created by or for the Plan, unless you provide the Plan with information that the person or entity that created the information is no longer available to make the amendment;
- is not part of your heath information maintained by or for the Plan;
- is not part of the health information that you would be permitted to inspect and copy; or
- is accurate and complete in the Plan's view.

The Plan will notify you in writing as to whether the Plan accepts or denies your request for an amendment to your health information. If the Plan denies your request, they will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures, which is a list of disclosures of your health information by the Plan to others. Generally, the following disclosures are not part of an accounting: disclosures that occur before April 14, 2003; disclosures for treatment, payment or health care operations; disclosures made to or authorized by you; and certain other disclosures. The accounting covers up to six years prior to the date of your request (but not disclosures made before April 14, 2003).

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting. The first accounting that you request within a twelve month period will be free. For additional accountings in a twelve month period, the Plan will charge you for the cost of providing the accounting. But the Plan will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. You also have the right to request restrictions on your health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is ***not*** required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether the Plan agrees to your request for restrictions. The Plan will also notify you in writing if the Plan terminates an agreement to the restrictions that you requested.

Right to Request Confidential Communications, Or Communications by Alternative Means or At an Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or in an alternative location. For example, you can ask that the Plan only contact you at work or by mail, or that the Plan provide you with access to your health information at a specific, reasonable location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. The Plan will accommodate reasonable requests and notify you appropriately.

Right to Complain

You have the right to file a complaint with the Plan and/or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the HIPAA Contact Person named above.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a separate paper copy of this Notice. To make such a request, submit a written request to the HIPAA Contact Person listed above.

CHANGES IN THE FUND'S PRIVACY POLICIES

The Plan reserves the right to change its privacy practices covered by this Notice and make the new practices effective for all protected health information that it maintains, including protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Plan materially changes any of its privacy practices that are covered by this Notice, it will revise its Notice and provide you with the revised Notice within sixty days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request.

CONTACT INFORMATION

If you have any questions or concerns about the Plan's privacy practices, or about this Notice, if you wish to obtain additional information about the Plan's privacy practices, or if you wish to file a complaint related to your health information, please contact:

HIPAA Contact Person
Teamsters Local 639 —
Employers Health Trust
3130 Ames Place, NE
Washington, DC 20018-1593
800-983-2699
202-636-8181

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

18 FREQUENTLY ASKED QUESTIONS

This booklet is a Summary Plan Description. It functions as the Plan document and it is designed to provide you with information about the Benefit Plan. The official name of the Benefit Plan is the Teamsters Local 639—Employers Health Trust Fund. At times we interchangeably refer to the Health Trust Fund as the Benefit Program, Benefit Plan, Trust, Fund, Health Plan or Plan.

Important — only the full Board of Trustees is authorized to interpret the rules, regulations and Plan of Benefits. No Employer or Union representative is authorized to interpret this Plan nor can any person act as an agent for the Trustees.

This "Frequently Asked Questions" section of this Summary Plan Description is designed to make you more familiar with the Plan. We have included questions about what to do and whom to call. A directory of telephone numbers and other information is at the end of this booklet.

Question 1: How do I find out if I am eligible for benefits?

Call the Fund Office at 202-636-8181 or, toll free, at 800-983-2699. The Fund Office hours are from 9:00 AM to 5:00 PM, Monday through Friday (closed on holidays). A fax machine is available 24 hours a day, seven days per week at 202-526-7959. The Fund Office is located at 3130 Ames Place, NE, Washington, DC 20018-1513.

For details as to how to become eligible and remain eligible, refer to the Eligibility rules in Section 1 of this booklet.

Question 2: Why do I have to send the Fund Office an enrollment card? My Employer and the Union already have my name, address and other information.

Claims can only be paid for persons who qualify for the coverage. The Fund Office must have information to be able to determine if you are eligible for benefits. We also need to know who your beneficiary is so that the life insurance benefits will be paid to the right person.

You can get an enrollment card by calling, writing to, or visiting the Fund Office. If you are married and if you have any eligible sons or daughters, you will have to furnish copies of your marriage certificate and your children's birth certificates.

Refer to the Dependent Coverage rules in Section 1 of this booklet for information about eligible Dependents.

Question 3: I just got married and want to add my spouse to the coverage. What should I do?

Bring or send a copy of your marriage certificate to the Fund Office. Please be sure that your name and Social Security Number are included with the information you are filing. Your spouse's coverage will be in force as of the date of your marriage.

If yours is a valid common law marriage, ask the Fund Office for a declaration of common law marriage. Recognize that if you enter into a valid common law marriage in a state that recognizes such marriages, you cannot become remarried without first getting a legal divorce. Your common law spouse will also have a right to your pension benefit under federal law.

Question 4: My spouse works and has coverage with her employer. What are her options under this plan?

If her employer meets the test for "adequate alternative coverage" she must take that coverage or pay the monthly spousal surcharge for coverage under this Plan. "Adequate alternative coverage" is explained in Section 1. If your spouse does select her employer's coverage she will retain secondary coverage under this Plan. This is described in the Coordination of Benefits discussion in Section 16. If your spouse has adequate alternative coverage you must provide the additional information described in Section 1 of this booklet.

Question 5: What should I do if I get a divorce or my spouse dies?

If you are divorced or your spouse is deceased, you must furnish a copy of your divorce decree or your spouse's death certificate to the Fund Office. Your name and Social Security Number must be included with the information you are filing. If you do not provide this information you will be personally liable for any benefits paid by the Plan to your divorced spouse.

If you are divorcing, your spouse may qualify for continued coverage by making monthly payments to the Plan. Refer to the COBRA Continuation Coverage in Section 2 of this booklet for more information.

Question 6: How do I change my beneficiary?

If you wish to change your beneficiary you should contact the Fund Office and complete a new enrollment card along with any additional information the Fund Office may require.

Question 7: We just had a new baby. What should I do?

If you wish to add a newborn child to your coverage, you must complete a new enrollment card and submit it along with a copy of the child's birth certificate to the Fund Office.

Question 8: I just got married and now I have stepchildren. Can I add them to the coverage?

Yes. And, your spouse also qualifies for coverage. To add stepchildren and your spouse to the coverage, you must complete a new enrollment card. You must also provide a copy of your marriage

certificate and the birth certificates of your stepchildren to the Fund Office. You should also complete a new enrollment card if you want to change your beneficiary.

Question 9: Does the Plan cover adopted children? What if I am appointed as a legal guardian?

The Plan will cover the child in either case. If you adopt a child or if you are appointed as the legal guardian of a child, you must submit a copy of the court's certification of the adoption or appointment as legal guardian to the Fund Office.

Question 10: How long are my children covered for benefits under the Plan other than life insurance?

Each of your children is eligible to be covered under the Plan until their 26th birthday, provided he or she is not eligible for other employer sponsored coverage. If your child is incapable of self-sustaining employment by reason of Mental retardation or physical handicap, coverage can be continued after the maximum age as long as the incapacity continues and proof is provided to the Fund Office.

Question 11: How long are my children covered for life insurance benefits?

For life insurance coverage only, your children are eligible to be covered under the Plan until the earlier of:

- their 19th birthday;
- the day they become married; or
- the day they cease to be your Dependent child.

Question 12: The Fund Office told me that my son isn't covered for life insurance benefits as of now. He's a college student. What can I do?

If your son is still under the age of 25, ask the Fund Office for a Student Certification Form or ask the Registrar's Office of the college, university, or otherwise accredited school to send a letter of verification of full- time student status to the Fund Office. Remember, all documentation regarding your enrollment record must include your name and Social Security Number. Refer to the Eligibility rules in Section 1 of this booklet for more information about the Plan's full-time student Dependent rules.

Question 13: Are Retirees covered by the Health Fund?

If you retired before January 1, 1980 and elected Retiree coverage, you may be covered by the Retiree benefits section of the Plan. You can find out by contacting the Fund Office. If you do qualify, your Schedule of Benefits is listed in Section 14 of this book.

If you retired on or after January 1, 1980, you are NOT covered for Retiree benefits by this Plan.

If you retired on or after January 1, 1989, you may qualify for coverage through the Teamsters Local 639—Employers Pension Trust Fund. The Retiree Medical Plan of the Pension Trust is administered at the same Fund Office. If you are covered by the Pension Fund's Retiree health plan, ask the Fund Office to send you the Summary Plan Description for that plan.

Question 14: Who provides the benefits?

Benefits are paid directly or indirectly from the Health Fund assets. This form of benefit funding is referred to as "self funding." Most of the claims are processed by the staff in the Fund Office. Some of the benefits are provided through service organizations that are hired by the Plan.

Question 15: What is a PPO?

A PPO is a Preferred Provider Organization. The CIGNA PPO is an example. CIGNA enters into agreements with physicians, Hospitals and other health care providers for reduced fees only. Under the CIGNA PPO agreement, you and your Dependents may freely seek medical care from any Doctor, Hospital or other facility of your choice. If the particular medical care provider is within the CIGNA network, the fee for service is lower than it would be from a provider who is out of the network. The reduced fee results in lower costs for the Health Fund and typically lower out-of-pocket expense for you.

Question 16: If I need medical care, do I have to go to a CIGNA Doctor or Hospital?

No. But, as a Participant in this Plan, you and your family members are encouraged to fully utilize the CIGNA Network because it will save you money. If, however, you choose to use an Out-of-Network provider, the total cost of the service will be larger and you will have to pay a larger part of that cost (see the description of Deductible and Covered Amount in Section 3 of this booklet). If you live outside of the network area, your claims will be covered at the In-Network benefit level.

Question 17: What are the advantages of using the CIGNA Network?

There are three advantages:

1. CIGNA's role is to re-price your claim. The result is typically lower total cost.
2. If you use the CIGNA Network the plan pays a larger portion of the cost and you pay a smaller portion.
3. You do not have to complete a claim form to file a CIGNA Network claim. All providers within the CIGNA Network will send your claims directly to CIGNA.

Please show your Health Fund identification card to the CIGNA provider to assure that the provider has the correct CIGNA Plan number.

Question 18: How do I find out if my Doctor is a CIGNA provider?

Call CIGNA's member services (800-768-4695) to verify if a health care provider is participating. Or, you can call the Fund Office (202-636-8181 or 800-983-2699) and ask for a CIGNA Directory. You can also find this information on the CIGNA website at www.cigna.com\SA-PPO2.

Question 19: How do I get a prescription filled?

When you become eligible under the Plan, you will receive a prescription card. Simply take your Doctor's prescription form and your identification card to any participating pharmacy. The pharmacy will verify your eligibility, fill your prescription and charge you the appropriate Co-Payment. If the pharmacy tells you that you or your Dependents are not eligible, contact the Fund Office.

Question 20: Do I always have to go to the drug store? Is there another way to get my prescription filled?

Caremark also has a mail order program for certain maintenance drugs. A mail order form is included in the package with your prescription card. Mail order forms are also available at the Fund Office.

Question 21: Do I have to file a claim form for my drugs?

You only have to complete a claim form for prescription drugs if you have your prescription filled at a pharmacy that is not in the Caremark network.

Question 22: How will I know if my pharmacy is part of the Caremark Network?

There are several ways. A listing of large chain network drugstores is available from the Fund Office on request. You can find out if your pharmacy is in the Caremark network by calling the Caremark member services center. The telephone number is 866-282-8503. You can check on the Caremark website at www.caremark.com. Finally, you can ask the druggist at your pharmacy.

Question 23: Does the Plan provide mental health benefits?

Yes. MHN administers the Plan's Mental and Nervous Conditions benefits through a network of providers. You must obtain pre-authorization from MHN prior to receiving treatment, otherwise the claims for Covered Expenses will be paid at 70% of UCR Charges and you are subject to balance billing by the provider. MHN can assist you in locating a qualified provider who has the credentials to serve your

needs. MHN customer service and intake counselors' telephone number is 800-327-6517.

Question 24: Can I go outside the Mental Health network?

Yes, but it will probably cost you more. MHN provides a network of preferred providers who have agreed to provide their services to Plan Participants at a discount. Claims can be paid for the services of psychiatrists, psychologists, and social workers up to the limits of the Plan. If the provider is in the MHN network, the charges to you will probably be less than from a provider who is not in the network. Refer to the Mental Health Benefits in Section 8 of this booklet for more information regarding these benefits.

Question 25: Does the Plan provide treatment for drug and alcohol dependency?

Yes. Active employees and their Dependents can get confidential treatment for drug and alcohol dependency. The drug and alcohol dependency program is administered by MHN through their network or preferred providers. No claims for treatment will be covered unless they are incurred at a MHN network provider. All Claims must be specifically approved in advance by MHN, otherwise Covered Expenses will be paid at 70% of UCR Charges and you are subject to balance billing by the provider. Refer to Drug and Alcohol Dependency Benefits in Section 9 of this booklet for all of the program's benefits and requirements. The phone number of MHN is 800-327-6517.

Question 26: Does the Plan have a vision care program?

Yes. Vision benefits are provided for Participants and Dependents and also for some Retirees. Benefits are provided through VSP, a Preferred Provider Organization (PPO) specializing in vision care at negotiated rates. Refer to Vision Care in Section 6 of this booklet for information about the specific benefits provided.

Question 27: My son injured his eye, should I make an appointment with a VSP specialist?

No. Vision care benefits cover exams, glasses and contact lenses. For injuries to the eye you should see an appropriate medical Doctor.

Question 28: How do I get dental benefits?

The Fund Office can provide a listing of nearly 700 participating dentists.

Question 29: Does the Plan provide life insurance coverage?

Yes. Life Insurance and Accidental Death and Dismemberment Insurance are

provided through an insurance policy with the ReliaStar Life Insurance Company, Minneapolis, Minnesota. The Group Policy Number is GL-12904-6. Refer to the Life Insurance Benefits in Section 11 of this booklet for your amounts of coverage.

Question 30: Are my Dependents covered by life insurance?

Yes, your Dependents have Life Insurance coverage. Dependents do not have Accidental Death and Dismemberment coverage.

STATEMENT OF YOUR RIGHTS UNDER ERISA

INFORMATION REQUIRED BY ERISA

STATEMENT OF YOUR RIGHTS UNDER ERISA

As a Participant in the Teamsters Local 639—Employers Health Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.
2. Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may charge a reasonable amount for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the Summary Annual Report.
4. Continue health coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation rights.
5. Receive a certificate of creditable coverage, free of charge, from the Plan Administrator when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The members of the Board of Trustees who operate the Plan, (called "fiduciaries" of the Plan), have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical support order, you may file suit in a federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

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

INFORMATION REQUIRED BY ERISA

The Employee Retirement Income Security Act of 1974 (Title 29 United States Code, Section 1001 Et seq.)

The following, together with information contained in other portions of this booklet, forms the Summary Plan Description under the Employee Retirement Income Security Act of 1974.

1. Name and Type of Plan

This Plan is known as the "Teamsters Local 639—Employers Health Trust Fund." The Plan is an "employee welfare benefit plan" under ERISA. The Plan provides hospitalization, surgical and medical, member assistance program, mental health, drug and alcohol dependency, disease case management, and prescription drugs to eligible Participants and their eligible Dependents, as well as accident and sickness to eligible Participants, on a self insured basis. The Plan's dental, vision, life, and accidental death and dismemberment benefits are provided on an insured basis.

2. Plan Identification Numbers

- Employer Identification Number: 53-0209136
- IRS Plan Number: 501
- Life Insurance and Accidental Death and Dismemberment Policy Number: GL-12904-6

3. Plan Administrator

The Plan Administrator is the Board of Trustees of the Teamsters Local 639—Employers Health Trust Fund, 3130 Ames Place, NE, Washington, DC 20018-1593. The telephone number is 202-636-8181. The Trustees are:

Union Trustees

Thomas Ratliff
John Gibson
Philip Giles
J. Anthony Smith

Employer Trustees

Michael R. Bull
Raymond Howard
Frank W. Stegman
Eric R. Weiss

All of the above at:

Teamsters 639 Center
3130 Ames Place, NE Washington, DC 20018-1593

4. Agent for Service of Legal Process

Any one of the Trustees is a qualified agent of the Board of Trustees for service of process. Service may also be made upon the Administrative Manager at the office of the Plan Administrator noted above.

5. Type of Administration

The Plan is administered by the Board of Trustees. However, the Trustees have engaged American Benefit Plan Administrators ("ABPA") on a contract basis to serve as Administrative Manager to oversee the operation and administration of the Health Trust's Plan on a day-to-day basis. Benefits are provided under the Plan as follows:

- Hospital, surgical and medical benefits in accordance with the Trust Agreement on a self-insured basis; but administered in accordance with a preferred provider contract between the Board of Trustees and CIGNA Healthcare, 10490 Little Patuxent Parkway, 60 Corporate Center, Suite 400, Columbia, MD 21044;
- Life and Accidental Death and Dismemberment benefits in accordance with provisions of a group insurance policy issued to the Board of Trustees by Reliastar, Minneapolis, Minnesota;
- Prescription drug benefits in accordance with a pharmacy benefit manager contract between the Board of Trustees and Caremark, 11350 McCormick Blvd, Suite 1000, Hunt Valley, MD 21031;
- Vision benefits in accordance with a vision care contract between the Board of Trustees and VSP, P.O. Box 997100, Sacramento, CA 95899-7100;
- Dental benefits in accordance with a dental services contract between the Board of Trustees and the Dental Health Center And Associates, 3700 Donnell Drive, Suite 215, Forestville, MD 20747;
- Drug and alcohol dependency benefits in accordance with a service contract between the Board of Trustees and Mental Health Network, One Far Mill Crossing, Shelton, CT 06484.
- Mental health benefits in accordance with a preferred provider contract between the Board of Trustees and Mental Health Network, One Far Mill Crossing, Shelton, CT 06484.

6. Labor Organizations Representing Participants in the Plan

This Plan is maintained by collective bargaining agreements executed by Drivers, Chauffeurs and Helpers Local Union 639 affiliated with the International Brotherhood of Teamsters and signatory employers. Some Participants may be covered by collective bargaining agreements executed by Automotive, Petroleum, Cylinder and Bottled Gas, Chemical Drivers, Helpers and Allied Workers and Public Transportation Employees Local 922 and signatory employers. A copy of any such agreements may be obtained by a Participant upon written request to the Plan Administrator. Also, collective bargaining agreements are

available for examination by a Participant at the Fund Office.

7. Name and Address of Employers Contributing to the Health Trust

Participants may obtain a complete list of the Employers who contribute to this Plan upon written directed request to the Plan Administrator. Also, this list is available for examination at the Trust Office by Participants or beneficiaries. A Participant or beneficiary may also receive from the Plan Administrator, upon request to the Fund Office, information as to whether a particular employer or union is a Contributing Employer or a collective bargaining representative of an employer who participates in the Plan and, if so, the address of such employer or union.

8. Source of Contributions to the Plan

Contributions to the Health Fund are made by individual employers under the provisions of collective bargaining agreements. Under certain conditions stipulated in the Plan, employees may qualify to contribute on their own behalf in order to continue their eligibility status for a limited period of time.

9. Fiscal Year of Health Trust Fund

The annual fiscal year of the Health Fund ends December 31.

10. Modification of Benefit Schedules, or Termination of Benefits, or Termination of the Health Plan

The Plan's ability to provide health and welfare benefits is dependent upon a number of factors that may vary from year to year or even month to month. Accordingly, the Trustees specifically reserve the right to change, eliminate, add to or delete from the Plan and the provisions of this Summary Plan Description, including the Schedule of Benefits provided to active and/ or retired Participants, and to the Dependents of such Participants. The Trustees also reserve the right to adopt new rules and regulations or to modify the existing rules and regulations. Nothing in this book or elsewhere should be construed to mean that the Plan's benefits are guaranteed. The Trustees will notify Participants when they make significant changes in the rules, regulations or Schedule of Benefits.

11. Discretionary Authority of the Trustees

The Trustees' reserve discretionary authority to construe and interpret the terms of the Trust Agreement, the Plan, the Summary Plan Description and the rules and regulations that they may make from time to time. The Trustees also reserve the right to make factual findings, fix omissions and resolve ambiguities in the Plan, this Summary Plan Description and the rules or regulations. Benefits under the Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

APPENDIX 20

DEFINITIONS

DEFINITIONS

The following definitions, although not all-inclusive, are used throughout this booklet to help you understand your benefits.

Co-Payment means the dollar amount of covered expenses the Participant or Dependent is required to pay under the terms of the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 and the regulations thereunder, as amended from time to time.

Contributions means payments made by a Contributing Employer to the Plan.

Contributing Employer means any person, firm, association, partnership or corporation entering into a Collective Bargaining Agreement or participation agreement that requires Contributions to the Plan on behalf of its employees. The Teamsters Union Local 639 is a contributing employer because it has entered into a Participation Agreement with the Trustees to provide health coverage through the Plan to its employees.

Covered Expense means all expenses for benefits or services specifically listed in the Plan/this SPD as being covered.

Deductible means the covered expenses incurred and payable by a Participant or Dependent before medical benefits are payable under this Plan.

Dependent has the meaning described on page 11.

Doctor means a legally qualified physician or surgeon and includes a Doctor of Chiropractic (DC), a Doctor of Dental Surgery (DDS), a Doctor of Dental Medicine (DMD), a Doctor of Osteopathy (DO), a Doctor of Podiatric Medicine (DPM), a Doctor of Psychology (Dps/PsyD), a Medical Doctor (MD), a Licensed Certified Midwife (LCMW), and a Doctor of Optometry (OD).

ERISA means the Employee Retirement Income Security Act of 1974, as amended and the regulations thereunder.

Hospital means a legally constituted institution which meets all of these tests:

- it is licensed as a Hospital (if Hospital licensing is required where it is situated);
- it is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient

basis and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under the supervision of a staff of legally qualified physicians;

- it continuously provides 24-hour a day nursing service by or under the supervision of registered graduate nurses and is operated continuously with organized facilities for operative surgery; and
- it is not, other than incidentally, a clinic, a place of rest or convalescence, a place for the aged, a nursing home, or similar establishment.

Illness or Sickness means a bodily disorder, disease, physical or mental infirmity, or functional nervous disorder or condition that requires treatment by a Doctor. All illnesses existing simultaneously resulting from the same or related causes shall be considered the same illness. For a Participant or Dependent spouse only, Illness also includes pregnancy, childbirth or any maternity-related condition.

Injury or Accident means accidental bodily injury which results neither from criminal activity engaged in by the Participant or Dependent nor from any employment for wage or profit, and which causes loss commencing while the benefits of the Participant or Dependent are in force.

Medically Necessary or Necessary means that the service received is required to identify or treat the Illness or Injury that a Doctor has diagnosed or reasonably suspects. The service must be consistent with the diagnosis and treatment of the patient's conditions, be in accordance with local standards of good medical practice, be required for reasons other than the convenience of the patient or the Doctor, and be performed in the least costly setting required by the patient's condition. The fact that a service is ordered, recommended, approved or prescribed by a Doctor does not necessarily mean that such service is a Necessary or Covered Expense even though it is not listed as an exclusion.

Medicare means the benefits program established under Title XVIII of Social Security Act of 1965, as amended.

Mental or Nervous Condition means a neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

Participant means any person who has attained and maintained eligibility through active employment with a Contributing Employer in an eligible class of employees.

Periods of Disability — all periods of disability resulting from the same or related cause or causes which occur before complete recovery will be considered one "Period of Disability" unless the periods are separated by your return to active employment for at least ninety days. If the periods of disability are separated by less than ninety days of active work, they will be considered one "Period of Disability" unless the second disability is due to an Injury or Illness entirely unrelated to the cause(s) of the first disability and starts after your return to active work on a full- time basis for one day.

Preferred Provider Organization (PPO) means a network of health care providers who have contracted with the Plan to provide health care while controlling costs.

Retiree means a former Employee who satisfies the requirements for retiree coverage under the Plan.

Room and Board means room, board, general duty nursing, intensive care in an intensive care unit, as defined, and any other services regularly rendered by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of physicians nor special nursing services rendered outside of an intensive care unit.

Schedule of Benefits means the specific benefits, waiting periods, maximums, Deductibles, out-of-pocket expenses, Co-Payments, limitations or allowances applicable to Participants and Dependents as adopted from time to time by the Board of Trustees.

Self-Payments are payments made to the Plan by you on your own behalf to maintain coverage under the Plan.

Treatment means a treatment or course of treatment which is ordered and/or provided by a Doctor to diagnose or treat an Injury or Illness, including:

- confinement and inpatient or outpatient services or procedures; and
- drugs, supplies, equipment, or devices.

The fact that a treatment was ordered or provided by a Doctor does not, in and of itself, mean that the treatment will be determined to be Medically Necessary.

Trustees and/or Board means the Board of Trustees of the Teamsters Local 639—Employers Health Trust Fund.

Usual, Customary and Reasonable Charge or UCR Charge — For In-Network Covered Expenses, UCR means the rate negotiated by the network provider for the service provided. For Out-of-Network Covered Expenses, UCR means that portion of any

charge which is not in excess of the charge made for similar services and supplies to individuals of similar age, circumstances and medical condition in the locality concerned, as determined by the use of a national database at the 90th percentile. The Plan does not pay for Covered Expenses in excess of the UCR Charge. Participants and Dependents who incur Out-of-Network Covered Expenses are subject to balance billing by the provider (i.e., the amount billed by the provider in excess of the amount the Plan determines is the UCR Charge).

INTERNATIONAL BROTHERHOOD OF TEAMSTERS

21 WHOM TO CALL

If you need eligibility or benefits information, contact:

The Fund Office
Teamsters Local 639 Center
3130 Ames Place, NE
Washington, DC 20018-1593
202-636-8181
800-983-2699 (toll-free)
202-526-7959 (fax)

The Fund Office can provide:

- your eligibility information
- enrollment cards
- identification cards
- claim forms
- student dependent certificates
- information about a claim or an appeal
- notice of privacy rights
- any other benefit information not listed above

When you call or visit the Fund Office please tell our staff member your Social Security Number. The Fund Office hours are 9:00 AM to 5:00 PM, Monday through Friday.

If you need to obtain pre-certification for any medical claim or have an urgent or concurrent* medical claim contact:

CIGNA
800-768-4695
*A "concurrent medical claim" is a claim to continue a current, ongoing course of treatment.

If you need information about prescription drugs, contact:

Caremark
11350 McCormick Blvd, Suite 1000
Hunt Valley, MD 21031
866-282-8503
www.caremark.com/local639

They can provide you with things like:

- a list of the Caremark participating national drug store chains
- verification that a drug store is participating in the Caremark program
- information about the Caremark mail order program

Your identification number is your Social Security Number and your Caremark group number which is printed on your identification card.

If you need information about eyeglasses, contact:

VSP
www.VSP.com
800-877-7195

If you need information about dental care, contact:

The participating dentist you last visited, or

Dr. Robert P. Cohen
Dental Health Center
3700 Donnell Drive, Suite 215
Forestville, MD 20747
301-736-1400
www.dhcandassociates.com

They can help you with things like:

- making an appointment for dental services,
- emergency dental care, and
- filing a dental claim for the services of out-of-network dental providers.

When you contact Dental Health Center or any of the participating dentists, please tell them you are covered by Teamsters Local 639—Employers Health Trust. The Dental Health Center is closed on Sunday and Monday.

If you need care and treatment of a mental health disorder, contact:

Mental Health Network ("MHN")
www.mhn.com
800-327-6517

When you contact MHN, please tell them that you are covered by Teamsters Local 639—Employers Health Trust.

Representatives and intake counselors are available Monday through Friday from 8:00 a.m. to 6:00 p.m. For emergency authorization requests, the MHN services are available 24 hours a day, seven days a week.

If you need confidential treatment of alcohol or drug dependency, contact:

Mental Health Network ("MHN")
www.mhn.com
800-327-6517

When contacting MHN, please tell them that you are covered by the Teamsters Local 639—Employers Health Trust.

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