TEAMSTERS LOCAL 639—
EMPLOYERS PENSION TRUST FUND

401(h) RETIREE MEDICAL PLAN

SUMMARY PLAN DESCRIPTION

HOW YOUR
401(h) RETIREE MEDICAL PLAN
WORKS

NOVEMBER 1, 2012

H O W Y O U R
401(h) RETIREE MEDICAL P L A N
W O R K S

Teamsters Local 639—Employers Pension Trust Fund
401(h) Retiree Medical Plan
3130 Ames Place, NE · Washington, DC 20018

800-983-2699

202-636-8181

November 1, 2012


INTERNATIONAL BROTHERHOOD OF TEAMSTERS

CONTENTS

IS THIS BOOKLET FOR YOU?

This booklet describes the benefits in the plan of retiree medical benefits ("Retiree Medical Plan" or "Plan") provided under the Teamsters Local 639 – Employers Pension Trust ("639 Pension Fund" or "Fund"), as amended through November 1, 2012. It applies to you if you are an eligible retiree or a retiree's Spouse on or after November 1, 2012, unless a specific effective date is set forth in the text. The rules of the Retiree Medical Plan are also described in Part II of the 639 Pension Fund's Pension Plan document. The word "401(h)" on the cover of this booklet reflects the fact that the Board of Trustees of the Pension Fund established this Retiree Medical Plan pursuant to Section 401(h) of the Internal Revenue Code.

The Trustees have provided this Summary Plan Description to give you the detailed rules of the Retiree Medical Plan. To make it easier to read, we have tried to write in plain English.

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 Retiree Medical 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 Retiree Medical 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.

1. ELIGIBILITY

Retirees and their Spouses are eligible for coverage under, and become Participants in, the Retiree Medical Plan if they meet the eligibility requirements described below. Retiree eligibility basically depends upon the retiree's age, the Credited Service the retiree earned under the 639 Pension Fund and the retiree's retirement status under the 639 Pension Fund. "Credited Service" is the number of service credits the retiree earned while working as an active employee under the 639 Pension Fund. The term "Credited Service" is defined in the 639 Pension Fund document and it is summarized briefly in the "What Is Credited Service?" section below. The words "Contribution Period" are also used to determine eligibility under the Retiree Medical Plan. Contribution Period is the period during which the retiree's former employer contributed on the retiree's behalf to the 639 Pension Fund while the retiree was working.

Retirees who retire with deferred vested pensions from the 639 Pension Fund are not eligible to participate in the Retiree Medical Plan. Deferred vested pensions are those where the retiree incurs a "one-year break-in-service" before retiring and commencing to receive pension benefits from the 639 Pension Fund. A one-year break-in-service occurs when a person completes fewer than 350 hours of service with a Contributing Employer in a calendar year. The Retiree Medical Plan eligibility rules are designed to extend coverage only to those retirees who move into retirement status very soon after they stop working in Covered Employment.

ELIGIBILITY REQUIREMENTS FOR RETIREES

Retirees are eligible to enroll in the Retiree Medical Plan if they meet one of the following four eligibility requirements:

1. Certain Age 55 Retirees

If you retire on a pension from the 639 Pension Fund (other than a deferred vested pension), and you meet the following four requirements:

- You have reached age 55 when you retire;
- You retire from active employment under the 639 Pension Fund and do not have a one-year break-in-service immediately prior to retirement;
- You have at least 10 years of Credited Service which were earned during the Contribution Period; and
- You elect to make the required contributions.

2. Certain Retirees With 25 Years of Credited Service

If you retire on a pension from the 639 Pension Fund (other than a deferred vested pension), and you meet the following three requirements:

- You retire from active employment under the 639 Pension Fund and do not have a one-year break-in-service immediately prior to retirement;
- You have at least 25 years of Credited Service, at least 10 of which are earned during the Contribution Period; and
- You elect to make the required contributions.

3. Certain Retirees on Partial ("Reciprocal") Pensions

Sometimes an employee will work in active employment under one or more Teamster pension funds. If the 639 Pension Fund is party to a reciprocal agreement with another Teamster pension fund, an employee who has split service between the 639 Pension Fund and the other Teamster fund may be eligible to retire on a Partial Pension from the 639 Pension Fund.

If you retire on a Partial Pension from the 639 Pension Fund (other than a deferred vested Partial Pension), and you meet the following five requirements:

- You have reached age 55 when you retire;
- The 639 Pension Fund is the terminal plan (meaning that the 639 Pension Fund is the last Teamster pension plan in which you participated before you retired);
- You retire from active employment under the 639 Pension Fund and you do not have a one-year break-in-service immediately prior to retirement;
- You have at least two years of Credited Service during the Contribution Period with the 639 Pension Fund immediately prior to your retirement; and
- You elect to make the required contributions.

4. Certain Retirees Receiving Disability Benefits

If you receive a disability benefit from the 639 Pension Fund (*i.e.*, not a disability lump sum, but a pension benefit paid to Participants with at least 10 years of Credited Service who left Covered Employment as a result of, or while suffering from, a total and permanent disability as determined by the Social Security Administration) on or after January 1, 1998 and you elect to make the required contributions.

5. Retirees with Compensable Injuries

If you cease working in active employment and you meet all the requirements to qualify for benefits under 1, 2 or 3 above, or you met such requirements following your cessation of active employment as a result of additional Credited Service based on additional Employer Contributions, and you meet the following additional requirements:

- You retire on or after April 1, 2003;
- You do not qualify for benefits under 1, 2, or 3 above because you had a one-year break-in-service immediately prior to retirement;
- You had a one-year break-in-service solely as a result of an illness or injury covered by Workers Compensation and for which you received Workers Compensation benefits after January 1, 2003;
- You were not employed following the illness or injury and prior to retirement; and
- You self-pay your health benefits under the Teamsters Local 639 – Employers Health Trust Fund or pursuant to COBRA up to the date of your retirement.

If you meet the above requirements, you will be eligible for benefits under the Retiree Medical Plan on the later of:

- the first day of the month in which you begin to receive pension payments from the 639 Pension Fund, or
- the first day of the month following the month in which your eligibility under the Teamsters Local 639 – Employers Health Trust ends.

ELECTION REQUIREMENTS FOR RETIREE COVERAGE

A retiree must elect to enroll in coverage under the Retiree Medical Plan before the retiree begins to receive his/her pension (or disability benefit) from the 639 Pension Fund. The retiree must agree in the enrollment documents to contribute to the Plan on a monthly basis in amounts determined by the Board of Trustees.

In general, you only have one chance to elect coverage from the Retiree Medical Plan. If you fail to do so before your pension starts, you will not get another chance, with one exception. If you satisfied all of the rules for Initial Eligibility in effect at the time you retired (other than the election requirement), but chose to defer Retiree Medical Plan benefits because you were receiving health care coverage from your Spouse's employer, you can then elect to receive coverage from the Retiree Medical Plan when your Spouse's coverage terminates. In order to do so, you must elect coverage from the Retiree Medical Plan no later than 45 days following the termination of your Spouse's coverage. Furthermore, you must provide proof that you were continuously covered and that the coverage terminated. Your Spouse's health plan should send a HIPAA Certificate of Coverage, which will show the period of coverage. If you do not receive a Certificate of Coverage, please contact the Fund Office for assistance.

HOW TO ENROLL

To enroll in Retiree Medical Plan coverage, the retiree or Spouse must complete an enrollment form. Forms are available from the Fund Office, which can be reached at 202-636-8181, during regular business hours.

WHEN RETIREE COVERAGE STARTS

If a retiree meets the eligibility requirements described above, completes an enrollment form electing coverage and agrees to make the required contributions, the retiree's coverage under the Retiree Medical Plan will start on the later of the first day of the month in which the retiree begins to receive his/her pension benefits under the 639 Pension Fund, or the first day of the month following the month in which the retiree's eligibility under the Teamsters Local 639 – Employers Health Trust ends.

OTHER RULES THAT AFFECT ELIGIBILITY

What Is Credited Service?

Credited Service is used to determine if you are eligible for benefits under this Retiree Medical Plan and for pension benefits under the 639 Pension Fund. In addition to Credited Service, there is something known as past Credited Service.

- Credited Service is credit for employment with your Employer while your Employer is contributing to the 639 Pension Fund.

- Past Credited Service is credit for employment with your Employer before your Employer began contributing to the 639 Pension Fund.

The rules for earning Credited Service have changed at various times in the past. Because these rules are so important, this booklet summarizes the present rules as well as rules in the past.

How is Credited Service Earned?

Credited Service is earned for hours you work while your Employer is making, or is obligated to make, Contributions to the 639 Pension Fund on your behalf.

Prior to 1976, the 639 Pension Fund awarded a year of Credited Service for a calendar year if you worked 1,400 hours or 35 weeks. If you worked at least 800 hours or 20 weeks in a calendar year, the 639 Pension Fund awarded ½ year of Credited Service.

For the years 1976 through 1982, the Plan awarded a year of Credited Service for a calendar year if you worked at least 1,400 hours. If you worked between 700 and 1,400 hours in Covered Employment, the Plan awarded you with a prorated portion of one year of Credited Service based on the ratio of your hours worked in Covered Employment to 1,400 hours.

For the years 1983 through February 29, 2008, Credited Service was awarded according to the following table:

Hours of Service	Credited Service
1,400 or more	1 year
1,050 but less than 1,400	3/4 year
700 but less than 1,050	1/2 year

After 2007, the 639 Pension Fund uses partial years of Credited Service only for determining eligibility for certain forms of retirement benefits, such as the 30-and-Out Pension and the 25-and-Out Pension. The rule that you must earn at least 700 hours of contributions in a year in order to earn a pension benefit for that year continues to apply on and after March 1, 2008. The amount of your benefit will depend on how many hours you have worked in a year and the amount of money your Employer has contributed during that year on your behalf. This is discussed in more detail in the 639 Pension Fund Summary Plan Description.

Covered Employment is the period of your employment during which your employer had an obligation to contribute on your behalf to the 639 Pension Fund.

How is Credited Service earned for periods prior to my Employer's participation in the Plan?

If Contributions were first reported for you on January 1, 1984, or later, you cannot receive past Credited Service for any years of employment with the same Employer prior to January 1, 1984.

If Contributions were first reported for you between May 1, 1971 and December 31, 1983, you may be eligible to receive Credited Service for years of employment with **the same employer** before the date the Employer began contributing to the 639 Pension Fund. If eligible, you must first earn 10 years of Credited Service before any Credited Service attributable to this earlier period is awarded.

If Contributions were first reported for you before May 1, 1971, you may be eligible to receive Credited Service for continuous employment in the trucking industry. If eligible, you must first earn 10 years of Credited Service before any Credited Service attributable to this earlier period is awarded.

For years prior to 1976, one year of past Credited Service is awarded for 1,000 hours of service or 25 weeks of service in a calendar year. One half-year of past Credited Service is awarded for at least 500 hours of service (but less than 1,000) or 18 weeks (but less than 25) in a calendar year.

For years after 1975, past Credited Service is measured the same as Credited Service.

What is Vesting Service?

Vesting Service is different from Credited Service. Vesting Service is used to determine if you are eligible for a Deferred Vested Pension. You are awarded one year of Vesting Service for each calendar year that you earn at least 700 hours of service in Covered Employment. You may also receive credit for service after December 31, 1975 with your Employer in a non-covered job. However, service in a non-covered job is credited only if it immediately precedes or follows service with the same employer in a covered job.

What about Military Service?

You may receive Credited Service for your period of service with the Armed Forces of the United States of America if you leave Covered Employment to enter the Armed Forces. In general, in order to qualify for such Credited Service, your total period of military service must not exceed five years and you must return to your place of employment within 90 days after leaving military service. If, however, you die while in such military service, you will be deemed to have been reemployed on the day before your death for purposes of vesting for the period of your military service.

For more information regarding your rights under USERRA and HEART (the federal law governing reemployment rights after leaving military service), please contact the Fund Office or your local office of the U.S. Department of Labor, Veterans' Employment and Training Service.

Can I Lose My Service Credit?

Yes. If you have a permanent break-in-service before you become vested under the 639 Pension Fund, you will lose all Credited Service and Vesting Service earned prior to the break.

Any calendar year in which you earn less than 350 hours of service is a one year break-in-service. You may be able to avoid a one year break-in-service if you have qualified military service, eligible service with another Teamster pension plan or if you are absent from work due to pregnancy, the birth of your child, or the adoption of a child.

The rules for a permanent break-in-service have changed over the years as follows:

1. For the period prior to January 1, 1984, you have a permanent break-in-service if you have consecutive one year breaks-in-service equal to or greater than the number of years of Vesting Service you earned before the permanent break. For example, if you earned four years of Vesting Service and are then inactive for four or more years, you would have a permanent break-in-service and lose all of your prior service credit.

2. For the period from January 1, 1984, through December 31, 1998, you have a permanent break-in-service if you have consecutive one year breaks-in-service equal to the greater of five years or the number of years of Vesting Service you earned before the permanent break.

3. For the period on and after January 1, 1999, you have a permanent break-in-service if you have five or more consecutive one year breaks-in-service.

However, **once you become vested, your service credit cannot be taken away from you**.

WHEN RETIREE ELIGIBILITY ENDS

You are no longer eligible for benefits on the earliest of the following dates:

- The first day of the month during which your required monthly contributions are not received;
- The date your pension benefits are suspended under the 639 Pension Fund;
- The date you elect to cancel coverage;
- The date Retiree Medical Plan benefits are discontinued;
- If you were receiving disability benefits under the 639 Pension Fund, the date you are no longer totally and permanently disabled; or
- If you are a Medicare-Eligible Participant, the date you fail to enroll in Medicare Part A and Part B coverage and pay the applicable Medicare premium.
- The first day of the month during which your Spouse obtains adequate alternate coverage (see page 11 -- 13).

If you are receiving disability benefits and you have a suspension of benefits under the 639 Pension Fund because you have returned to employment with a Contributing Employer, your Retiree Medical Plan coverage will continue for an additional three months after the date your monthly pension benefit is suspended.

SPOUSAL COVERAGE

"Spouse" is defined as the retiree's legal husband or wife at the time the retiree first becomes eligible for Retiree Medical Plan coverage or the time an active employee in the 639 Pension Fund dies while eligible for a normal pension or an early retirement pension under the 639 Pension Fund.

1. Spouses Of Retirees Who Meet The Initial Eligibility Requirements

A retiree who meets the requirements for Initial Eligibility for Retiree Medical Plan benefits on or after January 1, 1998 may elect to cover his/her Spouse. The retiree must enroll the Spouse in the Retiree Medical Plan and agree to make contributions on the Spouse's behalf at the same time as the retiree enrolls in the Retiree Medical Plan.

2. Spouses Of Certain Employees Who Die While In Active Employment

The Spouses of certain employees who die while working in active employment may also be eligible to participate in the Retiree Medical Plan. In order for such a Spouse to be eligible, the employee must have died while actively employed under the 639 Pension Fund and must have, at the time of his/her death:

- Reached age 55, earned at least 10 years of Credited Service during the Contribution Period, was otherwise eligible to retire on a pension from the 639 Pension Fund (other than a deferred vested pension) and did not have a one-year break-in-service immediately prior to the date of death; or
- Earned 25 or more years of Credited Service, at least 10 of which were earned during the Contribution Period, was otherwise eligible to retire on a pension from the 639 Pension Fund (other than a deferred vested pension) and did not have a one-year break-in-service immediately prior to the date of death.

ELECTION REQUIREMENTS FOR SPOUSAL COVERAGE

The Spouse or the retiree on behalf of the Spouse must make the election to enroll in Spousal Coverage under the Retiree Medical Plan benefits before the retiree begins to receive monthly pension benefits from the 639 Pension Fund. The retiree or Spouse must agree in the enrollment documents to contribute to the Plan on a monthly basis on behalf of the Spouse in amounts determined by the Board of Trustees. In the case of the Spouse of a deceased employee who was actively working at the time of death, the Spouse must elect to enroll in Spousal Coverage under the Retiree Medical Plan when the Spouse first satisfies the rules for Spousal Coverage and, if applicable, no later than the first day of the month in which the Spouse begins to receive a survivor's annuity from the 639 Pension Fund.

Subsequent elections will not be permitted unless the retiree/Spouse satisfied all of the rules for Spousal Coverage in effect at the time the retiree retired or the active employee died (other than the election requirement), but the retiree/Spouse chose to defer Retiree Medical Plan benefits due to the availability of health coverage through the Spouse's employer. In such a case, if the Spouse's coverage is subsequently terminated, the retiree/Spouse will be allowed to elect Retiree Medical Plan benefits at that time, provided the retiree/Spouse does so within 45 days of the termination of the Spouse's health coverage and provides proof of such termination. The Spouse's health plan carrier should send a HIPAA certificate of coverage, which will show the period of coverage. If your Spouse does not receive a certificate of coverage, please contact the Fund Office for assistance.

WHEN SPOUSAL COVERAGE STARTS

If a Spouse is properly enrolled at the time the retiree elects coverage under the Retiree Medical Plan, the Spouse's coverage will begin at the same time as the coverage of the retiree.

If the spouse is the Spouse of an employee who dies while in active employment (after satisfying the requirements described above) and is properly enrolled, Plan coverage will begin on the later of the date the Spouse is no longer eligible for benefits under the Teamsters Local 639 – Employers Health Trust, the date of the employee's death or the first day of the month in which the Spouse begins to receive a survivor's annuity from the 639 Pension Fund.

WHEN SPOUSAL COVERAGE ENDS

Spousal Coverage will end on the earliest of the following dates:

- The first day of the month during which the required contributions for the Spouse are not received;
- The first day of the month following the day on which the retiree and Spouse are divorced (the Spouse may be eligible for COBRA coverage, discussed below);
- The first day of the month during which the retiree's Retiree Medical Plan coverage ends, as described above, other than by reason of the retiree's death;
- The date your Spouse elects to cancel coverage;
- The date Retiree Medical Plan benefits are discontinued; or
- The date a Medicare-Eligible Participant fails to enroll in Medicare Part A and Part B coverage and pay the applicable Medicare premium.

ELIGIBILITY OF OTHER DEPENDENTS

The Spouse is the only dependent who is potentially eligible for coverage under this Retiree Medical Plan. Children of retirees, and other relatives of retirees, are not eligible for coverage.

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 Spouse.

You must also update your enrollment information whenever there is a change in the status of your Spouse (for example, a change of address, 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, 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. RETIREE/SPOUSE MONTHLY CONTRIBUTIONS/PREMIUMS

Retirees are required to make a monthly contribution for Retiree Medical Plan coverage. A separate monthly contribution is required if the Spouse is also covered under the Plan. The monthly contribution amount may be adjusted periodically by the Board of Trustees.

The monthly contribution rates if you retired before March 1, 2008 and elected Retiree Medical Plan coverage are as follows:

Non-Medicare Retirees and Spouses	**Monthly Premium**		**But not to exceed a percent of the monthly pension benefit ****
	For Retirees With 20 or More Years of Credited Service	**For Retirees With Less Than 20 Years of Credited Service and for all Spouses***	
Age at Retirement			
55 or younger	$230	$230	10%
56	$198	$230	10%
57	$166	$230	10%
58	$132	$230	10%
59	$100	$230	10%
60+	$ 66	$230	10%
Medicare-Eligible Retirees and Spouses	$ 54	$ 54	10%

* The monthly amount your Spouse will have to pay for coverage may be affected by the spousal surcharge plan described in a separate section below.

** The 10% limit on premiums will be based on the Retiree's monthly pension benefit at the Retiree's retirement date, adjusted for any subsequent increases adopted by the Trustees, payable in the form of a straight life annuity. The 10% limit will also apply separately to the retiree and the Spouse. The 10% limit will not apply to any person receiving a Partial Pension in accordance with the 639 Pension Fund. Finally, the 10% limit will not apply if it has the effect of reducing any retiree or Spouse premium below the amount in effect for January 2008 coverage.

The monthly contribution rates if you retired on or after March 1, 2008 and elected Retiree Medical Plan coverage are as follows:

Non-Medicare Retirees and Spouses			**But not to exceed a percent of the monthly pension benefit ****
	Monthly Retiree Premium	**Monthly Spouse Premium*** **(Based on the age of the pensioner retired)**	
Age at Retirement			
55 or younger	$460	$460	25%
56	$396	$396	24%
57	$332	$332	23%
58	$264	$264	22%
59	$200	$200	21%
60+	$132	$132	20%
Medicare-Eligible Retirees and Spouses	$108	$108	n/a

* The monthly amount your Spouse will have to pay for coverage may be affected by the spousal surcharge plan described in a separate section below.

** The percentage limit on premiums will be based on the Retiree's monthly pension benefit at the Retiree's retirement date, adjusted for any subsequent increases adopted by the Trustees, payable in the form of a straight life annuity. The percentage limit will also apply separately to the retiree and the Spouse. The percentage limit will not apply to any person receiving a Partial Pension in accordance with the 639 Pension Fund.

Contributions will be deducted directly from the retiree's/Spouse's pension check each month unless the retiree/Spouse makes arrangements with the Fund Office for an alternative form of payment. Contributions not deducted from a pension check must be received by the Fund Office 15 days before the first day of the month for that month's coverage. Contributions not received by the due date will result in the termination of coverage.

Spousal Surcharge

Effective March 1, 2008, the Retiree Medical Plan implemented a spousal surcharge, similar to the one in effect under the active member health plan. If your Spouse has "adequate alternate coverage" available through an employer, your Spouse will be required to take that coverage or pay the greater of the applicable monthly Spouse premium identified above or the monthly spousal "surcharge" of $388 in order to receive coverage from the Retiree Medical Plan. The monthly spousal surcharge amount of $388 (in 2012) 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 still must pay the monthly Spouse premium identified above in order to receive coverage from the Retiree Medical Plan.

"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 W-2 forms and your spouse's W-2 forms.

- 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 the greater of the monthly Spouse premium or the monthly spousal surcharge to receive spousal coverage under the Retiree Medical Plan.

- If you decide to pay the greater of the monthly Spouse premium or the monthly spousal surcharge in order to receive spousal coverage under the Retiree Medical 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 Retiree Medical Plan for a period of 12 months.

- You will not be required to start paying the greater of the monthly Spouse premium or the monthly spousal surcharge until your Spouse has a right to enroll in her/his employer's plan, but you will still have to pay the applicable monthly Spouse premium. (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 greater of the monthly Spouse premium or the monthly spousal surcharge, your Spouse will lose spousal coverage under the Retiree Medical Plan and you will not be allowed to re-enroll your Spouse in the Retiree Medical Plan for a period of 12 months.

- Retirees and Spouses who were receiving retiree medical benefits under this Plan on or before March 1, 2008 and who elected to opt out of the Retiree Medical Plan by March 14, 2008 in favor of the Spouse's employer-sponsored coverage will be allowed to opt back into the Plan when the Spouse's employer-sponsored coverage ends, provided they do so by making application to the Plan within 45 days of the termination of the Spouse's employer-sponsored coverage and provide proof of termination.

- 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 Retiree Medical 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 639 Pension 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, 5 years in prison, or both.

Changes in Spousal Surcharge Amount:

The monthly spousal surcharge amount of $388 (in 2012) 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.

Spouse Coverage Re-Election

Retirees whose Spouses are receiving Retiree Medical Plan coverage (and Spouses of deceased retirees who are receiving Plan coverage) must complete and sign the Spouse Coverage Re-Election Form annually prior to the beginning of each Plan Year. This Form may be obtained from the Fund Office and will be mailed to you annually.

For Spouses currently covered by the Retiree Medical Plan, failure to return a completed and signed Spouse Coverage Re-Election Form by the requested due date will cause the Spouse's coverage to be terminated.

3. COBRA CONTINUATION COVERAGE - DIVORCED SPOUSES

BASIC COBRA PROVISIONS

Under a federal law referred to as COBRA, if your Spouse looses eligibility as a result of a "qualifying event", your Spouse may be able to purchase temporary extension coverage at group rates. This is "COBRA continuation coverage." For purposes of the Retiree Medical Plan, the only applicable qualifying event is divorce, which would result in a loss of coverage for your Spouse.

WHAT BENEFITS ARE COVERED?

With COBRA continuation coverage your Spouse will generally be eligible for the same medical benefits provided under the Plan and in effect on the day before the qualifying event occurred. Your Spouse may elect to continue only Medical and Prescription benefits or Dental and/or Vision Care Benefits.

WHEN IS COBRA COVERAGE AVAILABLE?

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

YOU MUST NOTIFY THE FUND OFFICE ABOUT YOUR DIVORCE

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

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

If your Spouse does not elect COBRA continuation coverage within this time, your Spouse will not be eligible for such coverage.

HOW IS COBRA COVERAGE PROVIDED?

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

HOW LONG DOES COBRA CONTINUATION COVERAGE LAST?

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

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

Coverage for a particular benefit may end earlier if your Spouse is no longer eligible for that benefit.

IF YOU HAVE QUESTIONS ABOUT COBRA

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PAYING FOR COBRA CONTINUATION COVERAGE

You or your Spouse 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 Spouses unless a higher charge is permitted by law.

4. CLASSES OF BENEFITS

The Retiree Medical Plan has two classes of benefits. The first class is for covered retirees and Spouses who are not eligible for Medicare ("Non-Medicare Participants"). The second class is for covered retirees and Spouses who are eligible for Medicare ("Medicare-Eligible Participants").

BENEFITS FOR NON-MEDICARE PARTICIPANTS GENERALLY

The Plan provides Non-Medicare Participants with major medical-type benefits, with the Plan paying up to 80% of the first $10,000 of covered In-Network Usual, Customary and Reasonable Charges ("UCR Charges") per year after applying the Deductible and 100% of the excess covered In-Network UCR Charges over $10,000 per year, with the retiree or Spouse responsible for the balance. There is an out-of-pocket maximum described on page(s) 22 + 23. The Plan also provides Non-Medicare Participants with prescription drug, dental and vision care benefits. The benefits provided to Non-Medicare Participants are described more fully in Section 6 of this Summary Plan Description.

BENEFITS FOR MEDICARE-ELIGIBLE PARTICIPANTS GENERALLY

The Plan provides Medicare-Eligible Participants with Medicare Supplemental Coverage, which covers the medical services that Medicare deems to be "covered services," but for which Medicare does not pay because of applicable Medicare Deductibles and Co-Payments. Essentially, the Plan's Medicare Supplemental Coverage is designed to fill in Medicare's gaps. The Plan also provides Medicare-Eligible Participants with some preventative care benefits (physical exams, Pap tests and mammograms), but does not offer Medicare-Eligible Participants prescription drug, dental or vision benefits. The benefits provided to Medicare-Eligible Participants are described more fully in Section 7 of this Summary Plan Description.

Medicare-Eligible Participants are required to enroll in Medicare Parts A and B and pay the applicable Medicare premium to Medicare, in order to receive benefits from this Plan.

5. HOW YOUR MEDICAL BENEFITS WORK

THE CIGNA OPEN ACCESS PLUS NETWORK

The Board of Trustees has contracted with CIGNA HealthCare to make its Open Access Plus network ("OAP") available to Non-Medicare Participants through the CIGNA Health Care Open Access Plus ("CIGNA OAP"). The OAP is a group of selected physicians, specialists, Hospitals and other Treatment centers that have agreed to provide their services to Retiree Medical Plan Participants at a discount. The OAP can be used for regular or emergency medical services. Certain benefits are provided through a CIGNA subsidiary called CareAllies. Please note the following important information:

- In Network Benefits: If you live in the CIGNA OAP network area, you must use Hospitals, physicians, and other medical providers that participate in the CIGNA OAP in order to receive the In-Network benefit levels. Currently the CIGNA OAP 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 http://cigna.benefitnation.net/sarOAP/

- Out-of-Network Benefits: If you live in the CIGNA OAP network area but use a physician, Hospital or other medical provider that is not in the CIGNA OAP 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 OAP because **you will save money**. You pay a percentage of billed charges under the Plan. With the CIGNA OAP, you will be paying a smaller percentage of a smaller amount.

We also suggest that you and your Spouse choose a Cigna OAP Doctor to serve as your primary care physician. Your relationship with your personal physician is a key to maintaining good health as he/she is familiar with your health history and can better coordinate your care. However, you are not required to choose a primary care physician. To choose one, go to www.sharedadministration.com.

When you first become eligible for benefits under the Plan you will be given a CIGNA OAP I.D. Card. The Fund Office can provide a directory that lists all of the Doctors and Hospitals participating in the OAP. 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 an OAP 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 OAP 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 OAP.

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

MEDICAL CARE MANAGEMENT ENHANCEMENTS – NON-MEDICARE PARTICIPANTS

The following additional Participant enhancements are available through the CIGNA HealthCare program, via a CIGNA subsidiary called Care Allies. These programs are intended to improve your health, make the benefits program more convenient and easier to use, help you access the right level of care and help the Plan control future claims expenses.

WELLNESS BENEFITS

The Plan provides several additional benefits to encourage you and your Spouse 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.

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 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 now 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 or Spouse 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 Spouse.

MyCareAllies.com -- There are several other unique services available to you 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).

PRE-CERTIFICATION REQUIREMENT FOR HOSPITAL ADMISSIONS – NON-MEDICARE PARTICIPANTS

For Non-Medicare Participants, hospital admissions must be pre-certified by the CIGNA HealthCare OAP. Prior to any scheduled Hospital admission, you, your physician or this Hospital must contact CIGNA HealthCare through CareAllies for pre-certification at 800-768-4695. In an emergency or life threatening situation, you or a family member must notify CIGNA HealthCare within 24 hours of admission. This requirement applies whether or not your physician participates in the CIGNA HealthCare OAP. If you incur Hospital expenses that are not certified by CIGNA HealthCare OAP, the Plan will pay only 80% of the amount which would otherwise be paid by the Plan.

CASE MANAGEMENT – NON-MEDICARE PARTICIPANTS

The CIGNA OAP 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.

PRE-CERTIFICATION FOR SURGICAL PROCEDURES – NON-MEDICARE PARTICIPANTS

All non-emergency ambulatory and outpatient surgical procedures must be pre-certified by CIGNA HealthCare OAP. Prior to any scheduled ambulatory surgery, you or your physician must call CIGNA HealthCare for pre-certification at 800-768-4695. This phone number also appears on your CIGNA HealthCare I.D. card. This requirement applies whether or not your physician participates in the CIGNA HealthCare OAP. If you incur surgical expenses that are not certified by CIGNA HealthCare OAP, the Plan will pay only 80% of the amount which would otherwise be paid by the Plan.

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 HealthCare OAP 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.

SPECIAL RULES RELATED TO PREGNANCY AND CHILDBIRTH

Group health plans (like this Retiree Medical 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 HealthCare OAP) for a length of stay not in excess of 48 hours (or 96 hours as applicable). The Retiree Medical Plan does not provide coverage for newborn children.

SPECIAL RULES RELATED TO MASTECTOMY COVERAGE

As required by the Women's Health and Cancer Rights Act of 1998, 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 lymph edemas.

Coverage for these medical services is subject to applicable deductions and co-insurance amounts under the Plan.

6. MEDICAL BENEFITS – NON-MEDICARE PARTICIPANTS

This section of the Summary Plan Description applies to covered retirees and Spouses who are not eligible for Medicare ("Non-Medicare Participants").

SCHEDULE OF BENEFITS
("NON-MEDICARE PARTICIPANTS")

	In-Network *	**Out-of-Network ****
Annual Deductible per person ***#	$350	$700
Emergency Room Visits	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)
Covered Amount per person:		
First $10,000 of charges over the Deductible	80% of In-Network charges	60% of UCR Charges
Excess over $10,000 of charges over the Deductible	100% of In-Network charges	100% of UCR Charges
Maximum Annual Out-of-Pocket Payment # (for Covered Expenses, per calendar year, after the Deductible has been satisfied)	$2,000 plus $350 Deductible	$4,000 plus $700 Deductible

* In-Network Benefits: You must use Hospitals, physicians and other medical benefit providers that participate in the CIGNA HealthCare OAP in order to receive the In-Network benefit levels. You can request a provider directory from the Fund Office or you can access the most up-to-date version on-line at www.cignahealthcare.com.

** Out-of-Network Benefits: If you use a physician or Hospital that is not in the CIGNA HealthCare OAP network, your benefits will be covered at the Out-of-Network benefit levels.

*** The requirement to meet the annual Deductible will not apply to routine physical exams, including PAP tests, mammograms and proctology screenings.

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

DEDUCTIBLE

Each Non-Medicare Participant must pay the first $350 for In-Network Covered Medical Expenses or the first $700 for Out-of-Network Covered Medical Expenses that the Participant incurs each year. 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. However, if you have Covered Medical Expenses during the last three months of a calendar year, which are applied to that year's Deductible, and the Deductible is not yet met, you may carry over these charges and apply them toward the Deductible for the following year.

MEDICAL COVERED AMOUNT

The Plan will pay 80% of the first $10,000 of the UCR Charges for In-Network Covered Expenses or 60% of the first $10,000 of the UCR Charges for Out-of-Network Covered Expenses The Plan will also pay 100% of the UCR Charges for In-Network Covered Expenses over $10,000 or 100% of the UCR Charges for Out-of-Network Covered Expenses over $10,000. You are responsible for any Out-of-Network expenses above UCR.

There is a lifetime maximum per person of $1,000,000. However, after you have exhausted the lifetime maximum benefit, $1,000 of available benefits will be added back into this lifetime maximum each January 1.

COVERED MEDICAL EXPENSES

Covered Expenses include the medical services described on the following pages. The Plan will pay only the UCR Charges for Medically Necessary services provided on the recommendation and approval of your 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 Charges.

HOSPITAL ROOM AND BOARD -- The Retiree Medical Plan will pay charges for a semi-private room, or intensive care unit if needed. Hospital admissions must be pre-certified by the CIGNA HealthCare OAP. Prior to any scheduled Hospital admission, you or your physician must call CIGNA HealthCare for pre-certification at 800-768-4695. In an emergency or life-threatening situation, you or a family member must notify CIGNA HealthCare within 24 hours of admission. This requirement applies whether or not your physician participates in the CIGNA HealthCare OAP. If you incur Hospital expenses which are not certified by CIGNA HealthCare OAP, the Plan will pay only 80% of the amount which would otherwise be paid by the Plan.

Treatment in an approved Hospice Program, which is approved by CIGNA HealthCare OAP in lieu of hospitalization, is a Covered Expense.

HOSPITAL SERVICES AND SUPPLIES -- Charges 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 for charges 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 except as specifically allowed as Mental Health benefits (Section 11 of this booklet).

INPATIENT DOCTOR VISITS - If you or your covered Spouse are in the Hospital and receive a Medically Necessary visit from your Doctor, the Plan will pay the UCR Charges 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 f*ee for the surgery.

X-RAY AND LABORATORY EXPENSES -- The Plan will pay UCR Charges 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 – Outpatient Surgical Expenses are Hospital type charges 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).

TRANSPORATION by ambulance, regularly scheduled airlines or railroad from the city in which the Participant or Spouse 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 8;
- 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 for the purchase and fitting of a hearing aid. The Retiree Medical Plan will pay the UCR Charges up to a maximum of $1,000 for each ear. There is no Deductible. The Plan will pay this benefit only once every 36 months.

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 certified by CIGNA HealthCare OAP, the Plan will pay only 80% of the amount which would otherwise be paid by the Plan.

WELLNESS BENEFITS -- The Plan provides several additional benefits, such as routine physical examinations and flu shots, to encourage you and your Spouse to live healthy, take preventive action and test for early discovery of conditions that may need Treatment. The Plan pays 100% of UCR charges for these benefits up to a $200 annual maximum and they are not subject to the Deductible or Co-Insurance. The following wellness benefits are not subject to the $200 maximum:

- **Pap test –** Once every two years for all female Participants age 18 or older;

- **Mammogram** -- Once each year for all female Participants age 50 and older; and once every other year for female Participants between the ages of 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 age 50 or older, and once every other year for male Participants ages 40 to 49.

SERVICES AT A POST HOSPITAL SKILLED NURSING FACILITY are a Covered Expense when such facilities serve as an alternative to hospitalization and are not for custodial or rest care.

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;
- 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;
- Rehabilitative therapy (other than physiotherapy) including but not limited to, speech, occupational, recreational or educational therapy, or forms of non-medical self-care or self-help training and any diagnostic testing provided on a out-patient basis; and
- Any other general limitations listed in Section 12 of this booklet.

7. MEDICAL BENEFITS – MEDICARE-ELIGIBLE PARTICIPANTS

This section of the Summary Plan Description applies to covered retirees and Spouses who are eligible for Medicare ("Medicare-Eligible Participants").

MEDICARE SUPPLEMENTAL COVERAGE

If you are a Medicare-Eligible Participant, you will receive Medicare Supplemental Coverage provided by the Retiree Medical Plan. Except for the benefits described in the "Other Available Medical Benefits" section below, the Medicare Supplemental Coverage covers only services that Medicare considers to be "covered services." Medicare is the primary payor for these services and the Plan covers what Medicare does not pay – usually the Deductibles and Co-Payments – as long as the charges are usual, customary and reasonable. Medicare-Eligible Participants and their Spouses are required to enroll in Medicare Parts A and B and pay the applicable Medicare premium to Medicare, in order to receive benefits from this Plan.

SCHEDULE OF BENEFITS

Deductible		
Per Person		N/A for Medicare "covered services"
Covered Amount		
For medical expenses that Medicare considers to be "covered services"		The difference between the Medicare Approved Amount and the amount that Medicare pays, but not greater than UCR
The maximum Deductible plus out-of-pocket payment for Covered Expenses **per individual**, per calendar year, will be:		N/A
Maximum Medical Benefit Payable		
Per calendar year		N/A
Per person per lifetime		$1,000,000 (cumulative benefits paid per individual Participant, whether Non-Medicare or Medicare-Eligible)

The maximum benefit under this Retiree Medical Plan per lifetime per individual is $1,000,000. This lifetime maximum benefit includes benefits paid while you were a Non-Medicare Participant and while you are a Medicare-Eligible Participant. After you have exhausted the lifetime maximum benefit, $1,000 of available benefits will be added back into this lifetime maximum each January 1.

OTHER AVAILABLE MEDICAL BENEFITS

Medicare-Eligible Participants are also entitled to the following additional medical benefits, subject to a $250 annual per person Deductible and a 20% Co-Payment:

WELLNESS BENEFITS

Routine physical examinations -- once every year up to $200 per Participant. Part of the routine physical for men covers the Prostate Screening Analysis (PSA) once each year for all male Participants age 50 and older, and once every other year for male Participants ages 40 to 49. Benefits are paid at 100% of UCR Charges and are not subject to the Deductible;

Pap tests -- once every 2 years for all female Participants age 18 or older; and

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

EXCLUSIONS

The Retiree Medical Plan does not cover the following services for Medicare-Eligible Participants, regardless of whether the services subsequently become covered by Medicare:

- Prescription drug benefits;
- Dental benefits; and
- Vision care benefits.

The Plan also does not cover expenses that are not Necessary medical expenses approved by Medicare and charges over the amounts determined to be reasonable charges by Medicare.

8. PRESCRIPTION DRUGS – NON-MEDICARE PARTICIPANTS ONLY

If you are a Non-Medicare Participant, you are eligible for Prescription Drug benefits, in accordance with the following Schedule of Benefits:

SCHEDULE OF BENEFITS

Deductible per year per covered individual	**$100**	
Maximum per year per covered individual	**$5,000**	
Type of Drug	**Retail Network**	**Mail Order**
Generic Drugs Co-pay	$5.00	$10.00
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 Co-pay	$20.00	$30.00
Brands not on the Primary Drug (Voluntary Formulary) List Co-pay	$35.00	$50.00
Brand name drug without "Brand Name Letter of Medical Necessity" Co-pay	$5.00 plus the difference in cost between brand name and generic	$10.00 plus the difference in cost between brand name and generic
Supply Limit for Maintenance Drugs	up to 30 days	up to 90 days
Fill Limit for Maintenance Drugs	3 fills only on and after 7/1/2011	None

Once you meet the $100 Deductible, you are responsible for paying a $5 (or $10 for mail order) Co-Payment per prescription. There is a maximum amount or quantity considered as eligible charges for a prescription, described below under Limitations and Exclusions. Once you reach the $5,000 maximum, no additional Prescription Drug benefits will be payable to you for that calendar year.

CAREMARK

The Plan provides Prescription Drug benefits for Non-Medicare Participants through Caremark, a prescription benefit provider under contract with the Retiree Medical Plan.

Once you are covered under the Retiree Medical 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 safely be 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.

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 $10. This saves $5 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 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;
- Viagra and other erectile dysfunction drugs, limited to six (6) pills per month;* and
- 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.

* You may be entitled to exceed this quantity limit if your physician provides a letter of medical necessity to the Fund Office that reflects that a drug is prescribed for the treatment of a medical condition other than erectile dysfunction.

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 general limitations listed in Section 12 of this booklet.

PREAUTHORIZATION OF CERTAIN DRUGS

Caremark requires preauthorization of certain prescription drugs. These drugs will only be covered with prior approval from Caremark. Without such approval, you will pay the full price if you continue to purchase these prescription drugs. The Plan covers similar prescription drugs that do not require preauthorization. Caremark will notify you if you are currently prescribed a drug that will require preauthorization in the future. To switch to a covered drug, your doctor can call Caremark at 800-378-5697 or you can call Caremark toll free at 866-251-9383 and Caremark will contact your doctor for you.

9. DENTAL – NON-MEDICARE PARTICIPANTS ONLY

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 covered individual 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 Non-Medicare Participants. 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, Maryland 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 DHC's 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 Retiree Medical Plan provides the following basic services at no cost provided they are performed by a participating dentist:

Routine oral examination, limited to two visits per person per year (once every six 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 six 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 two 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 8 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 five 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 five 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 five 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 12 of this booklet.

10. VISION CARE – NON-MEDICARE PARTICIPANTS ONLY

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)	$70.00
Contact Lenses (in lieu of examination, lenses and frames, every other year)	$93.00

VISION SERVICE PLAN (VSP)

The Retiree Medical Plan provides Vision Care Benefits for Non-Medicare Participants 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 your unique identification number 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 through 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 frame allowance at private practice providers. If the frames you select cost more than $120, you will receive a 20% discount on the amount that exceeds $120 from in-network 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
- 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 your Social Security Number and the patient's 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. For example, 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 12.

11. MENTAL HEALTH – NON-MEDICARE PARTICIPANTS ONLY

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

This section describes the mental health benefits available to Non-Medicare Participants. Medicare-Eligible Participants may access mental health benefits, but must do so under the Medicare Supplemental Coverage described in Section 7 of this booklet.

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

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 preauthorization 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 applicable general exclusion listed in Section 12 of this booklet and the annual $1,000,000 combined maximum described in Section 6 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. For out-of-network providers, 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 your Social Security Number and the patient's name and date of birth, to:

Teamsters Local 639 — Employers Pension Trust (Retiree Health Fund)
3130 Ames Place, NE
Washington, D.C. 20018-1593

12. GENERAL LIMITATIONS

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 Physical Therapist (LPT), or
- Licensed Certified Midwife (LCMW).

The Retiree Medical 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;
- Charges for confinement or services in a Veterans' Administration or other government Hospital in connection with any service related Injury or Illness;
- 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 the Participant or the Participant's legal Spouse;
- Expenses for custodial care, except as directed by MHN or the Director of CIGNA OAP, 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 Spouse 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

- 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 and lifetime maximums described in the applicable Schedule of Benefits for Mental Health Benefits (see Section 11 of this booklet).

13. RULES OF THE PLAN

CLAIM APPEAL

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:

Claim	Time Limit for Claim Determination	Extension Permitted
Medical, Prescription Drug, Dental, Vision, Mental Health		
Urgent Claims (as medically determined)	72 hours	None
Pre-Service Claims	15 days	15 days
Post-Service Claims	30 days	15 days
Concurrent Claims (claims for ongoing course of Treatment)	Prior to termination of care (if sufficient notice)	None

If 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;
- 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;
- 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
- 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 of the 639 Pension Fund within 180 days from your receipt of 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 of Trustees will determine your appeal within a reasonable period of time, but not later than the following:

Type of Claim	**Time Limit for Appeal Determination**	**Extension Permitted**
Medical, Prescription Drug, Dental, Vision, Mental Health		
Urgent Claims	72 hours	None
Pre-Service Claims	30 days	None
Post-Service Claims	Board meeting (if claim received 30 days prior)	Next Board meeting
Concurrent Claims (claims for ongoing course of Treatment)	Prior to termination of care (if sufficient notice)	None

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

If the denial of a claim for medical, dental or vision 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 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.
- If 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
- 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 Spouse receive from other sources can affect payments from this Plan. The Fund Office will work with you or your Spouse'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.

Because this Plan covers only retirees and their Spouses – not actively working employees and dependents – and because this Plan is subject to rules under Section 401(h) of the Internal Revenue Code that limit the Trustees' ability to provide funding for the benefit plan, the Trustees have determined that this Plan is secondary to all other plans. Therefore, if you or your Spouse has coverage under another plan, the other plan will always be the primary plan.

You have the responsibility to fully inform the Plan of any and all health insurance coverage available to you and your Spouse. 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 Spouse'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 Spouse 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 you or your Spouse's medical 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 Spouse 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 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 Spouses.

At their core, the repayment rules require that, if you or your Spouse 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 Spouse must repay the Plan for the benefits it paid out on your or your Spouse'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 Spouse 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 Spouse's behalf, unless the Board of Trustees agrees in writing to a reduced amount.

Under the repayment rules, you or your Spouse 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 Spouse have a potential recovery, claim or legal action against another person related to an Injury or Illness that the Plan covers, you and your Spouse 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 Spouse (and your attorney if you have one) before the Plan will make payments on your or your Spouse's behalf. If you, your Spouse or your attorney fails to sign the form, the Plan may withhold paying any claims relating to you or your Spouse's Injury or Illness caused by the other person or party, as well as any and all future claims. Even if you or your Spouse 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 Spouse are consenting to the repayment rules.

If you or your Spouse 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 Spouse 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 Spouse 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 Spouse may not assign to any other party, including your attorney, any rights or causes of action that you or your Spouse 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 Spouse 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 Spouse 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 Spouse's behalf by the Plan. You and your Spouse 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 Spouse 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.

Either your or your Spouse'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 Spouse'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 Spouse 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 Spouse'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 Spouse.

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.

OVERPAYMENT AND MISTAKEN PAYMENT POLICY

If the Retiree Medical Plan makes an overpayment or mistaken payment directly to a Participant, Spouse 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/her Spouse 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/her Spouse 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.

STATEMENT ON HEALTHCARE DECISIONS

The Retiree Medical Plan's health care benefits provide solely for the payment of certain health care expenses. All decisions regarding health care will be solely the responsibility of each covered individual in consultation with the personal health care provider selected by the individual. The Retiree Medical Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed and whether particular Treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of health care reimbursement, or the coverage of a particular health care expense, may be disputed by the covered individual in accordance with the claims procedure. Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and the Plan will not have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the Plan for the payment of benefits.

14. 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.

TEAMSTERS LOCAL 639 – PENSION 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 health 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 PLAN'S PRIVACY POLICIES

THE PLAN'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 Pension Trust, 401(h) Retiree Medical Plan
3130 Ames Place, NE
Washington, D.C. 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 6 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 6 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 PLAN'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 60 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 Pension Trust, 401(h) Retiree Medical Plan
3130 Ames Place, NE
Washington, D.C. 20018-1593
800-983-2699
202-636-8181

15. FREQUENTLY ASKED QUESTIONS

This booklet is a Summary Plan Description. It is designed to provide you with summary information about the Retiree Medical Plan. The rules of the Retiree Medical Plan are also described in Part II of the 639 Pension Fund document.

Important — only the full Board of Trustees is authorized to interpret the rules, regulations and Plan as described in this Summary Plan Description. No Employer or Union representative is authorized to interpret this document or the 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 Retiree Medical 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, 7 days per week at 202-526-7959. The Fund Office is located at 3130 Ames Place, NE, Washington, DC 20018-1513.

For details on who is eligible, refer to the Eligibility rules in Section 1 of this booklet.

Question 2: I'm a retiree. What should I do if I get a divorce or my Spouse dies?

If your Spouse is covered by the Plan and 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 a copy of 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 3 of this booklet for more information.

Question 3: What benefits do Participants who are eligible for Medicare receive?

Participants who are Medicare-eligible receive Medicare Supplemental Coverage, as described in Section 7. Dental, Vision Care and Prescription drug benefits are provided only to Non-Medicare Participants.

Question 4: Who provides the benefits?

Benefits are paid directly or indirectly from the 639 Pension 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 639 Pension Fund.

Question 5: What is OAP?

OAP stands for Open Access Plus and is a preferred provider network offered by CIGNA for Non-Medicare Participants only. CIGNA enters into agreements with physicians, Hospitals and other health care providers for reduced fees only. Under the CIGNA OAP agreement, you and your Spouse 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 OAP 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 Fund and typically lower out-of-pocket expense for you.

Question 6: If I need medical care, do I have to go to a CIGNA HealthCare Doctor or Hospital?

No. But, as a Non-Medicare Participant in this Retiree Medical Plan, you and your Spouse are encouraged to fully utilize the CIGNA OAP 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 6 of this booklet). If you live outside of the network area, your claims will be covered at the In-Network benefit level.

Question 7: What are the advantages of Non-Medicare Participants using the CIGNA OAP Network?

There are two advantages:

1. CIGNA's role is to re-price your claim. The result is typically lower total cost.

2. If you use the CIGNA OAP 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 OAP Network claim. All providers within the CIGNA OAP Network will send your claims directly to CIGNA.

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

Question 8: How do I find out if my Doctor is a CIGNA OAP Network provider?

Non-Medicare Participants may call CIGNA 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 http://cigna.benefitnation.net/sarOAP/.

Question 9: How do I get a prescription filled?

Only Non-Medicare Participants are eligible for Prescription Drug benefits. When Non-Medicare Participants 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 Spouse are not eligible, contact the Fund Office.

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.

Question 10: 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. 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 $10. This saves $5 every 90 days.

Question 11: 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 12: 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 13: Does the Plan provide mental health benefits?

Non-Medicare Participants access mental health benefits through MHN, which administers the Plan's Mental and Nervous Conditions benefits through a network of providers. Non-Medicare Participants must obtain preauthorization 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. Medicare-Eligible Participants access mental health benefits through the Medicare Supplemental Coverage described in Section 7 of this booklet.

Question 14: I'm a Non-Medicare Participant. Can I go outside MHN?

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 11 of this booklet for more information regarding these benefits.

Question 15: Does the Plan have a vision care program?

Yes, but only Non-Medicare Participants are eligible for Vision Care Benefits. Benefits are provided through VSP, a Preferred Provider Organization (PPO) specializing in vision care at negotiated rates. Refer to Vision Care in Section 10 of this booklet for information about the specific benefits provided.

Question 16: How do I get dental benefits?

Only Non-Medicare Participants are eligible for dental benefits. The Fund Office can provide a listing of nearly 1,000 participating dentists.

Question 17: Are there alternatives to this Plan?

The International Brotherhood of Teamsters also sponsors several medical and prescription drug plans for retirees and their Spouses. The plans are currently known as TeamStar Plans. If a retiree chooses to enroll in a TeamStar plan rather than this 401(h) Plan, the 639 Pension Fund will allow the retiree to authorize voluntary deductions from the retiree's monthly pension check to pay the applicable TeamStar plan premiums. The 639 Pension Fund will only serve as a conduit for transmitting the monthly pension deductions when so authorized by the retiree and will have no responsibility for the provision of any TeamStar plan benefits. A retiree and/or Spouse who choose(s) to join a TeamStar plan will be subject to the rules and requirements for the TeamStar plan and will be responsible for 100% of the premium amount established by the TeamStar plan. You can obtain more information about the TeamStar plans by calling 800-808-3239 or by visiting the TeamStar website at www.teamstar.com.

16. ERISA INFORMATION

STATEMENT OF YOUR RIGHTS UNDER ERISA

As a Participant in the Retiree Medical Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

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 Employee Benefits Security 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 your Spouse if there is a loss of coverage under the Plan as a result of a qualifying event. Your Spouse may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing 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 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. If it should happen that the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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 Retiree Medical Plan is a part of the "Teamsters Local 639 – Employers Pension Trust." The name of the Plan is the "401(h) Retiree Medical Plan of the Teamsters Local 639 – Employers Pension Trust", which is an employee pension benefit plan under ERISA. The rules of the Retiree Medical Plan are published in Part II of the 639 Pension Fund document and are summarized in this booklet. The Retiree Medical Plan provides hospitalization, surgical and medical, dental, vision care, mental health and prescription drug, benefits to certain eligible Participants and their Spouses on a self-insured basis.

2. Plan Identification Numbers

- Employer Identification Number: 53-0237142
- IRS Plan Number: 001

3. Plan Administrator

The Plan Administrator is the Board of Trustees of the Teamsters Local 639 – Employers Pension Trust, 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

Eric R. Weiss
Raymond Howard
Frank W. Stegman

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 Retiree Medical Plan is administered by the Board of Trustees. However, the Trustees have engaged Zenith American Solutions on a contract basis to serve as Administrative Manager to oversee the operation and administration of the Retiree Medical Plan on a day-to-day basis. Benefits are provided under the Retiree Medical 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;
- 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; and
- 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 Employees Earning Credit For Participation in the Plan

The 639 Pension Fund of which this Retiree Medical Plan is a part 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 Teamsters Local 922. 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 639 Pension Fund for the Benefit of the Retiree Medical Plan

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 Fund 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 Retiree Medical Plan Account Within the 639 Pension Fund

Contributions to 639 Pension Fund are made by individual employers under the provisions of collective bargaining agreements and are directed to the Retiree Medical Plan account as determined by the Trustees. Covered retirees and Spouses are required to contribute to the Retiree Medical Plan account on a monthly basis to provide financial support for the Plan.

9. Fiscal Year of Pension Trust Fund.

The annual fiscal year of the Retiree Medical Plan ends December 31.

10. Modification of Benefit Schedules, or Termination of Benefits, or Termination of the Retiree Medical Plan, or 639 Pension Fund

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 Retiree Medical 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 Retiree Medical Plan, this Summary Plan Description and the rules or regulations. Benefits under the Retiree Medical Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

17. APPENDIX

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 Spouse 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 mean payments made by a Contributing Employer to the Fund.

Contributing Employer means any person, firm, association, partnership or corporation entering into a Collective Bargaining Agreement or participation agreement that requires Contributions to the Fund 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 Fund to its retired employees.

Covered Employment means work done for an employer who is required to contribute to the Plan on your behalf under a collective bargaining agreement.

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 and his/her Spouse before medical benefits are payable under this Plan.

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. 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 Spouse nor from any employment for wage or profit, and which causes loss commencing while the benefits of the Participant or Spouse 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 the 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 meets the eligibility requirements for participation and is enrolled in the Retiree Medical 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 their Spouses as adopted from time to time by the Board of Trustees.

Spouse means the retired employee's legal spouse at the time the retired employee first becomes covered under the Plan or dies while eligible for a normal pension or an early retirement pension under the 639 Pension Fund.

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 Pension 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 Spouses 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).

18. 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
- benefit class information
- enrollment cards
- identification cards
- claim forms
- 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 are a Non-Medicare Participant and need information about prescription drugs, contact:

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

If you need information about the mail order program for maintenance prescription drugs, contact:

Caremark
P.O. Box 94467
Palatine, IL 60094-4467
800-875-0867 (Caremark FastStart for Participants)
800-378-5697 (Caremark FastStart for Doctors)
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, and
- 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 are a Non-Medicare Participant and need information about vision care, contact:

VSP
www.VSP.com
800-877-7195

If you are a Non-Medicare Participant and 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 the Retiree Medical Plan under the Teamsters Local 639 – Employers Pension Fund. The Dental Health Center is closed on Sunday and Monday.

If you are a Non-Medicare Participant and need care and Treatment of a mental health disorder, contact:

Mental Health Network ("MHN")
www.mhn.com
800-888-4024

When you contact MHN please tell them that you are covered by the Retiree Medical Plan under the Teamsters Local 639 – Employers Pension 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.

Teamsters Local 639—Employers Pension Trust Fund
401(h) Retiree Medical Plan
3130 Ames Place, NE • Washington, DC 20018
800-983-2699 • 202-636-8181