TEAMSTERS UNION NO. 142
HEALTH AND WELFARE TRUST FUND

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INTRODUCTION

The Board of Trustees of the Teamsters Union No. 142 Health and Welfare Trust Fund is proud to provide you with medical and prescription drug benefits when you Retire. This 2008 Edition of your Summary Plan Description (SPD) describes the benefits available to you as a retiree through the Fund as of June 1, 2008.

About this Booklet
In this booklet, benefits are described as completely as possible and in everyday language. In addition, the booklet is organized in a way that will be useful to you. This booklet includes:

- A summary of the medical and prescription drug benefits provided by the Plan;
- A listing of important contact information;
- Information about when you and your Dependents can participate in the Plan;
- A life events section designed to show you how your benefits work and how they fit into the different stages of your life;
- An explanation of your coverage under each benefit program;
- Information about how to file claims and appeals;
- General administrative information; and
- A glossary of important definitions.

Your Responsibility
It is important to remember that the Plan is not designed to cover every health care expense. The Plan pays charges for eligible expenses, up to the limits and under the conditions established by the Plan’s rules. The decisions about how and when you receive medical care are up to you and your Physician—not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

More Information
This booklet is designed to help you understand the benefits available to you. Please read this booklet and share it with your family. You should keep this booklet with your important papers so you can refer to it when needed.

If you have any questions about the information contained in your SPD or about your benefits in general, contact the Fund Office by:

- Calling 219-949-1550, 773-721-8800, or 1-800-348-7027; or
- Writing to or visiting their office at 1300 Clark Road, Gary, IN 46404.

This booklet has been prepared for Retired Participants of the Teamsters Union No. 142 Health and Welfare Trust Fund and describes the benefits in effect as of June 1, 2008. This Edition replaces and supersedes any previous Summary Plan Description. Full details are contained in the legal Plan Document. If there is a discrepancy between this booklet and the legal Plan Document, the legal Plan Document will govern. The Trustees reserve the right and have the authority to amend, modify, eliminate benefits, or terminate the Plan at any time. In addition, the Trustees, or such other persons as delegated by the Trustees, have the discretion to interpret and construe the rules of the Plan.
## SUMMARY OF BENEFITS

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>No lifetime maximum</td>
</tr>
<tr>
<td><strong>Annual Deductibles</strong></td>
<td></td>
</tr>
<tr>
<td>• Medical Benefits</td>
<td>$200 per person</td>
</tr>
<tr>
<td>• Prescription Drug Benefits</td>
<td>$100 per person</td>
</tr>
<tr>
<td><strong>Network Physician Office Visit</strong></td>
<td>$10 copayment per visit</td>
</tr>
<tr>
<td><strong>Medical Coinsurance</strong></td>
<td>After the medical deductible, the Plan pays:</td>
</tr>
<tr>
<td>• Network Providers</td>
<td>80%</td>
</tr>
<tr>
<td>• Non-Network Providers</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Prescription Drug Coinsurance</strong></td>
<td>After the prescription drug deductible, the Plan pays 80%</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$5,000 per person (includes deductibles)</td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>$100,000 per person (includes medical and prescription drug benefits)</td>
</tr>
<tr>
<td><strong>Chiropractic Treatment</strong></td>
<td></td>
</tr>
<tr>
<td>• Maximum benefit payable per visit</td>
<td>$25</td>
</tr>
<tr>
<td>• Maximum covered treatments per year</td>
<td>20</td>
</tr>
<tr>
<td>• Annual benefit maximum</td>
<td>$500 per person (network and non-network combined)</td>
</tr>
<tr>
<td><strong>Mental Health Treatment</strong></td>
<td>After medical deductible, Plan pays:</td>
</tr>
<tr>
<td>• Inpatient</td>
<td>80%, up to 30 days per year</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>80%, up to $50 per visit</td>
</tr>
</tbody>
</table>

1 This copayment does not apply to your annual deductible or out-of-pocket maximum. In addition, you are responsible for paying this copayment once you have met your out-of-pocket maximum.

2 Benefits are paid at the network level if the covered individual requires Emergency treatment and/or lives outside the network service area (for example, if you live at least 25 miles from the nearest network provider).

3 If you receive a brand name medication when a generic is available, in addition to your coinsurance amount, you will be responsible for paying the difference in cost between the generic and brand name medication, unless your Physician specifies “dispense as written” (DAW).
The chart that follows shows the contact information for the various organizations that provide services under the Teamsters Union No. 142 Health and Welfare Trust Fund.

<table>
<thead>
<tr>
<th>If You Have a Question or Need Information About</th>
<th>Contact</th>
<th>Phone Number(s)</th>
<th>Web Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical PPO Network Providers</td>
<td>First Health Network</td>
<td>1-800-226-5116</td>
<td><a href="http://www.firsthealth.com">www.firsthealth.com</a></td>
</tr>
<tr>
<td>Medical Claims (all medical claims)</td>
<td>Stewart C. Miller &amp; Co., Inc. Merrillville Claims Office 2111 West Lincoln Highway Merrillville, IN 46410</td>
<td>1-800-759-6944 219-769-6944 Fax: 219-769-4834</td>
<td><a href="http://www.scmiller.com">www.scmiller.com</a></td>
</tr>
<tr>
<td>Prescription Drug Providers, Mail Order Program, and Reimbursement Requests</td>
<td>Sav-Rx 224 North Park Avenue Fremont, NE 68025</td>
<td>1-800-228-2181</td>
<td><a href="http://www.savrx.com">www.savrx.com</a></td>
</tr>
</tbody>
</table>
**BECOMING A PARTICIPANT**

**Initial Eligibility**

You become eligible for coverage if you:

- Are not eligible for Medicare or covered under another employer sponsored group health plan, as an active employee or Retired employee;
- Are at least:
  - 57 years old; or
  - 50 years old and receiving a Service Pension (earned 30 Eligibility Credits) under the Teamsters Union No. 142 Pension Plan;
- Are receiving a:
  - Regular, Early Regular, or Service Pension from the Teamsters Union No. 142 Pension Fund; or
  - Pension benefit from the State of Indiana Retirement System, provided you worked 15 or more years under a collective bargaining agreement between Teamsters Local No. 142 and a governmental unit participating in the State of Indiana Retirement System;
- Before your Retirement you had contributions made on your behalf for a minimum of:
  - Four weeks after July 1, 1997, and you Retire between July 1, 1997 and June 30, 2000;
  - 35 weeks in the calendar year immediately before you Retire and you Retire between July 1, 2000 and June 30, 2001;
  - 35 weeks in each of the two calendar years immediately before you Retire if you Retire between July 1, 2001 and June 30, 2002;
  - 35 weeks in each of the three calendar years immediately before you Retire and you Retire between July 1, 2002 and June 30, 2003; or
  - 35 weeks in each of the five years immediately before you Retire or in seven of the last ten years immediately before you Retire and you Retire on or after July 1, 2003;
- Have properly applied for coverage under the Plan with the Trustees; and
- Make the required monthly self-payments.

**Dependent Eligibility**

Your Dependent(s) becomes eligible for medical benefits on the date that you become eligible. You may apply for coverage for your Dependents at the time you apply for coverage.

If you later acquire a Dependent (i.e., through marriage or birth), you may apply for coverage for your new Dependent. You must notify the Fund Office of any new Dependents within 30 days of the date you acquire that Dependent for your Dependent to be eligible for coverage.

In general, your Dependents include your legal spouse and your unmarried Dependent Children. See page 42 for a definition of Dependents eligible for coverage under the Plan.
If your Dependent is covered under another plan when you become eligible for this Plan, and your Dependent loses the other plan coverage, then your Dependent may elect coverage under this Plan, provided coverage is elected within 30 days of when the other coverage ends. If coverage is elected within 30 days, coverage under this Plan will begin on the first day of the month after coverage is elected.

There is an additional monthly charge for each covered Dependent.

In the event of your death or if you become eligible for Medicare before retiring, your eligible spouse may apply for coverage, provided you otherwise satisfy all of the requirements for Plan coverage. Under either of these circumstances, your spouse’s coverage may continue for a three-year period beginning with your Retirement Date or, if later, the date of your death. Your spouse will be responsible for making monthly self-payments for this coverage. The self-payment amount will be the same as the cost of COBRA Continuation Coverage.

**Continued Eligibility**

Once you meet the initial eligibility requirements, you will continue to be eligible for benefits on a month-by-month basis, provided you continue to make timely monthly self-payments and continue to meet all other eligibility requirements.

Self-payments are due no later than the first business day of the month for which coverage is to be provided. You may elect to have your monthly self-payments deducted automatically from your pension check. If the Fund Office does not receive your payment by the due date, your coverage, and that of your Dependents, will end.

Self-payments are not refundable. However, if the Trustees determine you or your Dependent was not eligible for coverage and therefore was not covered under the Plan during the period in question, the Trustees may approve a refund of a self-payment.

**When Eligibility Ends**

When your coverage or your Dependent’s coverage ends, you will be provided with certification of the length of coverage under the Plan (Certificate of Creditable Coverage). This may help reduce or eliminate any preexisting condition limitation under a new group medical plan. The certificate will be sent by first class mail within 45 days after your or your Dependent’s coverage under this Plan ends. If COBRA Continuation Coverage is elected, another certificate will be provided within 60 days after the COBRA Continuation Coverage ends. In addition, a certificate will be provided within 45 days after receipt of a request for the certificate if the request is received by the Plan within two years after the later of the date coverage under this Plan ended or the date COBRA Continuation Coverage ended.
For You

Your eligibility for coverage under the Plan will end as of the date any one of the following events occurs:

- You become eligible for Medicare, whether you enroll for Medicare or not;
- A monthly self-payment is due and not received;
- You become covered under another employer-sponsored health plan as an employee or retired employee;
- The Plan ends; or
- Your death.

For Your Dependent

Your Dependent’s eligibility for coverage will end as of the first day of the month in which any one of the following events occurs:

- Your Dependent becomes eligible for Medicare, whether your Dependent enrolls or not;
- Your Dependent no longer meets the Plan’s definition of Dependent;
- A monthly self-payment is due and not received;
- Your eligibility ends due to your death, eligibility for Medicare, or any other reason;
- The Plan no longer provides Dependent benefits; or
- The Plan ends.

Reinstating Eligibility

If your or your Dependent’s eligibility for coverage under the Plan ends, it cannot be reinstated.

Continuing Coverage Through COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, also called COBRA, your Dependents may continue health care coverage past the date coverage would normally end. In general, COBRA Continuation Coverage is identical to the coverage your Dependents had before beginning COBRA Continuation Coverage. COBRA Continuation Coverage is only available to your eligible Dependents (spouse and/or child(ren)) under certain circumstances when their coverage would otherwise end.

Qualifying Events

COBRA Continuation Coverage is offered to your Dependents if your Dependents lose coverage as a result of your:

- Death;
- Divorce or legal separation;
- Loss of coverage due to you becoming eligible for Medicare; or
- Child losing Dependent status as defined by the Plan.
Notify the Fund Office

Your Dependent must notify the Fund Office of any qualifying events within 60 days of the qualifying event. If your Dependent does not notify the Fund Office within 60 days of the qualifying event, he or she will lose the right to elect COBRA Continuation Coverage.

When the Fund Office is notified of a qualifying event, the Fund Office will notify all affected individuals, within 30 days, as to whether or not they have the right to elect COBRA Continuation Coverage. Notification to a spouse is treated as notification to all other affected Dependents residing with the spouse at the time notification is made.

If your Dependents elect to receive COBRA Continuation Coverage, the Fund Office must receive their election at least 60 days from the later of the date:

- Coverage ended; or
- Of the notice advising your Dependents of their right to COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage

The Fund Office will notify your Dependents of the cost of COBRA Continuation Coverage when it notifies them of their right to coverage. The cost for COBRA Continuation Coverage will be determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this coverage.

The first payment for COBRA Continuation Coverage must include payments for any months retroactive to the day your Dependents’ coverage under the Plan ended. This payment is due no later than 45 days after the date you or your Dependents sign the election form and return it to the Fund Office.

Subsequent payments are due the first of the month. If payment is made later than the first day of the month to which it applies, coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated to the first day of the month when the payment is received. This means that any claim submitted for benefits while coverage was suspended may be denied and may have to be resubmitted once coverage is reinstated. If payment is not received within 30 days of the due date, all benefits will end immediately and no retroactive benefits will be paid. Once COBRA Continuation Coverage ends, it cannot be reinstated. Your Dependents will be notified when their COBRA Continuation Coverage ends.

Period of Coverage

Your Dependents may elect to continue coverage for up to 36 months.
Loss of COBRA Continuation Coverage

The period of COBRA Continuation Coverage for your Dependents may end or be reduced if:

- Your Dependents do not make the required monthly self-payments within 30 days of the due date;
- The Plan ends;
- Your Dependents becomes covered under any other group health care plan after the date COBRA Continuation Coverage is elected (provided the plan does not contain any preexisting condition exclusions or limitations); or
- Your Dependent becomes entitled to Medicare after the date COBRA Continuation Coverage is elected.

If COBRA Continuation Coverage ends before the end of the 36-month COBRA Continuation Coverage period, your Dependents will be notified that their coverage has ended and why. The Fund will provide your Dependents with certification of the length of coverage under the Plan (Certificate of Creditable Coverage). See page 5 for more information about the Certificate of Creditable Coverage.
Since different life events can affect your benefits coverage, this section describes how your coverage is affected and what you may need to do when different events occur.

**Getting Married**

When you marry, your spouse is eligible for medical coverage as of the date of your marriage. However, you must apply for coverage for your spouse within 30 days of the marriage and pay the additional monthly amount for coverage. If you do not apply for coverage for your spouse within 30 days of the marriage, your spouse will not be covered under the Plan.

Contact the Fund Office to apply for coverage for your spouse.

**Adding a Child**

Your natural Child will be eligible for coverage on the date of birth. If you adopt a Child, have a Child placed with you for adoption, or have a foster Child placed with you, he or she will be eligible for coverage on the date of placement as long as you are responsible for health care coverage and your Child meets the Plan’s definition of a Dependent Child. Stepchildren who live in your home are eligible for coverage on the date of your marriage.

However, you must apply for coverage for your Child within 30 days of the date you acquire the Dependent and pay the additional monthly amount for coverage. If you do not apply for coverage for your Child within 30 days of the event, your Child will not be covered under the Plan.

Contact the Fund Office to apply for coverage for your Child.

**Getting Legally Separated or Divorced**

If you and your spouse get a legal separation or divorce, your spouse will no longer be eligible for coverage. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your spouse must notify the Fund Office within 60 days of the divorce or legal separation for your spouse to elect COBRA Continuation Coverage.

A Qualified Medical Child Support Order (QMCSO) could have an effect on the benefit eligibility of your Child. Please notify the Fund Office if your situation involves a QMCSO. You or your Dependent may request a free copy of the Fund’s procedures for handling these orders.

**Child Losing Eligibility**

In general, your Dependent Child is no longer eligible for coverage when he or she marries, reaches the limiting age, is no longer dependent upon you for support, or becomes eligible for Medicare (see page 6). You should notify the Fund Office when one of these events occurs.

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**Limiting Age**

Under the Plan, the limiting age for your unmarried Dependent Child is:

- Age 19; or
- Age 23, if your Child is a full-time student; refer to page 42 for more information about full-time students.
Your Dependent Child may elect to continue coverage under COBRA for up to 36 months. You or your Dependent Child must notify the Fund Office within 60 days of the date your Dependent Child no longer meets the eligibility requirements to obtain COBRA Continuation Coverage.

If your Dependent Child is Disabled when he or she attains the limiting age, your Child may be eligible for continued coverage. See the definition of “Child” on page 42.

**In the Event of Death**

In the event of your death, your eligible Dependents may continue coverage for up to 36 months by electing COBRA Continuation Coverage and making the necessary monthly self-payments (see page 6).
Your medical benefits are designed to help protect you and your family against catastrophic medical expenses. The medical program pays benefits for a wide range of services and supplies, including Hospital charges and surgery.

The Summary of Benefits (on page 2) outlines specific benefit coverages available under the Plan.

How Your Medical Benefits Work

Medical benefits pay for a wide range of services and supplies. How the Plan works is simple. Each calendar year (January 1 through December 31), medical benefits work like this:

- **Medical Deductible:** You are responsible for meeting your medical annual deductible. The medical annual deductible is the dollar amount you pay each year before the Plan begins to pay medical benefits. The medical annual deductible applies to each covered person each calendar year. (There is a separate prescription drug annual deductible, see page 15.)

- **Physician Office Visit Copayment:** When you or a family member go to a Physician’s office, you pay a separate copayment for each Physician office visit, before the Plan pays any benefits. This copayment is separate from your medical deductible and does not apply toward meeting the medical annual deductible or out-of-pocket maximum. In addition, you are responsible for paying this copayment once you have met your out-of-pocket maximum.

- **Coinsurance:** Once you meet the medical annual deductible, the Plan pays a percentage of Covered Expenses, and you pay the rest. The coinsurance percentage the Plan pays varies, depending on whether you use network or non-network providers. However, the Plan may pay benefits at the network provider level if you require Emergency treatment and/or if you live outside the network service area; see page 12 for more information.

- **Out-of-Pocket Maximum:** The out-of-pocket maximum helps limit your out-of-pocket medical expenses. Once the coinsurance amounts you pay for Covered Expenses reach the annual out-of-pocket maximum, the Plan pays 100% of most Covered Expenses for the remainder of that calendar year. The out-of-pocket maximum includes amounts you pay toward meeting your medical and prescription drug annual deductibles.

- **Annual Maximum:** The Plan pays medical benefits up to the annual maximum amount listed on the Summary of Benefits on page 2. This maximum applies to all benefits paid on your or your Dependent’s behalf, including any benefits that apply toward specific benefit maximums. In addition to the Plan’s annual maximum, certain benefits are also subject to specific benefit maximums. All specific benefit maximums are listed on the Summary of Benefits. There is no lifetime maximum.
Your Responsibility

It is your responsibility to pay for any charges that are:

- Not considered Covered Expenses;
- In excess of the Usual and Customary charge;
- Used to satisfy any applicable Deductibles;
- Not paid by the Plan after the Plan has paid the Plan’s portion; and
- In excess of any specific Plan maximum or limitation.

Providers

To save you and the Fund money, the Fund has entered into an agreement with a Preferred Provider Organization (PPO) network. Providers that participate in the PPO network (network providers) have agreed to charge negotiated prices. The Fund’s current PPO network is the First Health Network. Each time you need health care, you have the choice to use a network or non-network provider (a provider that does not participate in the network).

When you or your family use a network provider, you maximize the amount of health care benefits you receive. Since network providers have agreed to charge negotiated rates, your out-of-pocket expenses are less than if you use a non-network provider.

Generally, provider networks are large enough to provide most health care services that you and your family will need. However, since health care is a very personal issue, sometimes you might prefer to go to a provider that does not participate in the Plan’s network. The network/non-network provider feature of our Plan accommodates these circumstances. Each time you receive medical care, you can choose whether to use a network or non-network provider. To encourage you to use network providers whenever possible, the Plan pays a higher percentage of your health care expenses when you go to a network provider.

To take advantage of the savings the network provides, you must check to see if your provider is in the network (providers participating in the network change periodically). In addition, you must show your ID card at the time that you receive services. Finding a network provider is easy. The Fund Office provides you with a provider directory (at no cost to you) or, for the most up-to-date information, you can:

- Ask your provider if he/she participates in the network; or
- Contact the network directly—by phone or by visiting their web site (see Important Contact Information on page 3).

If You Require Emergency Treatment and/or Live Outside the Network Service Area

If you receive treatment from a non-network provider because you require Emergency treatment or because you live outside the network service area (which means you live at least 25 miles from the nearest network provider), you may be eligible for benefits at the network provider level.
If your benefits are paid at the non-network level and either of these circumstances apply, please contact the Fund Office. In general, you will need to request that your claim be reviewed. If it is determined that your treatment was considered an Emergency (see page 43 for a definition of Emergency) and/or that you live outside of the network service area, your benefits will be adjusted accordingly.

**Covered Medical Expenses**

The Plan pays for Medically Necessary services, supplies, care, treatment, or procedures based on the Usual and Customary charge. Covered Expenses include:

- Hospital room and board. For a private room, benefits will be paid up to the average semi-private room rate in the Hospital where confined. This Plan complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarian section. This Plan does not require a health care provider to obtain authorization from the Plan for prescribing a length of stay within these periods.
- Hospital drugs, medicines, and other services and supplies. (Drugs and medicines not dispensed in the Hospital, when required by a Physician’s written prescription, are covered only under the Plan’s prescription drug benefits.)
- Hospital outpatient services.
- Physician services for the performance of an operation, repair of a dislocation or fracture, and medical services. Assisting Physician services in surgery are also covered.
- Emergency care.
- Reconstructive surgery following a mastectomy, including:
  - Reconstruction of the breast on which a mastectomy was performed;
  - Surgery on the other breast to produce a symmetrical appearance; and
  - Prostheses and physical complications of all stages of mastectomy, including lymphedemas.
- Professional anesthetist services, provided the anesthetist is not employed by a Hospital that submits a charge for services.
- Registered graduate nurse, chiropractor, and licensed physiotherapist services, unless the person ordinarily resides in the Participant’s household or is a member of the covered individual’s immediate family.
- Local professional ambulance service. In addition, if, in the opinion of the attending Physician, the Injury or Illness requires special and unique Hospital treatment not available in any local Hospital, transportation within the United States or Canada, or not to exceed 500 miles elsewhere in the world, by professional land, air (including helicopter ambulances), or sea ambulance, railroad, or regularly-scheduled commercial airline flight to the locality of the nearest Hospital in which the required treatment is available, is covered.
Diagnostic X-ray and laboratory services.

One mammogram and pap test per calendar year for female Participants and Dependents, if the procedures are performed by a network provider.

One PSA test per calendar year for male Participants and Dependents, if the procedures are performed by a network provider.

Oxygen and the rental of equipment for its administration.

Blood and blood plasma and its administration.

Radium, radioactive isotopes, and X-ray therapy.

Casts, splints, braces, trusses, and crutches when not returnable to the provider.

Rental, or purchase when approved in writing by the Fund Manager, of Hospital-type equipment, including a Hospital bed, wheel chair, or other similar durable therapeutic equipment.

Artificial limbs and eyes to replace natural limbs and eyes and prosthetic devices, excluding dentures, eyeglasses, and hearing aids, to supplement natural organs, limited to one such charge for each artificial limb, eye, or prosthetic device.

Dental services rendered by a Physician or dentist for the treatment of an Injury to the jaw or to natural teeth, including the initial replacement of these teeth and any necessary dental X-rays resulting from an Accident, provided the treatment is rendered within six months of the Accident.

Second surgical opinions obtained before elective surgery.

Cataract surgery.

Corneal transplants and bone transplants, excluding bone marrow transplants.

Mental health treatment, up to the maximums listed on the Summary of Benefits.

Chiropractic treatment, up to the maximums listed on the Summary of Benefits.

Inpatient rehabilitation services in an acute Hospital, rehabilitation unit or facility, or skilled nursing facility for short term, active, progressive rehabilitation services (occupational, physical, or speech therapy) ordered by a Physician that cannot be provided in an outpatient or home setting. Inpatient rehabilitation services will be covered for a maximum of 20 days and only if they immediately follow and are related to an Illness or Injury that required a Hospital stay of not less than three days.

**Expenses Not Covered by Medical Benefits**

Medical benefits provide coverage for many medical expenses related to an Illness or Injury. You should be aware that some expenses are not covered by the Plan. See General Plan Exclusions and Limitations on page 18 for expenses that are not covered under the Plan.
Prescription drug expenses are rising faster than most other health care expenses, and can be a significant expense for you and your family. Recognizing this, the Fund offers prescription drug benefits to you and your Dependents. The Fund has contracted with Sav-Rx, a Pharmacy Benefit Manager, to provide you with access to a retail pharmacy and mail order program.

**Prescription Drug Annual Deductible**

Prescription drug benefits are subject to a separate prescription drug annual deductible. This means that amounts you pay for covered prescription drug expenses count toward meeting your prescription drug annual deductible but do not count toward meeting your medical annual deductible. However, amounts you pay for covered prescription drug expenses before the prescription drug deductible is met do apply toward meeting your medical annual out-of-pocket maximum.

You are responsible for meeting the prescription drug annual deductible before the Plan begins to pay prescription drug benefits.

**Generic Equivalents and Brand Name Medications**

Many prescription drugs have two names: the generic name and the brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. On average, generic medications can save about half the cost of the brand name medications, but for some medications this savings can be as great as 90%. This can be a significant source of savings for you and the Fund.

While the Plan covers generic and brand name medications, you pay more when you receive a brand name medication. **If you receive a brand name medication when a generic is available, in addition to your coinsurance amount, you will be responsible for the difference in cost between the generic and brand name medication, unless your Physician specifies to dispense as written (DAW).** If your Physician specifies DAW, you do not have to pay the additional amount.

You should discuss with your Physician if a generic equivalent is available, and appropriate, for any prescriptions you need filled. Your Physician or pharmacist can assist you in substituting generic medications when appropriate.

**Retail Pharmacy Program**

The retail pharmacy program offers benefits for short-term prescriptions, up to a 30-day supply. When you are eligible for benefits under the Plan, you receive a prescription drug card. You can use your card at a pharmacy that participates in the Sav-Rx network (participating pharmacy). For a list of participating pharmacies, contact Sav-Rx at 1-800-228-2181 or www.savrx.com.
While you can go to any retail pharmacy and have your prescription filled, when you have your prescriptions filled at a participating pharmacy, you save money for yourself and the Plan. That’s because participating pharmacies have agreed to charge discounted rates.

When you go to a participating pharmacy, simply show the pharmacist your prescription drug ID card. No forms, receipts, or submission of claims is necessary. You simply pay the required amount when you fill your prescription.

If you have your prescription filled at a non-participating pharmacy, you will have to pay the full, undiscounted cost of your prescription when you pick it up. You will then need to submit a claim for reimbursement. You will be reimbursed based on the discounted price of the medication, minus your deductible and coinsurance amount for that prescription.

**Mail Order Program**

The mail order program allows you to get up to a 90-day supply of your medication at one time. If you need to have a prescription filled for long-term or maintenance medication, you may want to use the mail order program. Maintenance medications are prescription medications that are used on an ongoing basis, such as for arthritis, high cholesterol, diabetes, or high blood pressure. The mail order program provides a safe, convenient way for you to have a larger supply of your medications delivered right to your home.

You must complete and send in a mail order form, along with your prescription, to Sav-Rx. Forms are available from Sav-Rx or the Fund Office, including online at the Fund’s web site at www.teamsters142.org. You will need to pay for your prescription when you mail it in. If you are not paying by credit card, you will need to contact Sav-Rx for the exact amount of your prescription (see *Important Contact Information* on page 3).

It will take approximately 10-14 days from the time you send in your order until you receive your prescription(s). With each delivery, you will receive an order form and a pre-addressed, postage paid envelope.

If your written prescription indicates that refills are available, you will receive a refill number with your prescription order. You then have several options on refilling your prescription; you can refill your prescription online, by phone, or by mail.

**Covered Prescription Drug Expenses**

Generally, the Plan covers federal legend drugs that require a written prescription from a Physician or dentist. A licensed pharmacist must dispense these prescriptions. The Plan also covers:

- Retin-A for covered individuals up to age 23.
- Insulin.
- Insulin syringes and other Medically Necessary diabetic supplies, such as glucagon kits and test strips.
- Other syringes.
• Medications prescribed to treat mental health conditions.
• Medications prescribed to treat attention deficit disorder.
• Vitamins that require a prescription.
• Weight loss medications, prior authorization required.
• Devices and appliances required for the administration of prescription drugs, prior authorization required.
• Injectable medications, prior authorization required.

**Expenses Not Covered by Prescription Drug Benefits**

The following prescription drug expenses are not covered under the Plan’s prescription drug benefits.

1. Ortho evra.
2. Contraceptives, including oral, implants, or topical.
3. Medications used to treat erectile dysfunction, including, but not limited to, Viagra or Cialis.
5. Pre-natal vitamins.
6. Fertility agents or medications.
7. Smoking deterrents (e.g., nicotine patches, Nicorette gum, etc.).
8. Medications for cosmetic use.
10. Any of the circumstances listed under *General Plan Exclusions and Limitations* beginning on page 18.
The Plan provides coverage for many medical and prescription drug benefits. In addition to any specific exclusions and limitations listed throughout this booklet, Plan benefits will not be paid or payable for any loss caused by, incurred for, or resulting from any of the following:

1. Services or supplies furnished by or for the U.S. Government, or by or for any other government unless payment is legally required, or to the extent provided under any governmental program or law under which the individual is, or could be, covered.

2. Services or supplies that are not rendered or provided in connection with, or as treatment for, a specific Injury or Illness, unless the services or supplies are specifically covered under the Plan.

3. Anything not ordered by a Physician or not necessary for medical care.

4. Services, supplies, or treatments that are preventive in nature, unless specifically covered under the Plan.

5. Charges for check-up examinations, including screening or routine physical examinations or research studies.

6. Hospital charges unless the Hospitalization is recommended and approved by a Physician.

7. Hospital charges incurred for a Friday or Saturday admission unless Medically Necessary.

8. Charges incurred for Physician services in excess of the Usual and Customary charges, or for Hospital room and board and general nursing services in excess of the Usual and Customary charges for semi-private accommodations made by the Hospital in which the individual is confined, or, if the Hospital does not provide semi-private accommodations, in excess of the prevailing charge made for the accommodations by similar Hospitals in the area.

9. Charges for medicines, drugs, or nutritional supplements that can be obtained without a Physician’s prescription or that have not been legally dispensed by a pharmacist upon a Physician’s prescription.

10. Services or supplies administered resulting from an act of war (declared or undeclared), resulting from an act of terrorism, given during military service, or resulting from participation in an insurrection, riot, or commission of an assault or offense that is punishable as a felony.


12. Examinations and testing for prescribing corrective lenses or for the fitting of glasses or charges for eyeglasses and their fitting.

13. Charges for hearing aids and their fitting.

14. Charges for failure to keep a scheduled visit or completion of a claim form.

15. Supplies or equipment for personal hygiene, comfort, or convenience, such as, but not limited to, air conditioners, humidifiers, and physical fitness equipment.

16. Routine physical examinations.

17. Medical expenses of a person enrolled and covered in an HMO, whether or not that person utilized HMO providers.
18. Expenses resulting from intentionally self-inflicted bodily Injury, while sane or insane, unless due to an underlying physical or mental condition.

19. Charges of an extended care facility, nursing home, or similar facility for nursing, rest, treatment of alcoholism or drug addiction, or custodial care, except as otherwise specified as covered under the Plan.

20. Services or supplies for which the person is not required to make payment or would have no obligation to pay if he or she did not have this coverage.

21. Services or supplies that are Experimental, Investigative, or do not meet accepted standards of medical practice.

22. Charges for dentistry or dental X-rays, except as otherwise specified as covered under the Plan.

23. Treatment for alcohol and/or substance abuse.

24. Sterilization procedures for a Dependent other than a Participant’s spouse.

25. Operations to reverse sterilization procedures.

26. Charges for contraceptive drugs or devices.

27. Charges incurred because of pregnancy or pregnancy-related medical conditions, miscarriage, or childbirth except when the charges are incurred by a covered female Participant or a covered Dependent spouse of a Participant.

28. Expenses resulting from elective abortion unless for a Participant or Participant’s spouse and only if the pregnancy is a result of rape or incest or the purpose of the abortion is to save the life of the mother.

29. Charges for the treatment of infertility, including fertility drugs, in-vitro fertilization, artificial insemination, or similar procedures.

30. Charges for the treatment of temporomandibular joint (TMJ) syndrome or other conditions of the joint linking the jawbone and the skull.

31. Treatment leading to or in connection with transsexual surgery.

32. Charges in connection with the purchase or fitting of appliances or implants relating to sexual dysfunction or impotence, such as penile implants and prostheses.

33. Expenses for education or training of any type.

34. Expenses for transportation to a place of treatment (except for transportation by ambulance when Medically Necessary) and for room and board incurred in connection with travel for medical treatment.

35. Services and supplies rendered for the treatment of obesity, including diagnostic testing and surgical procedures.

36. Expenses for surgical correction of refractive errors of the eye.

37. Charges incurred in connection with organ transplants, except for corneal and bone transplants (but not bone marrow transplants), which are covered by the Plan.

38. Work-related Injuries or Illnesses.
Payment of Benefits

Benefits are only paid for Covered Expenses incurred by individuals covered under the Plan at the time the expenses are incurred, provided a timely claim(s) is made.

Generally, payment is made direct to the provider if you have assigned Plan benefits to the provider (see Assignment of Benefits below). However, if you submit the claim along with a paid receipt, payment will be made directly to you. If payment is made to you, you are responsible for payment to the provider. Once the Fund makes payment on a claim, no further payment will be made. You will receive an Explanation of Benefits (EOB) showing what the Plan has paid. You are responsible for paying any amounts not paid by the Plan.

If an individual is, in the opinion of the Trustees, legally incapable of giving a valid receipt for any payment due and no guardian has been appointed, the Trustees may, at their option, make payment to the person or persons who, in the opinion of the Trustees, have assumed the care and principal support of the individual.

If an individual dies before all amounts due have been paid, the Trustees may, at their option, make payment to the executor, administrator, or personal representative of the individual’s estate or to his or her surviving spouse, parent, child(ren), or to any other person(s) entitled to the payments.

Any payments made by the Fund fully discharge the liability of the Fund to the extent of the payment.

Assignment of Benefits

An “assignment of benefits” is a written statement, signed by you, that gives a medical provider the right to receive Plan benefits for services provided to you. Other than payments made directly to a provider, you cannot assign your benefits or other rights to which you are entitled to under the Plan.

Additionally, benefit payments are exempt from execution, attachment, garnishment, or other legal or equitable process for your or your Dependent’s debts.

Claim and Appeal Procedures

Many health care providers will submit claims for you. Be sure to show your ID card so your provider knows where to submit your claim.

If your provider does not submit your claim for you, it is then your responsibility to do so. Contact the Fund Office for the appropriate claim form and be sure to provide all requested information. All claims must be submitted in writing (or electronic format) on a form provided by the Plan or one of the Plan’s providers. All claims must be filed within 180 days of the date of service for benefits to be paid under the Plan.
To assist in processing claims as quickly as possible, be sure to:

- Submit a separate claim for each unrelated Injury or Illness.
- Complete all requested information, including having your Physician complete and sign the appropriate section.
- Include your name and social security number with your claim.
- If the claim is for a Dependent, include the Dependent’s name and birth date.
- Include the name of the specific medical condition or symptom being treated.
- Attach any bills or receipts relating to services provided. Make sure each bill clearly identifies (or provides) the diagnosis, service or supply, fee, date each charge was incurred, patient’s name, and date of service.
- Identify the provider’s name, address, phone number, professional degree or license, and federal tax identification number (TIN).
- If you or a Dependent has coverage under more than one plan, include the name of the other health plan(s). Also, if this Plan is secondary (see page 26), include a copy of the Explanation of Benefits (EOB) form from the other plan(s).

**Filing A Claim**

A claim must be filed for the Plan to pay benefits. A claim may be filed by you (the Participant), your eligible Dependent, or by someone authorized to act on your behalf or your Dependent’s behalf. The person who incurred the claim is the “Claimant,” except that, if the claim is incurred by a Dependent Child, then the adult who files the claim on the Child’s behalf is the Claimant.

A claim for benefits is considered to be filed on the date it is received by the Plan’s Claims Office. The claim is considered to be filed on the date the Claims Office first receives notice of the claim, even if the claim is incomplete (for example, if the Claims Office received a medical bill but not a claim form).

The Claims Office is:

Stewart C. Miller, Inc.
Merrillville Claims Office
2111 West Lincoln Highway
Merrillville, IN 46410
1-800-759-6944 or 219-769-6944

The Fund Office is:

Teamsters Union No. 142 Health and Welfare Trust Fund
1300 Clark Road
Gary, IN 46404
219-949-1550, 773-721-8800, or 1-800-348-7027

To obtain claim forms, you may visit, call, or write to the Claims Office or the Fund Office.
If you incur a medical expense and ask the Plan to pay benefits, that is considered a claim. However, a request for confirmation of Plan coverage is not a claim if you have not yet incurred the expense. Also, a claim is not an inquiry about general benefit eligibility or a dispute concerning a Plan finding that you or a Dependent is not eligible for benefits (where no medical costs have been incurred).

You may designate another person as your authorized representative for filing a claim. The designation must be in writing, on a form supplied by the Fund Office. Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative. A routine assignment of benefits to a medical provider (where the Plan will make payment directly to the provider) is not considered to be a designation of the provider as your authorized representative.

Claim Processing Periods

Generally, a claim approval or denial will be made within 30 days after the Plan receives your claim. If additional time is required, there are two types of extensions that may apply:

- **Plan Extension:** A Plan extension occurs when there are circumstances beyond the Plan’s control that cause the Plan to need an extension of time (this does not include cases where you have not provided the Plan will all the information or documents need to process the claim).

- **Claimant Extension:** A claimant extension occurs when you do not provide the Plan will all information or documents needed to process your claim.

If the Plan needs information or materials from your Physician or other medical provider, that is a Claimant extension, even though the materials will come from your medical provider and not from you. As a convenience to you, the Plan may request necessary materials or information directly from your medical provider but you are ultimately responsible to see that the Plan receives that material.

With a Plan extension, the Plan can extend the 30-day claim processing period by 15 days. Before the end of the original 30-day period, you will receive written notice of the circumstances requiring the extension and of the date by which the Plan expects to make a final decision on the claim.

With a claimant extension, the Plan will request the necessary information or material in writing. If the request goes to your medical provider, you will receive a copy of the request. You will then have 45 days to provide, or have your medical provider submit, the information the Plan needs to process your claim. Under a claimant extension, the time for the Plan to decide your claim is extended by the time it takes you to provide the requested information. Once the Plan receives a response to the request, the ordinary time limits (the 30-day period or the 15-day extension), which was suspended, will begin to run again. If you do not respond to the Plan’s request within 45 days, the Plan will decide your claim without the information, which may result in a denial of your claim.
Claim Denial

If your claim is denied (in whole or in part), the Plan will send you a written notice stating:

- The specific reason or reasons for the denial, making reference to the Plan provisions on which the denial was based;
- A summary of the Plan’s appeal procedures;
- A description of any additional information or material necessary to process your claim, along with an explanation of why the material or information is necessary (if applicable);
- A statement that a copy of any rule, guideline, or policy that the Plan relied on in processing your claim is available, at no cost, upon request (if applicable);
- A statement that an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan determined that the treatment was Experimental or not Medically Necessary is available, at no cost, upon request (if applicable); and
- A statement that ERISA §502(a) provides that a Participant or beneficiary of a Plan may file suit to recover benefits due under the terms of the Plan, to enforce the terms of the Plan, or to clarify the person’s right to future benefits under the Plan.

Appealing a Denied Claim

If your claim is denied (in whole or in part), you may request a full and fair review by filing a written notice of appeal with the Plan (referred to in these procedures as an appeal). An appeal must be received by the Fund Office within 180 days after receipt by the Claimant of the written notice of denial of the claim. Your appeal is considered filed on the date the written notice of appeal is received at the Fund Office.

If you want, another person may represent you in connection with an appeal. If another person claims to be representing you in your appeal, the Trustees have the right to require that you give the Plan a signed statement, advising the Trustees that you have authorized that person to act on your behalf regarding your appeal. Any representation by another person will be at your own expense.

In connection with your appeal, you or your authorized representative may review pertinent documents and submit issues and comments in writing. Upon written request, the Plan will provide reasonable access to, and copies of, all documents, records, or other information relevant to your claim. If the Plan obtained an opinion from a medical or vocational expert in connection with your claim, the Plan will, on written request, provide you with the name of that expert. The Plan will not charge you for copies of documents you request in connection with an appeal.
Appeal Determinations

Your appeal will be decided by the Board of Trustees. The person who decides the appeal will not be the same person, or a subordinate of the person, who made the original claim denial. You (or your authorized representative, if any) are not entitled to appear before the Board of Trustees and no hearing will be held on the appeal. In deciding your appeal, the Board of Trustees:

- Will consider all comments and documents that you submit, regardless of whether that information was available at the time of the original claim denial; and
- Will not presume that the original denial was correct and will consider the issues with no deference to the original decisions.

Appeal Processing Periods

The Board of Trustees meets at least four times per year. If your appeal is filed more than 30 days before a regular Trustees’ meeting, your appeal will be decided at that meeting. However, if special circumstances require an extension of time for processing, a decision will be made on your appeal at the next following Trustees’ meeting. If special circumstances require that the decision be delayed until the next following Trustees’ meeting, you will be notified in writing of why the extension is needed and when the appeal will be decided.

If your appeal is filed within 30 days immediately before a regular Trustees’ meeting, the appeal may not be decided at that meeting but may be decided at the next following meeting. However, if special circumstances require an extension of time for processing, a decision will be made at the third meeting following the date the appeal was filed. If special circumstances require that the decision be delayed until the next following Trustees’ meeting, you will be advised in writing of why the extension of time was needed and when the appeal will be decided.

When the Board of Trustees, in its discretion, determines that it can decide an appeal sooner than the time limits stated above, they will do so.

Once the Board of Trustees has decided your appeal, the Plan will send you a written notice of that decision. The notice will be mailed within five days of the Board of Trustees’ decision. The notice that the Board of Trustees has decided your appeal will:

- State the specific reason or reasons for the decision, making reference to the pertinent Plan provisions on which the decision was based; and
- Include, if applicable:
  - A statement that, upon written request, you will be provided with a copy of any internal rule, guideline, or policy that the Plan relied on in processing your claim; and
A statement that, upon written request, you will be provided with an explanation of any scientific or clinical judgment used by the Plan in denying your claim if the Plan determined that the treatment was Experimental or not Medically Necessary.

If your appeal is denied, you are entitled to receive, upon written request and at no cost, copies of documents and information that the Plan relied on in denying your claim.

If the Board of Trustees upholds the denial of your claim, you will then have the right to file suit, under the authority of ERISA. If the decision on a claim or the decision on appeal is not furnished within the time limits stated in these procedures, the claim or appeal is deemed to have been denied. No claim will be considered to have been denied, and a Claimant may not file suit against the Plan, until the Claimant has exhausted all of the procedures described in these Claim and Appeal Procedures.

**Limitations Period**

The Plan provides for a “limitations period,” which is the period within which any lawsuit must be filed. The limitations period is three years from the date of the Plan’s notice advising you of the determination on your claim. If you file a timely appeal, the limitations period is three years from the date of the Plan’s notice advising you of the determination on your appeal. Also, if your claim is denied and you fail to file a timely appeal, a lawsuit, even if you filed within the limitations period, will be subject to dismissal because, as explained above, the Plan requires you to use the appeal process before filing a lawsuit. Finally, if the Plan fails to send a notice advising you of the determination on your claim, the limitations period is three years from the date a determination was due under these Claim and Appeal Procedures.

**Medical Judgments**

You have the right, upon written request, to be advised of the identity of any medical experts consulted in making a determination of your appeal. The Trustees reserve the right, through a medical examiner of their choosing, to examine an eligible person as often as they may reasonably require during the pendency of a claim.

**Coordination of Benefits**

The Plan has been designed to help you meet the cost of medical and prescription drug benefits. It is not intended that you receive greater benefits than your actual health care expenses. The amount of benefits payable under this Plan will be coordinated with any coverage you or your Dependent has under any:

- Group insurance coverage;
- Employer-sponsored health plan, whether insured or self-funded;
Coverage under a labor-management trusteed plan or employee benefit organization plan; or

Coverage under governmental programs or any coverage required or provided by any state.

This Plan will always pay you either its regular benefits in full or a reduced amount that, when added to the benefits payable by the other plan(s), will equal the total allowable expenses. If a plan provides benefits in the form of services or supplies instead of cash, the reasonable cash value of the service rendered and supplies furnished (if otherwise an allowable expense) will be considered both an allowable expense and a benefit paid. However, no more than the maximum benefits payable under this Plan will be paid.

Please note that you must file a claim for any benefits you are entitled to from any other source.

**Order of Payment**

If you and/or your Dependent are covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total of benefits payable does not exceed 100% of the allowable expense incurred.

In the event that this Plan’s coverage is secondary but the primary plan includes a provision that results in the primary plan paying a lesser benefit because of secondary coverage, notwithstanding any other provision of this Plan, this Plan’s secondary benefits will be limited to the difference between the amount that the covered person’s primary plan would have paid if the primary plan had been the only plan providing coverage, and the total amount of Covered Expenses. In no event will this Plan pay more than the amount it would have paid as a primary payer.

In general, a plan that covers an individual as an employee or as the dependent of an employee is primary. If an individual is an employee under more than one plan or no other rule determines the order of payment, the plan that has covered the eligible individual longer is primary.

If an individual is covered under two or more plans, the order in which benefits are determined is as follows:

- When one of two plans providing benefits for an individual does not have a non-duplication provision, the plan with the non-duplication provision is secondary.
- The benefits of a plan covering the person other than as a Dependent are determined before the benefits of a plan covering the person as a Dependent.

**Allowable Expenses**

Any necessary, Usual and Customary expense, at least a portion of which is covered under at least one of the plans covering the person for which the claim is made.

If you and/or your Dependents are covered under another plan, you must report all other coverage when you file a claim.
If a Dependent Child is covered under more than one plan and the parents are not divorced or legally separated, the plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding the year of birth, is primary. If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period is primary.

If a Dependent Child is covered under more than one plan and the parents are divorced or legally separated, the following rules determine which plan's benefits are primary:

- Where there is a court decree that establishes financial responsibility for medical expenses, the plan covering the Dependent Child of the parent who has financial responsibility will pay first; or
- Where there is no court decree or a court order does not specify which plan is primary, the plan of the parent with custody is primary. If the parent with custody has remarried, then the Plan covering the:
  - Stepparent with custody of the Child pays second; and
  - Parent without custody of the Child pays third.

For coordination of benefits purposes, this Plan:

- May, subject to the Plan's privacy rules, release to or obtain from any other insurance company or other organization or person, any claim information. Any person claiming benefits under the Plan will furnish any information that the Plan may require.
- Has the right, if an overpayment is made, to recover the overpayment from any other person, or any other insurance company or organization.
- Has the right to pay to any other organization an amount it determines to be warranted, if payments that should have been made by the Plan have been made by the organization.

Privacy Policy

The Teamsters Union No. 142 Health and Welfare Trust Fund (Welfare Fund) exists for one purpose—to provide health and welfare benefits to Welfare Fund participants and their eligible Dependents. In the course of providing welfare benefits, the Welfare Fund receives and maintains information that constitutes Protected Health Information (PHI), as defined in federal privacy rules. This section describes the Welfare Fund’s policies that protect you from unnecessary disclosure of your PHI and give you certain rights regarding your health information.

In this section, “you” means any person whose health information is received by the Welfare Fund. The Welfare Fund’s Privacy Policy applies to you whether you are the Plan participant or an eligible dependent. Privacy rights can be exercised either by you or your Personal Representative (defined on page 31). For a minor child, the parent is the Personal Representative.
The Welfare Fund’s Trustees have retained Stewart C. Miller, Inc., to process medical claims and Sav-Rx, to process prescription reimbursement requests. In this section, references to the Welfare Fund include Stewart C. Miller, Inc. and Sav-Rx, to the extent that these firms are acting on behalf of the Welfare Fund. In addition, references in this section to the Fund Office refer to both the Welfare Fund’s administrative office, the offices of Stewart C. Miller, Inc., and Sav-Rx.

When Health Information May be Used or Disclosed

- **Process and Pay Claims.** The Welfare Fund may use or disclose health information to process and pay benefit claims. Claim processing includes all aspects of the process including, for example:
  - Determining benefit eligibility or Plan coverage.
  - Reviewing health care services for medical necessity and reasonableness of charges and duration of hospital stays.
  - Providing information regarding coverage or health care treatment to another health plan to coordinate payment of benefits.
  - Processing claim appeals.
  - Contacting you (or in your absence, a member of your household) to obtain information needed to process your claim.
  - Answering claim and benefit questions from you, your family members, or other relatives or close personal friends, if such person is involved with your health care or the payment of your claim.

- **Collect Contributions for Coverage.** The Welfare Fund may use or disclose health information in the process of collecting any payment for coverage under the Plan.

- **Administrative Purposes.** The Welfare Fund may use or disclose health information for its own operations, including, for example:
  - Quality assessment and improvement activities.
  - Activities designed to improve health or reduce health care costs.
  - Underwriting, premium rating, or related functions to create, renew, or replace Plan benefits.
  - Review and auditing, including compliance reviews, medical reviews, legal services, and compliance programs.
  - Business planning and development, including cost management and planning related analyses.
  - General Welfare Fund administrative activities, including customer service and resolution of internal grievances.
• **Provide Health-Related Information.** The Welfare Fund may use and disclose your health information to tell you about or recommend possible treatment options or alternatives, or to advise you of health-related benefits and services that may be of interest to you.

• **Legally Required.** The Welfare Fund will disclose health information when it is required to do so by any federal, state, or local law, including, for example when the Welfare Fund receives:
  - An order, issued by a court or a state agency, to disclose your health information.
  - A subpoena or discovery request in a lawsuit or workers’ compensation case. In the case of a discovery request that has not been issued under a court order, the party requesting the information is obligated to attempt to notify you of the request so that you will have an opportunity to obtain a court order protecting your health information.

• **Conduct Health Oversight Activities.** The Welfare Fund may disclose health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensing, or disciplinary action.

• **Law Enforcement Purposes.** As permitted or required by state law, the Welfare Fund may disclose health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, reporting a crime in an emergency or if the Welfare Fund has reason to believe that your death was the result of criminal conduct.

• **Specified Government Functions.** In certain circumstances, federal regulations require the Welfare Fund to use or disclose your health information to facilitate specified government functions, for example, those related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

• **In the Event of a Serious Threat to Health or Safety.** The Welfare Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Welfare Fund, in good faith, believes that disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**Persons Who May Use Health Information**

Claims adjusters and other employees in the Fund Office will use your health information to process benefit claims. Supervisory personnel may use health information for claim payment, training, and administrative purposes, among others. The Board of Trustees, as the Welfare Fund administrator, may have access to health information for appeals or other administrative or supervisory purposes.
Releasing Health Information with Authorization

The categories beginning on page 28 (When Health Information May be Used or Disclosed) describe when the Welfare Fund may use or disclose your health information without your authorization. Other than as stated above, the Welfare Fund will not disclose your health information, except with your written authorization. The following rules apply to authorizations to release health information:

- Authorizations will be in writing, signed by you or your Personal Representative.
- You or your Personal Representative will receive a copy of the authorization form.
- Authorizations have an expiration date that is stated on the authorization form.
- You or your Personal Representative can revoke the authorization at any time. The revocation must be in writing, delivered to the Welfare Fund at the address listed at the end of this section (page 32).

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information maintained by the Welfare Fund:

- **Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. The Welfare Fund is not required to agree to your request but will ordinarily honor any request that the Welfare Fund communicate only with you (that is, not disclose your claim or benefit information to your relatives, friends, or members of your household). If you want to make a request for restrictions, please contact the Welfare Fund’s Privacy Coordinator.

- **Right to Receive Confidential Communications.** You have the right to request that the Welfare Fund communicate with you in a certain way. The Welfare Fund is not required to honor such requests but will do so if it can be done without interfering with normal Fund Office operations or if you believe that the disclosure of your health information could endanger you. If you want to receive confidential communications, please make your request in writing to the Welfare Fund’s Privacy Coordinator. Requests for confidential communications include, for example, a request that the Welfare Fund:
  - Communicate only with you (that is, not disclose your claim or benefit information to your relatives, friends, or members of your household). The Welfare Fund will routinely grant this request.
  - Only communicate with you at a certain telephone number or send written communications to a P.O. box instead of your home.

- **Right to Inspect and Copy Health Information.** You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Welfare Fund’s Privacy Coordinator. If you request a copy of your health information, the Welfare Fund will charge you $0.25 per page for copying, plus actual mailing costs.
Right to Amend Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Welfare Fund amend the records. That request may be made as long as the information is maintained by the Welfare Fund. A request for an amendment of records must be made in writing to the Welfare Fund’s Privacy Coordinator. The Welfare Fund may deny the request if, for example:
- The request does not include a reason to support the amendment.
- Your health information records were not created by the Welfare Fund.
- The health information you are requesting to amend is not part of the Welfare Fund’s records.
- The Welfare Fund determines the records containing your health information are accurate and complete.
If the health information you want to amend falls within an exception, you are permitted to inspect and copy this health information.

Right to an Accounting. You have the right to request a list of certain disclosures of your health information that the Welfare Fund is required to keep a record of under federal privacy rules, such as disclosures for public purposes, disclosures authorized by law, or disclosures that are not in accordance with the Welfare Fund’s privacy policies or applicable law. The request must be made in writing to the Welfare Fund’s Privacy Coordinator. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2004. Accounting requests may not be made for periods in excess of six years. The Welfare Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests will be subject to a reasonable cost-based fee. The Welfare Fund will inform you in advance of the fee, if applicable.

Right to a Copy of Fund’s Privacy Notice. You have a right to request and receive a copy of the Welfare Fund’s Privacy Notice at any time, even if you previously received the Notice. To obtain a copy, please contact the Welfare Fund’s Privacy Coordinator or any Fund Office employee.

Personal Representative

If you are of legal age, you can exercise your privacy rights as explained in this section. Your rights can also be exercised by your Personal Representative. A Personal Representative is:
- The parent of a minor child.
- The person designated in Health Care Power of Attorney (limited to the rights stated in the Power of Attorney).
- The legal guardian of a mentally incompetent adult.
- The administrator or executor of your estate or your next of kin.
Welfare Fund Obligations

The Welfare Fund is required by law to maintain the privacy of your health information as described in this section and to provide to you the Welfare Fund’s Privacy Notice of duties and privacy practices. The Welfare Fund is required to conform to the terms of this Privacy Policy. The Welfare Fund reserves the right to change the terms of the Privacy Policy at any time. If that happens, the Welfare Fund will revise the Notice and will provide you with a copy of the revised Notice within 60 days of the change. Any change in the Welfare Fund’s privacy practices will apply to all health information that the Welfare Fund has, regardless of whether the information was obtained before or after the change in privacy practices. You have the right to submit any complaints regarding privacy issues to the Welfare Fund’s Privacy Coordinator. If you believe that your privacy rights have been violated, you have the right to report any violations to the Secretary of the Department of Health and Human Services. The Welfare Fund encourages you to express any concerns you may have regarding the privacy of your information. Neither the Welfare Fund, your employer, or your Union are permitted to retaliate against you in any way for filing a complaint.

Welfare Fund Privacy Coordinator

The Welfare Fund has designated Jay R. Smith, Fund Manager, as the Privacy Coordinator. He is the contact person for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Coordinator at 1300 Clark Road, Gary, IN 46404 or by telephone at 219-949-1550, 773-721-8800, or 800-348-7027.

Right of Recovery

If any benefits are paid to or on behalf of you or your Dependent that should not have been paid or should have been paid in a lesser amount, the Trustees or their representatives will make a written demand on the person, or person’s successors, assigns, estate, or other representative, for repayment of the overpayment. If the amount of the overpayment is not returned to the Fund promptly, the Trustees are authorized to recover the amount of the overpayment from any benefits then payable, or to be payable in the future, to or with respect to the recipient of the overpayment. The Plan’s right of recovery is intended to enable the Trustees to carry out their obligation to pay benefits in accordance with Plan terms and the Plan’s right of recovery applies regardless of any other Plan provision or of the nature of the error that led to the overpayment.

Subrogation

The Plan’s subrogation rules apply whenever you and/or your Dependent is Injured and, because of that Injury, you and/or your Dependent became entitled to reimbursement from another source. Another source means any third party, including an insurance company that is required to pay claims due to acts of a third party or you and/or your Dependent’s own insurance carrier, although these subrogation rules do not apply to benefits paid under another employer-sponsored group health plan if that coverage is subject to coordination of benefits.
Subrogation means that the Fund has the same right as you and/or your Dependent to make a claim against another source to recover the amount of benefits paid. If you and/or your Dependent (or you and/or your Dependent’s representative) fails to make a claim against a person or insurer that is liable to you and/or your Dependent, the Fund is entitled to do so in your and/or your Dependent’s name, for the purpose of recovering the amount of benefits paid for the Injury. In that event, the Fund’s expenses, costs and attorneys’ fees will also be paid out of any recovery or settlement.

In any case in which you and/or your Dependent may be able to recover money or benefits from another source, you and/or your Dependent’s entitlement to benefits from the Fund is conditioned upon compliance with the Plan’s subrogation rules and upon the signing of a Reimbursement Agreement.

Reimbursement Agreement

The Reimbursement Agreement is an agreement by which you and/or your Dependent agree to reimburse the Fund from any money recovered from another source. If the Injured Dependent is a minor, the Reimbursement Agreement must be signed by you or a person legally authorized to act on behalf of the minor. The Reimbursement Agreement must be on a form approved by the Trustees. It will require you and/or your Dependent to repay the Fund for the amount of all benefits paid on account of the Injury, whether or not the recovery was sufficient to fully reimburse you and/or your Dependent for your losses. However, neither you nor your Dependent will be required to repay to the Fund more than the amount of benefits the Fund paid on the claim, or more than the gross amount you and/or your Dependent (or your representative) received in recovery. The Fund is not responsible for legal fees and expenses incurred in obtaining a recovery from another source, unless the Fund has agreed in writing to assume a share of those fees and expenses.

The Fund is also entitled to a lien on the proceeds of any recovery from another source, to the extent of the full amount of benefits paid for the Injury in question. This lien arises under both the Reimbursement Agreement and the Plan itself and the lien applies even if a Reimbursement Agreement is not signed or is invalid for any reason.

You and/or your Dependent are obligated to do everything that is necessary to enable the Fund to bring about a recovery of the amount of benefits paid. Neither you nor your Dependent (or your representative) may assign to another person the right to recover money from another source. You and/or your Dependent (or your representative) is not permitted to compromise the Fund’s subrogation claim and lien and is required to obtain the Fund’s consent before releasing another person from liability for any Injury. If you and/or your Dependent fail to reimburse the Fund as required by the Reimbursement Agreement, or if you and/or your Dependent otherwise violate the Plan’s subrogation rules, the Fund has the right, in addition to any other legal rights it may have, to reduce future benefits on claims made by you and/or your Dependent, until the full amount of the repayment has been recovered by the Fund.
**Compensated Injuries**

Once you and/or your Dependent have obtained a recovery from another source, benefits are not payable under the Plan for any claims related to that Injury, unless the total of Covered Expenses arising out of or related to the compensated Injury equals or exceeds the gross amount of the recovery paid to or on behalf of you and/or your Dependent. The Fund will then consider only the amount of claims that exceeds the amount of the gross recovery. This rule applies, regardless of who makes the claim against the responsible party and who pays the recovery. The Fund will also have subrogation rights with respect to any benefits paid before the time that you and/or your Dependent recover money from another source for the Injury.
**Plan Name**

The name of the Plan is the Teamsters Union No. 142 Health and Welfare Trust Fund.

**Plan Numbers**

The Employer Identification Number (EIN), assigned to the Board of Trustees by the Internal Revenue Service, is 35-0918199. The Plan number, assigned by the Board of Trustees, is 501.

**Plan Sponsor and Plan Administrator**

The Board of Trustees is both the Plan Sponsor and Plan Administrator. The Board consists of Employer and Union representatives selected by the Employers and Unions who have entered into collective bargaining agreements that relate to this Plan. If you want to contact the Board of Trustees, you may use the address and phone number below:

Teamsters Union No. 142 Health and Welfare Trust Fund  
1300 Clark Road  
Gary, IN 46404  
219-949-1550, 773-721-8800, or 1-800-348-7027

**Board of Trustees**

<table>
<thead>
<tr>
<th>Union Trustees</th>
<th>Employer Trustees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard D. Kenney, Chairman</td>
<td>Gary Kebert</td>
</tr>
<tr>
<td>Teamsters Union No. 142</td>
<td>Meccon Industries</td>
</tr>
<tr>
<td>1300 Clark Road</td>
<td>2705 Bernice Road</td>
</tr>
<tr>
<td>Gary, IN 46404</td>
<td>Lansing, IL 60438</td>
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<tr>
<td>Richard Knipp</td>
<td>Robert McGreal</td>
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<tr>
<td>Teamsters Union No. 142</td>
<td>Monosol, LLC</td>
</tr>
<tr>
<td>1300 Clark Road</td>
<td>6560 Melton Road</td>
</tr>
<tr>
<td>Gary, IN 46404</td>
<td>Portage, IN 46368</td>
</tr>
<tr>
<td>Mitch Sawochka</td>
<td>Perry VanRosendale</td>
</tr>
<tr>
<td>Teamsters Union No. 142</td>
<td>Tube City IMS Corp.</td>
</tr>
<tr>
<td>1300 Clark Road</td>
<td>#1 N. Broadway</td>
</tr>
<tr>
<td>Gary, IN 46404</td>
<td>Gary, IN 46401</td>
</tr>
</tbody>
</table>
Jay R. Smith has been appointed by the Board of Trustees as the Fund Manager. In addition, the Board of Trustees has delegated administrative responsibilities as follows:

- **Fund Office:**
  - Maintains eligibility records and accounts for Participant self-payments and Employer contributions; and
  - Answers Participant inquiries.

- **First Health Network:**
  - Administers the Plan’s Preferred Provider Organization (PPO) network.

- **Stewart C. Miller and Co., Inc. (Claims Office):**
  - Administers and pays medical claims.

- **Sav-Rx:**
  - Administers the Plan’s retail pharmacy network; and
  - Administers the Plan’s mail order program.

### Collective Bargaining Agreements

The Plan is maintained pursuant to collective bargaining agreements. A copy of the collective bargaining agreement under which you worked may be obtained, upon written request, from the Fund Office. Participants and beneficiaries may obtain, upon written request to the Fund Office, the name and address of a particular employer and whether that employer participates in the Plan.

### Agent for Service of Legal Process

Richard D. Kenney, Chairman of the Board of Trustees, is the Plan’s agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon him at:

Teamsters Union No. 142 Health and Welfare Trust Fund  
1300 Clark Road  
Gary, IN 46404

However, the documents may also be served upon any individual Trustee at the address of the Teamsters Union No. 142 Health and Welfare Trust Fund.

### Plan Funding

Employer contributions and Participant self-payments finance the benefits described in this booklet. All Employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements.

These agreements specify the amount of contributions, due date of contributions, type of work for which contributions are payable, and the geographic area covered by these agreements.
Plan benefits are self-funded from accumulated assets and are provided directly from the Trust Fund. A portion of Fund assets is allocated for reserves to carry out the objectives of the Plan.

The Board of Trustees holds all assets in trust. Benefits and administrative expenses are paid from the Trust.

**Plan Year**

The records of the Plan are kept on a fiscal year basis, beginning each July 1 and ending June 30.

**Plan Type**

This Plan is considered a welfare plan, providing medical and prescription drug benefits for Participants and Dependents who meet the eligibility requirements described in this booklet.

**Eligibility Requirements**

A summary of the Plan’s requirements for eligibility for benefits is shown in this booklet. Circumstances that may cause you to lose eligibility are also explained. Your coverage by this Plan does not constitute a guarantee of employment.

**Benefits Not Vested**

No one, neither you nor your Dependent, has a vested, non-forfeitable right to future Plan coverage or to the continuation of any given Plan benefit. The Trustees have the right to modify or discontinue any benefit or Plan component at any time and from time to time. The Trustees also have the right to terminate the Plan and the Trust under which the Plan is maintained.

**Claims**

The procedures for filing claims are described in this booklet. If your claim is denied, in whole or in part, this booklet also describes the procedures to request a review of your claim. For a complete description, see the claim and appeal procedures described in this SPD booklet beginning on page 20.

**Workers’ Compensation and the Plan**

The Plan does not replace and is not affected by any requirement for coverage under workers’ compensation or any occupational disease act or similar law. Benefits that would otherwise be payable under the provisions of these laws are not paid by the Plan.
Plan Amendment and Termination

The Board of Trustees expects that the Plan will continue. However, the Trustees have the authority to increase, decrease, or change benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of Plan Participants and beneficiaries. Any amendment will be communicated in writing and will not affect valid claims that originated before the date of the amendment.

This Plan may be discontinued or terminated under certain circumstances. In such event, all coverage for eligible individuals will end immediately. Any discontinuation will not affect valid claims that originate before the termination date of the Plan as long as the Plan’s assets are more than the Plan’s liabilities. Full benefits may not be paid if the Plan’s liabilities are more than its assets, and benefit payments will be limited to the assets available in the Trust Fund for these purposes. The Trustees will not be liable for the adequacy or inadequacy of assets. If there are any excess assets remaining after the payment of all Plan liabilities, those excess assets will be used for purposes determined by the Trustees in accordance with the provisions of the Trust Agreement.

Board of Trustees’ Discretion and Authority

Under the Plan Document and the Trust Agreement creating the Fund, the Trustees or persons acting for them have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan’s benefits, the Trust Agreement, and any other regulations, procedures, or administrative rules adopted by the Trustees. Decisions of the Trustees (or where appropriate, decisions of those acting for the Trustees) in these matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan.

The Trustees or, where Trustee responsibility has been delegated to others, the other persons, will be the sole judges of the standard of proof required in any case and the application and interpretation of the Plan, and decisions of the Trustees or their delegates are final and binding. Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them, decide, in their discretion, that you or a beneficiary is entitled to benefits in accordance with the terms of the Plan. In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for appeal under the ERISA-mandated appeal procedure adopted by the Trustees. The decision on appeal is binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that the decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over the matter.

If a provision of the Trust Agreement or the Plan, or any amendment made to the Trust Agreement or the Plan, is determined or judged unlawful or illegal, the illegality will apply
only to the provision in question and will not apply to any other provisions or the Trust Agreement or Plan.

**Your ERISA Rights**

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to the rights described in this section.

**Receive Information About Your Plan and Benefits**

You have the right to:

- Examine, without charge, at the Fund Office and at other specified locations, 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 (EBSA);
- Obtain, upon written request to the Plan Administrator or Fund Manager, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan’s annual financial report, which the Plan Administrator is required by law to provide to each Participant.

**Continue Group Health Plan Coverage**

You also have the right to:

- Continue health care coverage for your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event (your Dependents may have to pay for the coverage; review this Summary Plan Description and any documents governing the Plan on the rules governing your COBRA Continuation Coverage rights); and
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA Continuation Coverage; or
  - Your COBRA Continuation Coverage ends.

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You may obtain a Certificate of Creditable Coverage upon written request to the Plan Administrator or Fund Manager. Your request may be hand-delivered or sent by mail. Certificates will be sent to you by first-class mail to the Participant’s last known address, unless a Dependent is known to reside at a different address, in which case the Certificate for that Dependent will be sent to that address.
You may also request the Certificate of Creditable Coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries**

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

**Enforce Your Rights**

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 a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan’s claim and appeal procedures (see page 20). In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan’s money, or if you believe that you have been 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.
Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator or Fund Manager. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the EBSA, U.S. Department of Labor:

National Office:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210
1-866-444-3272

Nearest Regional Office:
Employee Benefits Security Administration
Chicago Regional Office
200 West Adams Street, Suite 1600
Chicago, IL 60606
312-353-0900

For more information on your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting the web site of the EBSA at www.dol.gov/ebsa.
GLOSSARY

Accident
An Injury occurring from an unexpected and unavoidable act.

Child
A Child includes your:
- Legitimate child born of a valid marriage or natural child who is not born of a valid marriage;
- Legally-adopted child, including a child placed with you for adoption;
- Stepchild, which means a child of your current spouse who was born to or was legally adopted by your spouse before your marriage; or
- Foster child, which means a child who has been placed in your home by an authorized placement agency or by a court judgment, decree, or other court order, provided that no state or private social service agency pays any support or compensation to any member of your household for the support or maintenance of the child.

Covered Expense
Reasonable expenses incurred because of an Accident or Illness for medical, surgical, Hospital, and nursing services, X-ray exams and treatments, laboratory tests, anesthesia, drugs, medicines, and other therapeutic and prosthetic services and supplies, subject to any Plan exclusions.

Dependent
Dependents under the Plan include your:
- Legal spouse;
- Unmarried Child who lives with you for at least half of the calendar year and is dependent on you for at least one-half of his or her support;
- Unmarried Child who does not live with you for at least half of the calendar year, provided that the Child:
  - Does not provide more than half of his or her own support;
  - Is your legitimate Child born of a valid marriage;
  - Is in your custody or the custody of his or her other parent from whom you are divorced or legally separated; and
  - Is entitled to be claimed by you as a Dependent for income tax purposes in accordance with a domestic relations order or a written agreement with the Child's custodial parent;
- Unmarried Child who does not live with you but for whom the Plan is required by a Qualified Medical Child Support Order (QMCOSO) to be considered your Dependent Child; and
• Unmarried legitimate Child, born of a lawful marriage, who does not live with you for at least half of the calendar year but for whom you provide more than half of the Child’s support and the Child cannot be claimed as a Dependent for income tax purposes by any person other than you.

A Dependent Child must also fall within certain age limitations or be disabled as defined by the Plan. A Child meets the Plan’s age requirement if he or she is:

• Less than 19 years old; or
• Age 19 but less than 23 years old and is a registered full-time student in an accredited secondary school, college, or university.

A Child who does not meet the above age requirement is a Dependent if he or she is 19 years or older and became disabled before age 19. Disabled means that the Child is unable to engage in any gainful activity due to a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more. The Trustees may require that you furnish proof of the Child’s continued disability from time to time, but not more often than once in any 12-month period. Coverage will end for the Child if the Trustees determine, based upon medical evidence, that the Child is no longer disabled or if the Child does not undergo an examination or furnish proof as required by the Trustees.

An individual is not a Dependent if he or she is entitled to Medicare coverage.

**Emergency**

A medical condition that, if immediate medical attention is not provided, can reasonably be expected to lead to death, serious dysfunction of any bodily organ or part, or other serious medical consequences. These conditions must be severe, sudden in onset, and involve one or more of the major organ systems of the body, such as the cardiovascular, metabolic, respiratory, nervous, gastrointestinal, or urinary system. In no event will a condition be considered an Emergency if the first treatment by a Physician is provided more than 24 hours after the onset of symptoms.

If symptoms exist that reasonably may have been interpreted as an Emergency, the condition will be considered an Emergency even if the final diagnosis is of another condition.

In addition, being taken for treatment to the nearest Hospital by police, fire department, or ambulance when the transportation is made under circumstances over which the person has no control will be considered an Emergency, except in cases of transportation to a Hospital for reasons related to the use of alcohol or use of illegal drugs.

**Employee**

Any individual:

• Actively employed by an Employer, on whose behalf the Employer, pursuant to a collective bargaining agreement with the Union, is or has been required to make contributions to the Trust Fund; and
On whose behalf Employer contributions are required to be made to the Fund pursuant to a written participation agreement.

**Employer**

An employer of Employees who because of a collective bargaining agreement with the Union or a participation agreement is or has been required to make contributions to the Trust Fund.

**Experimental or Investigative**

Services, supplies, and procedures that require approval by an agency of the U.S. Government that has not yet been received. Experimental treatments, services, and supplies are also those that largely have been confined to laboratory or research settings. Investigative treatments, services, and supplies are also those that have progressed to limited human application but lack wide recognition as proven and effective in clinical medicine. The Trustees have the authority to determine whether a treatment, service, or supply is Experimental or Investigative. The fact that a provider has prescribed, ordered, recommended, or approved the treatment, service, or supply does not in itself make it eligible for payment.

**Fund**

The Teamsters Union No. 142 Health and Welfare Trust Fund.

**Hospital**

A place for the diagnosis and treatment of Illness that operates legally, provided it:

- Is primarily engaged in providing medical, diagnostic, and surgical facilities for medical care of Ill and Injured persons on an inpatient basis and for compensation;
- Has a Physician in regular attendance;
- Provides services by registered nurses at all times; and
- Is not a rest home, nursing home, place for the aged, place for alcoholics, or place for drug addicts.

**Illness**

A physical or Mental Condition not included under the definition of Injury, including pregnancy, pregnancy-related medical conditions, miscarriage, therapeutic abortion, and childbirth.

**Injury**

A bodily Injury caused by an Accident, including any Illness that results directly from the Accident.
Medically Necessary or Medical Necessity

A service or supply that is:

- Consistent with the patient’s diagnosis or symptoms;
- Rendered for the treatment or diagnosis of an Injury or disease, including premature birth, congenital defect, and birth defect;
- Appropriate treatment according to generally accepted standards of medical practice;
- Not provided only as a convenience to the patient;
- Not Experimental or Investigative; and
- The most appropriate supply or level of service needed to provide safe, adequate, and appropriate treatment. When applied to confinement in a Hospital or other facility, this means that the eligible person needs to be confined as an inpatient due to the nature of the services rendered or due to the eligible person's condition and that the person cannot receive safe and adequate care through outpatient treatment.

Mental Condition or Mental Disorder

A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or Illness of any kind.

Participant

A former, Retired Employee who meets all of the Plan’s eligibility requirements (see page 4).

Physician

A person who is legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and is authorized to practice medicine, to perform surgery, and to administer drugs under the laws of the state or jurisdiction where the services are provided, who acts within the scope of his or her license, and who is not the patient or the parent, spouse, sibling (by birth or marriage), or child of the patient.

Plan

The plan of benefits provided by the Teamsters Union No. 142 Health and Welfare Trust Fund, as amended from time to time.

Plan Year

July 1 of each year through June 30 of the following year.
Qualified Medical Child Support Order

A medical child support order that creates or recognizes the existence of an alternate recipient’s rights to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or Dependent is covered under this Plan, provided:

- The medical child support order clearly specifies:
  - The name and last known mailing address, if any, of the Participant and the name and mailing address of each alternate recipient covered by the order;
  - A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient or the manner in which the type of coverage is to be determined;
  - The period to which the order applies; and
  - The Plan to which the order applies;

- The medical child support order does not require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan, except to the extent necessary to satisfy the requirements of law relating to medical child support orders pertaining to Medicaid-eligible Children as described in Section 1908 of the Social Security Act, as added by Section 13623 of OBRA 1993;

- Benefits paid to the alternate recipient are at the level of benefits available under the Plan at the time the expense is incurred; and

- The Participant is eligible for benefits and the alternate recipient is the Participant’s Dependent as defined by the Plan.

In the event you lose eligibility and are later reinstated for benefits, any previous Qualified Medical Child Support Order, which according to its terms is still in effect, will be automatically renewed.

Retired, Retirement, or Retirement Date

You are Retired or in Retirement if you area receiving a retirement benefit from the Teamsters Union No. 142 Pension Fund or the State of Indiana Retirement System. Your Retirement Date is the effective date of your pension from the Teamsters Union No. 142 Pension Fund or, if applicable, the date as of which you begin to receive retirement benefits from the State of Indiana Retirement System.

Union

Local Union No. 142, affiliated with the International Brotherhood of Teamsters.

Usual and Customary

The level of fees or charges for comparable services and supplies that is Usual and Customary in the geographic area where the services and supplies are provided.