Inland Empire Teamsters Trust

To All Eligible Employees:

The Board of Trustees is pleased to present you with this new Summary Plan Description, describing the medical, prescription drug, dental, time loss, life and accidental death and dismemberment benefits available to you and your family through the Inland Empire Teamsters Trust.

Please read this booklet carefully so you understand your benefits. Only the Trust Administration Office, Rehn & Associates, Inc., represents the Board of Trustees in administering the Plan and providing information relating to eligibility, the amount of benefits and other Plan provisions.

If you have any questions about your Plan, please contact the Trust Administration Office at 800.872.8979 for assistance.

Sincerely,

The Board of Trustees

NOTICE:

Trustee Discretion Retained. The Board of Trustees reserves the maximum legal discretionary authority to construe, interpret and apply any terms, rules and provisions of the Plan covered in this booklet. The Trustees retain full discretionary authority to make determinations on matters relating to eligibility for benefits, on matters relating to what services, supplies, care, drug therapy and treatments are experimental and investigational, and on matters which pertain to participants' rights. The decisions of the claims adjudicators, Trust Administration Office and the Board of Trustees as to the facts related to any claim for benefits and the meaning and intent of any provisions of the Plan, or application of such to any claim for benefits, shall receive the maximum deference allowed by law and will be final binding on all interested parties.

Amendment and Termination of Plan. The Board of Trustees expects to maintain this Plan indefinitely. However, the Trustees may at their sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending the benefits covered by the Plan and/or the governing Trust Agreement and/or any Policies. If this Plan is terminated, the rights of the Participants are limited to benefits incurred before termination. All amendments to this Plan shall become effective as of a date established by the Board of Trustees.

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CONTACT INFORMATION

How to Reach the Trust Administration Office

Rehn & Associates
Inland Empire Teamsters Trust
1322 N. Post Street
Spokane, Washington 99201
Website: www.teamsterbenefits.com
Telephone: (509) 534.0600 Toll Free: (800) 872.8979 Fax: (509) 535.7883

Trust Administration Office Hours:

8:00 a.m. to 5:00 p.m. Monday through Thursday
8:00 a.m. to 4:00 p.m. Friday
All times are Pacific Standard Time
Messages may be left on voicemail after hours

How to Reach Your PPO Network

Premera Blue Cross
Website: www.premera.com

How to Reach Your Pharmacy Benefit Manager

Medco Pharmacy
Customer Service: (866) 888.0103
Website: www.teamstersrx.com

How to Reach Your Preauthorization / Utilization Management Consultant

Innovative Care Management (ICM)
PO Box 875
Gladstone, OR 97027
Website: www.innovativecare.com
Telephone: (800) 862.3338 Fax: (503) 654.8570

MONEY SAVING TIPS FOR SELF-INSURED HEALTH PLANS

- **Carry Your Card** with you and show it to all health care providers and pharmacies. Your card has important information your doctor, dentist, pharmacist or provider needs in order to file your claim.
- It's important to understand that this Plan offers higher benefits – saving you money – when you use preferred (PPO) providers (doctors, hospitals, labs, etc.) in the Premera Blue Cross PPO Network and purchase your prescription drugs through the Medco pharmacy network.
- Please note this Plan does have exclusions, limitations and benefits that require preauthorization. Make yourself familiar with these benefits in order to utilize your Plan effectively.
- **Cut the cost of your prescriptions.** If possible, get your doctor to prescribe you ***generic drugs.***
- Take advantage of the **preventive care benefits** your Plan offers.
- **Practice healthy living.** One of the easiest ways to lower your medical expenses over the long term is to establish and maintain a healthy lifestyle.

Never assume anything about your health insurance. Get your information up front and BEFORE you need it by contacting the Trust Administration Office.

ABOUT THIS BOOKLET

The Inland Empire Teamsters Trust was established August 1, 1966, to provide health coverage for Participants and their families. This booklet describes Inland Empire Teamsters Trust benefits as of February 1, 2014, for eligible Plan participants

We encourage you to become familiar with your benefits and the valuable protection they offer. This booklet will also help you understand what services are and are not covered and any special steps you need to take to get the highest level of coverage.

It's important for all Plan participants to use these benefits wisely, which starts with understanding them. The perspective of the booklet is written from the participant's view. When reviewing a benefit, listed is what the Plan pays. Carefully read and keep this booklet for future reference, so you understand how to make the Plan work best for you.

Each benefit listed in this booklet is accompanied by a code indicating under which component of the Plan the benefit is paid. The definition of each code is listed below:

- **Base** = benefits under this component are paid prior to any participant's deductibles and out of pocket expenses. Not all of the benefits apply to the Base component.
- **Major Medical** = benefits under this component are payable after participant's deductibles and out of pocket expenses. Not all of the benefits apply to the Major Medical component.
- **Base & Major Medical** = applicable benefits will be applied to the Base component first and any remaining balance will be applied to the Major Medical component.

If you have questions regarding your coverage or eligibility, please contact the Trust Administration Office, Rehn & Associates.

SUMMARY OF BENEFITS

Please refer to the specific plan provisions for full details of each benefit.

***PLEASE NOTE*: Benefits may apply to the Base Plan, the Major Medical Plan or Both Plans as listed further in the SPD. If a benefit is not listed in the Summary of Benefits, it doesn't mean it is not covered. Please refer to the "Medical Overview" to see how benefits coordinate between the Base Plan and Major Medical Plan.**

BASE MEDICAL PLAN	PLAN PAYS	BASE PLAN ONLY
Chiropractor - Employee, Extremity Manipulation		*Base Only*
Preferred Provider:	$10 Copay, then $27 Maximum Payment	
Non-Preferred Provider:	$10 Copay, then $27 Maximum Payment	
Chiropractor – Spouse & Dependent(s), Extremity Manipulation		*Base Only*
Preferred Provider:	$10 Copay, then $22 Maximum Payment	
Non-Preferred Provider:	$10 Copay, then $22 Maximum Payment	
Chiropractor – X-Rays		*Base Only*
Preferred Provider:	20% of PPO Allowed Charges	
Non-Preferred Provider:	20% of Usual & Customary Allowed	
Contraception, Implantable, Injectable, Insertable Devices, Oral/Topical		*Base Only*
Preferred Provider:	Plan pays 100% of PPO Allowed Charges	
Non-Preferred Provider:	Plan pays 100% of Usual & Customary Amount	
Home Health Care		*Base Only*
Preferred Provider:	Plan pays 100% of PPO Allowed Charges	
Non-Preferred Provider:	Plan pays 100% of Usual & Customary Amount	
Hospice Care		*Base Only*
Preferred Provider:	Plan pays 100% of PPO Allowed Charges	
Non-Preferred Provider:	Plan pays 100% of Usual & Customary Amount	
Immunizations, Adult and Child		*Base Only*
Preferred Provider:	Plan pays 100% of PPO Allowed Charges	
Non-Preferred Provider:	Plan pays 100% of Usual & Customary Amount	
Preventive Care, Adult and Child		*Base Only*
Preferred Provider:	Plan pays 100% of PPO Allowed Charges	
Non-Preferred Provider:	Plan pays 100% of Usual & Customary Amount	

MAJOR MEDICAL PLAN	PLAN PAYS	MAJOR MEDICAL ONLY
Allergy Injection and Testing		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Blood, Products, Storage & Transportation, Transfusion		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Chemical Dependency, Inpatient, Outpatient		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
DME – Durable Medical Equipment, Major Equipment, Other / Supplies		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Emergency Services, Facility and Professional		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Hearing, Testing		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Hospital Services, Inpatient, Facility, New born, Other, Inpatient, Visit		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Hospital Services, Outpatient, Facility, Surgery, Other, Outpatient, Visit		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Injectable Medication, Growth Hormone, Spinal Steroid, Vitamin B, Other		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Maternity, Genetic Counseling and Testing		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Maternity, Inpatient, Facility, Inpatient, Visit		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Maternity, Outpatient, Facility, Surgery, Outpatient, Facility, Other		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Mental or Neuropsychiatric Conditions, Inpatient Services		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Mental or Neuropsychiatric Conditions, Outpatient Service, Visit, Testing		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Orthopedic Appliance		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Osteopathic Manipulation		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	
Phototherapy		***Major Medical Only***
Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum	
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum	

MAJOR MEDICAL PLAN (continued)

Prosthetics ***Major Medical Only***

Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum

Reduction Mammoplasty, Facility ***Major Medical Only***

Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum

Rehabilitation Therapy, Cardiac Rehabilitation, Inpatient, Outpatient ***Major Medical Only***

Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum

Skilled Nursing Facility ***Major Medical Only***

Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum

Sleep Studies ***Major Medical Only***

Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum

Sterilization, Female, Male, ASC, Facility ***Major Medical Only***

Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum

Surgical Suite, Facility ***Major Medical Only***

Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum

Teeth, Injury / Accident ***Major Medical Only***

Preferred Provider:	Deductible, 20% of PPO Allowed Charges, Coinsurance Maximum
Non-Preferred Provider:	Deductible, 20% of the Usual & Customary Amount, Coinsurance Maximum

PLEASE NOTE: This Summary of Benefits is intended to be a summary only. Benefits may apply to either the Base Plan, the Major Medical Plan or Both Plans as listed further in the SPD. If a benefit is not listed in the Summary of Benefits, this does not necessarily mean it is not covered. Please see the following page to see how claims are coordinated between the Base Medical Plan and the Major Medical Plan.

COORDINATION BETWEEN BASE MEDICAL PLAN AND MAJOR MEDICAL PLAN

Below is an explanation of how claims are coordinated between the Base Medical Plan and the Major Medical Plan

Example: An employee sustains an injury that requires immediate treatment and is transported to the hospital emergency room by ambulance. The employee has a follow up office call with the doctor the following week.

The expenses are submitted to the Plan and are paid as follows:

Service / Treatment	**Allowed Charges**	**Base Medical Pays**	***then* Major Medical Pays**
A) Ambulance	$445.00	$100.00 Benefit Pays	$345.00 Remaining
			-$300.00 Deductible
			$45.00 To Major Med
			X 80%
			$36.00 Plan Payment
B) Hospital Emergency	$859.00	Does not apply to Base Medical Plan	$859.00
			X 80% To Major Med
			$687.20 Plan Payment
C) Physician Office Call	$75.00	Does not apply to Base Medical Plan	$75.00
			-$25.00 Copay
			$50.00 Plan Payment

Summary:

Service / Treatment	**Allowed Charge**	**Benefits Paid**	**Employee Pays**
A) Ambulance	$445.00	$136.00	$309.00
B) Hospital ER	$859.00	$687.20	$171.80
C) Physician OC	$75.00	$50.00	$25.00
TOTALS:	**$1,379.00**	**$873.20**	**$505.80**

INTRODUCTION

This Summary Plan Description has been prepared for the Employees and their Dependents of Inland Empire Teamsters Trust effective February 1, 2014.

This document provides a general summary as required of Inland Empire Teamsters Trust Plan benefits and contains medical, dental, vision and pharmacy benefits program. This document does not constitute an employment contract or guarantee to continue employment for any period of time. In addition, medical benefits are not vested. Inland Empire Teamsters Trust may delegate some or all of its responsibilities to other entities such as insurance companies and claims payers. Inland Empire Teamsters Trust reserves the right to amend or delete any of the benefits or Plan provisions described herein at any time.

Please review this benefit booklet carefully. It contains a schedule of benefits and all the general provisions of the Plan. To receive the maximum benefits of this Plan, a Preferred Provider must provide health care services.

This document is a description of the Inland Empire Teamsters Trust (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. Coverage under the Plan will take effect for an eligible employee and designated dependents when the employee and such dependents satisfy all of the eligibility requirements of the Plan, including any applicable waiting periods. Participants are responsible for any copay, deductible and coinsurance amounts, as well as any non-covered services and amounts in excess of the allowed charge when a Non-Preferred Provider provides services. Amounts in excess of the Participant's copay, deductible, coinsurance, and the payment by the Trust for covered services rendered by a Preferred Provider shall be considered to be contractual adjustments and shall not be billed to the Participant.

Rehn & Associates will act as the third party administrator and claims processing fiduciary for this self-funded plan. Inland Empire Teamsters Trust, as a self-funded multi-employer Trust, is the Plan Administrator with discretionary authority to determine eligibility for benefits, and to construe and interpret the terms of the Plan, except as delegated to Rehn & Associates under Plan processes.

The Trust fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason, with or without notice. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, coinsurance, maximums, copayments, exclusions, limitations, definitions, eligibility, and the like, at any time with or without notice, in accordance with governing laws.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections and payment, utilization review or other cost management requirements, lack of medical necessity, lack of timely filing of claims or lack of coverage. Failure to provide Coordination of Benefits information may result in delay of coverage or temporary termination of coverage until information is received. Fraudulent use of Coordination of Benefits rules will result in automatic termination of eligibility.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage is terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for service or supply is incurred on the date it is furnished. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment or elimination.

ELIGIBILITY REQUIREMENTS

The Plan Administrator has the discretionary authority to determine eligbility for benefits, to construe the terms used in this Plan and to interpret the terms of the benefit Plan, as provided under Plan Processes. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. In order for an applicant to become entitled to, or a Participant to continue the benefits of this Plan, the following qualifications must be met:

General Rule
To establish eligibility, an employee must first meet the requirements established in the Collective Bargaining Agreement or other Signatory Agreement with a Participating Employer. The number of hours an employee must work in each month to satisfy the requirements of these agreements are not the same for each Employee. Please check your particular Collective Bargaining Agreement to determine the minimum number of hours required for your Employer to pay a contribution on your behalf.

Initial Eligibility
Employees must meet the eligibility requirements of a Collective Bargaining Agreement in four calendar months within a nine-month period. Coverage begins the first day of the month immediately following the fourth month the eligibility requirements of the Collective Bargaining Agreement are met and provided the required contributions for all four (4) months are paid to the Plan.

> Example: In January, an Employee begins working for a Participating Employer. The Employee works the required number of hours in January, February, March and April, and the required contributions are paid for those months. The employee is then eligible on May 1st.

Continued Eligibility
Once an Employee becomes eligible, he or she shall continue to be eligible on a monthly basis, as long as the monthly eligibility requirements of the Agreement are met and the required Employer contribution is paid to the Plan. Such employment and the contribution payment will make the Employee eligible for benefits in the following month.

Termination of Eligibility
An Employee shall cease to be eligible on the last day of a calendar month during which he or she fails to meet the eligibility requirements of the Agreement, unless COBRA payments are made.

Reinstatement of Eligibility
If eligibility is lost for less than four consecutive months, the Employee may reinstate eligibility by working the required number of hours in a calendar month and coverage will be effective on the first day of the next succeeding month.

However, if the Employee DOES NOT reinstate his or her eligibility during a period of four consecutive calendar months, then the Employee must work for a contributing Employer and have contributions paid on his or her behalf under the terms of the "Initial Eligibility Rules" – just as if he or she were a "new Employee."

An exception is made if the Employee loses eligibility due to a layoff by a participating Employer. In that case, he or she may reinstate their eligibility any time during the eight consecutive month period following his or her loss of eligibility. Such reinstatement shall be the first day of the month following a month in which the eligibility requirements of the Agreement are met and the required contribution is paid to the Plan.

Dependent Eligibility
Eligible dependents of Employees who meet the preceding eligibility requirements are also covered under the Plan. The eligibility of dependents is subject to the continued eligibility of the Employee. When the Employee's eligibility terminates, the eligibility of the dependents also terminates.

An enrolled dependent hereunder is any dependent as to whom each and all of the following qualifications exists:

- The legal spouse of the Subscriber; or
- Dependent child from birth through age twenty-five (25); further a dependent child must be one of the following:
    - A natural, step, or adopted child of the Participant, a child placed for adoption;
    - A legally placed ward in the Participant's home;
    - A child of a divorced Participant if the child is not self-supporting; or
    - A foster child is not eligible.
    - Dependent child(ren) whose coverage must continue pursuant to a state court's medical child support order (Qualified Medical Child Support Order, (QMCSO)).

Enrollment Requirements
A participant must file an enrollment form with the Trust Fund office to list qualified dependents. A new enrollment form should be filed to correct errors in the original, or to record changes in dependents. Failure to keep the enrollment form current may delay approval or cause denial of benefits.

Continued Eligibility Based on Total Disability (Waiver of Premium)
An Employee who becomes ineligible because of total disability, whether occupational or non-occupational shall have his or her Basic Medical and Major Medical benefits continued during the term of the disability up to a maximum of 90 days. This continued eligibility does not include dental, vision or prescription drug benefits. Total disability shall be established by qualifying for weekly income disability benefits under the Worker's Compensation Act or by providing the Trust with satisfactory proof of disability. For purposes of this section, evidence that the Employee is physically unable to perform any and every duty of his/her occupation and does not engage in any other occupation for wage or profit shall constitute satisfactory proof of disability.

Extension of Benefits
Under certain circumstances, benefits may be available up to 12 months after the termination of your coverage if the covered person is totally disabled when your coverage terminates. This extension of benefits will apply only to expenses due to the sickness or injury which caused the total disability. The disabled individual must make written application to the Trust within sixty (60) days of termination of coverage. For specific information concerning Extended Benefits, please contact the Trust Administration Office.

Military Services
Participants who satisfy conditions imposed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) may be entitled to have their period of military service count as service with their Employer for purposes of contributions made on your behalf and benefit accrual. To receive credit, a participant must have left covered employment with at least 1,000 hours total with Employers, including 500 hours in the year or immediately preceding year before entering military service and at least 40 hours in the 3 months prior to entering military service. The requirements of USERRA apply to all veterans who are reemployed in covered employment on or after December 4, 1994. Any reemployment of veterans before that date is governed by prior law.

Under current law, veterans will receive credit for purposes of vesting and benefit accrual for a period of up to 5 years of active duty service in the U.S. Armed Forces, National Guard, Coast Guard or Public Health Service. A veteran is entitled to all benefit increases granted to active participants during the period of military service.

In order to be eligible for the reemployment and benefit rights under USERRA, a veteran's discharge from the military must be other than dishonorable, and he or she must have worked in covered employment before and after the period of military service. To be eligible for military service credit, a veteran must return to (or apply for) covered employment within the following time periods after the end of his or her military service:

Length of Military Service	Re-employment Deadline
Less than 31 days	1 day after discharge
31 through 180 days	14 days after discharge
More than 180 days	90 days after discharge

If the participant was hospitalized or otherwise incapacitated by a service-related illness or injury, those reemployment periods may be extended up to two years. A participant that is activated for military service may elect to continue coverage for dependents under COBRA or if no election is made, upon return to covered employment, the participant will resume coverage without lapse.

MEDICAL OVERVIEW

NETWORKS

Preferred Provider Network	Premera Blue Cross

Preferred Provider Networks *are provider networks with whom The Inland Empire Teamsters Trust has contracted to ensure its Participants have access to Preferred Providers.*

DEDUCTIBLE

Annual Deductible – Individual	$300
Annual Deductible – Family	$900

Deductible *is the amount of expense, up to the Allowed Charges, for Covered Services payable by a participant under the Major Medical component of this Plan before the Trust will assume any liability for all or part of the remaining Covered Services. Benefits paid under the Major Medical component except as otherwise specified, shall apply only after the deductible has been met.*

Charges for services payable by the participant, due to a reduction/denial of benefits, or amounts charged in excess of the Allowed Charge are the financial responsibility of the participant and shall not be considered an eligible expense for application towards the deductible amount.

DEDUCTIBLE CARRYOVER

Includes any eligible expense incurred to satisfy the deductible in whole or in part during the last three (3) months of the previous year. This amount would be applied toward the current plan year deductible, provided enrollment has been continuous.

COINSURANCE MAXIMUM

Annual Coinsurance Maximum – Individual	$2,200
Annual Coinsurance Maximum – Family	$4,100
Coinsurance Maximum plus Deductible – Individual	$2,500
Coinsurance Maximum plus Deductible – Family	$5,000

Coinsurance Maximum *refers to the maximum out-of-pocket amount a covered participant will have to pay for expenses covered under the Plan. Coinsurance maximum includes only the coinsurance amount.*

PRE-AUTHORIZATION

Pre-Authorization *is the process a Provider of service must follow when required by the plan design. When the Provider contacts Innovative Care Management (ICM) to initiate the process, ICM will review the treatment plan for, among other things, appropriateness of care, place of service, and medical necessity.*

Some medical services require a Pre-Authorization be obtained. If a Pre-Authorization is not obtained, a penalty will be assessed in the amount of 10% of billed charges, not to exceed a $250 penalty.

PLEASE NOTE: ***All Benefits are subject to the exclusions found in this booklet.***

MEDICAL BENEFITS

Allergy Injections and Testing **Major Medical Only**

Immunotherapy ("allergy shots") is a form of preventive and anti-inflammatory treatment of allergies to substances such as pollens, house dust mites, fungi, and stinging insect venom. Allergy tests provide specific information about what you are and are not allergic to.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Chiropractor - Employee, Extremity Manipulation **Base Only**

Extremity manipulation is a corrective procedure, performed by a chiropractor, applied to a joint of an appendage or appendages performed on Employees. *Maximum benefit of twenty-four (24) visit(s) per calendar year.*

Preferred Provider:	Base Plan pays $27 Maximum Payment, after $10 copay
Non-Preferred Provider:	Base Plan pays $27 Maximum Payment, after $10 copay

Chiropractor - Spouse & Dependent(s), Extremity Manipulation **Base Only**

Extremity manipulation is a corrective procedure, performed by a chiropractor, applied to a joint of an appendage or appendages performed on Spouse and Child(ren). *Maximum combined benefit of fifteen (15) visit(s) per calendar year.*

Preferred Provider:	Base Plan pays $22 Maximum Payment, after $10 copay
Non-Preferred Provider:	Base Plan pays $22 Maximum Payment, after $10 copay

Chiropractor - X-Rays **Base Only**

X-Ray taken by a Chiropractor.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary Amount

Ambulance, Air and Ground **Base & Major Medical**

Vehicle such as an airplane, helicopter or a designated ground vehicle which transports a sick or injured person to a care facility and is equipped and staffed to provide medical care during transit. An air ambulance is used when ground ambulance is not available or would cause life threatening delays in treatment.

Preferred Provider:	Base Plan pays $100 towards this benefit Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays $100 towards this benefit Plan pays 80%of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Anesthesiologist, Inpatient and Outpatient **Base & Major Medical**

Anesthesia is the use of drugs or other agents that cause insensibility to pain during a surgery or other procedure. The different types of anesthesia include, but are not limited to: general anesthesia, epidural anesthesia, spinal anesthesia, topical anesthesia, regional anesthesia, and local anesthesia.

Preferred Provider:	Plan pays $330 towards this benefit Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays $330 towards this benefit Plan pays 80%of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Blood, Products **Major Medical Only**

Blood is made up of plasma, red blood cells, white blood cells, cryoprecipitate and platelets; blood circulates through the body to carry away waste matter and carbon dioxide and brings nourishment to the tissues.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Blood, Storage & Transportation **Major Medical Only**

Storage and transportation of blood products.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Blood, Transfusion **Major Medical Only**

Drawing and processing of autologous blood.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Chemical Dependency, Inpatient **Major Medical Only**

Inpatient Chemical Dependency Services are provided at an inpatient facility whose function is to provide a structured program for the treatment, rehabilitation and prevention of chemical dependency. These services are special clinical services that are available only in an inpatient hospital setting. Specific criteria must be met by the Participant in order for inpatient chemical dependency to be approved. *Maximum benefit of 30 days visit(s) per calendar year applies to all Chemical Dependency benefits combined.*

Preferred Provider:	**Pre-authorization is required for these services.** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services.** Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Chemical Dependency, Outpatient Visit **Major Medical Only**

A visit with a provider regarding Chemical Dependency services not in an inpatient setting. *Maximum benefit of 30 days visit(s) per calendar year applies to all Chemical Dependency benefits combined.*

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Chemical Dependency, Outpatient, Other **Major Medical Only**

All other services provided in conjunction with necessary Chemical Dependency treatment not in an inpatient facility. Maximum benefit of 30 days visit(s) per calendar year applies to all Chemical Dependency benefits combined.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Chemotherapy Services **Base & Major Medical**

Treatment where drugs flow through the bloodstream usually for the treatment of cancer.

Preferred Provider:	**Pre-authorization is required for these services.** Base Plan pays 80% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum

Non-Preferred Provider:	**Pre-authorization is required for these services.** Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Contraception, Implantable, Injectable, Insertable Devices, Oral, Topical **Base Only**

Contraceptive processes, devices, or methods that prevent conception, received from a medical provider in their place of service.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Contraception, Office Visit **Major Medical Only**

Office visit related to contraception management.

Preferred Provider:	$25 Copay
Non-Preferred Provider:	$25 Copay

Dialysis Services **Base & Major Medical**

Procedure that is a substitute for the function of the kidneys, which are responsible for filtering waste products from the blood. Alternate Names: Artificial Kidneys, End Stage Renal Disease (ESRD), Hemodialysis, Peritoneal Dialysis, Renal Replacement Therapy. The participant must contact Innovate Care Management (ICM), (800) 862-3338, prior to beginning dialysis treatment.

In regard to End Stage Renal Disease (ESRD), enrollment is required in the Medicare ESRD program. Dialysis benefits remain unchanged for the first three (3) months of treatment. Reimbursement will be made to the participant for Medicare Part B premiums during months four (4) through thirty-four (34).

Preferred Provider:	**Pre-authorization is required for these services.** Base Plan pays 80% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services.** Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

The participant will not incur out-of-pocket expenses for dialysis treatment during this time. For treatment during month thirty-five (35) and beyond, Medicare becomes the primary payer and the Trust will process the remaining amount under standard coordination of benefits.

DME - Durable Medical Equipment, Major Equipment **Major Medical Only**

Includes, but is not limited to, infusion pumps, insulin pumps, hospital beds, wheelchairs, apnea monitors, c-pap machines, and enteral/parenteral formula. Items shall be limited to the standard model of such medical equipment. Repairs and replacement costs will only be covered if the equipment was used by the Participant in the manner and for the purpose for which the equipment was intended and the replacement costs are necessarily incurred due to normal wear and tear of the equipment. Durable medical equipment may be rented or purchased. When equipment is rented, the rental charges shall not exceed the purchase price.

Preferred Provider:	**Pre-authorization is required for these services.** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services.** Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

DME - Durable Medical Equipment, Other / Supplies **Major Medical Only**

Supplies include, but are not limited to, minor equipment such as bandages, wraps, crutches, canes, and ostomy supplies.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Emergency Services, Facility **Major Medical Only**

Health care services required to treat an emergency medical condition. A medical emergency is an accidental bodily injury or the sudden onset of severe symptoms of sufficient seriousness that the absence of immediate medical care would result in placing Participant's life in jeopardy or permanent impairment or dysfunction of any body parts, organs or bodily functions.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Emergency Services, Professional **Major Medical Only**

Professional charges associated with a visit to an emergency room.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Hearing, Office Visit **Major Medical Only**

Office visit related to the measure of hearing accuracy and/or deficiency.

Preferred Provider:	$25 Copay
Non-Preferred Provider:	$25 Copay

Hearing, Testing **Major Medical Only**

Hearing tests to measure hearing accuracy and/or deficiency.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Home Health Care **Base Only**

Care is provided in the home by a home health agency that must be Medicare-certified or licensed/certified by the state in which it operates. To be eligible for this benefit the Participant must be confined to the home or receiving therapy which the Plan determines to be best provided in the home. These services will no longer be available when there is a failure to progress with said therapy. *Maximum benefit of $10,000 per calendar year.*

Preferred Provider:	**Pre-authorization is required for these services.** Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services.** Base Plan pays 100% of Usual & Customary Amount

Hospice Care **Base Only**

Healthcare option for Participants who are faced with a terminal illness and not expected to live more than six (6) months. Services must be provided by an agency that is Medicare-certified or licensed/certified by the state in which it operates. *Maximum benefit of $10,000 per lifetime.*

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Hospital Services, Inpatient, Facility, Newborn Delivery **Major Medical Only**

Hospital services are provided for injured or ill persons. A hospital is a facility that provides diagnosis, treatment, and care of persons who need acute care under the supervision of physicians. Certain procedures may be considered cosmetic and subject to review. Inpatient facility services rendered to a newborn.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Hospital Services, Inpatient, Facility, Other **Major Medical Only**

Inpatient facility services rendered to hospital patients other than newborns.

Preferred Provider:	**Pre-authorization is required for these services.** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services.** Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Hospital Services, Inpatient, Surgeon **Base & Major Medical**

Professional surgical services provided in an inpatient setting.

Preferred Provider:	Base Plan pays 60% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays 60% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance maximum

Hospital Services, Inpatient, Visit **Major Medical Only**

A patient encounter with a health care provider in an inpatient setting.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Hospital Services, Outpatient, Facility, Surgery **Major Medical Only**

Professional surgical services provided in an outpatient setting. Surgical services include services of a surgeon and an assistant surgeon or co-surgeon.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Hospital Services, Outpatient, Facility, Other **Major Medical Only**

Services other than a surgery or visit received in an outpatient setting.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Hospital Services, Outpatient, Surgeon **Base & Major Medical**

Professional surgical services provided in an outpatient setting.

Preferred Provider:	Base Plan pays 60% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays 60% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance maximum

Hospital Services, Outpatient, Professional **Major Medical Only**
A patient encounter with a health care provider in an outpatient setting.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Immunizations, Adult, Shingles over age Fifty-Nine (59) **Base Only**
Immunization to prevent Shingles performed in an office setting, if performed at a pharmacy, please see pharmacy benefit.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Immunizations, Adult, Shingles through age Fifty-Nine (59) **Base Only**
Immunization to prevent Shingles performed in an office setting.

Preferred Provider:	**Pre-authorization is required for these services.** Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services.** Base Plan pays 100% of Usual & Customary Amount

Immunizations, Adult, Tetanus **Base Only**
Immunization to prevent Diphtheria, Tetanus and Pertussis (DTaP).

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Immunizations, Adult, HPV **Base Only**
Immunization to prevent human papillomavirus (HPV) for males and females through twenty-six (26) years of age.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Immunizations, Adult, Other **Base Only**
Other Immunization for males and females, including flu shot, age eighteen (18) years and over.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Immunizations, Child **Base Only**
Immunizations for Plan Participants through age seventeen (17).

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Injectable Medications, Pre-Auth List, Growth Hormone **Major Medical Only**
Human Growth Hormone delivered via intravenous injection in a provider's office or outpatient setting.

Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Injectable Medications, Pre-Auth List, Other **Major Medical Only**

The following Injectable Medications require Prior-Authorization: Amevive, Avonex, Botox, Carticel, Depo-Lupron, Enbrel, Forteo, Humira, Hyalgan, Inerferon, IVIG medications, Kineret, Orencia, Prolastin, Remicade, Remodulin, Rituxan, Supartz, Synagis, Synvisc, Thyrogen, Visudyne, and Xolair. This list is subject to change.

Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Injectable Medications, Spinal Steroid **Major Medical Only**

Injection of a steroid for diagnostic or therapeutic purposes to relieve pain and/or inflammation.

Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Injectable Medications, Vitamin B, Pernicious Anemia and Vitamin B Deficiency **Major Medical Only**

Receiving a Vitamin B shot for the condition of pernicious anemia or Vitamin B deficiency.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Injectable Medications, Other **Major Medical Only**

All other injectable medications.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Maternity

Any service, treatment, or procedure rendered during the antepartum and postpartum periods as a result of conception. Maternity benefits shall include, but not be limited to, care required for vaginal delivery, cesarean section, and/or complications related to a pregnancy. Maternity admission for vaginal delivery does not require pre-authorization. If the Hospital stay extends beyond forty eight (48) hours post-admission notification will be required. Maternity admission for cesarean section delivery does not require pre-authorization. If the Hospital stay extends beyond ninety six (96) hours post-admission notification will be required.

Maternity services, as described, for a dependent child (not Subscriber or Subscriber's Spouse) are not a covered benefit. Home Births and charges related to a home birth are not a covered benefit.

Maternity, Genetic Counseling and Testing **Major Medical Only**

Analysis of DNA, RNA, chromosomes, proteins, and metabolites to detect genotypes, mutations or chromosomal changes to see if an unborn child may be at risk of inheriting or developing a disease or genetic abnormality.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Maternity, Inpatient, Anesthesiologist **Base & Major Medical**

Services provided by an anesthesiologist in an inpatient hospital setting for maternity care.

Preferred Provider:	Base Plan pays $330 towards this benefit Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays $330 towards this benefit Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Maternity, Inpatient, Facility **Major Medical Only**

Inpatient facility services for maternity care.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Maternity, Inpatient, Surgeon **Base & Major Medical**

Professional surgical services provided in an inpatient setting for maternity care.

Preferred Provider:	Base Plan pays 60% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays 60% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance maximum

Maternity, Inpatient, Visit **Major Medical Only**

A patient encounter with a health care provider in an inpatient setting for maternity care.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Maternity, Office Visit **Major Medical Only**

A patient encounter with a health care provider in an office or clinic for maternity care.

Preferred Provider:	$25 Copay
Non-Preferred Provider:	$25 Copay

Maternity, Outpatient, Anesthesiologist **Base & Major Medical**

Maternity outpatient refers to non-emergency services or treatment received in a Hospital when the Participant is not admitted. Services provided by an anesthesiologist in an outpatient hospital or office setting for maternity care.

Preferred Provider:	Base Plan pays $330 towards this benefit Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays $330 towards this benefit Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Maternity, Outpatient, Facility, Surgery **Major Medical Only**

Outpatient facility services for maternity care.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Maternity, Outpatient, Facility, Other **Major Medical Only**

Services other than a surgery or visit received in an outpatient setting for maternity care.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Maternity, Outpatient, Surgeon **Base & Major Medical**

Professional surgical services provided in an outpatient setting for maternity care.

Preferred Provider:	Base Plan pays 60% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays 60% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance maximum

Maternity, Outpatient, Visit **Major Medical Only**

A patient encounter with a health care provider in an outpatient setting for maternity care.

Preferred Provider:	$25 Copay
Non-Preferred Provider:	$25 Copay

Maternity, Pathology / Diagnostic Testing **Base & Major Medical**

Maternity pathology and diagnostic testing services.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	Base Plan 80% of Usual & Customary charges Plan pays 80% of Usual & Customary Charges, after Deductible, Coinsurance Maximum

Maternity, Radiology, Ultrasound **Base & Major Medical**

Maternity ultrasounds which use high-frequency sound waves to produce images during maternity.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary charges Plan pays 80% of Usual & Customary Charges, after Deductible, Coinsurance Maximum

Maternity, Radiology, Other **Base & Major Medical**

Maternity Radiology services.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary charges Plan pays 80% of Usual & Customary Charges, after Deductible, Coinsurance Maximum

Mental or Neuropsychiatric Conditions, Inpatient Services **Major Medical Only**

Acute Inpatient Hospitalization is provided specifically for those Participants who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or are acutely and significantly disabled, or whose activities of daily living are significantly impaired. This level of care involves the highest level of skilled psychiatric services. It is rendered in a freestanding psychiatric hospital or the psychiatric unit of a general hospital. *Maximum benefit of thirty (30) days per calendar year.*

Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum

Mental or Neuropsychiatric Conditions, Outpatient Services, Visit **Major Medical Only**

Visit for a Mental or Neuropsychiatric condition. This benefit applies to individual sessions and does not cover any group/family coverage.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Mental or Neuropsychiatric Conditions, Outpatient Services, Testing **Major Medical Only**

Testing for Mental or Neuropsychiatric conditions.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Office Visit, Primary Care Physician (PCP) **Major Medical Only**

A Primary Care Physician (PCP) is a general medical practitioner who will see adults of all ages or a pediatrician who will see children through adolescence for uncomplicated and common medical problems. A Primary Care Physician can be a general practitioner, general internist, family practitioner, general pediatrician and/or an obstetrician/gynecologist (OB/GYN).

Preferred Provider:	$25 Copay
Non-Preferred Provider:	$25 Copay

Office Visit, Specialist **Major Medical Only**

A Specialist is a physician whose practice concentrates on certain body systems, specific age groups, or complex scientific techniques developed to diagnose or treat certain types of disorders. Types of Specialists; Allergy, Immunology, Cardiology, Dermatology, Gastroenterology, Neurology, Otolaryngology, Pulmonologist, Rheumatology, Surgeons, Urology, and all Other.

Preferred Provider:	$25 Copay
Non-Preferred Provider:	$25 Copay

Orthopedic Appliances **Major Medical Only**

Orthopedic appliances are appliances, braces and splints required for normal daily activities or treatment of any illness or injury.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Osteopathic Manipulation **Major Medical Only**

Osteopathic Manipulation is a system of hands-on techniques meant to help alleviate pain, restore motion, support the body's natural functions and influence the body's structure to help it function more efficiently.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Pathology and Diagnostic Testing **Base & Major Medical**

Laboratory tests are provided for inpatient, outpatient and professional services. Pathology is the science of interpreting microscopic views of body tissues.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Phototherapy **Major Medical Only**

Phototherapy is exposure to non-ionizing radiation for therapeutic benefit. It may involve exposure to ultraviolet B (UVB), ultraviolet A (UVA) or various combinations of UVB and UVA.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of the Usual & Customary Amount, after Deductible, Coinsurance Maximum

Preventive Care, Gynecological Examinations **Base Only**

Preventive Care examinations are for the evaluation and management of a healthy individual without complaints or symptoms associated with Illness or Injury, including routine diagnostic examinations and tests. Routine gynecological examinations, including pelvic examination and breast examination.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Preventive Care, Colonoscopy **Base Only**

Preventive Colonoscopy examinations for ages fifty (50) and over. The procedure enables the physician to see things such as inflamed tissue, abnormal growths, and ulcers. It is most often used to look for early signs of cancer in the colon and rectum. Colonoscopies are considered diagnostic if they are being used to look for causes of unexplained changes in bowel habits or to evaluate symptoms like abdominal pain, rectal bleeding, and weight loss.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Preventive Care, Pathology and Diagnostic Testing **Base Only**

Laboratory and diagnostic testing billed along with the well examination.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Preventive Care, Pathology and Diagnostic Testing, Annual Gynecological **Base Only**

Laboratory and diagnostic testing billed along with the Annual Gynecological examination.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Preventive Care, Radiology, Screening Mammogram **Base Only**

A screening mammogram is performed for women who have no symptoms that would be of medical concern. It usually involves two X-rays of each breast.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Preventive Care, Radiology, Other **Base Only**

Radiology billed along with the well examination.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Preventive Care, Well Examination, Well Adult, Well Child, Well Baby **Base Only**

Well physical examinations are provided for healthy individuals, age nineteen (19) or over (adult), healthy children two (2) years through eighteen (18) years of age (child), infants and babies newborn through twenty-four (24) months of age (baby). This includes routine prostate examinations, including digital rectal examination (DRE) exam for adult men. This would include physicals done for the sole purpose of sports eligibility.

Preferred Provider:	Base Plan pays 100% of PPO Allowed Charges
Non-Preferred Provider:	Base Plan pays 100% of Usual & Customary Amount

Prosthetics **Major Medical Only**

A prosthesis is a device used to replace an absent body part with an artificial substitute. Prosthetics include, but are not limited to, the purchase, fitting, necessary adjustments, repairs and replacements of prosthetic devices and supplies which replace all or part of an absent body organ including contiguous tissue.

Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Radiation Therapy **Base & Major Medical**

Radiation therapy shall consist of the use of high energy penetrating rays, or natural or artificial radioactive substances to treat disease.

Preferred Provider:	**Pre-authorization is required for these services** Base Plan pays 80% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Radiology, Bone Density **Base & Major Medical**

Bone Density Testing measures the strength and density of bone and the mineral concentration in the skeleton. A bone density test assists physicians to understand what treatments, if any, are needed to arrest further bone loss and perhaps reverse the effects of osteoporosis.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges, Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Radiology, CT Scan **Base & Major Medical**

A CT scan is used to define normal and abnormal structures in the body and/or assist in procedures by helping to accurately guide the placement of instruments or treatments.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges, Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Radiology, Diagnostic Mammography **Base & Major Medical**

Diagnostic mammograms are done to evaluate abnormalities that have been seen or suspected on a prior screening mammogram; subjective or objective abnormalities in the breast; or an inexplicable change in breast size or shape. Diagnostic mammography typically takes longer and involves correspondingly more radiation exposure than a screening mammogram.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges, Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Radiology, Echocardiogram **Base & Major Medical**

Echocardiograms are ultrasound images that help identify abnormalities in the heart muscle and valves, and find any fluid that may surround the heart.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges, Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Radiology, MRI / MRA **Base & Major Medical**

MRI (magnetic resonance imaging) or MRA (magnetic resonance angiography) scans are radiology techniques which use magnetism, radio waves, and a computer to produce images of body structures.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Radiology, PET Scan **Base & Major Medical**

PET (positron emission tomography) scans, and similar SPECT (single photon emission computed tomography) scans, forms of nuclear imaging, use low doses of radioactive substances to diagnose or treat a variety of diseases, including many types of cancers, heart disease and certain other abnormalities within the body.

Preferred Provider:	**Pre-authorization is required for these services** Base Plan pays 80% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Radiology, Ultrasound **Base & Major Medical**

Ultrasound or "sonography" is a radiology technique, which uses high-frequency sound waves to produce images of the organs and structures of the body.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges, Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Radiology, Other Imaging **Base & Major Medical**

Includes but is not limited to X-ray. Radiologists and technologists record X-ray images of bones, blood vessels, tissues and various internal organs so that an accurate diagnosis can be made.

Preferred Provider:	Base Plan pays 80% of PPO Allowed Charges, Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance maximum
Non-Preferred Provider:	Base Plan pays 80% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Reduction Mammoplasty, Surgeon **Base & Major Medical**

Professional surgical services for Breast Reduction, or reduction mammoplasty. The surgery is to reduce the weight, mass and otherwise size of the breasts for any reason.

Preferred Provider:	**Pre-authorization is required for these services** Base Plan pays 60% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Base Plan pays 60% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance maximum

Reduction Mammoplasty, Facility **Major Medical Only**

Surgical Facility providing Breast Reduction, or reduction mammoplasty. The surgery is to reduce the weight, mass and otherwise size of the breasts for any reason.

Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Rehabilitation Therapy, Cardiac Rehabilitation **Major Medical Only**

Cardiac Rehabilitation involves treatment and education that lead the cardiac patient to attain maximum physical and psychological function.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Rehabilitation Therapy, Inpatient **Major Medical Only**

Inpatient Rehabilitation is to restore a Participant who was disabled as the result of a covered acute Illness, Injury, condition, or disease to a level of function which allows that Participant to live as independently as possible. Conditions for Inpatient Rehabilitation services covered under this Plan must be acute in nature. The applicable requirements set forth in the paragraphs below must be met to qualify for this benefit.

Covered benefits are limited to: Extensive intracranial injury, cerebral laceration and contusions, subarachnoid subdural extradural hemorrhage following injury, intracranial bleeding following injury, and other intracranial injury. Extensive spinal cord injury. Extensive crushing injury involving multiple fractures, lower extremity amputation due to trauma or new amputation due to illness. Inflammatory diseases of the central nervous system resulting in marked neurological neuromuscular deficiency limited to encephalitis, intracranial and intraspinal abscess. Disorders of the central nervous system are limited to hemiplegia and paraplegia. Strokes of all etiologies are covered if the patient is able to actively participate in rehabilitation. Neoplasms resulting in marked neurological and or neuromuscular deficit are limited to spinal cord compression due to neoplasm and intracranial neoplasm.

Diagnosis alone does not justify benefit application for Inpatient Rehabilitation. The medical condition of the Participant must meet the following criteria for benefit consideration and must be documented in writing: Severe physical neuromuscular neurological impairment necessitating the need for twenty-four (24) hour nursing care must be present; The Participant must be responsive to verbal and visual stimuli; No other medical, surgical, or psychological impairing condition shall be present which may limit rehabilitation progress; The Participant must show potential for rehabilitation.

Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Rehabilitation Therapy, Outpatient **Major Medical Only**

Outpatient Rehabilitation includes services and supplies required to improve or restore lost bodily function that was previously normal. Benefit includes but is not limited to Occupational Therapy, Speech Therapy and Physical Therapy.

Physical Therapy only is limited to twenty (20) visits per calendar year.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Skilled Nursing Facility **Major Medical Only**

Facility providing skilled nursing care on a 24-hour basis as well as rehabilitative services at an inpatient level. A hospital inpatient level of care would be required if a SNF were not available. SNF care is necessary when alternative levels of care, such as office, outpatient, home, or an intermediate care facility or rest home are unable to provide the frequency and/or intensity of services needed. Covered services include room and board and ancillary services.

To be eligible for this benefit all of the following conditions must be satisfied: (1) The Participant's admittance must be subsequent to hospitalization in an acute care hospital for at least three days and must be within fourteen days following discharge from the acute care hospital (2) The Illness or Injury must require skilled nursing care on a continuing basis (3) Confinement must be for circumstances reflecting the need for convalescence from an Illness, treatment of a terminal condition, or a long term Illness. *Maximum benefit of one hundred twenty (120) days per calendar year.*

Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	**Pre-authorization is required for these services** Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Sleep Studies **Major Medical Only**

Studies conducted while the Participant sleeps to diagnose sleep disorders and/or sleep apnea.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Sterilization, Female, Facility **Major Medical Only**

Female Sterilization is a surgical procedure which renders an individual incapable of reproduction.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Sterilization, Male, Facility **Major Medical Only**

Male Sterilization is a surgical procedure which renders an individual incapable of reproduction.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Surgical Services, ASC, Facility **Major Medical Only**

Ambulatory Surgery Center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization. Facility charges related to surgery provided at an ASC.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Surgical Services, ASC, Surgeon **Base & Major Medical**

Professional surgical services provided in an ASC setting.

Preferred Provider:	Base Plan pays 60% of PPO Allowed Charges Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Base Plan pays 60% of Usual & Customary Amount Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Surgical Suite, Facility **Major Medical Only**

Charges related to surgery provided at a licensed, free-standing surgical suite in a Provider's Office. Facility charges related to surgery provided at a Surgical Suite.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Second Opinion **Major Medical Only**

A second opinion may be obtained prior to a surgical service or professional service.

Preferred Provider:	$25 Copay
Non-Preferred Provider:	$25 Copay

Teeth, Injury / Accident **Major Medical Only**

The initial repair, not replacement, to Sound Natural Teeth, which are without disease, fillings, or crowns; including the services of a licensed Dentist or Oral Surgeon for the prompt, initial repair of Injury to Sound Natural Teeth within twelve (12) months from the date of injury. An injury or accident is caused from an outside force or trauma to the teeth and mouth. This does not include biting or chewing accidents.

Preferred Provider:	Plan pays 80% of PPO Allowed Charges, after Deductible, Coinsurance Maximum
Non-Preferred Provider:	Plan pays 80% of Usual & Customary Amount, after Deductible, Coinsurance Maximum

Urgent Care Services **Major Medical Only**

Urgent Care/Minor Emergency Services are minor medical emergency services for minor injury or illness that is non-life threatening. Minor injuries or illnesses include, but are not limited to, sprains and minor broken bones, earaches, severe sore throat or cough, minor infections, and cuts requiring stitches.

Preferred Provider:	$25 Copay
Non-Preferred Provider:	$25 Copay

TRANSPLANTS

A transplant is the transferring of a healthy tissue or organ to replace a damaged tissue or organ; also refers to the tissue or organ transplanted. Benefits are paid when the Plan Participant is receiving or donating organs or tissue.

No benefits will be provided unless the Participant obtains written pre-authorization from Innovated Care Management, (800) 862-3338, prior to Inpatient admission for a transplant. Innovated Care Management reserves the right to review all requests for prior approval based on the Participant's medical condition, the Physician who will perform the transplant procedure, and the Facility in which the transplant procedure will be performed. Innovated Care Management reserves the right, at its sole option, to contract with specific facilities to perform these transplant services and to base benefit payments upon the terms and conditions of such third party contract. Experimental and investigational services are not covered.

Transplants, Kidney, Donor

When only the donor is a Participant of this Plan, benefits for the donor's expenses are limited to payment of organ procurement services and costs incurred when the Plan Participant is donating organs or tissue to another. No donor expenses shall be paid unless the donor's organ is actually used in the transplant. Medical complications and unforeseen medical effects of the donation will be covered as any other Illness regardless of whether the organ is actually used in the transplant. If the donor is not a Participant under this Plan, benefits for the recipient's expenses shall be paid according to the terms of this Plan. Benefits for the donor's expenses shall be provided up to a maximum of ten (10) consecutive days beginning with the day of surgery.

Transplants, Kidney, Recipient

Costs incurred when the Plan Participant is receiving donated organs or tissue. No benefits whatsoever are available to a Non-Participant recipient.

Transplants, Cornea, Donor

When only the donor is a Participant of this Plan, benefits for the donor's expenses are limited to payment of organ procurement services and costs incurred when the Plan Participant is donating organs or tissue to another. No donor expenses shall be paid unless the donor's organ is actually used in the transplant. Medical complications and unforeseen medical effects of the donation will be covered as any other Illness regardless of whether the organ is actually used in the transplant. If the donor is not a Participant under this Plan, benefits for the recipient's expenses shall be paid according to the terms of this Plan. Benefits for the donor's expenses shall be provided up to a maximum of ten (10) consecutive days beginning with the day of surgery.

Transplants, Cornea, Recipient

Costs incurred when the Plan Participant is receiving donated organs or tissue. No benefits whatsoever are available to a Non-Participant recipient.

Transplants, Other

Other transplants include: Pancreas with Kidney, Liver, Heart, and Heart with Pair of Lungs, Single Lung, Double Lung and Bone Marrow.

Bone marrow transplant is defined as stem cell (includes peripheral) rescue and/or support, or transplantation/reinfusion of bone marrow. Bone marrow from a different person is covered for these diagnoses only: Acutelymphocytic or acute non-lymphocytic leukemia; Aplastic or chronic myelogenous leukemia; Hodgkin's lymphoma, limited to stage 3 or 4; Non-Hodgkin's lymphoma, limited to stage 3 or 4 of intermediate or high grade; Severe combined immunodeficiency (not HIV or AIDS); Wiskott-Aldrich syndrome; Infantile malignant osteoporosis; Neuroblastoma, limited to stage 3 or 4 in children over age one; and Homozygous beta thalassemia. Bone marrow from the beneficiary (self-donated) is covered for these diagnoses only: Acute lymphocytic or acute non-lymphocytic leukemia; Hodgkin's lymphoma, limited to stage 3 or 4; Non-Hodgkin's lymphoma, limited to stage 3 or 4 of intermediate or high grade; Neuroblastoma, limited to stage 3 or 4; and Germ cell.

Transplants, Other, Donor
When only the donor is a Participant of this Plan, benefits for the donor's expenses are limited to payment of organ procurement services and costs incurred when the Plan Participant is donating organs or tissue to another. No donor expenses shall be paid unless the donor's organ is actually used in the transplant. Medical complications and unforeseen medical effects of the donation will be covered as any other Illness regardless of whether the organ is actually used in the transplant. If the donor is not a Participant under this Plan, benefits for the recipient's expenses shall be paid according to the terms of this Plan. Benefits for the donor's expenses shall be provided up to a maximum of ten (10) consecutive days beginning with the day of surgery.

Transplants, Other, Recipient
Costs incurred when the Plan Participant is receiving donated organs or tissue. No benefits whatsoever are available to a Non-Participant recipient.

Transplants, Procurement Costs
Organ procurement services means those diagnostic or medical services to evaluate, select, store, identify, or test the organ that is actually used in a transplant. It also means the donor's surgical and Hospital services directly related to the removal of an organ or tissue that is actually used in a transplant. Organ procurement costs also include those expenses incurred by recipients in the medical process to locate a compatible donor. Transportation of the donor or for the donated organ or tissue is not an organ procurement service.

PRE-AUTHORIZATIONS

All benefits payable under this Plan must be medically necessary. If you are thinking about having surgery or getting a test or treatment that will involve a major expense, you should ensure the procedure is medically necessary first, to avoid having your claim denied. The Plan recommends that you pre-authorize all inpatient hospital stays and certain other services *before* receiving treatment, or as soon as possible after an emergency hospital admission. When you're about to have a major treatment or hospital stay, getting the service pre-authorized ensures that the treatment is reviewed for medically necessary. Pre-certification doesn't guarantee eligibility or benefits, however. Eligibility and benefits should be also verified with the Trust Administration Office.

Pre-certification is strongly recommended, but not limited, to the following services:

- Adult Shingles Immunizations through age 59
- Chemotherapy Services
- Cochlear Implants
- Eyelid Surgery
- Growth Hormone Injectable Medications
- Home Health Care
- Inpatient Chemical Dependency
- Inpatient Hospital Services Facility
- Inpatient Mental Or Neuropsychiatric Conditions
- Inpatient Rehabilitation Therapy
- Major Durable Medical Equipment
- Other Injectable Medications
- Prosthetics
- Radiation Therapy
- Radiology: PET Scans
- Reduction Mammoplasty
- Skilled Nursing Facility
- Spinal Steroid Injections
- Varicose Vein Procedures

Your provider must request pre-authorizations from ICM (Innovative Care Management). Your provider will have to submit a form and will have to present evidence of the necessity of the procedure by supplying ICM with a report, lab and/or test results, scans, x-rays, photographs or other supporting materials that indicate that the procedure is medically necessary. Once all necessary documentation is received and reviewed, your provider will be notified whether it has been approved or denied.

PRE-AUTHORIZATION REQUIREMENTS

Pre-Authorization Access
Pre-authorizations can be initiated by contacting Innovative Care Management. See contact information at the beginning of this booklet.

Pre-Admission Authorization
Innovative Care Management will review proposed admissions, other than for emergency or urgent care (see Post-Admission Authorization below). Medically Necessary hospitalization will be pre-certified and written notice will be provided to the Participant and the referring Physician. Maternity admission does not require pre-authorization.

If the admission is determined to be medically unnecessary, Innovative Care Management may propose alternatives to the Inpatient admission after discussing the case with the attending Physician. The Participant and the Participant's Physician may wish to consider alternatives suggested by the physician reviewer.

If pre-admission authorization is not obtained services may be subject to a pre-authorization penalty. Such reduced benefit may not be considered an eligible expense for application to the Participant's coinsurance maximum provision of this Plan.

Pre-admission authorization does not guarantee benefit payment will be made. Benefit payments will be made based upon Plan provisions and eligibility criteria.

Post-Admission Authorization
Emergency and urgent admissions require post-admission authorization, to substantiate medical necessity of continued Inpatient care. These admissions are subject to post-admission review on the first working day following the admission.

Post-admission authorization does not guarantee benefit payment will be made. Benefit payment shall be made based upon Plan provisions and eligibility criteria.

CASE MANAGEMENT

The Case Management program is strictly confidential. The Trust has contracted with Innovative Care Management (ICM) to provide case management services in certain health care treatment situations. The Case Management program provides professional intervention to help participants who have catastrophic or significant ongoing health conditions. Case Managers (registered nurses) will evaluate patients for inclusion in the Case Management program based on diagnosis, hospital stays, or at the request of the Trust or participant. The Case Manager will work with the patient, doctors and family Participants to coordinate care. The purpose of the program is to help the patient navigate the complex health care system and ensure that proper and cost-effective care is being received.

Discharge Planning
Discharge planning provides assistance by a discharge planner in coordinating discharge from an acute care provider when a less acute level of care is appropriate as prescribed by the Participant's Physician or attending Physician, if other than the Participant's Physician. The discharge planner will assist the Participant in transfer to the next appropriate level of care.

Continued Stay Review
Inpatient admission shall be subject to continued review as to medical necessity. If, at any time, a Participant's continued Inpatient hospitalization is determined to be medically unnecessary, the Participant, the Participant's Physician, and the admitting Physician, if other than the Participant's Physician, will be notified by telephone and in writing that a recommendation for denial of benefits will be issued.

Individual Case Management Benefits
Innovative Care Management may authorize benefits in an individual case for specific services that would not ordinarily be covered services if it appears to Innovative Care Management that use of such services will reduce costs and not compromise the quality of care. Innovative Care Management shall advise the Trust Administration Office who will follow through and inform the Participant and the Providers in writing when, and to what extent, such benefits will be provided. Providing such benefits shall not constitute an amendment to this Plan.

MEDICAL PLAN EXCLUSIONS

Act of War: Any Injury, Illness, or physical disability resulting from any act of war or from explosion of atomic or similar fissionable materials in war (declared or undeclared), armed invasion, or aggression, national disaster, or from any Illness or Injury contracted or incurred during military service, including any complications or recurrences thereof.

Acupuncture: Acupuncture is the practice of inserting very fine needles into the skin to stimulate specific anatomic points in the body for therapeutic purposes.

Administrative Fees: For telephone consultations, missed appointments, claim form completion, interest charges, legal services, obtaining and/or copying medical records, or Provider travel and/or lodging expenses.

Adoption: Neither expenses relating in any way to the natural mother, nor expenses relating to the adopted child prior to the date upon which the child becomes a covered dependent under the Plan.

Air Filtration: Humidifiers, vaporizers, air conditioners, or any other air filtration, purification unit or system.

Armed Services: Any condition for which the Veterans Administration or any of the armed services is responsible or to the extent benefits are provided or covered by any governmental agency, except as otherwise provided by law. Condition caused by or arising from service in the armed forces of any country, including the Air Force, Army, Coast Guard, Marines, National Guard, Navy, or civilian forces or units auxiliary thereto.

Automobile Coverage: Services and supplies to the extent that benefits are payable under the terms of an automobile medical, automobile no-fault, automobile uninsured motorist and/or underinsured motorist, personal injury protection (PIP), commercial liability, or homeowner's policy, or similar contract or insurance when such contract or insurance is issued to or provides benefits for any Participant. Any benefits paid by the Trust contrary to this exclusion are provided as an advance solely to assist the Participant, and is the participants obligation to reimburse the Trust. By providing such benefits, the Trust is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Biofeedback - All Conditions: Biofeedback for the treatment of any condition.

Complication for Non-Covered Services: No benefits shall be provided for services, supplies, or charges which result from the treatment of any direct or indirect complication of any Injury, Illness, physical disability, or condition for which coverage is not or was not provided.

Conduct Disorders: Including but not limited to, under socialized and socialized conduct disorders; impulse control disorders such as pathological gambling, kleptomania and pyromania; explosive or aggressive outburst disorder; oppositional disorders in childhood or adolescence; and hyperkinetic conduct disorder (this exclusion does not include Attention Deficit Disorder, with and without hyperactivity, which is covered under the Mental or Neuropsychiatric section of this Plan).

Convenience Items: Including, but not limited to items such as telephones, television, guest trays or meals, clothing, personal hygiene items or services; food services such as Meals on Wheels, ramps, handrails, air conditioners, communication devices or other supportive environmental equipment; housing, homemaker or housekeeping services, except by home health aides or as ordered in a hospice treatment plan.

Cosmetic: Cosmetic appliances (including non-prescription color contact lenses) or re-constructive procedures and attendant hospitalization, except for Newborn Children, done for aesthetic purposes and not to restore an impaired function of the body. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Cosmetic procedures include sclerotherapy regardless of reason. Services for re-constructive surgery incidental to or following covered surgery resulting from trauma, infection, or other diseases of the involved part, or re-constructive breast surgery resulting from a mastectomy shall not be excluded as Cosmetic.

Counseling: Benefits for counseling in the absence of Illness or Injury, except as specifically set forth in the Plan, including, but not limited to, educational, social skills, or bereavement counseling; marital; sex or interpersonal relationship counseling, lifestyle, or fitness counseling, financial, legal, spiritual or pastoral counseling; or counseling with the Participant's friends, employer, school counselor, or school teacher.

Criminal or Illegal Act: Charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior or by participating in a riot or public disturbance.

Custodial Care: Regardless of where such care is rendered, convalescent care when the need for definitive medical treatment no

longer exists, or for any portion of confinement that becomes convalescent or Custodial Care. This includes care principally for senile deterioration, mental retardation, mental deficiency or mental illness.

Dentistry: Whether resulting from disease or dental treatment, or Injury, except for treatment of a fractured jaw or injury to Sound Natural Teeth up to 12 months after the accident or injury. Dental services and supplies, including, but not limited to extractions, prosthetics, fillings, crowns, treatment of dental caries or gingivitis, braces, banding, retainers, splinting, dental implants, removal or replacement of teeth, dental surgery, malocclusion including development abnormalities or any other procedures or appliances for tooth movement provided for, or in conjunction with, dental and/or orthodontic care, are specifically excluded under the medical benefits Plan.

Developmental Delays: Evaluation, habilitative treatment, education, or training services or supplies for dyslexia.

Dietician and Nutritionist: Dieticians and Nutritionists provide nutritional assessment, education and medical nutritional therapy.

Educational or Vocational Testing: Services for educational or vocational testing or training, including driver's education.

Employment: Any Injury or Illness which arises out of and/or in the course of employment for which the Participant is covered under the provisions of State or self-insured Industrial Insurance, Worker's Compensation, or any federal act or similar law. Additionally, DOT licensing fees, pre-employment screenings and evaluations, or vision exams in connection with employment, etc, are not covered.

Excess Charges: The part of an expense for care and treatment of an Injury or Illness that is in excess of the allowed amount. Additionally, "boutique" charges, subscription or retainer fees, concierge fees or any related fees, Membership fees, or charges related to the completion of forms, even if required, are not covered.

Experimental/Investigational: Any service or supply which is determined by Innovative Care Management to be Experimental or Investigational on the date furnished. Experimental/Investigational services include, but are not limited to: cloning, gene therapy, genetic testing and other similar services.

Foreign Travel: Care, treatment, or supplies received outside of the United States if travel is for the sole purpose of obtaining medical services or care. If medical emergency while traveling please see Other Plan Provisions section 4.

Fraudulent or Misrepresented Charges: Expenses related in any way to billings or statements containing fraudulent information or misrepresentations.

Hair Loss: Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

Health Education: Accessed to gain understanding of a Participant's current Diabetic Illness, Injury, physical disability, or condition.

Health Education, Other: Classes such as childbirth education programs and Smoking Cessation

Hearing -Aids and Devices: Hearing aides are instruments to help in hearing, including Behind-the-ear (BTE) hearing aids, In-the-ear (ITE) hearing aids, In-the-canal (ITC) hearing aids, and Completely-in-the-canal (CIC) hearing aids.

Heating pads, contour chairs, or therapeutic beds.

Hypnosis: Expenses for hypnosis, regardless of purpose or application.

Immunizations -Travel: Vaccines, immunizations and prophylactic medications for the purpose of travel outside the United States.

Infertility: Testing, diagnosis and treatment of infertility, including procedures, supplies and drugs. Assisted Reproductive Technology (ART) is any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, donor sperm utilized for artificial insemination or procedures to induce fertilization with professional or technical assistance, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), peritoneal oocyte and sperm transfer (POST), tubal ovum transfer (TOT), and pronuclear stage tubal transfer. This includes services, supplies, drugs, and procedures for reproductive disorders, defects, and/or inadequacies, whether or not the consequence of Illness, disease, or Injury. Disorders, defects, and/or inadequacies shall include, but not be limited to: impotency, frigidity, infertility, sterility, reversal of surgical sterilization.

Injectable Medications -Vitamin B, Other Conditions: Receiving a Vitamin B shot for any cause other than pernicious anemia or

Vitamin B deficiency.

Insurance Coverage: Any and all services, supplies and benefits that result from or arise out of an accident, occurrence or incident for which there exists any first party medical payment coverage or first party medical reimbursement coverage or any third party liability coverage, to include but not limited to, medical payment coverage, automobile medical, automobile no-fault coverage, automobile uninsured motorist and/or underinsured motorist coverage, personal injury protection (PIP), automobile bodily injury coverage, automobile liability insurance policy, third-party automobile liability coverage, commercial liability coverage, homeowner's liability coverage, a personal liability umbrella policy or any other similar contract, coverage or insurance policy when such contract or insurance is issued to or provides benefits for any Participant. Any benefits which may be paid by the Trust contrary to this exclusion are provided solely to assist the Participant in the form of an "advance." By providing such benefits, the Trust is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Intracellular Vitamin Analysis: Any services and supplies related to Intracellular Vitamin Analysis, including, but not limited to the patented blood test called Functional Intracellular Analysis (FIA).

Massage Therapy: Massage therapy is a health care service involving the external manipulation or pressure of soft tissue for therapeutic purposes.

Maternity - dependent child: Maternity services for a dependent child (not Subscriber or Subscriber's Spouse).

Maternity - home births: Home births and charges related to a home birth.

Mental or Neuropsychiatric Conditions - Outpatient Services, Light Therapy: Treatment for Seasonal Affective Disorder by the use of light.

Mental or Neuropsychiatric Conditions - Outpatient Services, Group/Family: Group/Family treatment for Mental or Neuropsychiatric Conditions.

Missed Appointments: Expenses for missed appointments, regardless of reason.

Naturopath: Naturopathic doctors are trained specialists in a separate and distinct healing art which uses non-invasive natural medicine. They are not medical doctors (M.D.s).

Non-Medically Necessary Services: Services and supplies to the extent that they are not Medically Necessary for treatment of an Illness, Injury, physical disability, or condition, or are not recommended and approved by the attending Physician. This includes care and treatment billed by a hospital for non-emergency admissions and autopsy services.

Obesity -Other: Non-surgical services for the treatment of obesity. This provision does not include professional surgical services.

Obesity -Surgery: Bariatric surgery of any type for the purpose of addressing obesity.

Orthognathic Surgery: Orthognathic surgery is surgery performed on the bones of the jaws to change their positions.

Orthotics: Custom-made foot orthotics are medical devices that support and gently reposition the heel, arch, muscles, ligaments, tendons, and bones in the feet, enabling these structures to work together to make each step you take pain-free. Unlike shoe inserts bought over the counter, custom-made orthotics are built from molds of your feet to meet your unique needs.

Physical/Fitness Equipment: Physical fitness or physical therapy equipment, including, but not limited to whirlpools, spas, hot tubs, weight lifting equipment, charges in or by health spas, or weight loss/exercise programs.

Recreational Therapy: Provides treatment services and recreation activities to individuals with disabilities or illnesses, including but not limited to: arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings, meant to treat and maintain physical, mental, and emotional well-being by reducing depression, stress, and anxiety; to recover basic motor functioning and reasoning abilities; to build confidence; and to socialize effectively so that patients can enjoy greater independence, as well as reduce or eliminate the effects of their illness or disability.

Services and Supplies: (1) for which a Participant is not required to make payment, (2) that are obtained only because benefits are available under this Plan, or (3) for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage.

Services by Relation: Services and supplies furnished by a person who is related by blood, marriage, adoption, or who lives in the Participant's home.

Sexual Disorders: Services, supplies and procedures for sexual disorders, defects, and/or inadequacies, whether or not the consequence of Illness, disease or injury. Disorders, defects, and/or inadequacies shall include, but not be limited to impotency,

frigidity, sterility, reversal of surgical sterilization, or gender transformations.

Smoking Cessation -Over the Counter Aids: Pills, patches, gums and like products, available over the counter, which aid in tobacco cessation.

Special Nutritional Supplements: Special foods or diets, vitamins, minerals, dietary and nutritional supplements, and nutritional therapy.

Surrogate Pregnancy: Services or supplies related to surrogate pregnancy.

Thermography: A procedure in which a heat-sensing infrared camera is used to record the surface heat produced by different parts of the body. Abnormal tissue growth can cause temperature changes, which may show up on the thermogram.

Third Party Liability: Services and supplies to the extent that benefits are payable by a liable third party. Any benefits paid by the Trust contrary to this exclusion are provided solely to assist the Participant in the form of an "advance." By providing such benefits, the Trust is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Transplants (non-human): Services and supplies in conjunction with non-human organ and/or tissue transplants, zenographs or artificial, manufactured organs (whether of permanent or temporary use). No benefits shall be paid for the purchase of any organ or body part. No benefits shall be paid for donor or organ procurement services and costs incurred outside the United States.

Vision: Vision analysis, therapy or training related to muscular imbalance of the eye (orthoptics), or pleoptics. Services and supplies for the purpose of surgically altering the refractive error of the cornea and their results both direct and indirect, including, but not limited to, radial keratotomy, corneal modulation, keratomileusis, or refractive keratoplasty.

DENTAL OVERVIEW

Dental Benefit Plan: Inland Empire Teamsters Trust
Customer Service: (800) 872.8979

Annual Maximum $1,200

Please Note: ***Benefits may not be borrowed, loaned or traded from year to year for additional benefits.***

Annual Maximum does not apply to dependent children through eighteen (18) years of age for dentally necessary procedures.

Annual Deductible – Individual $50

Preventive charges subject to $10 deductible, all other charges are subject to a $40 deductible.
If no preventive charges during the calendar year then a $50 deductible will apply.

Deductible *is the amount of charges, up to the Allowed Charge, for Covered Services payable by a Participant to a Provider who is recognized for payment under this Plan before the Plan will assume any liability for all or part of the remaining Covered Services. Benefits, except as otherwise specified, shall apply only after the deductible has been met. Charges for services payable by the Participant due to a reduction in benefits, denial of benefits, or amounts charged in excess of Allowed Charge are the financial responsibility of the Participant and shall not be considered as an eligible expense for application towards the deductible amount.*

Dental Pre-Treatment Estimate
Prior to beginning a Dental treatment program, the Participant may wish to have an estimate of the benefits available by the Plan. The dentist should complete a "Pre-treatment Estimate" on the standard claim form. This completed form should be sent to the Trust Administration Office for review and a written estimate of covered services will be sent to the patient/subscriber and the dentist.

DENTAL BENEFITS

Dental benefits are subject to dental exclusions found on page 44-45 of this Summary Plan Description

Class I - Diagnostic and Preventive Services
Diagnostic services are necessary procedures to assist the dentist in evaluating existing conditions to determine the required dental treatment. Preventive services are necessary procedures to prevent the occurrence of oral disease.

Emergency Treatment
Emergency services which; (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this plan.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Fluoride Treatments, Child
Fluoride absorbs into the enamel of the teeth making them more resistant to acid producing bacteria. Maximum benefit of one (1) treatment every six (6) months.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Lab
Laboratory testing or pathology procedures related to examination and/or diagnosis of dental conditions.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Oral Evaluations
An evaluation and recording of the patient's dental health. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, occlusal relationships, conditions, hard and soft tissue anomalies, oral cancer screening, etc. Maximum benefit of one (1) visit every six (6) months.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Prophylaxis
Scaling and polishing procedure performed to remove coronal plaque, calculus and stains. Maximum benefit of one (1) visit every six (6) months.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Sealants, Child
Plastic coating applied to grooves of teeth to prevent decay. Sealants for a child through age fifteen (15), permanent molars only and replaceable every five (5) years.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Space Maintainers, Adult and/or Child
Dental device that holds the space lost through loss of teeth.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

X-Rays Bitewings, Adult and/or Child
An x-ray is a non-invasive method of identifying and monitoring diseases or injuries via the generation of images representing the internal anatomic structures of the patient's body. An x-ray of the crown of the tooth.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

X-Rays, Full Mouth
An x-ray of the full mouth.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

X-Rays, Panorex
An x-ray of the outside of the mouth, on which the upper and lower jaw are depicted on a single film.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

X-Rays, Other X-Rays
Any other necessary x-ray administered by a dental professional.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Class II - Basic Dental Services
Dental procedures concerned with the repair or restoration of individual teeth due to decay, trauma, impaired function, attrition, abrasion, or erosion.

Anesthesia Services
Partial or complete elimination of pain sensation; numbing a tooth is an example of local anesthesia; general anesthesia produces partial or complete unconsciousness. Other covered services include nitrous oxide, conscious sedations, euphoric drugs, or injections.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Endodontics
Dental specialty concerned with the treatment of diseases of the nerves, blood vessels, etc. within the tooth.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Fillings/Restorations (other than gold)
Composite fillings, a tooth-colored filling material, or amalgam, a metallic filling made by combining an alloy of silver, zinc, lead, and tin with mercury. It is silver in color.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Full Dentures (installation and repair)
An artificial substitute for natural teeth and adjacent tissues. *Replaceable every five (5) years.*

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Occlusal Guard, Adult and/or Child: An occlusal guard for harmful habits only. Harmful habits include clenching and grinding.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Oral Surgery
Dental specialty concerned with the surgical procedures in and about the mouth and jaw.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Periodontics
Dental specialty concerned with diseases of the gums and other supportive structures of the teeth.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Simple Extractions
When the dentist can remove the tooth simply by grasping the crown above the gum line with forceps and pulling it out.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Surgical Extractions
Used when a simple extraction is not feasible. A surgical extraction follows the guidelines of general surgery and can be done using local or general anesthesia.

Dental Provider: Plan pays 90% of the Usual & Customary Amount

Class III - Major Dental Services
Replacement of an appliance or dental prosthesis as listed below; or it is due to loss of natural teeth or damaged while in the covered person's mouth.

Bridges/Implants (installation and repair)
One or more artificial teeth attached, usually on both sides, by crowns to adjacent teeth. It is used to maintain space and function for missing teeth. Replaceable every five (5) years.

Dental Provider: Plan pays 75% of Usual & Customary Amount

Crowns (installation and repair)
A crown or a cap is a cover for a decayed or damaged tooth made of porcelain and/or metal. Replaceable every three (3) years.

Dental Provider: Plan pays 75% of Usual & Customary Amount

Removable Partial Dentures (installation and repair)
An artificial substitute for natural teeth and adjacent tissues. Replaceable every five (5) years.

Dental Provider: Plan pays 75% of Usual & Customary Amount

Inlays/Onlays
A gold, porcelain, or composite custom-made filling cemented into the tooth. If it covers the tips of the teeth or otherwise supports the tips it is called an onlay. *Replaceable every three (3) years.*

Dental Provider: Plan pays 75% of Usual & Customary Amount

Recementing
Recementing bridges, crowns, or inlays.

Dental Provider: Plan pays 75% of Usual & Customary Amount

Orthodontic Services
Orthodontic services are Supplemental Benefits only. ***Please consult your employer and check your collective bargaining agreement to verify eligibility for this benefit.***

Orthodontic services for a dependent child(ren) only through age twenty-five (25) years of age. *Maximum lifetime benefit of $1,500.*

Dental Provider: Plan pays 70% of Usual & Customary Amount

DENTAL EXCLUSIONS

Act of War: any Injury, Illness, or physical disability resulting from any act of war or from explosion of atomic or similar fissionable materials in war (declared or undeclared), armed invasion, or aggression, national disaster, or from any Illness or Injury contracted or incurred during military service, including any complications or recurrences thereof.

Administrative Fees: for telephone consultations, missed appointments, claim form completion, interest charges, legal services, obtaining and/or copying medical records, or Provider travel and/or lodging expenses.

Armed Services: Any condition for which the Veterans Administration or any of the armed services is responsible or to the extent benefits are provided or covered by any governmental agency, except as otherwise provided by law.

Class I - Diagnostic and Preventive Services - Sealants, Adult: Sealants for age sixteen (16) and over.

Complication for Non-Covered Services: No benefits shall be provided for services, supplies, or charges which result from the treatment of any direct or indirect complication of any Injury, Illness, physical disability, or condition for which coverage is not or was not provided.

Congenital Defect: Treatment or services provided to correct any congenital defect or developmental malformation which does not interfere with function.

Cosmetic: Treatments performed to enhance appearance; not a recognized specialty.

Coverage not in effect: Expenses incurred solely because coverage exists or for which the patient has no legal obligation to pay, and expenses incurred prior to or after the period this Plan was effective.

Criminal or Illegal Act: charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior or by participating in a riot or public disturbance.

Duplicate set of dentures: a second duplicate set of dentures.

Employment: Any Injury or Illness which arises out of and/or in the course of employment for which the Participant is covered under the provisions of State or self-insured Industrial Insurance, Worker's Compensation, or any federal act or similar law. Including, but not limited to, DOT licensing fees, pre-employment screenings and evaluations, or vision exams in connection with employment, etc.

Experimental/Investigational: any service or supply which is determined to be Experimental or Investigational on the date furnished. Experimental/Investigational services include, but are not limited to: cloning, gene therapy, genetic testing and other similar services.

Foreign Travel: care, treatment, or supplies received outside of the United States if travel is for the sole purpose of obtaining dental services or care. If medical emergency while traveling please see Other Plan Provisions section 4.

Fraudulent or Misrepresented Charges: Expenses related in any way to billings or statements containing fraudulent information or misrepresentations.

Insurance Coverage: Any and all services, supplies and benefits that result from or arise out of an accident, occurrence or incident for which there exists any first party medical payment coverage or first party medical reimbursement coverage or any third party liability coverage, to include but not limited to, medical payment coverage, automobile medical, automobile no-fault coverage, automobile uninsured motorist and/or underinsured motorist coverage, personal injury protection (PIP), automobile bodily injury coverage, automobile liability insurance policy, third-party automobile liability coverage, commercial liability coverage, homeowner's liability coverage, a personal liability umbrella policy or any other similar contract, coverage or insurance policy when such contract or insurance is issued to or provides benefits for any Participant. Any benefits which may be paid by the Plan contrary to this exclusion are provided solely to assist the Participant in the form of an "advance." By providing such benefits, the Plan is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Late fees: Late charges billed by dental providers.

Medical Services: Services that, to any extent, are payable under any medical expense benefits of the Plan.

Medically Necessary: Services which are deemed to be not necessary medically or dentally.

No listing: Services which are not included in the list of covered dental services.

Oral Hygiene Instruction: Instruction in the process of maintaining cleanliness of the teeth and related structures.

Orthodontic Treatment: unless otherwise Collectively Bargained into your fringe benefit package.

Orthognathic Surgery: Surgery performed on the bones of the jaws to change their positions.

Reasonable and Customary: Charges made that are not medically necessary or are in excess of reasonable and customary charges as determined by industry standards.

Services and Supplies: (1) for which a Participant is not required to make payment, (2) that are made only because benefits are available under this Plan, or (3) for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage.

Services by Relation: Services and supplies furnished by a person who is related by blood, marriage, adoption, or who lives in the Participant's home.

Splinting: Appliance used to prevent motion of teeth are not covered.

Take-home fluoride solutions: Fluoride given in a dental office for use at home.

Temporomandibular Joint Dysfunction (TMJ): Treatment for a condition of facial pain causing muscle spasms in the jaw, dental misalignment, and/or difficulty chewing or swallowing.

Third Party Liability: Services and supplies to the extent that benefits are payable by a liable third party. Any benefits paid by the Plan contrary to this exclusion are provided solely to assist the Participant in the form of an "advance." By providing such benefits, the Plan is not waiving any right to reimbursement or to subrogation as provided in this Plan.

VISION OVERVIEW

Vision Benefit Plan: Inland Empire Teamsters Trust
Customer Service: (800) 872.8979

VISION BENEFITS

Hardware
Supplies which correct or improve function of the eye. Below is the maximum benefit for all vision hardware.

Contacts
A thin curved glass or plastic lens designed to fit over the cornea in order to correct vision or to deliver medication. Maximum of two (2) lenses every twenty four (24) months.

Preferred Provider: Plan pays 100% of PPO Allowed Charges
Up to $181.50 per Pair (In Lieu of Lens & Frames)

Frames
A supporting structure for your prescription lenses. Maximum of one (1) pair of frames every twenty four (24) months.

Preferred Provider: Plan pays 100% of PPO Allowed Charges
Up to $60 per Pair

Lenses, Bifocals
Eyeglasses incorporating two (2) different powers in each lens, usually for near and distant corrections. Maximum of two (2) lenses every twenty four (24) months.

Preferred Provider: Plan pays 90% of PPO Allowed Charges
Up to $100 per Lens

Lenses, Lenticular
A more complex lens, usually for post-cataract vision issues. Maximum of two (2) lenses every twenty four (24) months.

Preferred Provider: Plan pays 90% of PPO Allowed Charges
Up to $269 per Lens

Lenses, Progressive Lenses
Progressive, or no-line, lenses have no dividing line as focus changes from top to bottom. Maximum of two (2) lenses every twenty four (24) months.

Preferred Provider: Plan pays 90% of PPO Allowed Charges
Up to $269 per Lens

Lenses, Single Vision
Eyeglasses for those who are either farsighted or nearsighted. Maximum of two (2) lenses every twenty-four (24) months.

Preferred Provider: Plan pays 90% of PPO Allowed Charges
Up to $67.50 per Lens

Lenses, Trifocals
Eyeglasses incorporating two or more different powers in each lens. Maximum of two (2) lenses every twenty-four (24) months.

Preferred Provider:	Plan pays 90% of PPO Allowed Charges Up to $134.50 per Lens

Other Vision Hardware, Transition/Photochromic
Transition Photochromic lenses protect your eyes from the sun's rays by quickly adjusting and adapting in changing light for better eyesight. Maximum of two (2) lenses every twenty four (24) months.

Preferred Provider:	Plan pays 90% of PPO Allowed Charges Up to $95 per Lens

Examination
Routine vision examinations are a series of tests performed by an ophthalmologist or optometrist (eye doctor) that measure the refraction and visual acuity of the eye and test for disease. For adults age nineteen (19) and over, maximum benefit of one (1) visit(s) per calendar year applies to the following services combined.

Preferred Provider:	Plan pays 90% of PPO Allowed Charges Up to $185 per Examination

VISION EXCLUSIONS

Other Vision Hardware: Additional vision hardware services are not covered under the vision plan including;

Scratch resistance

Anti-reflection

Tints

Contact Fitting Fee

Sunglasses

Safety Glasses

PHARMACY OVERVIEW

Pharmacy Benefit Manager: Medco Pharmacy
Customer Service: (866) 888-0103
Website: www.teamstersrx.com

PHARMACY BENEFITS

Retail
Maximum days supply allowed: Ninety (90) days. One (1) to thirty (30) days for one (1) copay, thirty-one (31) to sixty (60) days for two (2) copays, sixty-one (61) to ninety (90) days for three (3) copays.

Generic Drugs:	$3 Copay
Preferred Brand:	$25 Copay
Multi-Source Brand (Physician Request):	$30 Copay
Multi-Source Brand (Participant Request):	$30 Copay plus the difference in the cost between Brand Name drug and Generic drug cost

The Plan does not pay for Brand Name drugs if a Generic equivalent is available. The participant is responsible for the difference in the cost between Brand Name drug and Generic drug cost.

Mail Order
Maximum days supply allowed: Ninety (90) days

Generic Drugs:	$3 Copay
Preferred Brand:	$25 Copay
Multi-Source Brand (Physician Request):	$30 Copay
Multi-Source Brand (Participant Request):	$30 Copay plus the difference in the cost between Brand Name drug and Generic drug cost

FDA Recommendations
Prescription drugs are available to be used in accordance with FDA dosing recommendations. Quantities greater than FDA standards must require prior-authorization. Quantity limits may apply to certain prescriptions.

Coordination of Benefits
There is no Coordination of Benefits (COB) for prescription benefits.

Contraceptive Coverage
Prescription Contraceptives (Oral and Topical) are covered. Injectable Contraceptives are covered. The Contraceptive Vaginal Ring is covered. 91-day packs of oral contraceptive such as Seasonale, Seasonique, etc. and their generics are covered under the plan for three (3) times the monthly copay.

Prescription Drug Prior-Authorization Program
Drugs that require prior approval, if covered by the Plan, include, but are not limited to: Botox, Campral, Differin, Growth Hormone, Naltrexone, Revia, Suboxone, Subutex, and Topical Vitamin A Derivatives. Prior approval is also required for any medication exceeding $1,500 at a Retail pharmacy or $4,500 at a Specialty or Mail Order pharmacy.

PHARMACY PLAN EXCLUSIONS

Biological Sera

Cosmetic: Drugs prescribed for cosmetic purposes, including but not limited to hair loss/growth, wrinkles or other dermatological agents, including Tretinoin, in all dosage forms.

Drugs dispensed in a hospital, rest home, or sanitarium: Medication received as an Inpatient in a licensed Hospital or other provider.

Experimental/Investigational: Drugs labeled for investigational use or experimental drugs, even though a charge is made to the Participant.

Fertility/infertility: Fertility or infertility drugs, regardless of intended use.

Fluoride: a mineral that helps prevent tooth decay. Benefit provided for children through age eighteen (18).

Infant Formulas

Lost/Stolen: Replacement of lost or stolen medication

Not Covered Services: prescription medications related to health care services which are not covered under this Plan.

Off Label Uses

Refills/Old Orders: Any prescription refilled more than the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.

Specialty medications administered in a Doctor's office setting

Supplements

Weight Loss: Anorectics (any drug used for the purpose of weight loss, obesity or weight management).

TIME LOSS BENEFITS (Income Replacement Benefit)

If you are unable to return to gainful employment with your employer due to an injury, accident or sickness which is not covered by Worker's Compensation or similar legislation, your weekly Income Benefit will be payable as described below, provided such accident occurs or such sickness commences while you are covered. It will be necessary to be under the care of a physician as defined by the Plan.

Benefits are payable for employees only from the 1st day of disability due to an accident, and from the 8th day of disability due to sickness. Payments will continue as long as you are disabled, up to a maximum of 26 weeks for each period of disability. You must contact the Trust Administration Office for the appropriate paperwork relating to this benefit.

Weekly Benefit

First (1^{st}) through the twenty sixth (26^{th}) week $150

There is no limit to the number of different periods of disability for which you may receive benefits.

Periods of disability due to the same cause will be considered the same period of disability unless they are separated by return to active full-time work for at least two weeks. Periods of disability due to different causes will be considered different periods of disability if they are separated by return to active full-time work.

Weekly income benefits are not payable for disabilities which are due to:

- Alcoholism
- Drug addiction
- Any dental procedure

Additional benefits under this portion of the Plan may be available to you. Please check your Collective Bargaining Agreement for additional details.

DEATH BENEFITS

If you die from any cause, your Death Benefit will be paid as follows: To the beneficiary, if any, you have designated in writing and filed with the Trust Administration Office. If there is no designated beneficiary, then to your wife or husband, if living; if no living spouse, equally among your surviving children; if none survive, equally to your father and mother or the survivor of them; if none of the above survive, equally amount your surviving brothers and sisters; if none of the above survive you, to your personal representative.

Employees $5,000

You may change your beneficiary whenever you wish by making a written request to the Trust Administration Office. However, if you marry or divorce after a written designation of beneficiary has been filed, your prior written designation shall automatically be revoked and unless a new written designation is filed prior to death the Death Benefit shall be paid according to the priorities listed in the preceding paragraph. You or your survivor(s) must contact the Trust Administration Office for the appropriate paperwork relating to this benefit.

Death Benefits for Dependents:

Spouse	$500
Children (while an eligible dependent)	$500

The Death Benefit shown above will be paid to you if one of your covered dependents dies.

Additional benefits under this portion of the Plan may be available to you. Please check your Collective Bargaining Agreement for additional details including but not limited to Orthodontia, Death Benefit and Time Loss.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

A benefit up to$5,000 will be paid for any of the following losses occurring solely through external, violent, and accidental means on or off the job, in addition to any other benefits. You must contact the Trust Administration Office for the appropriate paperwork relating to this benefit.

Employees $5,000

Loss of Life: Full amount of coverage (Paid to your beneficiary as defined above)

Loss of: (Full amount of coverage (Paid to you)

- Both hands
- Both feet
- Sight of both eyes
- One hand and one foot
- One hand and sight of one eye; or
- One foot and sight of one eye

Loss of: (One-half the amount of coverage (Paid to you)

- One hand
- One foot; or
- Sight of one eye

The total payment for any one accident may not be more than the full amount of coverage. The loss must take place within 90 days after the accident and not be caused by war, suicide, attempted suicide, or loss due to intentional self-inflicted injury.

Loss of sight means total and irrecoverable loss of sight. Loss of a hand means severance of the hand at or above the wrist. Loss of a foot means severance of the foot at or above the ankle.

EXTENDED COVERAGE IF TOTALLY DISABLED

If you become totally and permanently disabled while a covered Participant under this Plan, your death benefits, shown in the schedule above, will be continued at no cost to you as follows:

- If you are under age 60 and are a covered Participant under this Plan at the time you become totally and permanently disabled, your death benefits will remain in effect as long as you continue to be totally and permanently disabled.

- If you are age 60 or over and are covered Participant under the Plan at the time you become totally and permanently disabled, your death benefit will remain in force for a period not to exceed one year, or the date you recover from your disability, whichever is earlier.

Total and permanently disabled means you are unable to work because of an accidental injury or sickness that prevents you from performing the normal duties of your occupation, you are not engaged in any occupation for wage performing the normal duties of your occupation, you are not engaged in any occupation for wage or profit and are under the regular care of a physician for the disabling injury or sickness.

The continuation of your death benefit coverage under this provision shall terminate upon termination of the Plan.

Additional benefits under this portion of the Plan may be available to you. Please check your Collective Bargaining Agreement for additional details including but not limited to Orthodontia, Death Benefit and Time Loss.

DEFINITIONS

Allowed Charge is the maximum allowance for specific services or supplies. This allowance is based upon many factors, including: a Provider's fee schedule with a Preferred Network; the allowable amount for Non-Preferred Providers as determined by the Plan; or a negotiated payment amount. If the services rendered are a plan exclusion, or if the Provider is Non-Preferred, the Provider may not be obligated to accept the allowed charge as payment in full and you may, therefore, be billed the full amount.

Base Medical Benefits are paid prior to any deductibles and out of pocket expenses the participant has under this Plan. Not all of the benefits have this provision.

Claims Processing Fiduciary means Rehn & Associates, but only to the extent described under Plan Processes; otherwise, the Plan Administrator is the fiduciary under the plan.

Clean Claim is a claim which is payable under applicable claims processing guidelines and which does not require special handling, additional information or further review and which was submitted utilizing approved forms and procedures and within twelve (12) months of the date of service.

Coinsurance is the percentage share payable by you on claims for which the Trust provides benefits at less than 100% of the allowed charge.

Coinsurance Maximum refers to the maximum out-of-pocket amount that a covered employee will have to pay for expenses covered under the plan. Coinsurance maximum includes coinsurance (Out-of-Pocket) only.

Cosmetic Surgery means that surgery performed to alter the texture or configuration of the skin, or the configuration or relationship with contiguous structures of any feature of the human body, which is performed primarily for psychological purposes or which does not correct or materially improve a bodily function.

Copay is a specified dollar amount that a Participant must pay out-of-pocket for a specified service at the time the service is rendered. Copays are taken before coinsurance. One (1) copay applies per day per provider.

Covered Service is a medically necessary service or supply which is specifically set forth in the schedule of benefits section of this plan, provided by a licensed health care Provider, practicing within the scope of such Provider's license, and is recognized for payment under this Plan, and not otherwise excluded under this plan. Rehn & Associates and Board of Trustees, through utilization of its resources and agents, has the sole discretion to determine if a health care service or supply is a covered service.

Custodial Care is care provided primarily for maintenance of a patient or which is designed essentially to assist a patient in meeting his or her activities for daily living and which is not primarily provided for its therapeutic value in the treatment of an Illness, disease, bodily Injury, or condition. Custodial Care includes, but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications not requiring constant attention of trained medical personnel.

Deductible is an annual amount of charges, up to the Allowed Charge, for Covered Services payable by a Participant to a Provider who is recognized for payment under this Plan before the Plan will assume any liability for all or part of the remaining Covered Services. Benefits, except as otherwise specified, shall apply only after the deductible has been met. Charges for services payable by the Participant due to a reduction in benefits, denial of benefits, or amounts charged in excess of Allowed Charge are the financial responsibility of the Participant and shall not be considered as an eligible expense for application towards the deductible amount.

Dental Charges are the charges, as determined by the Inland Empire Teamsters Trust, made by a Dentist or other Physician for necessary care, appliances or other dental materials listed as a covered dental service. A dental charge is incurred on the date the service or supply for which it is made, is performed, or is furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Trust will apportion that overall charge to each of the separate visits or treatments. The charge will be considered to be incurred as each visit or treatment is completed.

Dentist is a person who has received a degree in Dentistry and is duly licensed to practice Dentistry by governmental authority having jurisdiction over the licensing and practice of Dentistry.

Dentistry refers to the treatment or repair of teeth, bones, tissues of the mouth and defects of the human jaw and associated structures. Dentistry shall include, but not be limited to, surgical procedures involving the mandible and maxilla where performed for the purpose, at least in part, of preparing such boney structure for dentures or the attachment of teeth, artificial or natural. Dentistry shall also include the administration of anesthetic in connection with any treatments listed above.

Employee means any employee of an employer participating in the Trust Fund, who qualifies for coverage in accordance with the terms of the Collective Bargaining Agreement or special agreement and the Eligibility rules established by the Board of Trustees.

ERISA means the Employee Retirement Income Security Act of 1974. This Act is what provides Federal Law and governs for this Self-Insured Health Care Trust.

Experimental and/or Investigational Treatment includes a service or supply if any of the following apply:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given for regular non-experimental or non-investigational purposes at the time the drug or device is furnished.
- The drug, device, or medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status.
- Federal law classifies the drug, device, or medical treatment or procedures under an investigational program.
- Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy compared with standard means of treatment or diagnosis.
- Reliable evidence shows the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trails are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below).

For this section, "reliable evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Family is two (2) or more persons related by blood, marriage, or law who are enrolled under the same identification number.

Health Care Plan Administrator is the Trust Administration Office.

Health Care Plan describes any medical plan offered by the Trust to covered employees, dependents, and/or for those individuals electing COBRA continuation coverage.

Illness refers to a bodily disorder, disease, or condition other than an Injury. All such bodily disorders existing concurrently, which are due to the same cause or pathologically related causes, shall be considered to be one Illness. Successive Illnesses from the same cause, or from treatment or complications thereof, shall be considered as the same Illness.

Injury refers to a physical Injury caused by an unexpected or unintended occurrence, independent of disease or bodily infirmity, or caused by unintended ingestion of toxic substances. All bodily disorders sustained in the same mishap or accident or from treatment or complications thereof or pathologically related thereto shall be considered as one Injury. Self-inflicted bodily injury resulting from a mental or physical health condition shall be considered an Injury. Bodily disorders resulting from allergies shall not be considered an Injury.

Major Medical Benefit is payable after any deductibles and out of pocket expenses the participant has under this Plan. Not all of the benefits have this provision.

Medical Emergency means the sudden severe physical symptoms that could not have been reasonably anticipated; and require immediate medical treatment.

Medically Necessary refers to those services or supplies provided by a Physician or Provider that are required to identify or treat a Participant's Illness or Injury and which, as determined by the Inland Empire Teamsters Trust are:

- consistent with the symptoms, diagnosis, and/or treatment of the Participant's condition, disease, ailment, or Injury and likely to stabilize or improve the Participant's condition;
- appropriate with regard to the standards of good medical practice recognized and approved at the time employed by Physicians practicing within the state of licensure and as accepted medical practice;
- not primarily for convenience of a Participant, Physician, or Provider; and
- the most appropriate supply or level of service that can safely be provided to the Participant.

When applied to the care of an Inpatient, it further means that the Participant's medical symptoms or condition requires that the services cannot safely be provided to the Participant as an Outpatient. The fact that a Physician or Provider may prescribe, order, recommend, or approve a service or supply does not, of itself, render such service or supply Medically Necessary or covered under this Plan.

Non-Preferred Provider is defined as a Provider which does not have a current contract with a Preferred Provider Organization (PPO) with whom the Inland Empire Teamsters Trust is contracted to provide healthcare services. Services provided by a Non-Preferred Provider shall be reimbursed according to the plan's Non-Preferred Provider benefit level. Any balance remaining after a Rehn & Associates payment shall be the responsibility of the Participant.

Orthodontic Services are defined as the movement of one or more teeth by the use of active appliances. It includes:

- treatment plan and records, including initial, interim and final records;

- periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances;
- orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

Participant is any person who satisfies the eligibility and enrollment qualifications and is enrolled for coverage under this Plan. The term Participant shall include eligible employees, dependents, and individuals qualified for continued coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272 (COBRA).

Physician is an individual who is licensed to practice medicine or osteopathy in the state in which he or she practices, has training and experience in the field in which he or she practices and is board certified or has completed an approved specialty training program.

Plan describes the written agreement identifying the terms and conditions of such agreement including general provisions, exclusions, limitations, schedule of benefits, any endorsements thereto, and application form(s). No oral statements or representations by any person, including employers, agents, or representatives of Rehn & Associates, can change, alter, delete, add, or otherwise modify the expressed written terms of this Plan or a validly executed endorsement to this Plan. The Plan may be modified or terminated at any time at the sole discretion of the Trust.

Plan Year refers to the period effective and coinciding with the Trust's benefit Plan Year. However, this may be modified or terminated at any time discretion of the Trust.

Pre-Authorization is the process a Provider of service must follow when required by Plan design. When the Provider contacts Innovative Care Management (ICM) to initiate the process, ICM will review the treatment plan for, among other things, appropriateness of care, place of service, and medical necessity.

Preferred Provider is a Physician, Hospital, or other Provider, as herein defined, who or which has contracted as PPO to provide covered services to Participants and to accept the Participant's deductible, copay, and coinsurance, plus the Inland Empire Teamsters Trust benefit payment as payment in full.

Prescribed means your provider orders the use of a medicine or other treatment.

Subscriber describes an eligible person who has applied for coverage, satisfied the enrollment qualifications, is accepted and enrolled for coverage, and in whose name the identification card is issued.

Terminal Illness refers to an Illness or condition, in which it is medically probable that the patient has less than six (6) months to live, provided such Illness or condition continues its normal course. His or her physician must certify the patient's condition as terminal.

Trust or The Trust means the Board of Trustees, who is the Plan Administrator.

Total Disability means you are unable to work because of an accidental injury or sickness that prevents you from performing the normal duties of your occupation (or, for a dependent, prevents the normal activities of a person of the same age and sex) and you are not engaged in any occupation for wage or profit and are under the regular care of a physician for the disabling injury or sickness.

Utilization Management is the evaluation of the treatment plan to determine whether recommended medical services and place of treatment are necessary, appropriate, and at or above quality standards for a Participant's Illness, Injury, physical disability, or condition.

COORDINATION OF BENEFITS

All of the benefits under this Plan are subject to these provisions:

This Plan will coordinate benefit payments with any other group or individual plan you or a Participant of your family may have, including motor vehicle policies. This means, for example in the event of an motor vehicle accident, that any other group or individual plan or medical coverage under an applicable motor vehicle policy will pay first and this Plan will pay second. Coordination of Benefits lowers the cost of health care for everyone because no one receives double payment for any medical service provided.

If you or your dependents have coverage in addition to this Plan, please submit the claim to us and all other insurers at the same time. This helps us coordinate benefits and pay your bills more quickly.

Order of Benefit Determination

The benefits payable of a plan that does not have a coordination of benefits provision described in this section will be determined before the benefits payable of a plan that does have such a provision. In all other instances, the order of determination will be as follows:

Nondependent/Dependent

The benefits of a plan which covers the individual for whom benefits are claimed as an employee (that is, other than as a Dependent) are determined before the benefits of a plan which covers the individual as a Dependent.

Dependent Child – Parents Not Separated or Divorced

When this Plan and another plan cover the same child as a Dependent of different persons called "parents," the benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if another plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

Dependent Child – Separated or Divorced parents

If two or more plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- first, the plan of the parent with custody of the child;
- then, the plan of the spouse of the parent with custody of the child; and
- finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

Active/Inactive Employee

The benefits of a plan which covers an individual as an employee who is neither laid off nor retired, or as that employee's Dependent, are determined before the benefits of a plan which covers that individual as a laid-off or retired employee or as that employee's Dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

Longer/Shorter Length of Coverage

If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the plan which covered that individual for the shorter time.

Eligibility and Plan Verification

Rehn & Associates shall provide a contact person, available during normal business hours, for Providers to further verify the eligibility, plan benefits, and obtain billing information for Participants. Providers shall be entitled to rely on Rehn & Associates verification of a Participant's eligibility under the Plan.

OTHER INFORMATION

Plan Processes

Rehn & Associates, as the claims processing fiduciary, is responsible for evaluating all benefit claims and is vested with full discretionary authority to approve or deny claims and appeals, and to interpret the Plan as necessary to do so, including for example determining whether treatment is "medically necessary" or "experimental." Rehn & Associates may delegate certain administrative or claims processing tasks to subcontractors for review.

Claims Filing

Claims for services of Preferred Providers will be submitted for you. For office visits and prescriptions, you will pay either a copay or coinsurance at the time of service. For other types of services, you will typically receive a bill from your provider for the balance you owe after the Plan has paid its portion of your claim.

Occasionally, you may need to file a claim directly to Rehn & Associates. Here's how to file a claim:

1. Obtain a Rehn & Associates claim form by downloading one at www.teamstersbenefits.com.
2. Complete and sign the form.
3. Attach the itemized doctor, hospital or other health care provider bill to your completed claim form. Rehn & Associates will accept any form that contains all of the itemized information necessary to process and pay benefits.
4. Submit the completed Statement of Claim form and attached bills within 90 days after the date of service to:

Inland Empire Teamsters Trust

PO Box 5433

Spokane, WA 99205

If all coverage and eligibility requirements are met, the benefit payment will be sent directly to the patient, or to the Assigned Provider of Services (your hospital, doctor, clinic, etc.) The deadline for submitting benefit claims is one year from the date of service: Claims submitted more than 12 months after the date of service will not be paid.

Clean Claim Submission

No benefits shall be provided for any claim submitted more than twelve (12) months from the date services were rendered.

If your claim is denied, you may appeal to Rehn & Associates for a review of the denied claim. Your appeal will be decided in accordance with reasonable claims procedures, as required by ERISA. See the "Appeal Process" section of this booklet.

APPEAL PROCESS

Procedure for Disputed Claims

In the event a claim for benefits is denied (in whole or in part), and you disagree with that decision you have the right to request that we review that adverse benefit determination through a formal, internal appeals process. The Board of Trustees has adopted the following procedures to address benefit claim denials:

Notification of Benefit Denial

If a claim is denied or partly denied, you will be notified in writing and given an opportunity for review. The Explanation of Benefits will provide:

- The specific reasons for denial
- Specific reference to pertinent Plan provisions on which the denial is based
- A description of any additional material or information necessary for the claimant to perfect the claim and explanation of why such material or information is necessary
- If the denial is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of scientific or clinical judgment for the determination , applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request
- An explanation of Plan's claim review procedure, including a statement of the claimant's right to bring civil action under ERISA § 502(a).

Appeal to the Board of Trustees

Notice of Appeal – Any employee or beneficiary who applies for benefits under this Plan and is ruled ineligible by the Trustees (or by the Trust Administration Office acting for the Trustees) or who believes he did not receive the full amount of benefits to which he is entitled or who is otherwise adversely affected by any action of the Trustees or the Trust Administration Office, shall have the right to appeal the matter to the Board of Trustees, provided that he files a written notice of appeal within 180 days after receipt of the adverse benefit determination. The Trustees or their representatives shall not consider applications for appeal which are submitted without an authorization to release health information relevant to the denied claim. The address to which to submit your written request is as follows:

Rehn & Associates - Trust Administration Office
Attn: Appeals Dept
PO Box 5433
Spokane, WA 99205-0433

The appeal shall be conducted by the Board of Trustees, or by the Appeals Committee of the Board of Trustees which has been delegated the authority for making a final decision in connection with the appeal.

Scheduling of Appeal – The Trustees shall review a properly filed appeal at the next regularly scheduled quarterly meeting of the Appeals Committee, unless the request for the review is received by the Trustees within thirty (30) days preceding the date of such meeting. In such case, the appeal will be reviewed no later than the date of the second quarterly meeting following the Trustees' receipt of the notice of appeal, unless there are special circumstances requiring a further extension of time, in which case a benefit determination shall be rendered not later than the third quarterly meeting of the Appeals Committee following the Trustees' receipt of the notice of appeal. If such an extension of time for review is required because of special circumstances,

such as a request for hearing on the appeal, then prior to the commencement of extension, the Plan shall notify the claimant in writing of the extension, describe the special circumstances and the date as of which the benefit determination will be made.

Appeal Procedures – The Claimant is generally entitled to present his position and any evidence in support thereof, at an appeal hearing. The claimant may be represented by an attorney or by any other representative of his choosing at his own expense.

The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to this or her claim for benefits.

The claimant must introduce sufficient credible evidence on appeal to establish, prima facie, entitlement to the relief from the decision or other action from which the appeal is taken. The claimant will have the burden of proving his right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records and other information submitted by the claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not afford deference to the initial adverse benefit determination.

When deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained of behalf of the Plan in connection with the adverse benefit determination will be identified to the claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Decision After Appeal Hearing – The Trustees will issue a written decision on review of a claim as soon as possible, but not later than 5 days following the conclusion of the Appeals Committee meeting. The written decision will indicate:

- The specific reasons for the determination and a specific reference to pertinent Plan provisions on which the determination is based
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claims for benefits
- A statement of claimant's right to bring a civil action under ERISA § 502(a)

Review of Trustees' Decision – If a claimant remains dissatisfied with the Plan's determination, and requests further external review the Trust Administration Office will send you a document at the end of the internal appeal process notifying you of your rights to an external review. We must receive your written request for an external review within four months of the date you received the final internal adverse benefit determination. Not all appeals are eligible for external review.

If you are not satisfied with the final internal review regarding our decision to modify, reduce, or end payment, coverage or authorization of coverage, you may have the right to have the decision reviewed by an Independent Review Organization (IRO). An IRO is an independent organization of medical reviewers who are certified to review medical and other relevant information. IROs are selected at random by the Plan. A cost may be associated with your plan to file an external review.

We, the Trust Administration Office, will notify the IRO of your request for an external review. We will forward your medical records and other relevant materials for your external review to the IRO. We will also provide the IRO with any additional information they request that is reasonably available to us.

Once the external review is completed, the IRO will notify you as well as the Trust Administration Office in writing of their decision. If you have requested an expedited external review, the IRO will notify you as well as the Trust Administration Office of their decision immediately by phone, email or fax, after they make their decision, and will follow up with a written decision by mail.

If you are still not satisfied with the external review performed by the IRO, the claimant may bring a civil action under ERISA § 502(a). The question on review of the Trustees' and IRO determination will be whether, in the particular instance, the Trustees and IRO: (1) were in error upon an issue of law; (2) acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence. The evidence will be limited to the record of appeal.

Sole and Exclusive Procedures – The Plan's appeal procedures are the sole and exclusive procedures available to a claimant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by an action of the Trustees. The appeal procedures must be exhausted prior to filing legal action.

SUBROGATION

If you or your eligible dependents are entitled to receive benefits from the Plan for injuries caused by a third party or as a result of any accident (for example, an auto accident), or if you or eligible dependents receive an overpayment of benefits from the Plan, the Plan has the right in equity, and a right in contract, to obtain full first dollar restitution of the benefits paid by the Plan from:

1. Any full or partial payment that your insurance carrier makes (or is obligated or liable to make) to you or your eligible dependents; and
2. You or your eligible dependents, if any full or partial payments are made to you or your eligible dependents by any party, including an insurance carrier, in connection with, but not limited to, your, your dependent's or a third party's:
   - Automobile liability coverage
   - Uninsured motorist coverage
   - Underinsured motorist coverage
   - Homeowner's coverage
   - Other insurance coverage

This means that, with respect to benefits the Plan pays in connection with an injury or accident, the Plan has the right to full first dollar restitution from any payment received by you or your eligible dependents from any third party, whether or not the payment separately allocates an amount to the restitution of the expenses or types expenses covered by the Plan or the benefits provided under the Plan. Any payment received by you, or your representative, is subject to a constructive trust. Any payment received by you must be used first to provide restitution to the Plan to the full extent of the benefits paid by or payable under the Plan. The balance of any payment must first be applied to reduce the amount of benefits that are paid by the Plan for benefits after the payment and second be retained by you or your eligible dependents. The Plan does not recognize the Make-Whole Doctrine.

You and your eligible dependents are responsible for all expenses incurred to obtain payment from third parties, including attorneys' fees, which amounts will not reduce the amount due to the Health Plan as restitution. The Plan expressly rejects the Common Fund Doctrine with respect to payment of Attorneys' fees. The Plan is entitled to obtain restitution of any amounts owed to it from funds received by you or your eligible dependents, regardless of whether you or your eligible dependents have been fully indemnified for losses sustained at the hands of the third party. The Plan may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable and/or contractual right to obtain full restitution.

By participating in the Plan, you and your eligible dependents acknowledge and agree to the terms of the Plan's equitable (or other) rights to full restitution. You and your eligible dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator, including the signing of any documents or agreements necessary for the Plan to investigate and obtain full restitution.

You and your eligible dependents are also required to:

- Notify the Trust Administrative Office as soon as possible and in writing that the Plan may have an equitable (or other) right to obtain restitution of any and all benefits paid by the Plan
- Inform the Trust Administrative Office in advance of any settlement proposals advanced or agreed to by the third party or third party's insurer, or by a first party insurer
- Provide the Trust Administrative Office all information requested by the Health Plan Administrator regarding an action against a third party, including an insurance carrier
- Fully cooperate with the Trust Administrative Office in all requests in the Plan's enforcement of its equitable (or other) rights to restitution
- Not settle, without the prior written consent of the Trust Administrative Office, any claim that you or your eligible dependents may have against a third party, including an insurance carrier
- Take all other action as may be necessary to protect the interests of the Health Plan.

In the event you or your eligible dependents do not comply with the requirements of this section, the Plan may deny benefits to you or your eligible dependents or take such other action as the Trustees deem appropriate. The Plan has the right to reduce future payments due to you or your eligible dependents by the amount of benefits paid by the Health Plan. This right of offset shall not limit the equitable and/or contractual right of the Plan to recover such moneys in any other manner.

If you have questions about how your benefits under the Plan are paid when another Plan is involved, please contact the Trust Administrative Office.

WORKERS' COMPENSATION OR INDUSTRIAL INSURANCE

This provision applies if you or your enrolled dependent has filed or is entitled to file a claim for Workers' Compensation or Industrial Insurance. Benefits for treatment of an illness or injury arising out of or in the course of employment or self-employment for wages or profit are excluded under this Plan. The only exception would be if you or your enrolled dependent is exempt from state or federal workers' compensation law.

Here are some rules which apply in situations where a Workers' Compensation or Industrial Insurance claim has been filed:

1. You must notify Rehn & Associates in writing within ten days of filing a workers' compensation or Industrial Insurance claim.
2. If the entity providing workers' compensation or Industrial Insurance coverage has denied you or your enrolled dependent's claims and you have filed an appeal, benefits under the Plan for covered expenses may be advanced if you or your enrolled dependent agrees in writing to hold any recovery you or your enrolled dependent obtains from the entity providing workers' compensation or Industrial Insurance coverage in trust for the Plan up to the amount of the benefits it has paid. You or your enrolled dependent may be required to sign an agreement guaranteeing the Plan's rights to reimbursement before any benefits are advanced.
3. If the benefits under the Plan have already been paid, the Plan will be entitled to reimbursement of the benefits it has paid from the proceeds of any recovery you or your enrolled dependent receives from or on behalf of the entity providing workers compensation or Industrial Insurance coverage.
4. The Plan is entitled to full reimbursement of the benefits it has paid from the proceeds of any recovery you or your enrolled dependent received from or on behalf of the entity providing workers' compensation or Industrial Insurance coverage. This is so regardless of whether:
   - 4.1 The recovery is the result of an arbitration award, compromise settlement, or any other arrangement;
   - 4.2 The entity providing workers' compensation or Industrial Insurance coverage admits liability; or
   - 4.3 The health care expenses are itemized or expressly excluded in the recovery.
5. A deduction of a proportionate share the reasonable expenses of obtaining a recovery such as attorney fees and court costs may be allowed from the amount reimbursed to the Plan.
6. If you or your enrolled dependent incurs health care expenses for treatment of the illness or injury after receiving a recovery, benefits under the plan for otherwise covered expenses will be excluded until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount, as defined in the "Subrogation" section of this booklet.

CONTINUATION OF COVERAGE - COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Trust. This outline is intended only to summarize your rights and obligations under the law. The Trust offers no greater COBRA rights than what the COBRA statute requires and this Notice should be construed accordingly.

The Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272 (COBRA) is a federal law that applies to employers of twenty (20) or more employees. This law gives enrolled Participants the right, in certain circumstances, to continue coverage under their employer's health plan for a limited time beyond the date coverage would otherwise have been terminated. Continued coverage is not automatic. Under COBRA, a qualified individual must apply for continued coverage within a certain time period and may also have to pay the full cost for the coverage plus 2%.
References below to the "Trust Administrator" and references to the COBRA Administrator refer to Rehn & Associates.

Conditions for Continuation of Coverage under COBRA

1. For COBRA continuation coverage to become effective, all of the following requirements must be satisfied:
   - The qualified individual(s) must elect continued coverage no more than sixty (60) days after either the date coverage was to end because of a "qualifying event", or the date he or she is notified of the right to continue coverage, whichever is later.
   - The qualified individual(s) must send the initial required premium payment to the COBRA Administrator, not more

than forty-five (45) days after the date he, she, or they have elected continued coverage.

- Subsequent required premiums must be paid monthly to the COBRA Administrator.

2. A qualified individual must be notified of his or her rights under COBRA within forty-four (45) days of the date the Trust Administrator receives notice of the qualifying event.

3. The Trust will offer COBRA continuation coverage to qualified beneficiaries only after the Trust or COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the employer must notify the Trust Administrator of the qualifying event within sixty (60) days of any of these events.

4. For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Trust or COBRA Administrator. The Trust requires you to notify the Trust or COBRA Administrator within sixty (60) days after the qualifying event occurs.

Qualifying Events

1. COBRA may be elected for up to eighteen (18) consecutive calendar months for an employee and his or her covered dependents if the "qualifying event" is that:

   a) The employee's work hours are reduced resulting in a loss of eligibility for medical benefits; or,

   b) The employee's employment terminates (voluntary or involuntary) for reasons other than gross misconduct.

   c) If the individual continuing coverage is determined to be disabled (under Title II (OASDI), within sixty (60) days of the "qualifying event," or Title XVI (SSI) of the Social Security Act) on the date of the "qualifying event" identified above, he or she may elect COBRA for up to a total of twenty-nine (29) consecutive calendar months from the date of the "qualifying event." To be eligible for the extended continuation period, the individual must present a copy of the disability determination to the COBRA Administrator, during the initial eighteen (18) month period and no later than sixty (60) days after the individual receives the disability determination.

2. COBRA may be elected for up to thirty-six (36) consecutive calendar months for the covered spouse or dependent children if the qualifying event resulting in loss of medical coverage is:

   a) The death of the employee;

   b) The employee and spouse legally separate or divorce;

   c) A child loses eligibility for dependent coverage (for example: age limitation or marriage)

   d) In addition, the occurrence of one of these events during the initial eighteen (18) month period described above can extend that period for a continuing dependent up to 36 months.

COBRA Election Period

1. Once the Trust or COBRA Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

2. You (the employee) or your qualified beneficiaries must elect continuation coverage within sixty (60) days after Plan coverage ends, or, if later, 60 days after the Trust or COBRA Administrator sends you notice of the right to elect continuation coverage. If you or your dependent does not elect continuation coverage within this sixty (60) day election period, you will lose your right to elect continuation coverage. Your (or your qualified beneficiaries) election, if mailed, is effective on the day the election is sent (post-marked) to the COBRA Administrator.

3. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only.

4. In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a sixty-three (63) day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which

you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Notices Required

1. The Trust provides that your spouse's coverage terminates as of the last day of the month in which a divorce or legal separation occurs. A dependent child's coverage terminates the last day of the month in which he or she ceases to be an eligible dependent under the Plan (for example, after attainment of a certain age). You (the employee) or a qualified beneficiary have the responsibility to notify the Trust or COBRA Administrator upon a divorce or legal separation, or a child losing dependent status within sixty (60) days after the later of the qualifying event or the date coverage is lost. If the qualifying event is a divorce or legal separation, you must present a copy of the divorce decree or proof of legal separation during the sixty (60) day notice period. If you or a family Participant fails to notify the Trust or COBRA Administrator during the sixty (60) day notice period, any family Participant who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family Participant fail to notify the Trust or COBRA Administrator, and contrary to Plan terms any claims are paid mistakenly for expenses incurred after the last day of the month of the divorce or legal separation or child losing dependent status, then you and your qualifying family Participants will be required to reimburse the Trust for any claims paid.

2. You (the employee) or your qualified beneficiaries must also notify the COBRA Administrator within thirty (30) days if, after electing COBRA coverage you or a qualified beneficiary becomes covered under another group health plan. Further, if you or a qualified beneficiary fails to notify the COBRA Administrator, and contrary to Plan terms any claims are paid mistakenly for expenses incurred, then you and your qualified beneficiaries will be required to reimburse the Trust for any claims paid.

3. Once the Trust or COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, and pays the required premium, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

4. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

5. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

COBRA Payment Procedures

1. Once your COBRA Administrator, has received your correctly completed COBRA election (or enrollment) form, the selections chosen will confirm that you wish to continue coverage under the COBRA plan. Coverage is not activated until payment is received even if the election form is received within the election deadline. As stated above, COBRA payments are due within the first forty-five (45) days after your sixty (60) day election period.

2. Rehn & Associates is your COBRA Administrator. The following procedures apply: Your COBRA payment is due (in full) the first (1st) of each month to the COBRA Administrator. Premium payments will have a thirty-one (31) day grace period. On the first (1st) day of each month, your eligibility status will be set as Terminated until your premium payment for that month is received. Once received, your eligibility status will be set as Effective retroactively back to the first (1st) day of that month and extending until the last day of that month. If your premium payment is not delivered or postmarked within the grace period, your coverage will be terminated back to the last day of the month for which we received a full premium payment. Payments by bounced checks indicating non-sufficient funds do not constitute payment. If funds are not made available by the end of the grace period, coverage will be terminated back to the last day of the month for which full payment was received.

3. COBRA premiums and benefits are subject to change at any time during the plan year. In the event of a premium or benefit change, you will be notified of new premiums and benefits. Upon annual plan renewal, you will receive a letter listing updated premiums.

Premium Payments

1. Each qualified beneficiary will be required to pay the entire cost of continuation coverage. The premium you will be charged will not be more than 102% of the total cost of providing coverage. The premium for an extension of continuation coverage due to a disability can be as much as 150% of the cost of coverage for the 19th through 29th months of coverage.

2. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form.

However, you must make your first payment for continuation coverage to the COBRA Administrator, within forty-five (45) days after the date of your election. (This is the date the Election Notice is post-marked, if mailed). If you do not make your first payment for continuation coverage within those forty-five (45) days, you will lose all continuation coverage rights under the Trust.

3. Your first payment for continuation coverage must cover the cost of continuation coverage from the time your coverage under the Trust would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period.

4. All other premiums are due (in full) the first (1st) of each month. Premium payments will have a thirty-one (31) day grace period, which will not be extended for holidays or weekends. A premium payment is made on the date it is sent (post-marked). The Trust will not send periodic notices of payments due for these coverage periods.

Maximum Length of COBRA Coverage

1. Thirty-six (36) Months: When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the plan, COBRA continuation coverage lasts for up to thirty-six (36) months.

2. Eighteen (18) Months: If you or your qualified beneficiaries lose group health coverage due to termination of employment (other than for gross misconduct) or reduction in hours of employment, coverage may be continued for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended:

   a) **Disability extension of eighteen (18) month period of continuation coverage**
   If you or your qualified beneficiaries covered under the Trust is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage, you and your family can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The Social Security Administration must formally determine under Title IX (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the twenty-nine (29) month continuation coverage period to apply, the qualified beneficiary must present the COBRA Administrator with a copy of the Social Security Determination of Disability within sixty (60) days of the date of the determination and before the end of the original eighteen (18) month period that applies to the qualifying event. If these procedures are not followed or if the notice is not provided to the Trust Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator of that fact within thirty (30) days of SSA's determination. Further, if you or a family Participant fails to notify the COBRA Administrator, and contrary to Plan terms any claims are paid mistakenly for expenses incurred, then you and your qualified beneficiaries will be required to reimburse the Trust for any claims paid.

   b) **Second qualifying event extension of eighteen (18) month period of continuation coverage**
      1. Eighteen (18) month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first eighteen (18) months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is thirty-six (36) months from the date of the initial termination of employment or reduction in hours. Such second qualifying events include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Trusts. You must notify the COBRA Administrator of the second qualifying event within sixty (60) days of the second qualifying event (see Notices Required). If these procedures are not followed or if the notice is not presented to the Trust Administrator within the required sixty (60) day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.

      2. An event cannot be a 2nd qualifying event entitling a qualified beneficiary to extended COBRA coverage unless the event would have caused a loss of coverage under the Plan.

      3. In no event will continuation coverage last beyond thirty-six (36) months from the date of the original qualifying event. The thirty-six (36) months is counted from the date of the first qualifying event.

Children Born or Placed for Adoption after the Qualifying Event

If, during the period of continuation coverage, a child is born to the covered employee or is placed for adoption with the covered employee and the covered employee has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The covered employee or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The covered employee or a family Participant must notify the Trust Administrator within sixty (60) days of the birth, adoption or placement to enroll the

child on COBRA and COBRA coverage will last as long as it lasts for other family Participants of the employee. (The sixty (60) day period is the Trust's normal enrollment window for newborn or adopted children.) If the covered employee or family Participant fails to notify the Trust Administrator in a timely fashion, the covered employee will NOT be offered the option to elect COBRA coverage for the newborn or adopted child.

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity to change their coverage option or add or drop dependents at open enrollment as similarly situated active employees. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and then later loses such coverage due to certain qualifying reasons. Except for children described above under Children Born or Placed for Adoption after the Qualifying Event, dependents that are added under HIPAA's special enrollment rights do not become qualified beneficiaries -their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

Termination of Continued Coverage (COBRA)

1. You and your qualified beneficiaries have the obligation to notify the COBRA Administrator within thirty (30) days after becoming covered under another group health plan. The Trust reserves the right to retroactively cancel COBRA coverage and to seek reimbursement of all benefits paid after that point in the event that you or any qualified beneficiary fails to notify the COBRA Administrator of the new coverage.
2. Continued coverage will end on the last day for which required contributions have been paid in the monthly period in which the first of the following occurs:
   - The applicable continuation period expires.
   - The next monthly required contribution is not paid when due or within the grace period.
   - For an individual whose coverage has been extended from eighteen (18) months to twenty-nine (29) months due to disability, continued coverage beyond eighteen (18) months ends if there is a final determination that the individual is no longer disabled under the Social Security Act. However, coverage will not end on the date indicated above, but on the last day for which required contributions have been paid in the first month that begins more than thirty (30) days after the date of the determination.
   - The individual subsequently becomes covered under another group health care program. If, however, the other group health care program contains exclusions or limits for benefits for pre-existing conditions that affect the individual's coverage, he or she may continue COBRA coverage for the shorter of the applicable COBRA term or until the pre-existing condition waiting period is satisfied. Note that under HIPAA, a federal law, exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other plan.
   - The employer no longer offers health coverage to any employee.
   - Occurrences of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses for a reason other than the COBRA coverage requirements of federal law.

Deadlines to Remember

1. You must notify the Trust or COBRA Administrator of a newborn child, or child placed for adoption in your home within sixty (60) days of the birth/placement or the child will not be offered the option to elect COBRA coverage.
2. You or your dependents must notify the Trust or COBRA Administrator of a divorce, legal separation, or a child's loss of dependent status within thirty-one (31) days of the event.
3. Upon termination of health plan coverage, immediately advise your Trust or COBRA Administrator if you desire continued coverage under COBRA. Complete instructions on how to elect continuation coverage will be given to you within fourteen (14) days of the date you provide the Trust or COBRA Administrator with timely notice of the "qualifying event." The person(s) eligible to continue coverage then has sixty (60) days in which to elect continuation.
4. After you elect COBRA continuation for you or your dependents, you have forty-five (45) days from the date of the election in which to pay the premium owed for continuous coverage during the period preceding the election (for example: back to the time of the "qualifying event"). Premium payments should be paid to the COBRA Administrator.

Keep Your Trust Informed of Address Changes
In order to protect your family's rights, you should keep the Trust Administrator informed of any changes in the addresses of family Participants. You should also keep a copy, for your records, of any notices you send to the Trust Administrator.

Health Insurance Marketplace Coverage Options and your Health Coverage
There may be other coverage options for you and your family. When key parts of the Health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. For more information about your coverage offered by your employer, please contact your employer.

STATEMENT OF YOUR RIGHTS UNDER ERISA

As a participant in this Trust you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Trust participants may be entitled to:

- Examine, without charge, at the Trust Administrative Office and at all local union offices upon 10 days written request, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all relevant Plan documents and other Plan information upon 10 days written request to the Board of Trustees. The Board of Trustees may impose a reasonable charge for the copies. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.
- Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each participant with a copy of this Summary Annual Report.
- File suit in a federal court if any materials requested are not received within 30 days of a participant's request, unless the materials were not sent because of matters beyond the control of the administrator. The court may require the Board of Trustees to pay up to $110 for each day's delay until the materials are received.

In addition to creating rights for Trust participants, ERISA imposes obligations upon the people who are responsible for the operation of the employee benefits plan. These persons are referred to as "fiduciaries" of the Trust. Fiduciaries must act solely in the interest of the Trust participants and they must exercise prudence in the performance of their Trust duties.

In the event Trust fiduciaries misuse the assets of the Trust, you may request assistance from the U.S. Department of Labor or sue in federal court, which may award you costs of suit, including your attorney fees if you are successful. If you are not successful, the court may award the Trusts attorney fees against you.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D. C. 20210.

All questions with respect to Trust participation, eligibility for benefits or the nature and amount of benefits, or with respect to any matter of Trust administration, should be referred to the office of:

Rehn & Associates
PO Box 5433
Spokane, WA 99205
(509) 534-0600 / (800) 872-8979

HIPAA - HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191 was enacted on August 21, 1996. HIPAA amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 (CODE) to provide for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with

employment. Sections 102(c)(4), 101(g)(4) and 401 (c)(4) of HIPAA require the Secretaries of Health and Human Services, Labor and the Treasury each to issue regulations necessary to carry out these provisions.

The Law

- limits exclusions for preexisting medical conditions;
- provides credit for prior health coverage and a process for providing certificates concerning prior coverage to a new group health plan or issuer;
- provides new rights that allow individuals to enroll for health coverage when they lose other health coverage or add a new dependent;
- prohibits discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors;
- guarantees availability of health insurance coverage for small employers and renewability of health insurance coverage in both the small and large group markets; and,
- preserves the states' role in regulating health insurance, including the states' authority to provide greater protections.

HIPAA Rules

The Health Insurance Portability and Accountability Act (HIPAA) offers protection for millions of American workers that improve portability and continuity of health insurance coverage.

HIPAA Protects Workers and Their Families By

- Providing credit against maximum preexisting condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer.
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent.
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors.
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers.
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under federal law.

YOUR HEALTH INFORMATION RIGHTS

Creditable Coverage

- Includes prior coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan.

Certificates of Creditable Coverage

- Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA continuation coverage. A certificate must also be provided free of charge upon request while you have health coverage or anytime within 24 months after your coverage ends.
- Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents.
- For plan years beginning on or after July 1, 2005, certificates of creditable coverage should also include an educational statement that describes individuals' HIPAA portability rights. A new model certificate is available on EBSAs Web site.
- If a certificate is not received, or the information on the certificate is wrong, you should contact your prior plan or issuer. You have a right to show prior creditable coverage with other evidence — like pay stubs, explanation of benefits, letters from a doctor — if you cannot get a certificate.

Special Enrollment Rights

- Are provided for individuals who lose their coverage in certain situations, including on separation, divorce, death, termination of employment and reduction in hours. Special enrollment rights also are provided if employer contributions toward the other coverage terminates.
- Are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption.

Discrimination Prohibitions

- Ensure that individuals are not excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors.

HIPAA - PRIVACY NOTICE

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

Pursuant to regulations issued by the federal government, the Plan is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As required by law, the Fund has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

Protected Health Information

Protected health information generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

Use and Disclosure of Health Information

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary," as defined under the Privacy Rules.

To Make or Obtain Payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may use your health information to pay claims, or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment. The Plan may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating physician to another treating physician for the purpose of obtaining x-rays.

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Plan participants. Health care operations include such activities as: contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Plan (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection With Judicial and Administrative Proceedings. If required or permitted by law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Plan will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required For Law Enforcement Purposes. The Plan will disclose your health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Conduct Health Oversight Activities. The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action.

The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such 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.

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

To Your Personal Representative. The Plan may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care. The Plan may disclose your health information to immediate family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates. The Plan may disclose your health information to its Business Associates, which are entities or individuals not employed by the Plan, but which perform functions for the Plan involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Plan's Business Associates are required to safeguard the confidentiality of your health information.

For Workers' Compensation. The Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

For Disclosure to the Plan Trustees. The Plan may disclose your health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors for plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the plan. The Plan may also disclose information to the Trustees regarding whether you are participating or enrolled in the plan.

Authorization to Use or Disclose Health Information

Other than as stated above, the Plan will not disclose your health information without your written authorization. Authorization forms are available from the Privacy Contact Person, listed below. If you have authorized the Plan to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Contact Person, listed below.

Special rules apply to disclosure of psychotherapy notes. Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

Your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Plan.

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that the Plan maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request unless the disclosure is to another health plan for the purposes of carrying out payment or health care operations and your health care provider has been paid out of pocket in full. If you wish to request restrictions, please make the request in writing to the Plan's Privacy Contact Person listed below.

Right to Confidential Communications. You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Plan's Privacy Contact Person, listed below. The Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information in paper or electronic format, if available. You also have the right to have the Plan transmit a copy of your health information to an entity or person of your choice. These rights, however, do not extend to psychotherapy notes or information compiled in anticipation of civil, criminal or administrative proceedings. The Plan may deny your request in certain situations subject to your right to request

review of the denial. A request to inspect, copy or transmit records containing your health information must be made in writing to the Privacy Contact Person, listed below. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic format shall not be greater than the Plan's labor costs in responding to the request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing to the Plan's Privacy Contact Person, listed below. The Plan may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the health information you are requesting be amended is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

If the Plan denies a request for amendment, you may write a statement of disagreement. The Plan may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Plan's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Plan. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003 when the Privacy Rules became effective. Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; or in other limited situations. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. If the Plan participates in fundraising, you have the right to opt-out of all fundraising communications.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person, listed below. You will also be able to obtain a copy of the current version of the Plan's Notice at its web site, www.wpas-inc.com.

Privacy Contact Person. To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Plan has also designated a Privacy Official, listed below.

Privacy Contact Person

Administrative Agent
Rehn and Associates
P.O. Box 5433
Spokane, WA 99205
(509)534-0600
Email: rehn@rehnonline.com

Other Plan Privacy Officer(s)

Chairman and Secretary of the Board of Trustees

What does this mean to me?

Every effort is made to protect your PHI and the trust you have placed in the Plan. You should be aware, however, that in the course of administering your health benefits, PHI must be disclosed. Disclosure is permitted only when required or allowed by law. The Trust considers the activities described in the previous section key for the management of your health plan. The Trust also recognizes that many people do not want to receive marketing materials based upon their health plan participation or health history. The Trust does not participate in this type of activity and would seek your special consent before disclosing your information.

What if I believe this Privacy Policy is violated?
Your privacy is important to the Trust. The Trust has systems and policies in place to prevent the unlawful or accidental disclosure of your information. If you believe that this policy has been violated or if you believe there has been an inappropriate or unauthorized disclosure of your PHI, please let the Trust know. You will not be retaliated against for filing a complaint. Please submit your complaint in writing to the Trust. You may also call in, or call to request additional information. Complaints can also be submitted to the Secretary of Health and Human Services. Please direct any concerns or complaints to the Trust Privacy Officer. Please see the General Information section located at the end of this document.

APPLICABLE FEDERAL LAWS

Family Medical Leave Act
A federal law called the Family and Medical Leave Act of 1993 (FMLA) may allow your benefits to be continued on the same basis as if you were an actively at-work employee during an eligible leave of absence to:

- Care for your child after the birth or placement of a child with you for adoption or foster care
- Care for your spouse, child or parent who has a serious health condition
- For your own serious health condition, as stated in the FMLA

You are eligible under FMLA to continue benefits if all of the following conditions are met:

- You have worked for your employer for at least one year
- You have worked at least 1,250 hours over the previous 12 months
- Your employer employs at least 50 employees within 75 miles from your worksite
- You continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer

If you meet these requirements, and if your employer has enough employees to be covered under the FMLA, the law requires your employer to continue contributions for you and your dependents' medical, dental and vision coverage for up to 12 weeks during a 12-month period while you are on an approved FMLA leave.

Contact your employer as soon as you think you are eligible for a family or medical leave, since the law requires you to give 30 days' notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell of your other obligations under FMLA.

When your medical, dental and vision coverage ends, you and your dependents will be able to elect self-payment under COBRA.

Women's Health and Cancer Rights Act of 1998
Your Trust, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Newborns' and Mothers' Health Protection Act
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Mental Health Parity Act
The Mental Health Parity Act (MHPA), signed into law on September 26, 1996, requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan.

MHPA applies to group health plans for plan years beginning on or after January 1, 1998. The original sunset provision (providing that the parity requirements would not apply to benefits for services furnished on or after September 30, 2001) has been extended several times. If you have questions about the sunset provision, contact the EBSA office nearest you.

The law:

- Generally requires parity of mental health benefits with medical/surgical benefits.

The law also contains the following two exemptions:

- Small employer exemption. MHPA does not apply to any group health plan or coverage of any employer who employed an average of between 2 and 50 employees on business days during the preceding calendar year, and who employs at least 2 employees on the first day of the plan year
- Increased cost exemption. MHPA does not apply to a group health plan or group health insurance coverage if the application of the parity provisions results in an increase in the cost under the plan or coverage of at least one percent

Qualified Medical Child Support Orders

The Trust Retirement Income Security Act of 1974 (ERISA) and the Child Support Performance and Incentive Act of 1998 (CSPIA) require the Employer to take certain actions to help enforce state administrative and court orders for medical child support.

The Employer adopts the following procedures under ERISA to determine whether medical child support orders qualify with ERISA's requirements and thus are to be carried out. The Trust may modify or terminate these procedures to satisfy legal requirements.

A qualified medical child support order (QMCSO) establishes a child's right to receive benefits for which a Trust participant or qualified beneficiary for continuation of coverage is eligible, and which the Trust has determined meets the requirements to be a qualified medical child support order.

A medical child support order must:

- Specify the name and last known mailing address of the participant and the name and mailing address of each child covered by the order; and,
- Include a reasonable description of the type of coverage to be provided by the Trust to each child, or the manner in which such type of coverage is to be determined; and,
- Specify each period to which such order applies; and,
- Specify each plan to which such order applies.

A QMCSO must not require the Trust to provide any type or form of benefit or any option not otherwise provided under the Trust, except to meet requirements of Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

Upon receiving a medical child support order from a court of law, Rehn & Associates shall:

- Promptly notify in writing the Participant, each child covered by the order, and each representative for these parties of the receipt of the medical child support order. The notice shall include a copy of the order and these QMCSO procedures for determining if the order is qualified;
- Permit the child to designate a representative to receive copies of notices sent to the alternate recipient regarding the medical child support order;
- Within a reasonable time after receiving a medical child support order, determine if it is qualified and notify the participant and child(ren) subject of the order; and

Once the order is determined to be qualified, ensure the child is enrolled according to Trust terms and the order and is otherwise treated by the Trust as a covered beneficiary for ERISA reporting and disclosure purposes. As such, the Trust will distribute to the child a copy of the Summary Plan Description (SPD) and any subsequent material modifications adopted by the plan sponsor.

In the event the Trust receives a state administrative or court medical child support order under CSPIA requiring the Trust to withhold employee contributions for group health coverage for a child, the Trust will determine whether the employee is covered or eligible under the Trust, and whether the child may be eligible under the Trust.

After the Trust determines the employee is subject to income withholding to pay for the child's coverage, the Trust and/or Rehn & Associates, shall notify the employee, the child and the child's custodial parent (when that is not the employee) that coverage is or will become available. The Trust and/or Rehn & Associates will furnish the custodial parent a description of the coverage available, the effective date of the coverage and any forms, documents or other information needed to put such coverage into effect, as well as information needed to submit claims for benefits.

The Trust will determine whether employee contributions are available to pay for the child(ren)'s coverage. If such funds are available, the Trust will withhold such contributions from the employee's income and notify the employee to that effect.

Uniformed Services Employment and Reemployment Rights Act (USERRA)
Participants who satisfy conditions imposed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) may be entitled to have eligibility frozen for their period of military service. Under current law, Veterans will receive credit for purposes of eligibility for a period of up to five years of active duty service in the U.S. Armed Forces, National Guard, Coast Guard or public health service. Upon his or her return from military services, a Veteran is entitled to all benefit changes granted to active participants during the period of military service. Also, returning Veterans may not be subject to exclusions or waiting periods to re-establish participation in the Health and Welfare Plan after their military services, provided they were eligible at the time they left for such service.

In order to be eligible for the reemployment and benefit rights under USERRA, a veteran's discharge from the military must be other than dishonorable, and he or she must have worked in covered employment before and after the period of military service. To be eligible for military service credit, a veteran must have been eligible for coverage at the

- Length of Military Service Reemployment Deadline:
    - Less than 31 days – 1 day post-discharge
    - 31 through 180 days – 14 days post-discharge
    - More than 180 days – 90 days post-discharge

If the participant was hospitalized or otherwise incapacitated by service-related illness or injury, those reemployment periods may be extended up to two years.

In the event that a participant voluntarily enlists or is called up for active duty military service, that participant should notify either his employer to the Trust Administrator of such military service, and the date such service will commence. If such military service is for less than 31 days, the Plan will continue coverage for the participant without expense to the participant. This includes preserving credit earned for non-eligible employees.

Should the participant have dependents, the dependents will be offered up to 24 months' coverage under COBRA after the absence begins or for the period of military service, whichever is shorter, with reinstatement upon return of the participant without any waiting period or new exclusions. If the dependents are eligible for CHAMPUS coverage through the military, then coverage through this Plan will be primary to the CHAMPUS coverage.

If you have any questions regarding USERRA protected rights, you may contact the Trust Administrator.

IMPORTANT STATEMENTS

Authorization as to Medical Information
Participants, for themselves, their heirs, executors, administrators, and assigns, do hereby expressly authorize any Provider to fully impart to Rehn & Associates any and all medical information or knowledge acquired by such Provider with reference to such Participant, by means of examination or otherwise, either prior to or subsequent to the effective date of this Trust, and further authorize Rehn & Associates to examine all professional and institutional records pertaining to such Participant's physical and/or mental condition.

Hold Harmless
Participants are responsible for applicable Deductibles, Copays and Coinsurance amounts for Covered Services, as identified in this Plan under the schedule of benefits. Any balances remaining after such amounts, and after Rehn & Associates benefit payment for Covered Services, shall be treated as contractual adjustments by PPO Providers and shall not be billed to the Participant. Any balances after Rehn & Associates payment to Non-Preferred Providers shall be the responsibility of the Participant. The Participant is one hundred percent (100%) responsible for non-covered services as billed by any provider.

Limitations of Liability
Providers rendering services to Participants are not agents of Rehn & Associates for any purpose hereunder. Neither the Trust nor Rehn & Associates shall have any liability whatsoever for any negligence, act, failure to act, or omission on the part of any such Provider, employees of such Provider or any other person.
Rehn & Associates shall not be liable to any person or entity for the inability or failure to procure or provide the benefits of this Plan by reason of epidemic, disaster, provider terminations, or other cause or condition beyond the control of the Trust or Rehn & Associates.

Participant Rights and Responsibilities
Failure to satisfy plan requirements or meet criteria does NOT deny access to service. It does, however, result in reduced

payment or denial of payment for non-authorized services or services not rendered by a specific provider. Charges for those services will be your responsibility.

By taking part in the responsibility for your care you are entitled to certain rights:

- You have the right to be informed. Be sure you understand the features and requirements of this Trust. This booklet is designed to provide you with details of your coverage including covered services as well as exclusions, limitations, and other terms and conditions.
- You have a right to expect considerate courteous treatment with respect to your privacy and dignity. Information regarding your health care will be kept confidential, subject to HIPAA unless you have given written permission to release information or if information is required by law.
- You have a right to ask questions and participate in making decisions involving your health and medical care. You have the right to refuse treatment and be informed of the possible consequences for refusing treatment.
- It is your responsibility to present your identification (ID) card to Providers at the time service is performed.

It is your responsibility to give accurate and complete medical information to all Providers, follow medical advice and ask questions if you do not understand or need an explanation.

Non-Assignability
The benefits hereunder shall not, by the Participant or any person entitled thereto, be pledged, hypothecated, encumbered, or assigned.

Vesting of Policies
Under no circumstances does a Participant acquire a vested interest in continued receipt of a particular benefit or level of benefits. If benefits for a service or supply are eliminated or modified for a new Plan Year, or during the Plan Year, benefits shall not be provided for those services or supplies rendered after the effective date of the elimination or modification. There will be no grandfathering of benefits. No oral or written statements or representations given in good faith by any person, including employers, agents, or representatives of Rehn & Associates or the Trust, can change, alter, delete, add, or otherwise modify the expressed written terms of this Trust or a validly executed endorsement to this Trust, even if the statements or representations are misleading or incorrect.

Wrongful Payment
Should Rehn & Associates make any incorrect payments or overpayments for services or supplies provided to a Participant or ineligible person, the Trust shall be fully reimbursed by the reprocessing of those incorrectly processed claims. This may include recovery of over payment from a provider or participant.

GENERAL PLAN INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the following information be furnished to you.

Name of Plan:
Inland Empire Teamsters Trust

Employer Identification Number "EIN":
91-6068602

Plan Number:
507

Original Effective Date:
August 1, 1966

Type of Administrator:
Administered by the Plan sponsor in accordance with the Summary Plan Description, Administrative Agreement, Business Associate Agreements and applicable Federal Regulations. Claims to be processed for benefits are sent to Rehn & Associates, Inc. The Plan sponsor (not Rehn & Associates, Inc.) is responsible for paying claims.

The Names and Addresses of the Trustees are:

Employers

Jerry D'Ambrosio
11019 SE 60th
Bellevue, WA 98006
(425) 226.1986

Laurie Bigej
URM Stores
7511 N Freya
Box 3365
Spokane, WA 99212
(509) 467.3624
(509) 468.1334 Fax

Scott Powers
Allied Employers, Inc.
4020 Lake Washington Blvd NE Suite 205
Kirkland, WA 98033-7870
(425) 576.1100
(425) 822.1076 Fax

Union Representatives

Leonard Crouch
Teamsters Local #760
1211 W Lincoln Ave
Yakima, WA 98902
(509) 452.7194
(509) 452.7354 Fax

Steve Bruchman
Teamsters Local #760
1211 W Lincoln Ave
Yakima, WA 98902
(509) 452.7194
(509) 452.7354 Fax

Val Holstrom
Teamsters Local #690
1912 N Division
Spokane, WA 99205
(509) 326.9504
(509) 326.9507 Fax

Contact Information of Plan Administrative Agent/Sponsor/Fiduciary
Rehn & Associates, Inc.
PO Box 5433
Spokane, WA 99205
(509) 534.0600 Local
(800) 872.8979 Toll Free
(509) 535.7883 Fax
Website: www.rehnonline.com
Hours of operation (Pacific Standard Time):
Monday through Thursday from 8:00 a.m. to 5:00 p.m., Friday 8:00 a.m. to 4:00 p.m.

Source of Contribution
The Plan is funded through employer and employee contributions, based on the provisions of each Collective Bargaining Agreement and other signatory agreement.

Funding Medium
This Plan is self-funded. Self-funded medical claims for employees and their dependents are paid from Trust assets.

Agent for Services of Legal Process
The Health Care Plan Administrator may be served with process. Please serve legal process (e.g., subpoena) to:
Rehn & Associates, Inc.
PO Box 5433
Spokane, WA 99205
(509) 534.0600 Local
(800) 872.8979 Toll Free
(509) 535.7883 Fax
Website: www.rehnonline.com
Hours of operation (Pacific Standard Time):
Monday through Thursday from 8:00 a.m. to 5:00 p.m., Friday 8:00 a.m. to 4:00 p.m.

Third Party Administrator, Claims, Eligibility and Customer Service
Rehn & Associates, Inc.
PO Box 5433
Spokane, WA 99205
(509) 534.0600 Local
(800) 872.8979 Toll Free
(509) 535.7883 Fax
Website: www.rehnonline.com
Participant Website: www.teamsterbeneftis.com
Hours of operation (Pacific Standard Time):
Monday through Thursday from 8:00 a.m. to 5:00 p.m., Friday 8:00 a.m. to 4:00 p.m.

Appeals Department
A.W. Rehn & Associates, Inc.
PO Box 5433
Spokane, WA 99205
(509) 534.0600 Local
(800) 872.8979 Toll Free
(509) 535.7883 Fax
Website: www.rehnonline.com
Hours of operation (Pacific Standard Time):
Monday through Thursday from 8:00 a.m. to 5:00 p.m., Friday 8:00 a.m. to 4:00 p.m.