

September 1, 2007

The Trustees are pleased to provide you with this updated summary of the benefits available under the United Teamster Fund (referred to in this booklet as the "Fund").

These benefits include:

- **hospital and medical benefits,**
- **prescription drug benefits dental benefits,**
- **vision services,**
- **life insurance, and**
- **Dental Access.**

You should use this booklet to find out:

- **who is eligible for coverage,**
- **the types of benefits that are provided and any limitations on those benefits,**
- **how to claim benefits, and**
- **who to contact for more information.**

This booklet provides a description, written in everyday language, of provisions in effect as of September 1, 2007, and together with the materials supplied by outside benefit providers; this booklet constitutes a summary plan description, or "SPD." Please keep all of this information together in a convenient place, where you will have them for future reference and can share them with your family.

Although the SPD provides essential information about your benefits, this information is intended only as a summary of the terms under which benefits are provided. Additional information concerning your benefits may be contained in related documents, such as contracts with insurance companies or health care networks. However, if there is ever a conflict between the SPD and any other documents, the SPD will govern.

If you have any questions about the Fund, please contact the Fund Office at (718) 859-1624, (718) 842-1212 or (732) 882-1901.

Sincerely,

The Board of Trustees

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## **GLOSSARY**

The following terms have special meanings for the purposes of the United Teamster Fund. To help you understand them in the context of our Fund, definitions are provided below.

***COBRA (Consolidated Omnibus Budget Reconciliation Act)***- Allows you to extend health care coverage for yourself and your eligible dependents- when certain circumstances would normally cause coverage to end by paying the full cost of coverage yourself.

***Co-Insurance***- The percentage you pay as your share of eligible expenses. Once the deductible is satisfied, the Fund shares the cost of services and treatment with you based on the appropriate Schedule. You are responsible for paying the difference for any charges in excess of the fees indicated on the Schedule.

***Contributing Employer***- Any employer who has a collective bargaining agreement with a participating Local of the International Brotherhood of Teamsters and who is required to make contributions to this Fund on behalf of members covered by the collective bargaining agreement.

***Coordination of Benefits (COB)***- If you are covered by another Fund or other coverage, the payments will be coordinated so that no more than 100% of the actual expenses are reimbursed.

***Co-payment***- A specified amount of the eligible expense, which you are required to pay to physicians, dentists, labs or pharmacies for services, treatment or supplies.

***Deductible***- The amount of eligible expenses which you are required to pay before benefits are payable. The deductible is payable only once in each Fund year (each May 1 through April 30) for each individual and is limited to a maximum amount.

***Dependent***- A spouse or unmarried dependent child who may be eligible for benefits coverage while you are a member of the Fund; a dependent must meet eligibility requirements in order to be covered for benefits.

***Eligible Expenses***- Expenses for certain covered medically necessary hospital services, treatments, procedures and medical supplies that you incur in connection with treatment of an injury or disease.

***Emergency Room***- The section of the hospital where serious, unexpected illness or injury cases, which require immediate attention, are treated.

***“Experimental” or “Investigational” Drugs and Procedures***- The technology for these drugs or procedures is not of proven benefit for the particular diagnosis or treatment of the eligible individual’s condition, or not generally recognized by medical community, as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the eligible individual’s condition. Government approval of a technology is not necessarily sufficient to render it a proven benefit or appropriate or effective for a particular diagnosis or treatment of an eligible individual’s particular condition.

The Fund may apply any or all of the following five standards in its discretion to determine whether a technology is experimental, investigational, obsolete or ineffective:

1. Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition. Once FDA approval is granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of these five standards be met.
2. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite and positive effect on health outcomes.
3. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes; that is, the beneficial effects outweigh any harmful effects.
4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
5. Proof as reflected in the published peer-reviewed medical literature must exist that improvement in health outcomes (as defined in #3 above) is possible in standards conditions of medical practice, outside clinical investigatory settings.

**Fund Year-** The period from May 1st through April 30th.

**Hospital-** A legally constituted and operated institution for the care and treatment of sick and injured people. The institution must be approved by the Joint Commission of Accreditation of Hospitals and provide bed care, have full diagnostic, surgical and therapeutic facilities, under the supervision of a staff of legally qualified physicians, and provide 24-hour nursing service by registered nurses. For purposes of this Fund, a birthing facility will be considered a hospital.

A hospital is *not* a college or university infirmary; old age home; rest home; nursing home; convalescent home; institution for rehabilitation, physiotherapy, addiction, alcoholism or nervous or mental disorders; or birth centers, operating rooms or surgical centers which are part of a physician's office space.

A hospital is *not* an institution where care is provided under federal, state or other laws, or the laws of any foreign country. A hospital is not a veteran's facility where care is provided in connection with service related disabilities or in a hospital operated by the United States (except for emergency care).

**Legally Qualified Physician, Medical Doctor or Surgeon-** A legally qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.). A doctor of podiatry (D.P.M.) or a dentist (D.D.S.) will be recognized as a legally qualified physician only when performing services in his or her specialty, which if performed by an M.D. or O.D. would be covered. For purposes of this Fund, a certified nurse midwife assisting in delivery is considered a legally qualified medical doctor, physician or surgeon.

**Maximum Scheduled Allowance (Magnacare Schedule)-** The amount of a claim that would have been covered, had a provider from the Magnacare Schedule been utilized.

**Medically Necessary-** Any service or supply which is broadly accepted professionally as essential to the treatment of disease or injury. This service or supply must be consistent with the symptoms, diagnosis and treatment of the disease or injury and is not solely for the convenience of your physician, hospital, other provider or to you.

***Participant-*** An individual who is employed by a contributing employer and meets the eligibility requirements of this Fund.

***Non-participating Pharmacy-*** A pharmacy which did not enter into an agreement with the pharmacy network to provide prescription drugs and does not accept the prescription card plan.

***Out-of-Pocket Expenses-*** The amount you must actually pay for eligible expenses, which are not reimbursed by the Fund.

***Participating Pharmacy-*** A pharmacy which has entered into an agreement with Express Script Inc. pharmacy network to provide prescription drugs and accepts the prescription card plan.

***Participating Provider-*** A provider that has a contract with Magnacare, and Express Script and accepts the pre-negotiated fees and co-pays as payment in full for covered charges. Healthplex has contracted with the Fund to provide dental access.

***Pharmacy-*** An establishment which is registered with the appropriate state licensing agency and at which prescription drugs are regularly compounded and dispensed by a pharmacist.

***Reasonable and Customary Charges-*** The cost of the service or supply that falls within the range of fees charged by most medical providers in your location for similar services within a geographic region as determined by the Funds Schedule.

***Spouse-*** Your husband or wife, to whom you are legally married.

***Waiting Period-*** The three-month period beginning on the date your participation for welfare benefits began under the Fund in which you or your eligible dependents cannot yet be treated for any disease, ailment or condition which existed on the date your participation became effective.

## YOUR BENEFITS AT A GLANCE

Effective September 1, 2007

For Active EMPLOYEES AND THEIR COVERED DEPENDENTS\*

### Hospital And Medical Benefits

- For “In-Network” services, there is a 20% coinsurance. There is also a \$20 co-payment for primary care office visits and a \$30 co -payment for specialist office visits.
- When you receive “Out-of-Network” services, you have an annual deductible of \$500 per person. The Fund then covers up to 80% of the Magnacare Schedule. If the provider charges more than the Magnacare Schedule, you are responsible for the charges in excess of the reimbursement.
- Note that a \$100 deductible applies for each emergency room visit, whether In-Network or Out-of-Network. After you have met the per-visit deductible, the reimbursement will be 80% of the Magnacare Schedule.
- For hospitalizations, there is a \$500 deductible per hospital stay. Hospital is covered up to 365 days for semi-private room.
- \*Your entitlement to "member-only coverage" or "member-and-family" coverage is dependent on the rate of contribution made by your Employer. Please call the Fund office to verify whether you have member-only coverage or member-and-family coverage before you attempt to use your plan to obtain medical services for your dependents.

### Prescription Drug Benefits

- Prescription drugs are only covered at a participating pharmacy. There is a \$25 co-pay for generic and brand name\* drugs and a \$30 co-pay for injectable medications. You will receive up to a 30-day supply.
- If you use the mail order service, you have a \$35 co-pay for generic and brand name\* drugs and a \$50 co-pay for injectable medications, but you will receive up to a 90-day supply.
- There is a \$15,000 maximum each fund year per covered participant (\$10,000 limit for the period September 1, 2007 to April 30, 2008).

**\*The Fund has a mandatory generic policy, which means that if you request a brand name drug when a generic equivalent is available, you will be responsible, in addition to your co-pay, for any difference in cost between the brand name and generic.**

### Dental Benefits

The Fund will provide access to certain participating dentists who will provide most dental services at a discount for you and your eligible dependents.

### **Vision Benefits**

You may go to any vision care provider. However, the Fund has an extensive panel of vision care providers. You can save out-of-pocket expenses when you utilize one of the vision care providers on the panel.

When you utilize a vision care provider that is not on the extensive panel you must obtain a vision care voucher (claim form) from the Fund Office. Then you pay the full cost up front for any vision services you obtain and the Fund will reimburse you its allowance for the vision service (see below for the Fund's reimbursement rate).

When you utilize a vision care provider from the Fund's extensive panel you must obtain a vision care voucher from the Fund Office in order to send in your claim. You have to pay the full cost up front for any vision services you obtain. However, after you receive reimbursement from the Fund you will have paid only the difference between the Fund allowance and, if there is one, the balance of the cost of the vision care you received. That cost will be considerably less than what you would have paid if you had used a vision provider that is not on the Fund's panel.

The Fund will reimburse you up to:

- \$15 for an eye exam, and
- \$65 for glasses (frames and lenses) or \$100 for contacts.

Benefits are available once every 12 months.

### **Life Insurance Benefit Subject To The Exclusions Described Later On In This Booklet**

- \$10,000 is paid to your named beneficiary if you die while covered by the Fund.
- \$5,000 is paid to you if your eligible dependent dies while he/she is covered by the Fund. This only applies to members with dependent coverage.

For information on filing a medical claim, see the section called "Claims and Appeals Procedures."

## **ELIGIBILITY AND PARTICIPATION**

### **Eligibility**

You are eligible to participate in the Fund if you work for an employer who is required by the terms of a collective bargaining or other written agreement to make contributions to the United Teamster Fund on your behalf. Please remember that your eligible dependents are covered only if your employer contributes for family coverage.

If you are eligible for family coverage, then your legal spouse and eligible dependents will be eligible for coverage at the same time that you are.

In order for someone to be considered your spouse, you and your spouse must be legally married as husband and wife, and the marriage must be recognized by the State of New York. No coverage is provided for domestic partners. A partner that resides with you, to whom you are not legally married, will not be considered to be your spouse, regardless of the length of time you have been together.

A marriage terminates on the date that the judgment of divorce is signed. Coverage for the spouse will terminate at the end of the month in which the divorce occurred. At that time of the divorce, the former spouse has the option of continuing coverage under the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. The Participant, however, is responsible for notifying the Fund of the divorce. If you fail to notify the Fund that your former spouse is no longer eligible for benefits you will be committing an act of fraud upon the Fund and you will be responsible for any claims that the Fund pays for your former spouse.

### **When Coverage Starts**

Your coverage automatically starts on the first day of the month following three months that an employer makes contributions to the Fund on your behalf.

### **Special Rule For Substance Abuse Benefits**

You must wait one year from the date your coverage starts, as described in the preceding section, "When Coverage Starts", before you become eligible for substance abuse benefits.

### **How Long Coverage Continues**

Once you meet the initial eligibility requirement, your coverage continues on a month-to-month basis.

### **Dependent Coverage**

When you qualify for coverage, the Fund Office will let you know whether your employer contribution level qualifies you for dependent coverage. If it does, then coverage for your eligible dependents generally starts at the same time as your coverage.

Your "eligible dependents" include:

- Your current legal spouse.
- Your unmarried dependent children through the last day of the month in which they reach age 19.

- Unmarried, unemployed, dependent children who have reached age 19 and who are full-time students at an accredited university or college. Coverage for such children lasts through the end of the month following the earlier of the month in which they:
  - \* reach age 23,
  - \* leave school (graduate or leave before graduation) or get married.
- For your child to receive continued coverage during college, you must submit proof of full-time student status to the Fund Office within 31 days after he/she reaches age 19. The proof of full-time student status must be renewed with the Fund each semester.
- Unmarried handicapped dependent children who are incapable of self-support because of mental or physical disability. The disability must have started before the child reached age 19. You must provide the Fund Office with proof of the child's disability within 31 days after the child's 19th birthday.

When you enroll a dependent you will be asked to provide proof of dependent status — for example, a birth certificate, a marriage certificate, or other proof of dependent status. You may also be required to give proof that your child or step-child is solely dependent on you for financial support.

### **Newly Acquired Dependents**

If you get married, or if you acquire a child by birth, adoption, or placement for adoption, and you are entitled to family coverage, your dependent will be covered from the date of the marriage, birth, or adoption, provided you file an application form at the Fund Office within 31 days of the acquisition. If you do not complete the application within 31 days from the date of the acquisition, coverage for your dependents will be delayed.

**Dependent children** include the following:

- Your natural children (including children born out of wedlock, but only if proper evidence of paternity is submitted to the Fund Office);
- Your legal spouse's natural children if they live in your home, depend on you for full financial support, and your spouse has legal custody of them;
- Legally adopted children or step-children;
- Foster children who live with you and depend on you for full financial support and maintenance, as long as no other health benefits are being provided by any governmental agency;
- Children required to be recognized as your legal dependent under a Qualified Medical Child Support Order ("QMCSO").

### **About QMCSOs**

A Qualified Medical Child Support Order, or QMCSO, is an order issued by a court or state administrative agency that requires that medical coverage be provided to a child or children. A QMCSO usually results from a divorce, legal separation or paternity proceeding.

The Fund Office will notify you if a QMCSO is received with regard to your coverage. The Fund's QMCSO procedures are described in greater detail later on in this booklet (see the section called "QMCSO Procedures").

### **When Coverage Ends**

**For employees:** Your coverage ends on the last day of the month:

- you stop working for a contributing employer,
- you enter active military service,
- the Fund discontinues group coverage, or
- you no longer meet the eligibility requirements.

If you lose your coverage because of a compensable disability, your coverage will continue for up to six months after your last day of employment with a contributing employer. The Fund may require proof of disability from your physician. You must apply for such coverage within 30 days of the onset of our disability.

**For dependents:** Coverage for your dependents ends on the last day of the month in which:

- your coverage ends,
- the dependent no longer meets the Fund's definition of dependent,
- for a dependent spouse, in the event of divorce or legal separation,
- you die.

When your coverage would otherwise end, you may be able to continue coverage by electing COBRA Continuation Coverage. The Fund also has rules for limited extensions of coverage during certain absences, and they are described in the next section.

### **Continuation Of Coverage During Certain Absences**

If you become disabled your coverage will continue for each month you are "totally disabled" and cannot work, for up to a total of six months. You may be required to submit proof of your disability to the Fund Office.

### **Family And Medical Leave**

If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act (FMLA). Under FMLA you may take up to 12 weeks of unpaid leave for specified family or medical purposes, such as your own serious medical condition, the birth or adoption of a child, or to provide care for a spouse, child or parent who is ill. Your employer, not this Fund, will determine if you are eligible for a FMLA leave of absence.

If you take an FMLA leave, your employer is obligated to continue to contribute to the Fund on your behalf and your coverage, through the Fund, will continue.

During your leave, you may continue all of your medical coverage and other benefits offered through the Fund. You are generally eligible for an FMLA leave if you:

- worked for an employer for at least 12 months,
- worked at least 1,250 hours in Covered Employment over the previous 12 months, and
- worked at a location where at least 50 employees are employed by the employer within 75 miles.

If you do not return to employment following an FMLA leave during which coverage was provided, you may be required to provide reimbursement for the cost of coverage received during the leave.

Call your employer if you have questions regarding your eligibility for an FMLA leave. Call the Fund Office regarding coverage during such a leave.

If you do not return to work after the end of your FMLA leave, you may be eligible to continue coverage under COBRA described in a later section.

**Military leave:** If you are on active military duty for 31 days or less, you will continue to receive health care coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active duty for more than 31 days, your coverage ends, but USERRA permits you to continue health care coverage for you and your dependents at your own expense for up to 18 months. This continuation right operates in the same way as COBRA coverage, which is described in the next section. In addition, your dependent(s) may be eligible for health care coverage under the federal program known as TRICARE (which includes the old "CHAMPUS" program). This Fund coordinates its coverage with TRICARE.

If you receive an honorable discharge and return to work with a contributing employer, your full eligibility will be reinstated on the day you return to work as long as you return within the applicable time frame prescribed by law.

Under USERRA an active employee is required to notify the employer (in writing or orally) that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your employer is required to notify the Fund within 30 days after you are reemployed following military service; however, it is a good idea for you to notify the Fund Office, too.

Note that, for leaves of absence covered by the Family and Medical Leave Act ("FMLA") or for qualified military service, your employer must properly grant the leave and make the required notification and any required payment to the Fund. You should contact your employer to confirm that you are eligible for a leave.

**Contact your employer if you have questions regarding your eligibility for a leave. Contact the Fund Office if you have any questions regarding Fund coverage during such a leave.**

### **Continuation Of Health Care Under COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), requires that this Fund offer you and your eligible dependents the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage would otherwise end (called "qualifying

events”). Continued coverage under COBRA applies to the medical, hospital, prescription drug, dental and vision benefits described in this booklet.

You should keep in mind that each individual entitled to coverage as the result of a qualifying event has a right to make his or her own election of coverage. For example, your spouse or other covered dependent may elect COBRA coverage even if you do not. In addition, one qualified beneficiary can elect COBRA for others.

**Qualifying COBRA Events**

The chart below shows when you and your eligible dependents may qualify for continued coverage under COBRA, when coverage may start and when it ends.

<b><u>Coverage Ends Because Of This reason</u></b>	<b><u>These People Would Be Eligible</u></b>	<b><u>For COBRA Coverage Up to (measured from the date coverage is lost)</u></b>
Your employment terminates*	You and your covered spouse and children	18 months **
Your working hours are reduced	You and your covered spouse and children	18 months **
You die	Your covered spouse and children	36 months
Your dependents lose coverage because you divorce or legally separate	Your covered spouse and children	36 months
Your dependent child no longer qualifies as an eligible dependent	Your covered children	36 months
You become entitled to Medicare	Your covered spouse and Children	36 months

\* For any reason other than gross misconduct (and including military leave and approved leaves granted according to the Family Medical Leave Act).

\*\* Continued coverage for up to 29 months from the date of initial event may be available to those who by no later than the first 60 days of your qualifying event, are totally disabled within the meaning of Title II or Title XVI of the Social Security Act. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage.

Proof of good health is NOT required for COBRA coverage.

**Newborn And Adopted Children**

If you have a newborn child, adopt a child, or have a child placed with you for adoption while continuation coverage under COBRA is in effect, [and you are eligible for family coverage], you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 31 days of the child’s birth, adoption or placement for adoption. Legal proof of your relationship to the child must also be provided.

### **Multiple Qualifying Events**

If your covered dependents experience more than one qualifying event while COBRA coverage is in force, they may be eligible for an additional period of continued coverage not to exceed a total of 36 months from the date of the first qualifying event.

**For example**, if your employment ends, you and your covered dependents may be eligible for 18 months of continued COBRA coverage. If you die (a second qualifying event) during this 18-month period, your covered dependents may be eligible for an additional period of COBRA continuation coverage. However, the two periods of coverage combined may not exceed a total of 36 months from the date of the first qualifying event (your termination).

This extended period of COBRA continuation coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of coverage is available to any child born to, adopted by, or placed for adoption with you during the 18-month period of continuation coverage.

Also note that if your first qualifying event is a reduction in hours, and then your employment is terminated, the termination of employment is not treated as a second qualifying event (so there is no extension beyond the initial 18-month period of coverage).

### **When Your Employer Must Notify the Fund Office**

Your employer must notify the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement no later than 60 days after your loss of coverage due to one of these events. However, you or your family should also notify the Fund Office if such an event occurs, in order to avoid confusion as to your status.

### **When You or Your Beneficiary Must Notify the Fund Office**

As a covered member or qualified beneficiary, you are responsible for providing the Fund Office with timely notice of certain qualifying events. These events include:

- Divorce or legal separation.
- A child losing dependent status under the Fund.
- The occurrence of a second qualifying event after a qualified beneficiary has become entitled to COBRA with a maximum of an additional 18 months, up to 36 months in total. This second qualifying event could include an employee's death, entitlement to Medicare, divorce or legal separation, or a child losing dependent status.

When a qualified beneficiary entitled to receive COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled. If this determination is made at any time during the first 60 days of COBRA coverage, the qualified beneficiary may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage.

You must make sure that the Fund Office is notified of any of the events listed above. Failure to provide this notice in the form and within the timeframes described below will prevent you and/or your dependents from obtaining or extending COBRA coverage.

### **How To Provide Notice**

Your notice should be sent to:

United Teamster Fund  
2137-2147 Utica Avenue  
Brooklyn, New York 11234

Please include the following in your notice:

- your name,
- the names of your dependents,
- your Social Security number and the Social Security numbers of your dependents,
- your address, and
- the nature and date of the occurrence you are reporting to the Fund.

### **When The Notice Must Be Sent**

You must provide notice to the Fund within 60 days of the date of the event (and do not forget to provide addresses for both you and the dependent(s)). **If you do not notify the Fund by the end of the period, your dependents will not be entitled to continuation coverage.**

#### **Keep the Fund Informed of Address Changes**

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

### **Electing COBRA Coverage**

The Fund must notify you and/or your covered dependents of your right to COBRA coverage within 14 days after it receives timely notice or becomes aware that a qualifying event has occurred. You will have 60 days to respond if you want to continue coverage – measured from the date coverage would otherwise end or, if later, the date the COBRA notice is sent to you.

### **Paying For COBRA Coverage**

You will be charged the full cost of continued coverage under COBRA, plus a 2% administrative fee. (If you are eligible for 29 months of continued coverage due to disability, the law permits the Fund to charge 150% of the full cost of the plan during the 19th to 29th months of coverage.) The following rules apply in making your COBRA payments:

It is easiest to make your first payment when you file your COBRA election form, that is, within 60 days from the date your Fund coverage would otherwise end. In no event may your payment be made later than 45 days from the date you mail your signed election form to the Fund Office. Your first check must cover the period from the date your group coverage ended and COBRA coverage began through the current month.

After the first payment all subsequent COBRA payments will be due by the 30th of each month. Keep in mind that the Fund Office does not send bills for COBRA coverage and it is your responsibility to see that your payment is at the Fund Office by the due date.

COBRA premiums are generally reviewed at least once a year and are subject to change.

You will be notified by the Fund Office if the amount of your COBRA payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

### **When COBRA Coverage Ends**

Your continued coverage under COBRA may end for any of the following reasons:

- Coverage has continued for the maximum 18, 29 or 36-month period, measured from the date coverage is lost.
- The Fund terminates. If the coverage is replaced, you may be continued under the new coverage.
- You or your dependent(s) fail to make the necessary payments on time.
- You or a covered dependent(s) become covered under another group health fund that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or a covered dependent becomes entitled to benefits under Medicare.
- You or your dependent(s) are continuing coverage during the 19th to 29th months of a disability, and the disability ends.
- Continuation coverage may also be terminated for any reason that would terminate coverage of any participant or beneficiary not receiving continuation coverage (such as fraud).

Full details of COBRA continuation coverage will be furnished to you or your eligible dependents when the Fund Office receives notice that a qualifying event has occurred.

### **Your Rights Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Under the federal law called the Health Insurance Portability and Accountability Act of 1996 (commonly called “HIPAA”) the Fund is required to provide the following.

#### **Special Enrollment Rights**

HIPAA requires that funds like ours guarantee that participants and dependents not otherwise covered by a fund have special enrollment rights if certain events occur, known as “qualifying circumstances.” [Note that, with regard to dependents, these rights apply only if you are entitled to family coverage.] Qualifying circumstances include:

- A change in family status, such as marriage, divorce, birth, adoption, placement for adoption, or death.
- You previously stated in writing that you and/or your dependents were waiving Fund coverage because of coverage under another medical plan, and that other coverage is lost for any of the following reasons:

- termination of employment;
- reduction in hours worked;
- your spouse dies;
- you and your spouse divorce or legally separate;
- the other coverage was COBRA continuation coverage, and you or your dependent reaches the maximum length of time for COBRA continuation coverage; or
- the other plan terminates because the employer [or other sponsor] did not pay the premium when due.

More information about these rights is available from the Fund Office.

### **Certificate of Creditable Coverage**

When your Fund coverage ends, you and/or your dependents will be provided with a "Certificate of Creditable Coverage." Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you are covered under a health insurance policy, within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

- on your request, within 24 months after your Fund coverage ends,
- when you are entitled to elect COBRA,
- when your coverage terminates, even if you are not entitled to COBRA,
- when your COBRA coverage ends.

You should retain these Certificates of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Fund Office.

**Other HIPAA rules.** This Fund is a covered entity under HIPAA's privacy regulations. For a copy of the Fund's "Notice of Privacy Practices" please contact the Fund Office.

**Military Leave:** If you are on active military duty for 31 days or less, you will continue to receive health care coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you are on active duty for more than 31 days USERRA permits you to continue health care coverage for you and your dependents at your own expense for up to 24 months. This continuation right operates in a similar way as COBRA coverage, which is described in this booklet. When your coverage ends because of a reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. You should contact the Fund Office if you are called up for service in order to determine how the leave affects your and your eligible dependents'

eligibility for Plan benefits and how USERRA protects your rights. In addition, your dependent(s) may be eligible for health care coverage under the federal program known as TRICARE.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

Under USERRA an active employee is required to notify the employer (in writing or orally) that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your employer is required to notify the Plan within 30 days after you are reemployed following military service; however, it is a good idea for you to notify the Fund Office, too.

When you are discharged (not less than honorably) from service in the uniformed services, your full eligibility will be reinstated on the day you return to employment with a contributing employer, provided that you return to employment within:

- 90 days from the date of discharge if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was at least 31 days, but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

## **MEDICAL BENEFITS**

This section describes the medical benefits available to you and your covered dependents. To help you understand how the Fund's medical coverage works, you will find the following information in this section:

- An overview of how coverage works.
- A side-by-side comparison of In-Network and Out-of-Network benefits in the section called "Your Benefits At A Glance."
- More details on covered medical expenses, starting in the section called "More About Covered Expenses."
- An explanation of ineligible and/or limited medical expenses in the section called "What is Not Covered."
- Definitions of key terms in the section called "Glossary."

### **Overview Of How Coverage Works**

If you have been covered by the Fund for a while, you may be accustomed to seeing some benefits described as covered by "Major Medical." We do not use that term now, but the Fund works pretty

much the same way it always has. Benefits provided through the Magnacare network are described as “In-Network.” Other benefits are described as “Out-of-Network.”

The Fund covers a wide range of health care services, from office visits, to lab tests and x-rays, to major surgery and hospital care. Most eligible expenses are covered through either a Magnacare network provider or an Out-of-Network provider.

### **The Magnacare Network Of Providers**

The Magnacare network consists of doctors, hospitals and other health care facilities selected by Magnacare to provide medical services. When you use a Magnacare provider for your medical care, the care is called “In-Network.” Here are some of the advantages of In-Network care:

- an extensive network of medical care providers to choose from,
- a co-payment for most covered charges and a 20% co-insurance, and
- there are usually no claim forms to file.

### **Finding A Network Provider**

Here is how to find a network participating doctor, hospital, lab or other network facility near you.

- **Look at Magnacare’s online directory.** To locate an In-Network doctor, hospital or other provider in the Magnacare network, log on to [www.magnacare.com](http://www.magnacare.com) and browse the online provider directory.
- **Contact the Fund Office.** The Fund Office can also help you find an In-Network provider.

**The Magnacare Network-** While you have the option of going to an In-Network provider or an Out-of-Network provider for your medical care, you pay the least when you use In-Network providers.

### **How Out-Of-Network Care Is Covered**

You also have the option of going to an Out-of-Network provider. When you see a provider that does not participate in Magnacare’s network, the services are considered “Out-of-Network”. Here are key facts you need to know if you choose to go Out-of-Network for your medical care:

- You must meet a \$500 annual deductible before being reimbursed for any eligible expenses. (Note that there is a separate \$100 deductible for emergency room visits, as described in the Schedule of benefits.)
- After you have met the annual deductible, expenses are only reimbursed at 80% in accordance with of the “Magnacare Schedule”.
- You are responsible for paying the balance, which is your coinsurance.
- You must file a claim form. In most cases, you have to pay the provider when the service is rendered, then submit a claim for reimbursement to Magnacare.

You must submit satisfactory proof of each charge for which benefits are being claimed, and each charge used to satisfy the deductible. Be sure to keep an accurate record of your medical expenses and retain all bills and receipts.

## YOUR BENEFITS AT A GLANCE

<b><u>MEDICAL BENEFITS</u></b>		
<b><u>Key Features and Benefits</u></b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
Annual Maximum Benefits (Fund Year-May 1 <sup>st</sup> – April 30 <sup>th</sup> )	The Fund Will pay up to a maximum of <b>\$250,000</b> per person per lifetime. There is a \$5,000 annual reinstatement towards maximum.	
Annual Deductible (For all covered services except emergency care)	None	\$500 per person
Physicians Services (Office Visits)	\$20 co-pay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Specialist Consultations (Referral Required)	First visit, \$30 copay, then 80% of Magnacare Schedule  Subsequent visits, \$20 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
X-ray	\$10 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Lab Tests	\$20 copay, then 100% of Magnacare Schedule	\$20 copay, then 100% of Magnacare Schedule after deductible
Well Baby/Well Child Care	\$20 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Annual Physical Exam	\$20 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Immunizations	\$20 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Podiatric Services (\$1,000 annual maximum benefit, In- and Out-of-Network combined)	\$20 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible

<b><u>Key Features and Benefits</u></b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
Chiropractic Services (\$1,000 annual maximum benefit, In- and Out-of-Network combined)	\$20 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Outpatient Physical Therapy (\$60 Visits each plan year)	\$20 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Outpatient Radiation Therapy	\$20 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Speech Therapy	\$20 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Inpatient Hospital	\$500 deductible per admission. Up to 365 days semi-private room.	\$500 deductible per admission. Up to 365 days semi-private room.
Emergency Care	\$100 deductible per visit, then 80% of Magnacare Schedule.	80% of Magnacare Schedule after \$100 Deductible
Presurgical Testing	\$0 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Outpatient Surgery	\$0 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Dialysis	\$0 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Anesthesia	\$0 copay, then 80% of Magnacare Schedule	80% of Magnacare Schedule after deductible
Mental Health (30 days inpatient maximum per Fund year)  (50 days outpatient maximum per Fund year)	\$500 deductible for inpatient admissions  50% copay for outpatient visits	\$500 deductible for inpatient admissions  50% copay after deductible
Substance Abuse (Lifetime maximum benefit of up to \$10,000/person and \$15,000/family) [Contact the Fund Office to pre-certify]	\$0 for inpatient admission. \$0 copay for outpatient visits	Not covered

<b><u>Key Features and Benefits</u></b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
Home Care (Limited to 60 visits per Fund year)	80% of Magnacare Schedule after \$50 deductible. However, there is no deductible if care is received within seven days of hospital discharge	80% of Magnacare Schedule after deductible, \$500 annual deductible
Hospice Care (210 days per lifetime for “terminally ill” patients)	\$500 deductible	100% of Magnacare Schedule after deductible of \$500.
Hearing Aid Benefit (Maximum benefit of \$500/ear for purchase and fitting – available once every three years)	Full coverage (up to maximum benefit)	Full coverage (up to maximum benefit)

The “deductible” is an initial annual amount that you pay for Out-of-Network and certain In-network services before the Fund pays any benefits. You only have to pay the deductible once in each Fund Year except in hospital stays are \$500 for each admission. When you are treated by a provider, you are responsible for the deductible and any amount of covered expenses that exceed the Magnacare Schedule reimbursed allowance. Emergency room visits are subject to a \$100 deductible per visit.

### **Hospital Benefits**

When you are hospitalized, the Fund covers semiprivate room and board after the \$500 per admission deductible. (If you have a private room, the Fund still pays no more than the semiprivate rate.) Also covered when you are hospitalized are the types of services and supplies typically required when you are hospitalized, including:

- anesthesia supplies and use of anesthesia equipment (administration only when given by a hospital employee, otherwise see the section called “Anesthesia”),
- bed and board including special diets,
- dressings,
- drugs and medicines for use in the hospital,
- electrocardiographic equipment use,
- general nurse care,
- laboratory examinations consistent with the diagnosis and treatment of the condition for which hospitalization is required (note that lab interpretations may be billed independently and therefore may not be covered in full),
- operating room and recovery room use,
- chemotherapy,
- oxygen and equipment use for its administration,
- physiotherapeutic equipment use,

- plaster casts,
- x-ray examinations consistent with the diagnosis and treatment of the condition for which hospitalization is required (note that x-ray interpretations are generally billed separately and are not covered under this benefit).

### **In-Hospital Medical Expense Benefits**

If you are hospitalized for an illness that does not require surgery or maternity care, you are eligible for hospital medical expense benefits. Coverage applies to illnesses that include heart disease, pneumonia, etc.

The in-hospital medical expense benefit does not cover services performed in conjunction with functional nervous and mental disorders, dental work or surgery covered by Workers' Compensation. In addition, benefits are not provided at a veteran's facility for care in connection with a military service related disability or at a hospital operated by a federal or state agency (except for emergency care).

### **In-Hospital Coverage**

The Fund covers up to 365 days per hospital confinement. A "confinement" is a period of hospitalization that is separated from the previous and following confinement by at least 90 days.

**You must have hospital stays approved in advance by Magnacare (see the section called "Managing Your Care.")**

### **Inpatient Dental Care**

The Fund covers up to two inpatient days for dental services that require extractions. Hospitalization must be "medically necessary" and pre-certified by the Fund Office.

### **Emergency Care**

In the event of an emergency, you should first consult with your family physician. If this is not possible, locate a hospital nearby or go to the nearest medical facility. The following emergency services are covered:

- The Fund covers emergency first aid rendered within 24 hours after accidental injury or 72 hours from the onset of illness.
- For the use of operating room facilities at the hospital for a surgical operation, the hospital must contact the Fund Office before treatment begins. If the Fund office is closed you must contact the Fund office as soon as possible after treatment has begun.

You are responsible for a \$100 deductible for each emergency room visit. After that, the Fund pays 80% of Magnacare allowance and you have to pay the balance of the charges, regardless of whether you are at an In-Network or Out-of-Network hospital.

### **Minor Surgery**

The Fund's coverage for an emergency room and minor surgery includes:

- closed reduction of fractured or dislocated bones,

- endoscopies requiring the use of the hospital's surgical facilities, and
- any incisions or punctures of the skin or other tissue except for inoculation, vaccination, collection of blood, drug administration, or injection.

### **Surgical Expenses**

The Fund provides coverage for surgery that is recommended, approved and performed by a legally qualified physician or surgeon.

If two or more surgical procedures are performed simultaneously during any one period, the most expensive is paid in full up to the limits on the Schedule and charges for the second procedure are reimbursed at half the allowance, but no more than two times the largest amount. The surgical expense benefit for an assistant surgeon is equal to 25% of the surgical expense benefit.

If two or more operations are performed through the same abdominal incision, the total amount paid for all operations cannot be more than the maximum amount specified on the Magnacare Schedule for the operation for which the largest benefit is payable.

Benefits for sterilization procedures or for reversal of such procedures are payable only once during an individual's lifetime for either or both procedures.

If the services are provided In-Network, then you pay the 20% co-insurance. If they are provided on an Out-of-Network basis, then you pay the deductible and coinsurance and any amount for services that exceeds the allowed reimbursement.

### **Women's Health and Cancer Rights Act of 1998**

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This includes coverage for the following:

- reconstruction of the breast on which the mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and physical complications associated with all stages of mastectomy, including lymphedemas, in a manner determined in consultation between the attending physician and the patient.

This coverage is subject to the Fund's standard rules and regulations for payment of benefits.

### **Anesthesia Expense Benefits**

The Fund covers anesthesia benefits if the anesthesia is administered by a legally qualified physician or a legally qualified anesthesiologist other than the operating surgeon or an employee of the hospital.

Services are paid at 80% of the Magnacare allowance. If out-of-network, the annual deductible must first be satisfied.

### **Pre-surgical Testing**

The Fund also covers diagnostic tests prescribed by your doctor performed in the same hospital as the surgery.

### **Maternity Care**

The Fund provides hospital maternity benefits for eligible members and eligible dependents. Regular hospital benefits are paid for normal delivery (including false labor) for at least two days and at least four days for a caesarian. Newborn surgery care is covered to the same extent as the mother. If a longer stay is required, authorization must be obtained from the Fund Office/Pre-certification Department.

### **Newborns' and Mothers' Health Protection Act of 1996**

The Fund may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable). In any case, the Fund may not, under federal law, require that a provider obtain pre-authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours). If a longer stay is required, authorization must be obtained from the Fund Office/Pre-certification Department.

### **Newborn Coverage**

If you have family coverage, hospitalization benefits are provided for newborn children from birth for the treatment of illness or injury. This includes care for the following:

- Premature infants weighing less than 4.4 pounds when care is provided in an approved premature unit, for as long as care is needed;
- All infants weighing between 4.4 to 5.5 pounds, from the time the mother leaves the hospital; and
- Premature infants in an approved premature unit because they need incubator care, regardless of how much the infant weighs.

**NOTE:** There is no coverage for a newborn child of a dependent child.

### **Abortion**

The Fund also covers semi-private accommodations for up to two days for elective abortion. If tubal ligation is performed during the same period of hospitalization, the Fund provides coverage for up to three days.

### **Hospital or Freestanding Clinics**

The Fund covers visits to these facilities the same as an office visit.

### **Office Visits**

The Fund covers visits to the offices of physicians and specialists. Specialist consultations are covered only when referred by your attending physician. If you go to an In-Network doctor, then you pay the standard co-pay (usually \$20, or \$30 in the case of your first visit with a specialist) and the 20% co-insurance. If you go to an Out-of-Network doctor, then you pay the standard deductible and coinsurance.

## **PREVENTIVE CARE**

### **Well-Child Care**

If you have family coverage, the Fund covers 12 physician visits during the first 12 months of a child's life, including the hospital visit upon birth. The Fund also covers three visits per calendar year for children ages one to six.

### **Well-Woman Care**

Well-woman care includes pelvic exams and Pap smears for female participants (age 18 or older), as well as annual mammograms when recommended by your doctor.

### **Annual Physical Exam**

The Fund covers one physical exam per plan year. Coverage includes diagnosis and x-rays.

### **Immunizations**

The Fund covers immunizations. The Fund also covers the office visits for immunization if charged separately.

### **Durable Medical Equipment**

Durable medical equipment ("DME") is covered in full when obtained from a Magnacare preferred provider. Otherwise, DME is covered at the standard Out-of-Network level of benefits.

### **Outpatient Chemotherapy**

The Fund provides coverage for outpatient chemotherapy, including medications, when care is given at a participating facility. Do not forget that if you go to an Out-of-Network provider, you will have to pay the deductible and any applicable coinsurance, as well as any amount that exceeds the Magnacare Schedule.

### **Radiation Therapy**

The Fund covers deep x-ray therapy and the physician's component of the charges. Hospital charges for the use of the technical component will be paid on the same basis as for therapy. If you go to an Out-of-Network provider, you will have to meet the deductible and any applicable coinsurance, as well as any amount that exceeds the Magnacare Schedule.

### **Dialysis**

The Fund covers dialysis benefits until you become eligible for such coverage under Medicare. Coverage includes hemodialysis and peritoneal dialysis during an inpatient hospitalization. Outpatient dialysis is covered as follows:

- **At home coverage** – All appropriate and necessary supplies required for home dialysis treatment, as well as the rental of equipment.
- **Coverage in a hospital or freestanding facility** – Necessary treatment if the facility's dialysis program is approved by the appropriate governmental authorities.

If you go to an Out-of-Network provider, you will have to pay the deductible and any applicable coinsurance, as well as any amount that exceeds the Magnacare Schedule.

### **Home Care**

The Fund covers a maximum of 60 home care visits for the year that runs from May 1 to April 30. Services must be rendered under a physician-approved treatment plan through a New York State certified home health agency. Home care benefits will be provided only if hospitalization or confinement in a skilled nursing facility would otherwise have been required. Covered services include the following:

- part-time professional nursing,
- part-time home health aide services (up to four hours of such care is equal to one home care visit),
- physical, occupational or speech therapy,
- medical supplies, drugs and medicines prescribed by a physician, and
- necessary laboratory services.

The home care benefit also covers the following:

- the services of a registered nurse or licensed practical nurse,
- the services of a licensed state certified home health aide, provided the individual does not live with you or is not a member of your immediate family,
- visits by hospice staff personnel who are full-time employees of the hospice,
- physical and respiratory therapy,
- oxygen and equipment for its administration,
- rental of wheel chairs and hospital type beds, and other medical equipment for patient's care, and
- medicine and drugs.

When care is provided within seven days of hospital discharge, coverage at 80% of Magnacare Schedule, will be provided. When care is provided without prior hospitalization, you must pay a \$50 deductible. Once you have met the deductible, the Fund covers 80% of the Magnacare Schedule. If you go to an Out-of-Network provider, you will have to pay the deductible and any applicable coinsurance, as well as any amount that exceeds the Magnacare Schedule.

### **Skilled Nursing Facility Care**

The Fund covers up to 30 (thirty) days of skilled nursing facility care, each Fund Year when a physician determines that the care is "medically necessary." The stay at the skilled nursing facility must be immediately following a hospital confinement for a serious illness. Benefits are payable only after the Fund Office receives a letter of medical necessity from your physician.

### **Exclusions for Skilled Nursing Facility Care**

In addition to the Fund's general exclusions, the following are not covered under the skilled nursing facility care benefit:

- benefits for an employment-related illness or accident,

- any service rendered by a person who is a member of the patient’s family or who ordinarily lives with the patient, and
- services for any illness that is not covered.

Full coverage is provided if you receive care at an In-Network participating facility. If you go to an Out-of-Network provider, you will have to pay the deductible and any applicable coinsurance, as well as any amount that exceeds the Magnacare Schedule.

**Hospice Care**

The Fund covers up to 210 days of hospice care less the \$500 deductible for patients with a “terminal illness.” Benefits are payable only after the Fund Office receives proof of your attending physician’s prognosis.

The following services and supplies are covered under the hospice care benefit:

- anesthesia supplies and use of anesthesia equipment (administration of anesthesia only by a hospital employee; otherwise see section on anesthesia),
- bed and board including special diets,
- dressings,
- drugs and medicines for use in the hospice,
- electrocardiographic equipment,
- general nursing care,
- laboratory examinations (note that lab interpretations may be billed independently and therefore may not be covered in full),
- operating room and recovery room use,
- oxygen and equipment use for its administration,
- physiotherapeutic equipment use,
- plaster casts, and
- x-ray examinations (note that x-ray interpretations may be billed independently and therefore may not be covered in full).

**Exclusions.** In addition to the general exclusions, the following are not covered under the hospice care benefit:

- benefits for an employment-related illness or accident,
- any service rendered by a person who is a member of the patient’s family or who ordinarily lives with the patient, and
- services for any illness that is not covered under this Fund.

Full coverage is provided after the \$500 deductible if you receive care at a participating facility. If you go to an Out-of-Network provider, you will have to pay the deductible and any applicable coinsurance, as well as any amount that exceeds the Magnacare Schedule.

**What is a Hospice** – A facility provides hospice care if it operates as a unit or program that only admits terminally ill patients. Such facility must be separate from any other facility. However, it may be affiliated with a Hospital or Home Health Care Agency. The Hospice must be approved by the Fund as meeting the legal requirements, if any, of the state, province, locality or authority having jurisdiction over licensing and approval of such institutions or facilities.

**Terminally Ill Patients** – are defined to mean those patients with a life expectancy of six months or less, as diagnosed by a physician.

### **Visiting Nurse Service**

The Fund covers medically necessary services provided by registered and licensed practical nurses, for up to 60 outpatient visits and 30 inpatient days per Fund year. Coverage includes the services of certified home health aides. Coverage is provided at 80% of the Magnacare Schedule for in-network and 80% the Magnacare Schedule after satisfying the \$500 annual deductible for an out-of-network provider.

### **Private Duty Nursing**

The Fund covers Private duty nursing by a registered graduate nurse or a licensed practical nurse. Benefits are limited to 30 inpatient days and 60 home visits. Coverage is provided at 80% of the Magnacare Schedule for in-network and 80% of the Magnacare Schedule after satisfying the \$500 annual deductible for an out-of-network provider.

### **Chiropractic Services**

The Fund covers chiropractic services on an In-Network and Out-of-Network basis, up to a maximum benefit of \$1,000 each Fund Year. If you go to an In-Network provider, you pay the standard co-pay. If you go to an Out-of-Network provider, you pay any amount that exceeds the Magnacare Schedule plus any deductible and co-insurance.

### **Injection Therapy**

The Fund covers injections to the joints, but not the cost of drugs. Coverage does not include:

- visits for injections of liver, iron and vitamin B-12 for secondary anemia, and
- hormone injections for menopause and for other non-specific medications, such as penicillin and other antibiotics.

### **Podiatric Services**

The Fund covers for medically necessary podiatric services, including services for treatments arising from diabetics for up to \$1,000 each Fund Year, In-Network and Out-of-Network combined. Covered services include treatment for corns, bunions, calluses, toenails, flat feet, fallen ankles, weak feet, chronic foot strain or systematic foot problems. Office visits are not covered on the same day as surgical procedures. If you go to an In-Network provider, you pay the \$20 copay and the 20% co-insurance. If you go to an Out-of-Network provider, you pay any amount that exceeds the Magnacare Schedule plus any deductible and co-insurance.

### **Outpatient Physical Therapy**

The Fund covers a maximum of 60 physical therapy visits each Fund Year, per diagnosis, for In-Network and Out-of-Network services combined. If you go to an In-Network provider, you pay the \$20 co-pay and the 20% co-insurance. If you go to an Out-of-Network provider, you pay any amount that exceeds the Magnacare Schedule plus any deductible and co-insurance.

### **Speech Therapy**

The Fund covers treatment by a speech therapist when requested by a legally qualified physician to restore loss of speech or to correct impairment due to a congenital defect for which corrective surgery has been performed, or for an accident or sickness (except for a functional nervous disorder). Speech Therapy is covered on an In-Network and Out-of-Network basis. If you go to an In-Network provider, you pay the standard co-pays and the co-insurance. If you go to an Out-of-Network provider, you pay any amount that exceeds the Magnacare Schedule plus annual any deductible and 20% co-insurance.

### **Hearing Benefits**

The Fund covers hearing evaluations by an audiologist and hearing aids prescribed by legally qualified physicians. The Fund covers a maximum of \$500 per ear every three years for the purchase and fitting of a hearing aid. Repair and maintenance are not covered.

### **Mental Health**

The Fund covers both inpatient and outpatient services. Benefits are provided for the administration of convulsive therapy, whether administered on an inpatient or outpatient basis. Hospitalization benefits are available only in general hospitals and in psychiatric hospitals when shock therapy is administered. Hospitalization benefits are not provided at a veteran's facility for care in connection with a service-related disability or a hospital operated by a federal or state agency (except for emergency care). The Fund covers 30 inpatient days subject to the \$500 deductible per hospital stay and 50 outpatient visits per 52-week period running from May 1<sup>st</sup> to April 30th.

### **Substance Abuse Benefits**

The Fund provides benefits for the treatment of alcohol and drug addiction on an In-Network basis only. You must contact the Fund Office before receiving benefits. The Fund Office will make arrangements with professionals in the field for an evaluation of the problem. The professional evaluation will determine whether you require inpatient or outpatient treatment. You will then be directed by the Fund Office to an appropriate facility for treatment. Note that there is a lifetime maximum benefit of \$10,000 for individuals and \$15,000 for families (if you have family coverage).

<p><b>If you do not obtain pre-certification from the Fund Office for substance abuse benefits, the Fund will not cover your treatment.</b></p>
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### **Additional Outpatient Benefits**

The following benefits are also available under the Fund subject to the 20% co-insurance if in-network or the \$500 annual deductible and the 80% of Magnacare Schedule for out-of-network:

- Blood and blood plasmas, artificial limbs and eyes, surgical dressings, casts, splints, trusses, braces, crutches, wheelchair rental, hospital bed or iron lung, oxygen and rental of equipment for its administration.
- Orthoptic training under the supervision of an optometrist.

- Non-surgical services, equipment and supplies provided for TMJ.
- Radium treatments and treatments with other radioactive substances.
- Licensed health aid from the state where service is provided.

**Managing Your Care**

There are two ways that the Fund helps you manage your medical care: through “Preadmission Certification” and “Case Management.” Both programs are handled by Magnacare.

**Outpatient/Ambulatory Facility**

For an operating room facility other than a Hospital, expenses are limited to \$3,000, which includes the use of the equipment.

**Preadmission Certification**

All non-emergency hospital stays must be approved under Magnacare’s Preadmission Certification Program *before* you are admitted. To do this, you, a family member or your doctor should call Magnacare at 516-282-8000. In addition to approving the admission itself, Magnacare will determine the appropriate length of your hospital stay. Should your doctor want you to stay longer than the number of days that have been approved, your additional days in the hospital must be approved by Magnacare.

**Case Management**

Case Management is designed to assist individuals who need special or extended care for serious illness or injuries. Its primary goal is to ensure that the patient receives appropriate care in the most effective setting (at home, in a hospital or in a specialized facility, for example). Your Magnacare Case Manager, whose role is advisory, will help you arrange for treatment and work with you, your family and your doctor to coordinate the treatment program, arrange for necessary resources and provide ongoing support for the family in times of medical crisis.

**When To Request Case Management**

Case Management is voluntary, and offered at no cost to you. However, when certain types of specialized care are recommended (home health care, hospice care or a stay in a skilled nursing facility, for example), you are encouraged to request Case Management, which you can do by calling Magnacare member services at 516-282-8000. (A family member or attending physician can also make the call.)

**Conditions That Require Case Management**

Cancer	AIDs
Multiple Sclerosis	Kidney failure
Obstructive pulmonary disease	Heart conditions
Long-term rehabilitation therapy following an accident	Newborn with high-risk complications or multiple birth defects
Alzheimer’s disease	Child and adolescent mental and nervous disorders
Diagnosis involving long-term IV therapy	

## **Exclusions**

### What Is Not Covered Under Hospitalization And Medical

The following expenses are not covered by the Fund:

- any services that are not medically necessary, not necessary for treatment of the injury or disease or are not recommended and approved by the attending physician;
- hospital confinements for custodial or convalescent care, rest cures, or long-term care;
- hospital confinements or any period of hospital confinement primarily for diagnostic studies;
- hospitalization furnished pursuant to federal, state, or other laws (except Medicaid);
- care which is provided for under any law of a government;
- care rendered in a hospital operated by federal or state government, municipality or agency;
- ambulance or ambulette service (except as provided under the section called “Home Care”);
- hospital benefits for services of physicians or private or special nurses, or other private attendants or their board;
- expenses covered by or which could be covered by motor vehicle insurance. This would include insurance for motorcycles and, motorbikes.
- technology treatments and any hospitalization in connection with such technology including surgery, treatments, procedures, drugs, biologicals or medical devices which, in the sole discretion of the Fund, are either experimental, investigational, obsolete or ineffective (see the section called “Glossary” for definitions of these terms);
- admissions primarily for physical therapy;
- veteran’s facilities for care in connection with a military service related disability or a hospital operated by a federal or state agency (except for emergency care);
- medical and hospital services, supplies and equipment which are paid or provided for because of your (or any person’s) past or present service in the armed forces of any government or are paid or provided for under any law of a government;
- medical and hospital services and supplies rendered in connection with accidents, illnesses or injuries covered by, or required to be covered by, Workers’ Compensation insurance;
- expenses for eye refractions or fitting of glasses (except coverage provided through Fund’s Vision Care benefits);
- cosmetic surgery except to correct defects caused by traumatic injury or disease that occurs while covered, such as breast surgery after a mastectomy or lumpectomy;
- charges for dental care, dental treatment or, drugs, except if hospitalization is required.
- Charges for services or supplies which are furnished, paid for or otherwise provided because of your past or present service in the armed forces of any government;
- charges that would not have been made if no coverage existed;
- charges that you are not required to pay;
- charges that are unreasonable;

- X-ray and laboratory expenses in connection with dental work exams performed at a veteran's facility in connection with a military service related disability or at a hospital operated by a federal or state agency;
- hospitalization which began before the effective date of coverage or after the end of coverage;
- charges for a private room in excess of semi-private rates;
- charges that have been paid for by another insurance carrier (see the section called "Coordination of Benefits");
- confinement provided at a veteran's facility for care in connection with a military service related disability;
- expenses resulting from an act of war occurring while covered;
- admissions or continuing hospitalizations primarily for any one of the following: diagnosis, physical therapy, X-ray therapy, radium therapy, transfusions for blood or blood plasma, custodial care, convalescent care, or rest cure;
- when hospitalized, the services of physicians, private nurses or special nurses who are on the hospital staff;
- nursing care rendered by you or your spouse, or a child, brother, sister or parent of you or your spouse;
- personal services such as haircuts, shampoos and sets, guest meals and radio/television rentals received in any in-patient or out-patient facility;
- personal convenience items such as air conditioners, humidifiers, physical fitness equipment or other such devices which are useful in the absence of illness or injury;
- services, supplies and equipment provided in connection with elective sterilization, except for elective sterilization as covered by the Plan;
- services involving equipment or facilities used when the rental or construction has not been approved in compliance with applicable state laws or regulations;
- travel or transportation whether or not recommended by a physician;
- care in a nursing home or home for the aged;
- custodial care such as sitters, homemaker's services or care in a place that serves you primarily as a residence;
- services, supplies and equipment provided to the donor of an organ for transplant, unless both the donor and the recipient are eligible participants and members of the same immediate family;
- services, supplies and equipment provided in connection with the testing or treatment of infertility, including but not limited to in vitro fertilization or genetic testing or counseling;
- services, supplies and equipment provided in connection with a sex change operation;
- treatment considered experimental or investigative in terms of generally accepted medical standards;
- a condition resulting from the illegal act of the individual with the condition;
- test to determine a donor match;

- services and supplies which are not necessary for or consistent with the diagnosis and treatment of the accident, illness or injury or which are not recommended and approved by a legally qualified physician operating within the scope of his or her specialty;
- self-inflicted injury;
- committing an unlawful act, or seeking to avoid lawful apprehension or arrest by a law enforcement officer;
- accidents caused by the operation of a manual or motor vehicle while under the influence of either intoxicating substances or general mind altering substances, regardless of the natural or artificial content of the substance or whether the substance is legal or otherwise;
- accidents caused by operating a motor vehicle in a race or speed test;
- accidents caused by operation or occupying a motor vehicle known to be stolen;
- care rendered in a hospital operated by federal or state government, municipality or agency;
- ambulance or ambulette service (except as provided under the section called “Home Care”);
- hospital benefits are not provided for services of physicians or private or special nurses, or other private attendant or their board;
- any loss, or portion thereof, resulting from a motor vehicle accident or which is covered by, or which could be covered by motor vehicle insurance;
- technology treatments, procedures, surgeries, drugs, biologicals or medical devices which, in the sole discretion of the Fund, are either experimental, investigational, obsolete, and/or ineffective (see the section called “Glossary” for definitions of these terms);
- admissions primarily for physical therapy;
- Note: Motor vehicle is to include motorcycle, motorbike, etc.

**Experimental or Investigational.** A process, treatment, device or surgery is experimental if it is not:

- of proven medical efficacy for the particular diagnosis or treatment of the covered person’s condition, and
- generally recognized by the medical community, as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of the covered person’s particular condition.

Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a covered person’s particular condition.

The Fund may apply any or all of the following criteria at its discretion in determining whether a technology is experimental or investigational, obsolete or ineffective:

- Any medical device, drug or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug, or biological product for another diagnosis or condition may require that any or all of these five criteria be met.

- Conclusive evidence from the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects.
- Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

**PRESCRIPTION DRUG BENEFITS**

**How the Fund Works**

The Fund provides coverage through Express Scripts for prescription drugs purchased at a participating pharmacy or through the Express Scripts mail-order program. Coverage depends on which option you use. The following table summarizes these benefits. There is a \$15,000 maximum per Fund year per participant for prescription drugs (\$10,000 for the period September 1, 2007 to April 30, 2008). This \$15,000 maximum is for both retail and mail-order combined.

**Summary of Benefits**

<b>Prescriptions From A Participating Pharmacy (up to 30-day supply)</b>	<b>What You Pay</b>
Generic drugs	\$25 co-pay
Brand name drugs when no generic equivalents are available	\$25 co-pay
Brand name drugs when generic equivalents are available	\$25 co-pay, plus cost difference between brand name and generic
Injectable medications	\$30 co-pay

<b>Prescriptions Through The Mail-Order Program (up to 90-day supply)</b>	<b>What You Pay</b>
Generic drugs	\$35 co-pay
Brand name drugs when no generic equivalents are available	\$35 co-pay
Brand name drugs when generic equivalents are available	\$35 co-pay, plus cost difference between brand name and generic
Injectable medications	\$50 co-pay

**What Types of Prescription Drugs Are Covered?**

Covered drugs include all federal or state legend drugs as well as insulin. Insulin syringes, lancets, and test strips are covered only through mail order. There are quantity limitations on certain drugs for the treatment of impotence, migraine headaches, asthma, and allergies as indicated by the manufacturer.

**Mandatory Generic Policy**

The Fund has a mandatory generic policy, which means that if you request a brand name drug when a generic equivalent is available, you will be responsible for the price difference between the brand and generic, plus the applicable co-payment.

### **Mandatory Mail-Order For Maintenance Drugs**

The mail-order option must be used for drugs that you take on a regular or long-term basis (called “maintenance medications”). You are allowed to fill your initial prescription and to obtain one additional refill at a retail pharmacy. After these two initial fillings, you must use the mail-order pharmacy to fill your prescription.

**If you lose your Express Scripts ID card, you should call the Fund office at (718) 859-1624, (718) 842-1212 or (732) 882-1901 for a replacement card**

### **Mail Order**

**Refills-** Prescription drug refills are not sent automatically. You must complete the refill form included with each shipment from Express Scripts and send it with your check or credit card number in the mailer provided. You may also call in your refill request by calling 800-451-6245 or by visiting the web site at [WWW.EXPRESS-SCRIPTS.COM](http://WWW.EXPRESS-SCRIPTS.COM). Your order will be held up if your balance due exceeds \$50. You should allow two weeks delivery time.

### **Exclusions And Limitations**

The following items are not covered by the Fund:

- vitamins,
- smoking cessation products,
- dental treatments,
- diet pills,
- fertility treatments,
- medications used for cosmetic purposes,
- over-the counter items such as cold remedies and wound dressings.
- Medications or drugs that are not medically necessary,
- Medications or drugs that are covered by, or required to be covered by, Workers Compensation Insurance
- Medications or drugs that are covered by, or required to be covered by, automobile insurance

Your prescription drug coverage is also subject to the following limitations:

- Oral and injectable contraceptives are covered only for non-contraceptive purposes. You must submit a letter of medical necessity to the Fund Office to request authorization for these drugs.
- Vaccines, growth hormones, and some cancer treatments also require a letter of medical necessity.

### **Diabetes Monitoring**

The Trustees of the United Teamster Fund are continuously searching for ways to improve the health and welfare of you and your family. As a result of this effort, a new pain free device for diabetes has been brought to our attention.

One of the prominent providers in the industry is Pharmacy Distributor Services who will provide our members with their family members if covered, who have diabetes with Freestyle meter, strips and lancets at **NO COST TO YOU**. The Freestyle monitor allows diabetics to test their blood sugar from their forearm or other body sites without the pain associated with the traditional finger stick test. The meter is rated the most accurate for home testing and is quick and easy to use.

Pharmacy Distributor Services will provide the meter strips and lancets to you at **NO COST AND WILL WAIVE THE CO-PAY** if you use their services. It is important that diabetics control their blood sugar to live a healthy life and that is why the Trustees feel this benefit is important to you.

Pharmacy Distributor Services will provide diabetic supplies to your home by mail at no cost. They can be reached during the hours of 9:00 a.m. to 5:00 p.m. Monday through Friday at (800) 440-2417.

The company has also assured us that they will answer all questions in a courteous and prompt manner and will assist in any way possible.

The Pharmacy Distributor Service does not provide insulin. Insulin should be obtained from the mail order pharmacy program.

### **Claiming Benefits**

For information on filing prescription drug claims, see the section called “Claims and Appeals Procedures.”

### **VISION BENEFITS**

The vision benefits described in this section are provided through the Fund Office. You and if applicable, your eligible dependents, are eligible to receive the allowance for vision benefits as described below for an eye examination and one pair of eyeglasses once every consecutive twelve months counting from the last time you received the vision benefits.

**Note:** if you utilize one of the vision care providers on the Fund's panel, you will receive considerable savings as compared to using a provider outside of the panel. You may obtain a list of providers on the Fund's panel from the Fund Office.

### **How It Works**

You can use any provider of your choosing. First call the Fund Office for an optical voucher. You will be required to pay the full cost of services and supplies up front, and the Fund will reimburse you once every consecutive twelve month period starting from the date that you last received the benefit for vision care services, up to the following amounts:

- \$15 for eye exams
- \$65 for prescription eyeglasses (lenses and frames) **or** up to \$100 for prescription contact lenses.

You will only be reimbursed up to the amounts listed above. If your exam, glasses or contacts cost more than the amount listed above, you will be responsible for that additional amount.

Keep in mind that medical treatment of the eyes and surgery performed on the eyes may be covered by your medical and/or surgery benefits. See the section called “Hospital and Medical Benefits” for more information.

### **What Is Not Covered**

The Fund does not provide coverage for the following:

- sunglasses (plain or prescription)
- any benefits covered, or required to be covered by, or which could be covered Workers’ Compensation insurance
- benefits payable through “no-fault” insurance law or an uninsured motorist law or other automobile insurance for such expenses; and
- services or benefits received from federal, state or municipal agencies or the Veteran’s administration

### **Claiming Benefits**

To get reimbursed for services, call the Fund Office for an optical voucher. Submit the completed voucher with the itemized receipt or bill for the vision service attached and sent it to the Fund Office. For more information on claiming benefits, see the section called “Claims and Appeals Procedures.”

## **LIFE INSURANCE BENEFITS**

### **Life Insurance Benefits (Participant Only)**

The Fund pays a \$10,000 lump sum to your named beneficiary if you die while covered by the Fund. This insurance is provided through the Fund Office.

<b>Covered Loss</b>	<b>Benefit</b>
Life	\$10,000

### **Designating A Beneficiary**

To designate or change your beneficiary for your life insurance benefit, you must complete a Designation of Beneficiary Card, which is available at the Fund Office.

If you do not name a beneficiary, or if the person you name dies before you, the benefit will be paid to the following surviving individual(s) in this order:

- your spouse,
- your children (in equal shares),
- your parents (in equal shares), or
- your sisters and brothers (in equal shares).

If you do not designate a beneficiary and the person(s) listed above are not living at the time of your death, benefits will be paid to the estate.

### **Dependent Life Insurance**

If one of your covered dependents dies while covered by the Fund, you will receive a \$5,000 life insurance benefit.

### **Exclusions And Limitations**

The following exclusions and limitations apply to the life insurance benefit.

- In the untimely event of your death, your beneficiary will receive a lump sum under the life insurance benefit, but **not** an accidental death benefit.
- No benefits will be payable if death occurs as a result of participation in automobile races, or riding in a stolen vehicle.
- No benefits will be payable if death occurs as a result of your intentional violent and/or criminal act or suicide.
- No benefits will be payable if death occurs as a result of the operation a motor vehicle while intoxicated or while the ability to operate such vehicle is impaired by use of a drug, whether legal or otherwise.
- No benefits will be payable if death occurs as a result of the commission of an act that constitutes a felony, or the avoidance lawful apprehension or arrest by a law enforcement officer.
- No benefits will be payable if death occurs as a result of the operation or occupation of a motor vehicle known to be stolen.
- No benefits will be payable if death occurs as a result of the operation a private passenger vehicle as a public or livery conveyance.

### **Claiming Benefits**

For information on filing a life insurance, see the section called “Claims and Appeals Procedures.”

### **GENERAL EXCLUSIONS, EXCEPTIONS AND LIMITATIONS**

The Fund does not provide coverage for all types of health-related expenses. In addition to any exclusions already mentioned in the various sections, no benefits are payable for the following:

- charges that have been paid for by another insurance carrier (see Coordination of Benefits Section);
- charges that would not have been made if coverage did not exist or for charges that neither you nor any of your dependents are required to pay;
- charges for services, treatment or supplies that are received from a dental or medical department sponsored by or for an employer, mutual benefit association, labor union, trustee or any similar person or group;
- charges for services or treatments to the extent the Fund is prohibited by law or regulation from providing such benefits;
- cosmetic services or supplies, except to correct defects caused by traumatic injury or disease that occurred while covered;
- expenses for eye refractions or fitting of glasses, except as provided for under the section called “Vision Benefits”;

- expenses resulting from an act of war occurring while covered;
- when hospitalized, the services of physicians, private nurses or special nurses who are on the hospital staff;
- charges for telephone consultations, missed appointments or fees sometimes added for filling out a claim form;
- drugs or vitamins which do not require a prescription order even if a prescription order has been written;
- services, supplies and equipment rendered in connection with functional nervous and mental disorders, dental work, accidents, illnesses or injuries covered by, or required to be covered by, Workers' Compensation insurance;
- services, supplies and equipment rendered in connection with functional nervous and mental disorders, dental work, accidents, illnesses or injuries resulting from an accident involving motor vehicles or covered by, or which could be covered by, no-fault auto insurance, uninsured motorist insurance or any other type of automobile insurance;
- services, supplies and equipment which are not necessary for or consistent with the diagnosis and treatment of the accident, illness or injury or which are not recommended and approved by a legally qualified physician operating within the scope of his or her specialty;
- charges that result from committing a felony or seeking to avoid lawful apprehension or arrest by a law enforcement officer;
- charges that result from operating a motor vehicle in a race or speed test or operating/occupying a stolen motor vehicle.

### **Coordination Of Benefits**

The Fund has a coordination of benefits (COB) provision. This provision ensures that if you or a covered dependent is covered by another group medical plan, there will be a coordination of benefits for reimbursement.

For purposes of this Fund, "group medical plan" means:

- a group or blanket insurance company, or
- a group hospital or medical service plan or other group medical payment coverage program.

If you or members of your family are covered by another group medical plan, the programs will coordinate their benefit payments so that payments from the two plans combined will pay up to the amount of covered expenses, but not more than the amount of actual expenses.

### **General Rules**

When you are covered under two funds, one fund has primary responsibility to pay benefits and the other has secondary responsibility. The fund with primary responsibility pays benefits first. In order to determine whether or not this Fund is the first payor fund, original bills for medical expenses must be submitted with your claim.

The order of payment is determined as follows:

- a fund without a coordination provision always pays first.
- if both funds have a coordination provision, the fund covering you as an employee pays your expenses first.
- if your spouse is covered under a separate fund, his or her fund should cover your spouse first.
- if you and your spouse are both covered employees in this Fund, you will receive payment first as an employee and second as a dependent.
- if you are covered by more than one fund, other than an individual fund, the fund which covered you the longest pays first.
- if your dependent children are covered under the funds of both parents, the fund that covers the parent whose birthday falls earliest in the year pays first (regardless of age). If both parents have the same birthday, the fund which has covered the parent for a longer period of time pays first.

### **If Parents Are Separated Or Divorced**

If you are separated or divorced, there are special rules regarding coverage for your eligible, dependent children unless otherwise directed by court order. If a court order establishes responsibility for the health care expenses of your children, benefits are paid according to that court order. If there is no court order, benefits are paid as follows:

- If the parents are not remarried:
  - \* The fund covering the parent with custody pays first;
  - \* The fund of the other parent pays second.
- If the parents are remarried:
  - \* The fund covering the parent with custody pays first;
  - \* The fund covering the stepparent with custody pays second;
  - \* The fund covering the parent without custody pays last;

When this fund pays second, a statement from the other insurance carrier indicating the benefits paid must be submitted with your claim for Fund benefits.

### **Special Rule For Prescription Drugs**

There is no COB provision for prescription drugs. This fund will make no secondary payments for prescription drug claims.

### **Motor Vehicle Accidents**

The medical care benefits are provided under this Fund for injuries resulting from a motor vehicle accident. Such benefits are subject to a \$25,000 deductible when:

- the owner/operator of the motor vehicle and the claimant are the same person;
- the owner/operator of the motor vehicle did not have motor vehicle insurance for the applicable motor vehicle on the date injuries were sustained, regardless of whether maintaining motor vehicle insurance is required by state or federal; and

- medical care coverage would have been available under a motor vehicle insurance contract if the claimant had maintained motor vehicle insurance such as "No-Fault" insurance in the State of New York or the Personal Injury Protection or Compulsory Medical Payments provisions of a New Jersey motor vehicle insurance contract or under similar provisions of a motor vehicle insurance contract required by any other federal or state no-fault motor vehicle insurance law.
- any deductible applicable to a motor vehicle insurance contract providing for hospital or medical expenses as a result of a motor vehicle accident is counted toward meeting the \$25,000 deductible under this Fund.
- In addition, effective July 1, 2008, no coverage is provided for the injuries to the driver or operator of a motor vehicle whose injuries arise from operating such motor vehicle and the vehicle is not covered by any motor vehicle insurance or the motor vehicle insurance provides no coverage for the operator's medical care.

### **Motor Vehicle Operation Exclusions**

No benefits are available to you or your eligible dependents, whether the claimant maintains Automobile Insurance or not if the claimant:

- intentionally causes own injury;
- is injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such vehicle is impaired by use of a drug;
- is committing an act that would constitute a felony, or seeking to avoid lawful apprehension or arrest by a law enforcement officer;
- is operating a motor vehicle in a race or speed test; or
- is operating or occupying a motor vehicle known to be stolen; or.
- is operating a private passenger vehicle as a public or livery conveyance.

### **RECOVERY, REIMBURSEMENT AND/OR RIGHT OF RECOVERY**

If you or a dependent receive any benefits from the Fund for which you are not entitled, you will be legally liable to reimburse the Fund for any payments you receive. The Fund reserves the right to collect this reimbursement by denying payment of future claims until an amount equal to the improper payment is recovered. The Trustees may also file a criminal complaint with respect to any fraud or misrepresentation resulting in the improper claim and payment by the United Teamster Fund.

If you or your dependent have the opportunity to recover monies in connection with an illness, injury, accident, occurrence, condition or other loss for which the Fund has paid, or will pay, medical expenses, the Fund must be reimbursed from any such monies to the full extent of benefits paid by the Fund. Further, the Fund has a lien against any monies recovered, and the Fund is subrogated to any such claim. A "claim against any third party" means a claim of any type whatsoever, whether the claims exists or may exist, or the monies are or may be recovered, from a third party through a claim, lawsuit, settlement, insurance policy or pool, uninsured or underinsured motorist or other policy or pool, governmental or private right of recovery, workers compensation or disability award or order, judgment, no-fault program, or personal injury protection, financial responsibility, medical benefit reimbursement insurance coverage not purchased by you, by compromise, or in any other way from any third party, person, agency, organization or fund of money, to the extent necessary, the Fund has an equitable lien.

The Fund is entitled to its full lien/and or its full recovery of the total amount of benefits which are payable, regardless of the amount of monies paid or awarded to you by the third party, even if those monies are less than the full amount which you do seek or could seek against the third party, regardless of whether the monies are or are described as for medical expenses, and regardless of how they are described or what they are for, and regardless of whether full compensation from the third party is obtained or available. No reduction in the Fund's full right to recover the total amount of Fund benefits payable is effective without the Fund's written consent. The Fund retains the sole and final discretion to decide whether and in what case such consent will be granted, if requested.

This provision applies to any type of payment, which in any way arises from or in connection with the illness, injury, accident, occurrence, loss or condition, whether or not the payor caused or is legally responsible or liable for it. It is applicable regardless of whether such liability or responsibility is or is not denied or is in dispute.

The Fund has sole and final discretion to determine whether to assert its rights under this provision as a lien, through subrogation, or through reimbursement, to advance payments of benefits and require repayment, or through any combination or variation of these methods. The determination of which method(s) will be used in a particular case will be made to protect the interests of the Fund and its participants, and is at the Fund's sole and final discretion.

If any claim exists or may exist by you or your dependent against any third party, you must notify the Fund within thirty (30) days of the date such claim becomes apparent in writing, stating the name, address, telephone number of the attorney, representative or other agent handling the claim on behalf of you or your dependent. You must also notify the third party and its counsel or representative in writing of the Fund's lien within thirty (30) days of the date you assert your claim against the third party.

You, your dependent, and any attorney, representative or agent who is representing you in connection with any claim against any third party, are required to sign and have notarized a written statement provided by the Fund saying that they acknowledge, agree to and will adhere to the Fund's lien, right of subrogation and/or reimbursement and this provision of the fund. The existing form which the Fund requires you and any such attorney to complete includes this entire provision as set forth herein. The Fund may modify this form at any time without further notice, in its sole and exclusive discretion, and will provide you with a copy of any new or revised form to be executed and returned to the Fund within ten (10) days of notification. The Fund also may, in its sole and final discretion, require you, your dependent and/or any such attorney, representative or agent to execute such other documents the Fund deems necessary, helpful or appropriate to protect the Fund's rights under this provision. You may also be required to permit the Fund to intervene in any proceeding, and you may be required to file a lien or Consent to Lien, assignment or other such forms, to protect the Fund's interests.

The Fund may withhold or suspend payment of any or all benefits in case a claim against any third party exists, pending reimbursement, pending guaranteed recognition of the Fund's reimbursement, or pending court order, as the Fund may decide, in its sole and final discretion. If you, your dependent, attorney, representative or agent fail or refuse to cooperate with this provision and with the Fund's right by disputing the Fund's lien, failing to advise the Fund of the status of the claim against the third party, withholding necessary information, not executing the consent to lien form described above, or in any other way the Fund will withhold, suspend and exclude payment of any benefits which would otherwise be payable under the Fund. This is a specific exclusion and limitation of the Fund, and is in addition to

any other legal rights, which the Fund may have, or any other action the Fund may take to protect its rights.

You, your dependent, your attorney, or representative or agent must advise the Fund as to the status of any claim against any third party, including providing the Fund with information as to the third party, insurers, lawsuits or any other data related to the claim or to the initiation of the claim, every twelve (12) months thereafter, whenever a settlement is proposed, and whenever requested by the Fund.

No claim against any third party may be settled or resolved, and no payment may be accepted from any third party, without written consent from the Fund. Unless and until the Fund has received full reimbursement, no monies from or through a third party may be distributed to you, your dependent, your attorney, representative or agent without the Fund's written consent if any monies are distributed to you or your attorney, they are to be held in constructive trust, and these monies are, to the extent of benefits payable or paid by the Fund, assets of this Fund and debt owed to the Fund, and will promptly be repaid to the Fund. The Fund's decision on whether to grant, or withhold, its consent is a final and binding decision, made in the sole discretion of the Fund's Trustees.

The Fund may, by written notice given to you, require that all other persons comply with this provision as well in order to secure the Fund's rights in the exercise of its sole and final discretion.

Full cooperation with this provision is a condition to payment of any benefits under this Fund. In case of any failure of cooperation or violation of this provision no benefits will be paid and, you, your dependent, your attorney, your representative or your agent will be liable to the Fund for full reimbursement of its lien, including costs, interest and fees.

This provision covers not only you as participant, but your dependents, spouses, attorney, representatives, agents and their heirs, guardians, executors, successors and assignees.

No other liens may be superior to the Fund's lien or rights under this provision. The Fund may in its discretion and in an appropriate case, agree to a reduction of its lien for the payment of a portion of attorneys' fees and costs of a legal proceeding, if all terms of this provision have been and are being observed.

Any disputes arising under or in connection with this section, including disputes over liens, their amount, reimbursement or withholding of benefits, or reductions or compromises in the Fund's lien shall, if not resolved with the Fund Office, be settled in accordance with the procedure for Claims and Appeals in this booklet, including review by the Board of Trustees.

## **CLAIMS AND APPEALS PROCEDURES**

This section describes the procedures for filing claims for benefits from the United Teamster Fund. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

### **How To File A Claim**

A claim for benefits is a request for benefits made in accordance with reasonable claims procedures. In order to file a claim for benefits, you must submit a completed claim form. Simple inquiries about the Fund's provisions that are unrelated to any specific benefit claim and will not be treated as a claim for

benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the fund is not a claim for benefits.

A claim form may be obtained from the Fund Office by calling (718) 859-1624, (718) 842-1212 or (732) 882-1901. Benefits obtained from providers who belong to the Magnacare network, do not require the submission of a claim form. The provider will complete the paperwork for you.

The following information must be completed in order for your request for benefits to be a claim.

- Participant name
- Patient name
- Patient Date of Birth
- SSN of participant
- If treatment is due to accident, accident details

The following information will be provided by your doctor or dentists:

- Date of Service
- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association)
- ICD-9 (the diagnosis code found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)
- Billed charge
- Number of Units (for anesthesia and certain other claims). Federal taxpayer identification number (TIN) of the provider.
- Billing name and address

When you present a prescription to a pharmacy to be filled out under the terms of this Fund, or a voucher to an optical provider, that request is not a “claim” under these procedures. However, if your request for prescription or optical services is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

### **When Claims Must Be Filed**

Claims must be filed within 90 days following the date the charges were incurred. If it was not reasonably possible to file the claim within such time, failure to file claims within the time required shall not invalidate or reduce any claim. However, in that case, the claim must be submitted as soon as reasonably possible and **in no event later than one year** from the date the charges were incurred.

### **Where To File Claims**

Services obtained from providers who belong to the Magnacare network do not require the submission of a claim form. The provider will complete the paperwork for you. Your claim will be considered to have been filed as soon as it is received at the appropriate Health Organization.

### **Authorized Representatives**

An authorized representative, such as your legal spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative.

### **Comprehensive Medical Benefits**

The claims procedures for comprehensive medical benefits will vary depending on whether your claim is for a **Pre-Service Claim**, an **Urgent Care Claim**, a **Concurrent Care Claim**, or a **Post-Service Claim**. The procedures will also vary for **Life Insurance Claims**, Dependent Life Insurance Claims and Accidental Death and Dismemberment Claims. Read each section carefully to determine which procedure is applicable to your request for benefits.

### **Pre-Service And Urgent Care Claims**

A **Pre-Service Claim** is a claim for a benefit for which the Fund requires approval of the benefit (in whole or in part) before medical care is obtained. Prior approval of services is required for:

- treatment of alcohol and drug addiction;
- the use of operating room facilities at a hospital for a surgical procedure in the case of an emergency. (The hospital must contact the Fund Office prior to such treatment);
- durable medical equipment;
- certain prescribed medications.

If you improperly file a **Pre-Service Claim**, the appropriate health organization will notify you as soon as possible but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a claim. You will only receive notice of an improperly filed Pre-service claim if the claim includes:

- your name;
- your specific medical condition or symptom; and
- a specific treatment, service or product for which approval is requested;

Unless the claim is re-filed properly, it will not constitute a claim.

For properly filed **Pre-Service Claims**, you will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the Fund. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Fund then has 15 days to make a decision on a **Pre-Service Claim** and notify you of the determination.

An **Urgent Care Claim** is any claim for medical care or treatment with respect to which the application of the time periods for making pre-service claim determinations:

- could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Whether your claim is an **Urgent Care Claim** is determined by the Fund applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an **Urgent Care Claim** within the meaning described above, shall be treated as an **Urgent Care Claim**.

If you improperly file an **Urgent Care Claim**, the appropriate Health Organization will notify you as soon as possible but not later than *24 hours* after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If you are requesting pre-certification of an **Urgent Care Claim**, the time deadlines are different. The Fund will respond to you with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than *72 hours* after receipt of the claim by the Fund. The determination will also be confirmed in writing.

If an **Urgent Care Claim** is received without sufficient information to determine whether or to what extent benefits are covered or payable, the appropriate Health Organization will notify you [and your doctor] as soon as possible, but not later than *24 hours* after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after receipt of the specified information or the end of the period given for you to provide this information, whichever is earlier.

**At the end of this Summary Plan Description is a list of the Fund's Health Organizations.**

### **Concurrent Claims**

A **Concurrent Claim** is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient

hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a **Concurrent Claim** that involves the *termination or reduction* of a previously-approved benefit (other than by plan amendment or termination) will be made by the appropriate Health Organization as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to *extend* approved Urgent Care treatment will be acted upon by the appropriate health organization within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

### **Post-Service Claim**

The following procedure applies to **Post-Service Claims**. A **Post-Service Claim** is a claim that is not a **Pre-Service Claim** (for example, a claim submitted for payment after health services and treatment have been obtained).

- Obtain a claim form.
- Complete the employee's portion of the claim form.
- Have your Physician either, complete the Attending Physician's Statement section of the claim form and submit the completed HCFA health insurance claim form, or submit an HIPAA-compliant electronic claims submission.
- Attach all itemized Hospital bills or doctor's statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

You do not have to submit an additional claim form if your bills are for a continuing disability and you have filed a claim within the past calendar year period. Mail any further bills or statements for any Medical or Hospital services covered by the Fund to the appropriate Health Organization as soon as you receive them. Ordinarily, you will be notified of the decision on your **Post-Service Claim** within *30 days* from the Fund's receipt of the claim. This period may be extended one time by the Fund for up to *15 days* if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision will be rendered.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is

earlier). The Fund then has *15 days* to make a decision on a **Post-Service Claim** and notify you of the determination.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund's request for the information, you will be notified of the Fund's decision on the claim within *30 days*.

### **Life Insurance Claims And Dependent Life Insurance Claims**

A **Life Insurance Claim** is a claim made by your beneficiary on the occasion of your death. A **Dependent Life Insurance Claim** is a claim made by you on the occasion of the death of your dependent.

The following procedure applies to claims for the Life Insurance Benefit or Dependent Death Benefit:

- You or your beneficiary, as applicable, must obtain a claim form from the Fund Office.
- Complete the claim form.
- Attach proof of death form (original certificate of death).
- Return the completed claim form and all necessary documentation to the Fund Office.

For **Life Insurance and Dependent Life Insurance**, the Fund will make a decision on the claim and notify you or your beneficiary within 90 days. If the Fund requires an extension of time due to matters beyond its control, it will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. A decision will be made within 90 days of the time the Fund notifies you of the delay. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. Until you supply this additional information, the normal period for making a decision on the claim will be suspended.

### **Notice Of Decision**

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination.
- Reference to the specific provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that was relied upon and it will be available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim, or a statement that it is available upon request at no charge.
- For **Urgent Care Claims**, the notice will describe the expedited review process applicable to **Urgent Care Claims**. For **Urgent Care Claims**, the required determination may be provided orally and followed with written notification within 3 (three) days.
- For **Urgent Care Claims** and **Pre-Service Claims**, you will receive notice of the determination even when the claim is approved.

### **Request For Review Of Denied Claim**

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Fund Office within 180 days after you receive notice of denial, whether in whole or part. For a request of a review of Life Insurance or, Dependent Life Insurance benefits, the request must be made within 60 days after you receive notice of denial, whether in whole or part. Appeals involving **Urgent Care Claims** may be made orally by calling the appropriate health organization at the number listed in this booklet.

### **Review Process**

The review process works as follows:

- Upon your written and notarized request, you have the right to receive copies of all documents, records, and other information relevant to your claim, free of charge. A document, record or other information is relevant if it was relied upon by the Fund in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Fund's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.
- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.
- A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.
- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

### **Timing Of Notice Of Decision On Appeal**

- **Pre-Service Claims**

You will be sent a notice of decision on review within 30 days of receipt of the appeal by the appropriate health organization.

- **Urgent Care Claims**

You will be sent a notice of a decision on review within 72 hours of receipt of the appeal by the appropriate health organization.

- **Post-Service Claims**

You will be sent a notice of the decision on review by the Health Organization within 30 days of the receipt of a request for review. If you are dissatisfied with the outcome, you may file an appeal within 180 calendar days from the date of the notice denying your first request for review. The request for an appeal must be made in writing to the Board of Trustees.

- **Post-Service Claims**

Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly Scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly Scheduled meeting, your request for review will be considered at the second regularly Scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly Scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

### **Notice Of Decision On Review**

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination
- Reference to the specific plan provision(s) on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement of your right to bring a civil action under ERISA Section 502(a).
- If an internal rule, guideline or protocol was relied upon by the Fund, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

### **When May A Lawsuit Be Started**

You may not start a lawsuit to obtain benefits until after you have requested a review of your benefit claim and a final decision has been reached, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No lawsuit may be started more than 180 days after the end of the year in which medical or dental services were provided.

### **IMPORTANT INFORMATION ABOUT THE UNITED TEAMSTER FUND**

The Employee Retirement Income Security Act of 1974 (ERISA) requires that participants in employee benefit plans receive certain administrative information about their funds and the people who run them. The Fund is subject to those rules and this section will tell you more about Plan operations.

#### **Name Of Fund**

The Fund's formal name is the United Teamster Fund.

#### **Board Of Trustees**

The Board of Trustees and/or its duly authorized designee(s) have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply and interpret this booklet, the Trust Agreement and any other Fund documents, and to decide all matters arising in connection with the operation or administration of the Fund or Trust. Without limiting the generality of the foregoing, the Board of Trustees and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Fund.
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund in accordance with the terms of the Fund.
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Fund.
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Fund, including this booklet, the Trust Agreement or other Fund documents.
- Process and approve or deny benefit claims.
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Fund. The Board of Trustees may delegate any other such duties or powers as it deems necessary to carry out the administration of the Fund.

The Board of Trustees also reserves the right in its sole and absolute discretion to amend or terminate the Fund at any time and for any reason. Continuation of benefits is not guaranteed. Neither you, nor your beneficiaries nor any other person has or will have a vested or nonforfeitable interest in the Fund.

In the event of the Fund's termination, the Board of Trustees will apply the monies in the Fund to provide benefits or otherwise carry out the purpose of the Fund in an equitable manner until the Fund

assets have been disbursed. In no event will any part of the Fund assets revert to the employers or to the Union. The Board of Trustees consists of an equal number of employer and Union representatives.

### **Sponsor And Administrator**

The Board of Trustees is the Fund's Sponsor and Administrator.

### **Identification Numbers**

The "employer identification number" assigned to the Fund by the Internal Revenue Service is 13-5549593. The Plan identification number assigned to the Fund by the Board of Trustees is 501.

### **Fund Year**

Records are kept on a "Fund Year" basis. The Fund Year is from May 1st to the following April 30th.

### **Type Of Fund**

The Fund is known as a "welfare" fund under federal law. It provides medical benefits, prescription drug benefits, dental benefits, visions benefits, life insurance, and accidental death and dismemberment benefits.

### **Agent For Service Of Legal Process**

Legal process may be served upon any Fund Trustee or the Fund Administrator at:

United Teamster Fund  
2137-2147 Utica Avenue  
Brooklyn, NY 11234  
Phone (718) 859-1624

### **Collective Bargaining Agreement/Contributing Employers**

The Fund was established and is maintained as a result of collective bargaining agreements between employers and unions. A copy of the collective bargaining agreement signed by your employer and union may be obtained upon written request to the Fund Office, and is available for examination during normal business hours at the Fund Office. In addition, a complete list of the bargaining units participating in the Fund may be obtained upon written request to the Fund Office and is available for examination by participants and beneficiaries during normal business hours at the Fund Office. The Fund Office may charge a reasonable amount for copies.

Participants and beneficiaries may also receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is participating in the Fund and, if the employer or employee organization is participating, its address.

### **Source Of Contributions**

The benefits described in this booklet are provided through employer contributions or COBRA premiums. The amount of employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the applicable collective bargaining agreements.

### **Trust Fund**

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants, either through the direct payment of benefits or the payment of premiums to entities that insure these benefits, and defraying reasonable administrative expenses.

### **Identification Of Insuring Or Administering Entities**

All benefits under the Fund are paid out of the Fund's assets. This means they are "self-funded." The Fund has entered administrative contracts with various entities to assist in administering the Fund. Contact information for all providers are at the end of this booklet.

### **QMSCO Procedures**

If a court or a state administrative agency has issued an order with respect to the provision of health care coverage for any of the participant's children, the Administrator or its designee will determine if the court or state administrative agency order is a Qualified Medical Child Support Order (QMSCO) as defined by Federal law, and that determination will be binding on all parties. The state administrative agency order must be issued through an administrative process established by state law and must have the force and effect of state law under the applicable state law.

An order is not a QMSCO if it requires the Fund to provide any type or form of benefit or any option that the Fund does not otherwise provide, or if it requires an individual employee who is not covered by the Fund to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws.

If an order is determined to be a QMSCO, and if the participant is covered by the Fund, the Administrator or its designee will so notify the parents and each child, and advise them of the Fund's procedures that must be followed to provide coverage to the child. However, no coverage will be provided for any child under a QMSCO unless the applicable employee contributions for that child's coverage are paid, and all of the Fund's requirements for coverage of that child have been satisfied.

For additional information regarding the QMSCOs and the procedures for payment of claims under them, see Claims Information.

### **YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

As a participant in the United Teamster Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act Of 1974 (ERISA). ERISA provides that all participants and eligible dependents shall be entitled to:

#### **Receive Information About Your Plan And Benefits**

- Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all documents governing the Fund, including summary plan descriptions, collective bargaining agreements signed by the participant's employer and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Fund, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Fund’s annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report, upon written request.

### **Continued Group Health Plan Coverage**

You may continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Fund as a result of a “qualifying event”. You or your dependents may have to pay for such coverage. Review the rules in this summary plan description on COBRA continuation coverage rights.

### **Reduction Or Elimination Of Exclusionary Periods Of Coverage For Preexisting Conditions**

You will be provided a certificate of creditable coverage, free of charge when you: lose coverage under the Fund, become entitled to COBRA, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Actions By Fiduciaries**

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Fund are called “fiduciaries.” Fiduciaries have a duty to act prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision, and to appeal any denial, all within certain time Schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Fund’s documents or the latest annual report and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

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

### **Assistance With Your Questions**

If you have any questions about the Fund, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest Office of the Employee Benefits

Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, N.W.  
Washington D.C, 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**HEALTH ORGANIZATION AND CONTACT INFORMATION**

<b>BENEFIT</b>	<b>HEALTH ORGANIZATION</b>	<b>TYPE OF FUNDING</b>
Medical/Hospital	Magnacare 825 East Gate Boulevard Garden City, New York 11530 (T) 516-282-8000 (F) 516-228-7743	Self-funded. The Fund pays the cost of benefits, which are administered by Magnacare and provides pre-certification and case management services.
Prescription Drugs	Prescription Drugs Express Scripts Inc. Mail Pharmacy Service P. O. Box 66773 St. Louis, Missouri 63166-6773	Self-funded. The Fund pays the cost of benefits, which are administered by Express Scripts.
Vision	United Teamster Fund 2137-2147 Utica Avenue Brooklyn, New York 11234  General Vision Service Comprehensive Professional System Vision Screening National Optical Services New County	Self-funded. The Fund provides and administers benefits.
Life Insurance	United Teamster Fund 2137-2147 Utica Avenue Brooklyn, New York 11234 718-859-1624	Self-funded. The Fund provides and administers benefits.