SUMMARY PLAN DESCRIPTION

of the

Plan of Benefits

of the

TEAMSTERS JOINT COUNCIL NO. 53 RETIREE HEALTH AND WELFARE FUND

April 2009

0409

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INTRODUCTION

About This Booklet

To All Eligible Participants:

The Teamsters Joint Council No. 53 Retiree Health & Welfare Fund helps provide you and , in most cases, your spouse with medical, dental, vision and prescription drug coverage during your retirement years.

This booklet, which also serves as the Plan Document, describes the Plan as in effect on April 1, 2009. The terms and conditions of the Plan, as well as the particular benefits provided through the Plan, are subject to change and/or amendment from time to time at the discretion of the Plan's Retirement Committee. Should changes be implemented, you will be sent a "Statement of Material Modification" describing any such changes. Such statements are generally sent via first class mail to the participant's last known address on file with the Plan.

We encourage you to read this booklet carefully and share it with your spouse to ensure that you understand your rights under the Plan. When you are finished reading this booklet, file it with your important papers (along with any "Statements of Material Modification") so you can refer to it later.

Sincerely,

The Retirement Committee

GENERAL INFORMATION

1. **Plan Identification:**

Teamsters Joint Council No. 53 Retiree Health & Welfare Fund
Employer Identification Number: 23-2530237
Plan Number: 501
Plan year: Fiscal year beginning July 1

2. **The Plan Sponsor is:**

Retirement Plan Committee of the
Teamsters Joint Council No. 53 Retiree Health & Welfare Fund
3460 N. Delaware Avenue
Suite 310
Philadelphia, PA 19134
215-634-4567

3. **The members of the Retirement Plan Committee are:**

William Hamilton, Chairman	Paul Cardullo, Treasurer
John Ryan	Howard Wells
John Laigaie	Dan Grace
Stephen Banus	Brian Reice
James Smith	John Dulczak

The mailing address for each of the Retirement Committee members is:

Teamsters Joint Council No. 53 Retiree Health & Welfare Fund
3460 N. Delaware Avenue
Suite 310
Philadelphia, PA 19134

4. **The Agent for Service of Legal Process is:**

Administrative Service Professionals, Inc.
6981 N. Park Drive – Suite 400
Pennsauken, NJ 08109

In addition, one or more of the Retirement Plan Committee members may be served with legal process.

5. **Service Providers** – The following provide the designated services to the Plan:

Legal Counsel:
Markowitz & Richman
1100 North American Bldg
121 S. Broad Street
Philadelphia, PA 19107

Actuarial Consultant:
The McKeogh Company
Four Tower Bridge
Suite 225
W Conshohocken, PA 19428

Investment Consultant:
SEI Investments
One Freedom Drive
Oaks, PA 19456

Administrative Services:
Administrative Service
Professionals, Inc.
6981 N. Park Drive
Suite 400
Pennsauken, NJ 08109

Fund Custodian:
Wachovia Bank, N.A.
Retirement Services
123 S. Broad Street
Philadelphia, PA 19109

Hosp/Med/Surg Carrier:
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103

Dental Benefit Carrier:
United Concordia
1000 First Avenue, Suite 403
King of Prussia, PA 19406

Vision Benefit Carrier:
Vision Benefits of America
300 Weyman Plaza
Pittsburgh, PA 15236

Rx Drug Benefit Manager:
Express Scripts, Inc.
One Express Way
St. Louis, MO 63121

6. **Financing** –

Benefits under the Plan are financed through Employer contributions and monthly premium copayments from eligible participants. The rate of Employer contributions and the amount of participant premium copayments are set from time to time by the Retirement Committee. As of April 1, 2009, the monthly participant premium copayments are as follows:

	Retired Member	Spouse
Pre-65	$119.00	$198.34
Post-64	$60.28	$100.47

Benefits under the Plan are provided through the purchase of insurance contracts for the Plan's medical, dental and vision programs, except for the Medicare Supplement Program and the Prescription Drug Benefit Program each of which are self-insured by the Plan.

ELIGIBILITY RULES

1. The Fund provides Health & Welfare benefits, as determined by the Committee, to all retirees who:

   a. have retired after January 1, 1987,
   b. are receiving a pension benefit from Teamsters Joint Council No. 53 Retirement Trust
   c. have reached the age of fifty-five (55),
   d. have ten (10) years of service,
   e. were in employment covered by the Teamsters Joint Council No. 53 Retirement Trust within five (5) years prior to the date of their retirement, and
   f. whose last employer remains a contributing employer, except in cases of dissolution or merger, to both the Teamsters Joint Council No. 53 Retirement Trust and this Plan as of that individual's initial eligibility date under this Plan.

   A year of service is defined as employment with a Contributing Employer in which the employee works at least one thousand (1,000) hours.

2. If a retired participant covered by this Plan returns to employment, such person will not be eligible for coverage by the Fund upon future retirement unless such person has been employed for one (1) year after returning to such employment. Persons who are actively employed by Teamsters Joint Council No. 53 or any Local Union or other entity that contribute to this Fund on behalf of its employees, are not entitled to coverage under this Plan during such period of active employment even if they are receiving a pension benefit from Teamsters Joint Council No. 53 Retirement Trust.

3. Health & Welfare benefits determined by the Committee will provide coverage of lifetime duration for eligible Retirees and their surviving spouses provided that the Retiree was married to said spouse at the date of his or her retirement. Such coverage will also be provided to persons who qualify for and are receiving a disability pension for the Teamsters Joint Council No. 53 Retirement Plan, who incur such disability while in active employment covered by such Retirement Plan, and who have ten (10) years of service and have reached fifty (50) years of age. However, when a Retiree reaches social security retirement age, such coverage may be modified by the Committee to provide for and encompassed the eligibility of a participant and/or beneficiary for Medicare coverage or such other or similar coverage provided by federal or state law. A retiree and his spouse shall have the right to waive entitlement to the benefits provided by this Plan upon execution of a wavier by the retiree and spouse; such waiver may be revoked provided proof of continued coverage is provided.

4. A spouse of an eligible retiree will lose coverage under the Plan upon divorce and will be afforded the opportunity to enroll in the Plan's Continuation of Coverage program (COBRA).

5. Should an eligible Retiree marry after his or her initial eligibility date, the spouse of such retiree shall become eligible under the Plan as of the date of marriage and payment of the applicable premium copayment. Said spouse shall continue to be eligible under the plan until (a) non-payment of the required monthly premium copayment, (b) his or her death, or (c) death of the eligible Retiree, whichever shall first occur. In the event of loss of coverage by reason of the death of the eligible Retiree, said surviving spouse will be afforded the opportunity to enroll in the Plan's Continuation of Coverage program (COBRA).

6. A participant will lose coverage under the Plan thirty (30) days after non-payment of the monthly premium copayment set by the Retirement Committee or upon his or her death, whichever shall first occur.

CONTINUATION OF COVERAGE

If you should lose coverage under the Plan by reason of a “qualifying event” (as that term is defined under applicable Federal law and regulation), the following provisions shall apply to you:

COBRA CONTINUATION COVERAGE

In some cases, should you and/or your spouse become ineligible for coverage under the Fund's Plan of Benefits, you have certain rights, under certain conditions, to continue your coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Under this law, there are circumstances under which you can receive a temporary extension of your health care coverage at group rates. This extension applies to you and your spouse if you and they were covered by the Fund on the day before your or their coverage ended. COBRA refers to these people as "Qualified Beneficiaries."

A Qualified Beneficiary need not show evidence of good health in order to continue coverage. However, the Qualified Beneficiary is obligated to pay a set amount as a premium for this continuation of coverage. The COBRA premium rates are formulated by the Fund's Actuary in accordance with formulas defined in the federal COBRA law.

A member has the right to extend his coverage if the coverage ends because you no longer meet the eligibility requirements due to the occurrence of a “qualifying event.”

Your spouse has the right to extend coverage if you die or no longer meet the eligibility requirements due to the occurrence of a “qualifying event,” or you are divorced or legally separated..

It is the responsibility of the person who will lose coverage to inform the Administrator of a divorce or legal separation. The Administrator must be notified, in writing, within sixty (60) days after one of these events occur. If the Administrator is not notified, then that person will not be able to elect to continue his or her other coverage.

Once the Administrator is notified of an event that affects the coverage of a Qualified Beneficiary, the Qualified Beneficiary will be notified that he or she has the right to choose continuation coverage. He or she then has at least sixty (60) days from the date he or she would lose coverage to let the Administrator know that he or she wants to continue coverage. If the Qualified Beneficiary did not choose it, the right to continue the group health coverage would then end. If he or she does choose it, he or she will be offered the right to continue the same coverage he or she was receiving the day before he or she lost coverage. Each Qualified Beneficiary can make a separate choice on whether to continue coverage. However, one person can make an effective choice to continue coverage for everybody. You can choose to continue only your core benefits - hospital, medical, surgical and prescription drug benefits - or these benefits plus your non-core benefits - vision and dental benefits.

Certificate of Former Coverage

If you or your spouse lose coverage under the Plan, you will receive a certificate of former coverage. You may need the certificate if your new plan excludes coverage for pre-existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may request another copy of the certificate within 24 months of losing coverage.

If coverage ended because you no longer meet the eligibility requirements, coverage may continue for up to 18 months. If coverage ended for any other reason, then coverage may be continued for up to thirty-six (36) months. These time periods may be shortened if:

a. The Fund no longer provides group health coverage for any employee;
b. You do not pay the required premium in a timely fashion;
c. You are later employed and are covered by another group health plan that does not contain any exclusion or limitation with respect to a pre-existing medical condition that is applied by the plan;
d. You become eligible for Medicare; or
e. You are divorced, subsequently remarry and are covered under your new spouse's group health plan.

Special Rule for Multiple Qualifying Events

If you elect continuation coverage following a termination of employment or reduction in hours and, during the 18 month period of continuation coverage, a second event (other than a bankruptcy proceeding) occurs that would have caused you to lose coverage under the Plan (if you had not lost coverage already), you may be given the opportunity to extend the period of continuation coverage to a total of 36 months. If you elected continuation coverage as the spouse of a covered employee who experienced a termination of employment or reduction in hours and, during the continuation period the employee or former employee becomes entitled to Medicare, you may be given the opportunity to extend coverage for 36 months from your initial qualifying event.

Special Rule for Totally Disabled Qualified Beneficiaries

The 18-month period of continuation coverage may be extended for an additional 11 months (up to a total of 29 months), for any individual who is determined to have been disabled (for Social Security purposes) at the time your work hours were reduced, or your employment ended, or any time during the first sixty (60) days of the 18 month period during which you are enrolled in the COBRA program. To qualify for this additional coverage, the individual must provide the Plan with notice, within sixty (60) days of the date of the determination and before the end of the 18-month coverage period, of Social Security's disability determination, and must remain disabled throughout the additional coverage period. The premium cost for COBRA continuation during the additional coverage period will be approximately 50 percent higher.

If you have any questions about this continuation coverage, please contact the Fund office.

PRIVACY PRACTICES

THESE PROVISIONS DESCRIBE HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

What follows is a Notice of Privacy Practices of the Teamsters Joint Council 53 Retiree Health & Welfare Fund (the "Plan"). The Notice establishes the circumstances under which the Plan may share your protected health information with others in accordance with the Health Insurance Portability and Administrative Accountability Act of 1996 (HIPAA) Privacy Rules.

The Plan may use your protected health information ("PHI") for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

YOUR PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED IN THE FOLLOWING CIRCUMSTANCES AND FOR THE FOLLOWING PURPOSES:

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

To Conduct Health Care Operations. The Plan may use or disclose PHI for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's participants and beneficiaries. Health care operations includes activities such as:

a. Quality assessment and improvement activities.
b. Activities designed to improve health or reduce health care costs.
c. Clinical guidelines and protocol development, case management and care condition.
d. Contacting health care providers, participants and beneficiaries with information about treatment alternatives and other related functions.
e. Health care professional competence or qualifications review and perform evaluations.
f. Accreditations, certification, licensing or credentialing activities.
g. Underwriting, premium rating to related functions to create, renew or replace health insurance or health benefits.
h. Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
i. Business planning and development including cost management and planning related analyses and formulary development.
j. Business management and general administrative activities of the Plan, including member services and resolution of internal grievances.

For example, the Plan may use your PHI to conduct case management quality improvement, disease management, utilization review, or engage in member service and grievance resolution activities.

For Treatment Alternatives. The Plan may use or disclose your PHI to tell you about or recommend possible treatment operations or alternatives that may be of interest to you.

For Distribution of Health Related Benefits and Services. The Plan may use or disclose your PHI to provide to you information on health related benefits and services that may be of interest to you.

For Disclosure to Plan Sponsor. The Plan may disclose your PHI to the plan sponsor, the Retirement Committee of the Plan, for plan administrative functions performed by the Retirement Committee on behalf of the Plan. In addition, the Plan may provide summary health information to the Retirement Committee so that the Retirement Committee may solicit premium bids from health insurers or modify, amend or terminate the plan. The Plan may also disclose to the Retirement Committee information on whether you are participating in the Plan.

Where Required or Permitted by Law. The Plan may also use or disclose your PHI where required or permitted by law. In that regard, HIPAA generally permits health plans to use or disclose PHI for the following purposes: where required by law; for public health activities; to report child or domestic abuse; for governmental oversight activities; pursuant to judicial or administrative proceedings; for certain law enforcement purposes; for a coroner, medical examiner, or funeral director to obtain information about a deceased individual; for organ, eye, or tissue donation purposes; for certain government-approved research functions, such as related to military service or national security; or to comply with the Workers' Compensation laws.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Except as stated above, the Plan will not disclose your PHI other than with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding your PHI that the Plan maintains:

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your PHI. You have the right to require a limit on the Plan's disclosures of your PHI to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Plan's Privacy Officer (see Contact Person below).

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

Right to Inspect and Copy your Protected Health Information. You have the right to inspect and copy your PHI with some limited exceptions. A request to inspect and copy records containing your PHI must be made in writing and mailed to the Plan's Privacy Officer (see Contact Person below). If you request a copy of your PHI, the Plan may charge a reasonable fee for copying, assembling and postage, if applicable, associated with your request.

Right to Amend your Protected Health Information. You have the right to request an amendment to your PHI records that you believe are inaccurate or incomplete. The request will be considered as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing and mailed to the Plan's Privacy Officer (see Contact Person below). The Plan may deny the request if you do not state why you believe your records to be inaccurate or incomplete. The request may also be denied if you PHI records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend includes information you are not permitted to change, or if the Plan determines that records containing your PHI are accurate and complete.

Right to an Accounting. You have the right to obtain a list of disclosures of your PHI made by the Plan for any reason other than for treatment, payment or health care operations, unless you have authorized the disclosure. The request must be made in writing and mailed to the Plan's Privacy Officer (see Contact Person below). The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2004. The right to an accounting does not extend beyond six (6) years back from the date of your request. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

Right to a Copy of This Notice. You have a right to obtain and receive a copy of this Notice at any time, even if you have received this Notice previously. To obtain a copy, please contact the Plan's Privacy Officer (see Contact Person below).

DUTIES OF THE PLAN

The Plan is required by law to maintain the privacy of your PHI as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within sixty (60) days of the change. You have the right to express complaints to

the Plan and to the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing and mailed to the Plan's Privacy Officer (see Contact Person below). The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Plan has designated William J. Einhorn as its contact person ("Privacy Officer") for all issues regarding patient privacy and your privacy rights. You may contact this person as follows:

William J. Einhorn, Privacy Officer
Teamsters Joint Council 53 Retiree Health & Welfare Fund
P.O. Box 132
Collingswood, NJ 08108.

EFFECTIVE DATE

This Notice is effective April 14, 2004 and was revised effective July 1, 2008.

If you have any questions regarding this Notice, please contact William J. Einhorn, Privacy Officer, Teamsters Joint Council 53 Retiree Health & Welfare Fund, P.O. 132, Collingswood, NJ 08108, 856-382-2470.

EMPLOYEE RETIREMENT INCOME SECURITY ACT ("ERISA")

IMPORTANT INFORMATION REQUIRED BY ERISA

1. The Plan Year starts on July 1 and ends on June 30, and consists of an entire twelve (12) month period for the purposes of accounting and preparing the reporting and disclosure information which must be submitted to the United States Department of Labor and other regulatory bodies.

2. The Plan is maintained by more than ten Participation Agreements which are between the Plan and various employers (primarily Local Unions affiliated with the International Brotherhood of Teamsters and related entities).

3. The Plan is funded through employer contributions, the amount of which is specified in the Participation Agreements, and monthly premium copayments set by the Retirement Committee and paid by retired participants.

4. Benefits provided under the Plan, other than Medicare Supplemental benefits and Prescription drug benefits, are insured through the purchase of group insurance. Medicare Supplement benefits and prescription drug benefits are self-insured and are paid directly from the corpus of the Trust Fund. The Retirement Committee retains the right to amend the Plan of Benefits set forth in this booklet to the fullest extent provided by law.

5. The Participation Agreements referenced above may be reviewed at the Fund office.

6. Upon written request, the Administrator will furnish you with information as to whether a particular employer participates in the Plan and, if so, his address.

7. This Plan provides comprehensive Hospitalization, Surgical, Medical, Dental, Vision, and Prescription Drug Benefits. Please refer to the Table of Contents and the Summary of Benefits Schedule for more information concerning the benefits provided under this Plan.

IMPORTANT INFORMATION REQUIRED BY ERISA

As a participant in the Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, provided that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, if any, Participation Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, insurance contracts, if any, Participation Agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continued health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subjected to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. **The Fund's Plan does not contain any exclusions for preexisting conditions.**

Prudent Actions by Plan Fiduciaries

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

Enforcing Your Rights

If your claim for a benefit under this Plan is denied or ignored, in whole or in part, your have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive

the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If 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 a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

PLAN CHANGE OR TERMINATION

The Retirement Committee reserves the right to change or discontinue: (a) the types and amounts of benefits under the Plan; and (b) the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Plan benefits and eligibility rules for active or disabled participants:

- are not guaranteed;
- may be changed or discontinued by the Retirement Committee;
- are subject to the rules and regulations adopted by the Retirement Committee;
- are subject to the Trust Agreement which establishes and governs the Fund's operations; and
- are subject to the provisions of any group insurance policies purchased by the Retirement Committee.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

BENEFITS PROVIDED UNDER THE PLAN

The type of medical benefits under which you enjoy coverage vary with your age, that is, whether you are over or under the age of 65. Those under the age of 65 are covered under an insured PPO program ("Personal Choice") administered by Independence Blue Cross. Those participants over age 64 are covered under a Medicare Supplement program that the Plan self-insures.

Coverage for dental, vision and prescription drug benefits is the same, regardless of the participant's age.

You are covered under:

If you are eligible and are:	Personal Choice PPO Plan	Medicare Supplement Plan*	Dental Program (United Concordia)	Prescription Drug Program (Express Scripts)	Vision Program (Vision Benefits of America)
Under Age 65	**√**		**√**	**√**	**√**
Age 65 or older		**√**	**√**	**√**	**√**

* You must be enrolled in Medicare Parts A and B to be eligible for this supplemental benefit

Detailed descriptions of the coverages provided under these programs are more fully described in the pages appended to this document.

In addition, and in accordance with Federal law:

- coverage under the Plan includes coverage for the following when performed subsequent to mastectomy: surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Coverage is also provided for: (a) the initial and subsequent insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and (b) the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

- Maternity care Inpatient benefits will be provided for forty-eight (48) hours for vaginal deliveries and ninety-six (96) hours for cesarean deliveries, except where otherwise approved by the PPO Claims Administrator.

COORDINATION/SUBROGATION OF BENEFITS

Under no circumstances will the Fund pay any benefits under this Plan as the Primary Plan when a Spouse has elected to make this Plan the Primary Plan by waiving any other insurance offered to the Spouse by virtue of his or her employment. This is true whether or not the other insurance is offered with or without charge and whether or not the waiver is made with or without consideration. Notwithstanding the foregoing, a Spouse is not required to purchase coverage through his or her Employer if the Spouse is required to pay the entire premium for the coverage. The Retirement Committee may implement rules and regulations regarding the level of co-payment for employer-provided insurance required of a Spouse under this provision.

The following rule applies to any situation in which the Plan makes any full or partial payment to or on behalf of a participant who subsequently recovers from any other source additional payments or benefits in any way related to the accident, illness, or treatment for which the Fund made full or partial payment:

Upon any such subsequent recovery by or on behalf of a participant, from any person or persons, party or parties, insurance company, firm, corporation, or government agency, whether by suit, judgment, settlement, compromise, or otherwise, the Plan, with or without the signing of a subrogation agreement, shall be entitled to immediate reimbursement to the extent of benefits paid to or on behalf of the participant. The Plan shall be first reimbursed fully by or on behalf of such participant to the extent of benefits paid from the monies paid by any person or persons, party or parties, insurance company, firm, corporation, or government agency and the balance of monies, if any, then remaining from such subsequent recovery shall be retained by or on behalf of the participant. The participant shall hold, as a fiduciary in constructive trust for the benefit of the Plan, any monies so recovered that are subject to the Plan's subrogation/reimbursement lien or these provisions.

All participants are obligated to cooperate with the Plan in its efforts to enforce its subrogation rights and to refrain from any actions which interfere with those efforts. This duty of cooperation includes (but is not limited to) the obligation to sign a subrogation agreement in a form prescribed by the Plan. The Plan shall have the right to take all appropriate actions necessary to enforce its subrogation rights in the event that a participant refuses to sign a subrogation agreement, refuses to reimburse the Plan in accordance with the Plan's subrogation rights, or takes any other action inconsistent with the Plan's subrogation rights. In such situations, the Plan's options shall include, without limitation, the right in appropriate cases to deny benefits to an individual who refuses to sign a subrogation agreement; to institute legal actions to recover sums wrongfully withheld or to obtain other relief; and/or to offset wrongfully withheld sums against future benefit payments otherwise owed the individual who retains such sums. The Plan may pay counsel fees in an amount not to exceed 20% in order to protect the Plan's subrogation interests.

CLAIMS APPEAL PROCEDURES

If you are covered under the pre-age 65 medical program (currently the Blue Cross Personal Choice program), appeals from claims denials are subject to and governed exclusively by the procedures set forth in the Member Handbook issued to you by Blue Cross.

Appeals relating to denials for dental and vision related claims are subject to and governed exclusively by the review procedures set forth in the group insurance booklets. Refer to those materials for a more full explanation of those procedures.

If the claim denial you wish to appeal falls under either the Medicare Supplement program or the Prescription Drug program, the following procedures apply with respect to the claim review/appeal of such a claim:

a. **Statement of Intent**. The Retirement Committee intends to establish and to maintain reasonable claim procedures as required by law.

b. **Authorized Representative**. A Claimant for benefits under this Pan may appoint an authorized representative to act on the Claimant's behalf in pursuing a claim or an appeal from an adverse benefit determination. Any person who wishes to be recognized by the Plan as the authorized representative of a Claimant should contact the Fund office.

c. **Filing of Claims**. Any participant or former participant under the Plan ("Claimant"), may file a written claim for benefits with the Retirement Committee through the Fund office.

d. **Notification on Denial of Claim**. In the event of an adverse benefit determination, the Plan (or Express Scripts, “the PBM,” in the case of prescription drug claims) will send the Claimant a written notification containing specific reasons for the adverse benefit determination. The written notification will contain specific reference to pertinent Plan provisions on which the adverse benefit determination is based. In addition, the written notification will contain a description of any additional material or information necessary for the Claimant to perfect the claim, as well as an explanation of why such material or information is necessary. Furthermore, the notification shall provide appropriate information as to the steps to be taken if the Claimant wishes to seek review of the adverse benefit determination.

e. **Time Frames**. The following time frames will apply to benefit determinations by the Plan:

   (1) **Urgent Care Claims**. In the case of a claim involving urgent care, the Plan shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant has failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan or the PBM shall notify the

Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with Paragraph d of this section. The Plan or the PBM shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the Claimant to provide the specified additional information.

(2) **Concurrent Care Decision**. If the Plan or the PBM has approved an ongoing course of treatment to be provided over a period of time or a number of treatments --

(a) Any reduction or termination by the Plan or the PBM of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan or the PBM shall notify the Claimant in accordance with Paragraph e of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and to obtain a determination on review that the adverse benefit determination before the benefit is reduced or terminated.

(b) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments concerning a claim involving urgent care shall be decided as soon as possible, taking into account medical exigencies, and the Plan or the PBM shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Paragraph e of this section, and appeal shall be governed by Paragraph g(5)(a), (b) or (c) of this section, as appropriate.

(3) **Pre-Service Claims**. In the case of a pre-service claim, the Plan or the PBM shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan or the PBM. This period may be extended one time by the Plan or the PBM for up to 15 days, provided the Plan or the PBM both determine that such an extension is necessary due to matters beyond the control of the Plan or the PBM, and notifies the Claimant prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan or the PBM expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant

shall be afforded at least 45 days from receipt of the notice within which to provide this specified information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with Paragraph e of this section.

(4) **Post-Service Claims**. In the case of a post-service claim, the Plan shall notify the Claimant, in accordance with Paragraph d of this section, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan or the PBM for up to 15 days, provided that the Plan or the PBM both determines that such an extension is necessary due to matters beyond the control of the Plan or the PBM and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan or the PBM expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

g. **Right of Review**

(1) **Full and Fair Review**. A Claimant who receives an adverse benefit determination with respect to any claim shall have the right to a full and fair review of that determination as required by law. For purposes of this Plan, an "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the determination of a Claimant's eligibility to participate in the Plan, and including a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review as well as a failure to cover an item or service for which benefits are otherwise provided because the service is determined to be experimental or investigational or not medically necessary or appropriate.

(2) **Time Frame for Seeking Review of an Adverse Benefit Determination**. A Claimant may institute review of an adverse benefit determination within 180 days of the Claimant's receipt of notification of that determination. Such a review should be initiated in writing, addressed to the Fund office.

(3) The following procedures shall apply to any review sought by a Claimant concerning an adverse benefit determination under this Plan:

(a) The Claimant shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.

(b) The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the

Claimant's claim for benefits. Whether a document, record or other information is relevant to a claim shall be governed by the following: The document shall be "relevant" if it was relied upon in making the benefit determination, submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination or demonstrates compliance with the administrative process and safeguards required herein or by applicable law.

(c) The review of the adverse benefit determination shall take into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(d) Review of the adverse benefit determination shall be give deference to the adverse benefit determination and will be conducted by an appropriate fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject to the appeal nor the subordinate of any such individual.

(e) If the adverse benefit determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medially necessary or appropriate, then the appropriate Plan fiduciary shall consult with a health care professional who has the appropriate training and experience in the relevant field.

(f) The review process shall identify the medical or vocational expert, if any, whose advise was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

(g) If a health care professional was consulted in connection with the adverse benefit determination, that person shall not be consulted in connection with the review of the adverse benefit determination.

(h) In the case of a claim involving urgent care, there shall be provided an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's adverse benefit determination on review, shall be transmitted between the Plan or IBC and the Claimant or Claimant's authorized representative by telephone, facsimile or other available similarly expeditious methods.

(4) **Right to Hearing Before the Retirement Committee**. The Retirement Committee, or a designated subcommittee of the Retirement Committee, shall, upon a claimant’s written request, conduct a hearing regarding the Claimant’s appeal from an adverse benefit determination. A Claimant or Claimant's authorized representative may appear

before the Committee or subcommittee to present any evidence or argument in support of the claim review.

(5) **Content of Claim Review Determination**. Each claim review determination shall be signed by at least two (2) Committee members authorized by the full Retirement Committee to resolve such claim review. The content of each determination will include: the specific reason or reasons for the adverse benefit determination; reference to the specific Plan provision on which the adverse benefit determination is based; and a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits. Whether a document, record or other information is relevant to a claim for benefits shall be determined by Paragraph g(3)(b) of this section.

(6) **Time Frames for Claim Review Determination**. The following time frames shall apply to any rulings upon a requested claim review:

(a) **Urgent Care Claims**. In the case of a claim involving urgent care, the Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.

(b) **Pre-Service Claims**. In the case of a pre-service claim, the Plan shall notify the Claimant in accordance with Paragraph e of this section, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the Plan of the Claimant's request for review of the adverse benefit determination period.

(c) **Post-Service Claims**. In the case of a post-service claim, the ruling on the claim review shall not be made later than the date of the Retirement Committee's Meeting that immediately follows the Plan's receipt of the request for review, unless the request for review was filed within 30 days preceding the date of such Meeting. In such a case, a benefit determination may be made no later than the date of the second Retirement Committee's Meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension for processing, a benefit determination shall be rendered not later than the third Retirement Committee's Meeting following the Plan's receipt of the claim review. If such an extension of time for review is required because of special circumstances, the Plan shall notify the Claimant in writing of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the

benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(7) **Furnishing Documents**. In the case of an adverse benefit determination on review, the Plan shall provide such access to, and copies of, documents, records and other information as appropriate and required by law.

(8) **Definitions**. The following definitions shall apply herein:

(a) A claim involving "urgent care" means any claim for medical care or treatment with respect to which the application of the time period for making non-urgent care 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 paid that cannot be adequately managed without the care or treatment that is the subject of the claim.

(b) "Pre-service claim" means any claim in which receipt of the benefit is conditioned, in whole or in part, upon precertification or preauthorization by the Plan.

(c) The term "post-service claim" means any claim that is not a pre-service claim.

APPENDIX

In the pages that follow, you will find descriptions of the coverages provided under the Pre-65 hospital/medical/surgical, Medicare Supplement, dental benefit, vision benefit and prescription drug benefit programs.

As of April 1, 2009, the Pre-65 medical benefit program requires a yearly patient deductible equal to the first $1,500 in allowable expense* of which the Fund will reimburse the participant up to $1,000 of allowable expense after the patient satisfies $500 of the $1,500 yearly deductible.

**Except for routine preventive examinations which are not subject to the deductible but are subject to a $20 patient copayment.*

Personal Choice

HDHP HD1-HC1 Summary of Benefits

Personal Choice®, our popular Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing your care through Personal Choice's large network of hospitals, doctors, and specialists, or by accessing care through preferred providers who participate in the BlueCard® PPO program. Of course, with Personal Choice, you have the freedom to select providers who do not participate in the Personal Choice network or BlueCard PPO program. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

With Personal Choice...

- You do not need to enroll with a primary care physician
- You never need a referral

Benefit	In-Network	Out-of-Network[1]
BENEFIT PERIOD	Calendar Year*	Calendar Year*
DEDUCTIBLE**		
Single	$1,500	$5,000
Family	$3,000	$10,000
OUT-OF-POCKET MAXIMUM[2]		
Single	$5,600	$10,000
Family	$11,200	$20,000
LIFETIME MAXIMUM	Unlimited	$500,000
DOCTOR'S OFFICE VISITS		
Primary Care Services	100%, after deductible	50%, after deductible
Specialist Services	100%, after deductible	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	$20 Copayment, NO deductible	50%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%[3], NO deductible	50%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per benefit period for women of any age[4]	$20 Copayment, NO deductible	50%, NO deductible

1 Out-of-network, nonparticipating providers may bill you for differences between the Plan allowance, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant. Claims payments for out-of-network professional providers (physicians) are based on IBC's own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under Independence Blue Cross (IBC) contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

2 In-network out-of-pocket maximum includes deductible, copays and coinsurance. Out-of-network out-of-pocket maximum includes deductible and coinsurance

3 Office visit subject to copayment

4 Combined in/out-of-network

* A calendar year benefit period begins on January 1 and ends on December 31.

** Single deductible and out-of-pocket maximum apply when an individual is enrolled without dependents. Family deductible and out-of-pocket maximum apply when an individual and one or more dependents are enrolled. Prior to benefits being paid, the entire family deductible must be met. In-network deductible and/or out-of-pocket maximum may be adjusted annually for inflation.

Independence Blue Cross

www.ibx.com

Benefit	In-Network	Out-of-Network[1]
MAMMOGRAM	100%, NO deductible	50%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per benefit period[3]	100%, NO deductible	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, after deductible	50%, after deductible
MATERNITY		
First OB visit	100%, after deductible	50%, after deductible
Hospital	100%, after deductible	50%, after deductible
INPATIENT HOSPITAL SERVICES	100%, after deductible	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70
OUTPATIENT SURGERY	100%, after deductible	50%, after deductible
EMERGENCY ROOM	100%, after deductible	Covered at In-Network level
AMBULANCE	100%, after deductible	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	100%, after deductible	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	100%, after deductible	50%, after deductible
THERAPY SERVICES		
Physical and Occupational 30 visits per benefit period[4]	100%, after deductible	50%, after deductible
Cardiac Rehabilitation 36 visits per benefit period[4]	100%, after deductible	50%, after deductible
Pulmonary Rehabilitation 36 visits per benefit period[4]	100%, after deductible	50%, after deductible
Speech 20 visits per benefit period[4]	100%, after deductible	50%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum[4]	100%, after deductible	50%, after deductible
SPINAL MANIPULATIONS 20 visits per benefit period[4]	100%, after deductible	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%, after deductible	50%, after deductible
Biotech/Specialty Injectables	100%, after deductible	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%, after deductible	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per benefit period[4]	100%, after deductible	50%, after deductible
SKILLED NURSING FACILITY 120 days per benefit period[4]	100%, after deductible	50%, after deductible
HOSPICE AND HOME HEALTH CARE	100%, after deductible	50%, after deductible
DURABLE MEDICAL EQUIPMENT	100%, after deductible	50%, after deductible, $2,500 benefit maximum/benefit period
PROSTHETICS	100%, after deductible	50%, after deductible

1 Out-of-network, nonparticipating providers may bill you for differences between the Plan allowance, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant. Claims payments for out-of-network professional providers (physicians) are based on IBC's own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under Independence Blue Cross (IBC) contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

3 Office visit subject to copayment

4 Combined in/out-of-network

Benefit	In-Network	Out-of-Network[1]
MENTAL HEALTH CARE		
Outpatient 20 visits per benefit period[4]	100%, after deductible	50%, after deductible
Inpatient 30 days per benefit period[4]	100%, after deductible	50%, after deductible
SERIOUS MENTAL ILLNESS CARE		
Outpatient 60 days per benefit period[4]	100%, after deductible	50%, after deductible
Inpatient 30 days per benefit period[4]	100%, after deductible	50%, after deductible
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits 60 visits per benefit period[4], 120 visits lifetime maximum[4]	100%, after deductible	50%, after deductible
Rehabilitation 30 days per benefit period[4], 90 day lifetime maximum[4]	100%, after deductible	50%, after deductible
Detoxification 7 days per admission[4], 4 admissions lifetime maximum[4]	100%, after deductible	50%, after deductible

1 Out-of-network, nonparticipating providers may bill you for differences between the Plan allowance, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant. Claims payments for out-of-network professional providers (physicians) are based on IBC's own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under Independence Blue Cross (IBC) contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

4 Combined in/out-of-network

What Is Not Covered?

- Services not medically necessary
- Services or supplies that are experimental or investigative except routine costs associated with clinical trials
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Alternative therapies/complementary medicine
- Dental care, including dental implants, and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy, and hippotherapy
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses including wigs intended to replace hair
- Routine physical exams for nonpreventive purposes such as insurance or employment applications, college, or premarital examinations
- Contraceptives
- Immunizations for travel or employment
- Service or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Vision care (except as specified in a group contract)

This summary represents only a partial listing of the benefits and exclusions of the Personal Choice Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully for a complete listing of the terms, limitations and exclusions of the program. If you need more information, please call 1-800-626-8144 (outside Philadelphia) or 215-557-7577 (if calling within the Philadelphia area).

Services That Require Precertification

INPATIENT SERVICES

- Surgical and Nonsurgical Inpatient Admissions
- Acute Rehabilitation
- Skilled Nursing Facility
- Inpatient Hospice
- Maternity Admission (for notification only)

OUTPATIENT FACILITY/OFFICE SERVICES (other than inpatient)

- CT/CTA Scans
- MRI/MRA
- Nuclear Cardiac Studies
- PET Scans
- Hysterectomy
- Cataract Surgery
- Nasal Surgery for Submucous Resection and Septoplasty
- Transplants (except cornea)
- Comprehensive Outpatient Pain Management Programs (including epidural injections)
- Obesity Surgery
- Sleep Studies
- Day Rehabilitation Programs
- Dental Services as a Result of Accidental Injury
- Uvulopalatopharyngoplasty (including laser-assisted)

ALL HOME CARE SERVICES (including infusion therapy in the home)

INFUSION THERAPY DRUGS
Administered in an Outpatient Facility or in a Professional Provider's Office (see list included in your open enrollment packet)

BIRTHING CENTER (for notification only)

ELECTIVE (non-emergency) AMBULANCE TRANSPORT

OUTPATIENT PRIVATE DUTY NURSING

PROSTHETICS AND ORTHOTICS
Purchase items (including repairs and replacements) over $500 (excluding ostomy supplies)

DURABLE MEDICAL EQUIPMENT
Purchase items (including repairs and replacements) over $500, and ALL rentals (except oxygen, diabetic supplies, and unit dose medication for nebulizer)

RECONSTRUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES

- Abdominoplasty
- Augmentation Mammoplasty
- Blepharoplasty
- Chemical Peels
- Dermabrasion
- Excision of Redundant Skin
- Keloid Removal
- Lipectomy/Liposuction
- Orthognathic Surgery Procedures
- Mastopexy
- Otoplasty
- Panniculectomy
- Reduction Mammoplasty
- Removal or Reinsertion of Breast Implants
- Rhinoplasty
- Surgery for Varicose Veins
- Scar Revision
- Subcutaneous Mastectomy for Gynecomastia

MENTAL HEALTH/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

- Mental Health and Serious Mental Illness Treatment (Inpatient/Outpatient/Partial Hospitalization)
- Substance Abuse Treatment (Inpatient/Outpatient/Partial Hospitalization)

BIOTECHNOLOGY/SPECIALTY INJECTABLE DRUGS
(See list included in your open enrollment packet)

Personal Choice® network providers will obtain precertification for you if it is required. You are not required to obtain precertification when treated in a Personal Choice network hospital or facility or by a Personal Choice network physician. Members are not responsible for financial penalties because a Personal Choice network provider does not obtain precertification.

If the provider is a BlueCard® PPO provider of another Blue Plan or an out-of-network provider, you must obtain precertification if required. You may be subject to a 20% reduction in benefits if precertification is not obtained.

In addition to the precertification requirements listed above, you should contact Independence Blue Cross and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. This applies to network providers and members who elect to receive treatment provided by BlueCard providers, or out-of-network providers. The categories of treatment (in any setting) include:

- Any surgical procedure that may be considered potentially cosmetic; and
- Any procedure, treatment, drug, or device that represents new or emerging technology; and
- Services that might be considered experimental/investigative.

Your provider should be able to assist you in determining whether a proposed treatment falls into one of these three categories. You are encouraged to have your provider place the call for you.

Precertification is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the precertification is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

TEAMSTERS JOINT COUNCIL NO. 53
RETIREE HEALTH AND WELFARE FUND

MEDICARE SUPPLEMENTAL COVERAGE - 2009 DEDUCTIBLES AND COINSURANCE

Medicare Part A - Hospital Services (per Benefit Period♦)		
SERVICES	MEDICARE PAYS	SUPPLEMENT PLAN PAYS
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous services and supplies.		
First 60 days	All but $1,068	$1,068
Days 61-90	All but $267/day	$267/day
After 90 days For 60 Lifetime Reserve days	All but $534/day	$534/day
After Lifetime Reserve days are used	$0	100% of Medicare eligible expenses for additional 365 days
Beyond the additional 365 days	$0	$0
SKILLED NURSING FACILITY You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility with 30 days after leaving the hospital.		
First 20 days	100%	$0
Days 21-100	All but $133.50/day	$133.50/day
After 100 days	$0	$0

Notes:

- ♦ A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 consecutive days.

Medicare Part B - Medical Services (per Calendar Year)

Medicare Part B - Medical Services (per Calendar Year)		
SERVICES	MEDICARE PAYS	SUPPLEMENTAL PLAN PAYS
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and out patient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment.		
First $135 of Medicare-approved amounts	$0	$135
Remainder of Medicare-approved amounts	80% (50% of outpatient psychiatric services)	20% (50% of outpatient psychiatric services)
Part B excess charges (above Medicare-approved amounts)	$0	$0
Medicare Parts A and B - Services		
HOME HEALTH CARE - MEDICARE/APPROVED SERVICES		
Medically necessary skilled care services and medical supplies	100%	$0
Durable medical equipment		
First $135 of Medicare-approved amounts	$0	$135
Remainder of Medicare-approved amounts	80%	20%

TEAMSTERS JOINT COUNCIL NO. 53
RETIREE HEALTH AND WELFARE FUND

Express Scripts - Prescription Drug Coverage

	Formulary	Non-Formulary
Retail (30-day supply)		
Generic	$5 copayment	50% copayment
Brand Name	$20 copayment	50% copayment (minimum $30, maximum $50 copayment)
Mail Order (90-day supply)		
Generic	$10 copayment	50% copayment
Brand Name	$40 copayment	50% copayment (minimum $50, maximum $100 copayment)

You receive coverage for prescription drugs under this program when the drugs are prescribed by a licensed, practicing physician.

Your drug program uses a formulary, which is a defined list of selected drugs that have been evaluated for their medical effectiveness, positive results and value.

In addition, covered medications for chronic conditions (such as blood pressure medications) may be provided through mail order service for up to a 90-day supply. You will pay two times the copayment charged at the retail pharmacy. This benefit can save you time and money.

Some drugs require prior authorization. Your physician can initiate prior authorization for these medications if they are medically appropriate.

You may use any participating pharmacy to fill your prescription needs. Covered prescription drugs purchased at non-participating retail pharmacy will be reimbursed at 25% of the drug's retail cost.

Express Scripts Customer Service Number is 1-800-467-2006.

UNITED CONCORDIA
Insuring America's Dental Health

CONCORDIA FLEX

Dental Benefits Summary for Teamsters Joint Council 53

Network: Advantage

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

Benefit Category[2]	Plan Pays[1]
Class I – Diagnostic/Preventive Services	
Exams	100%
Cleanings & Fluoride Treatments	
X-rays	
Sealants	
Space Maintainers	
Palliative Treatment (Emergency)	
Class II – Basic Services	
Basic Restorative (Fillings, etc.)	100%
Simple Extractions	
Endodontics	
General Anesthesia	
Class III – Major Services	
Surgical & Non-surgical Periodontics	N/A
Oral Surgery	
Inlays, Onlays, Crowns	
Prosthetics (Bridges, Dentures)	
Repairs to Inlays, Onlays and Crowns and Prosthetics	
Orthodontics (dependents to any age)	
Diagnostic, Active, Retention Treatment	N/A
Program Maximums/Deductibles	
Annual Program Maximum (per covered person)	$1,000
Lifetime Orthodontic Maximum (per covered person)	N/A
Annual Program Deductible (per person/per family)	N/A

1. The listed network percentages represent the portion of United Concordia's maximum allowable charges (MACs) for which the plan will be responsible. Network providers agree to accept United Concordia's MAC for covered services as payment in full and also agree to file claims for you. If you or your family members receive services from a non-network provider, United Concordia will apply the percentages shown to the [non-network reimbursement] for covered services and you will be responsible for the difference, up to the provider's charge. United Concordia's standard exclusions and limitations apply.
2. Unmarried dependent children covered to age 19. Unmarried dependent students covered to age 23. Disabled dependents covered to any age.

CONTACT UNITED CONCORDIA

Phone 1-800-332-0366
Customer service representatives are available from 8 a.m. to 8 p.m. ET.

Mail United Concordia, PO Box 69420, Harrisburg, PA 17103-9420

Web www.unitedconcordia.com
Once enrolled, register to use My Dental Benefits for 24/7, secure access to benefit information including eligibility, claim status, procedure history, ID card requests and more!

UNITED CONCORDIA

UNITED CONCORDIA

4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan
Certificate of Insurance

Network Plan

In AL, United Concordia is underwritten by
United Concordia Dental Corporation of Alabama

In AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MN, MI, MS, MT, NE, NV, NH, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI, WV, WY, United Concordia is underwritten by
United Concordia Insurance Company

In DE, DC, IL, KY, MD, MO, NC, NJ, PA, United Concordia is underwritten by
United Concordia Life and Health Insurance Company

In NY, United Concordia is underwritten by
United Concordia Insurance Company of New York

Notice to Florida residents: The benefits of the policy providing your coverage are governed by a state other than Florida.

9804-C (07/05)

CERTIFICATE OF INSURANCE

INTRODUCTION

This Certificate of Insurance provides information about Your dental coverage. Read it carefully and keep it in a safe place with Your other valuable documents. Review it to become familiar with Your benefits and when You have a specific question regarding Your coverage.

To offer these benefits, Your Group has entered into a Group Policy of insurance with United Concordia. The benefits are available to You as long as the Premium for You and any enrolled Dependents is paid and obligations under the Group Policy are satisfied. In the event of conflict between this Certificate and the Group Policy, the Group Policy will rule. This Certificate is not a summary plan description under the Employee Retirement Income Security Act (ERISA).

If You have any questions about Your coverage or benefits, please call our Customer Service Department toll-free at:

(800) 332-0366

For general information, Participating Dentist or benefit information, You may also log on to our website at:

www.unitedconcordia.com

Claim forms should be sent to:

United Concordia Companies, Inc.
Dental Claims
PO Box 69421
Harrisburg, PA 17106-9421

TABLE OF CONTENTS

Attached:

Appeal Procedure Addendum
State Law Provisions Addendum
Schedule of Benefits
Schedule of Exclusions and Limitations

DEFINITIONS

Certain terms used throughout this Certificate begin with capital letters. When these terms are capitalized, use the following definitions to understand their meanings as they pertain to Your benefits and the way the dental plan works.

Certificate Holder(s) - An individual who has enrolled him/herself and his/her Dependents for dental coverage and for whom Premium payments are due and payable. Also referred to as "You" or "Your" or "Yourself".

Certificate of Insurance ("Certificate") - This document, including riders, schedules, addenda and/or endorsements, if any, which describes the coverage purchased from the Company by the Policyholder.

Coinsurance - Those remaining percentages or dollar amounts of the Maximum Allowable Charge for a Covered Service that are the responsibility of either the Certificate Holder or his/her enrolled Dependents after the Plan pays the percentages or dollar amounts shown on the Schedule of Benefits for a Covered Service.

Company - United Concordia, the insurer. Also referred to as "We", "Our" or "Us".

Coordination of Benefits ("COB") - A method of determining benefits for Covered Services when the Member is covered under more than one plan to prevent duplication of payment so that no more than the incurred expense is paid.

Cosmetic - Those procedures which are undertaken primarily to improve or otherwise modify the Member's appearance.

Covered Service(s) - A service or supply specified in this Certificate and the Schedule of Benefits for which benefits will be covered subject to the Schedule of Exclusions and Limitations, when rendered by a dentist, or any other duly licensed dental practitioner under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Deductible(s) - A specified amount of expenses set forth in the Schedule of Benefits for Covered Services that must be paid by the Member before the Company will pay any benefit.

Dentally Necessary - A dental service or procedure is determined by a dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the dentist and the prevailing standards of care in the professional community. The determination will be made by the dentist in accordance with guidelines established by the Company. When there is a conflict of opinion between the dentist and the Company on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Company will be final.

Dependent(s*)* - Certificate Holder's spouse and any unmarried child or stepchild of a Certificate Holder or unmarried member of the Certificate Holder's household resulting from a court order or placement by an administrative agency, enrolled in the Plan:

(a) until the end of the contract year which he/she reaches age 19; or
(b) until the end of the contract year which he/she reaches age 23 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Certificate Holder for maintenance and support; or
(c) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

Effective Date - The date on which the Group Policy begins or coverage of enrolled Members begins.

Exclusion(s) – Services, supplies or charges that are not covered under the Group Policy as stated in the Schedule of Exclusions and Limitations.

Experimental or Investigative - The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company, determines is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered. The Company will rely on the advice of the general dental community including, but not limited to dental consultants, dental journals and/or governmental regulations, to make this determination.

Grace Period - A period of no less than 31 days after Premium payment is due under the Policy, in which the Policyholder may make such payment and during which the protection of the Group Policy continues, subject to payment of Premium by the end of the Grace Period.

Group Policy - The agreement between the Company and the Policyholder, under which the Certificate Holder is eligible to enroll.

Limitation(s) - The maximum frequency or age limit applied to a Covered Service set forth in the Schedule of Exclusions and Limitations incorporated by reference into this Certificate.

Maximum(s) - The greatest amount the Company is obligated to pay for all Covered Services rendered during a specified period as shown on the Schedule of Benefits.

Maximum Allowable Charge - The maximum amount the Plan will allow for a specific Covered Service. Maximum Allowable Charges may vary depending upon the contract between the Company and the particular Participating Dentist rendering the service. Depending upon the Plan purchased by the Policyholder, Maximum Allowable Charges for Covered Services rendered by Non-Participating Dentists may be the same or higher than such charges for Covered Services rendered by Participating Dentists in order to help limit out-of-pocket costs of Members choosing Non-Participating Dentists.

Member(s) - Certificate Holder(s) and their Dependent(s).

Non-Participating Dentist - A dentist who has not signed a contract with the Company or an affiliate of the Company.

Participating Dentist - A dentist who has executed a Participating Dentist Agreement with the Company or an affiliate of the Company, under which he/she agrees to accept the Company's Maximum Allowable Charges as payment in full for Covered Services.

Plan - Dental benefits pursuant to this Certificate and attached Schedule of Exclusions and Limitations and Schedule of Benefits.

Policyholder - Organization that executes the Group Policy. Also referred to as "Your Group".

Premium - Payment that the Policyholder must remit to the Company in exchange for coverage of the Policyholder's Members.

Renewal Date - The date on which the Group Policy renews. Also known as anniversary date.

Schedule of Benefits - Attached summary of Covered Services, Plan payment percentages, Deductibles, Waiting Periods and Maximums applicable to benefits payable under the Plan.

Schedule of Exclusions and Limitations – Attached list of Exclusions and Limitations applicable to benefits, services, supplies or charges under the Plan.

State Law Provisions Addendum – Attached document containing specific provisions required by state law to be modified, deleted from, and/or added to the Certificate of Insurance.

Termination Date - The date on which the dental coverage ends for a Member or the Group Policy terminates.

Waiting Period(s) - A period of time a Member must be enrolled under the Group Policy before benefits will be paid for Covered Services as shown on the attached Schedule of Benefits.

ELIGIBILITY AND ENROLLMENT -- WHEN COVERAGE BEGINS

New Enrollment

If You have already satisfied Your Group's eligibility requirements when the Group Policy begins and Your enrollment information is supplied to Us, Your coverage and Your Dependents' coverage will begin on the Effective Date of the Group Policy provided We receive the Premium.

If You join the Group or become employed after the initial Effective Date of the Group Policy, in order to be eligible to enroll, You must first satisfy any eligibility requirements of Your Group. Your Group will inform You of these requirements.

You must supply the required enrollment information on Yourself and Your Dependents within 31 days of the date You meet these requirements. Your Dependents must also meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

Your coverage and Your Dependents' coverage will begin on the date specified in the enrollment information supplied to Us provided Premium is paid.

The Company is not liable to pay benefits for any services started prior to a Member's Effective Date of coverage. Multi-visit procedures are considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. Procedures started prior to the Member's Effective Date are the liability of the Member or a prior insurance carrier.

Enrollment Changes

After Your initial enrollment, there are certain life change events that permit You to add Dependents. These events are:

- birth
- adoption
- court order of placement or custody
- change in student status for a child
- marriage.

To enroll a new Dependent as a result of one of these events, You must notify Your Group and supply the required enrollment change information within 31 days of the date You acquired the Dependent. The Dependent must meet the requirements detailed in the definition of Dependent in the Definitions section of this Certificate.

Except for newly born or adoptive children, coverage for the new Dependent will begin on the date specified in the enrollment information provided to Us as long as the Premium is paid.

Newly born children of a Member will be considered enrolled from the moment of birth. Adoptive children will be considered enrolled from the date of adoption or placement, except for those adopted or placed within 31 days of birth who will be considered enrolled Dependents from the moment of birth. In order for coverage of newly born or adoptive children to continue beyond the first 31 day period, the child's enrollment information must be provided to Us and the required Premium must be paid within the 31 day period.

For an enrolled Dependent child who is a full-time student, evidence of his/her student status and reliance on You for maintenance and support must be furnished to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. Such evidence will be requested annually thereafter until the Dependent reaches the limiting age for students and his/her coverage ends.

For an enrolled Dependent child who is mentally or physically handicapped, evidence of his/her reliance on You for maintenance and support due to his/her condition must also be supplied to Us within 30 days after said Dependent attains the limiting age shown in the definition of Dependent. If the Dependent is a full-time student at an accredited educational institution, the evidence must be provided within 30 days after the Dependent attains the limiting age for students. Such evidence will be requested based on information provided by the Member's physician but no more frequently than annually.

Dependent coverage may only be terminated when certain life change events occur including death, divorce or reaching the limiting age or during open enrollment periods.

Late Enrollment

If You or Your Dependents are not enrolled within 31 days of initial eligibility or a life change event, You or Your Dependents cannot enroll until the next open enrollment period conducted for Your Group or unless otherwise specified in any applicable Late Entrant Rider to the Certificate of Insurance. If You are required to provide coverage for a Dependent child pursuant to a court order, You will be permitted to enroll the Dependent child without regard to enrollment season restrictions.

HOW THE DENTAL PLAN WORKS

Choice of Provider

You may choose any licensed dentist for services. However, Your out-of-pocket costs will vary depending upon whether or not Your dentist participates with United Concordia. If You choose a Participating Dentist, You may limit Your out-of-pocket cost. Participating Dentists agree by contract to accept Maximum Allowable Charges as payment in full for Covered Services. Participating dentists also complete and send claims directly to Us for processing. To find a Participating Dentist, visit *Find a Dentist* on Our website at *www.unitedconcordia.com* or call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Certificate.

If You go to a dentist who is not a United Concordia Participating Dentist, You may have to pay the dentist at the time of service, complete and submit Your own claims and wait for Us to reimburse You. You will be responsible for the dentist's full charge which may result in higher out-of-pocket costs for You.

When You visit the dental office, let Your dentist know that You are covered under a United Concordia program and give the dental office Your contract ID number and group number. If Your dentist has questions about Your eligibility or benefits, instruct the office to call Our Interactive Voice Response System at the toll-free number in the Introduction section of this Certificate or visit *My Patients' Benefits* on Our website at *www.unitedconcordia.com.*

Claims Submission

Upon completion of treatment, the services performed must be reported to Us in order for You to receive benefits. This is done through submission of a paper claim or electronically. Participating Dentists will report services to Us directly for You and Your Dependents.

Most dental offices submit claims or report services for patients. However, if You do not receive treatment from a Participating Dentist, You may have to complete and send claims to Us in the event the dental office will not do this for You. To obtain a claim form, visit the Members link on our website at *www.unitedconcordia.com*. Be sure to include on the claim:

- the patient's name
- date of birth
- Your contract ID number
- patient's relationship to You
- Your name and address
- the name and policy number of a second insurer if the patient is covered by another dental plan.

Your dentist should complete the treatment and provider information or supply an itemized receipt for You to attach to the claim form. Send the claim form or predetermination to the address in the Introduction section of this Certificate.

For orthodontic treatment, if covered under the Plan, an explanation of the planned treatment must be submitted to Us. Upon review of the information, We will notify You and Your dentist of the reimbursement schedule, frequency of payment over the course of the treatment, and Your share of the cost.

Should You have any questions concerning Your coverage, eligibility or a specific claim, contact Us at the address and telephone number in the Introduction section of this Certificate or log onto *My Dental Benefits* at *www.unitedconcordia.com*.

Predetermination

A predetermination is a review in advance of treatment by Us to determine patient eligibility and coverage for planned services. Predetermination is not required to receive a benefit for any service under the Plan. However, it is recommended for extensive, more costly treatment such as crowns and bridges. A predetermination gives You and Your dentist an estimate of Your coverage and how much Your share of the cost will be for the treatment being considered.

To have services predetermined, You or Your dentist should submit a claim showing the planned procedures but leaving out the dates of services. Be sure to sign the predetermination request. Substantiating material such as radiographs and periodontal charting may be requested by Us to estimate benefits and coverage. We will determine benefits payable, taking into account Exclusions and Limitations including alternate treatment options based upon the provisions of the Plan. We will notify you of the estimated benefits.

When the services are performed, simply have Your dentist call Our Interactive Voice Response System at the telephone number in the Introduction section of this Certificate, or fill in the dates of service for the completed procedures on the predetermination notification and re-submit it to Us for processing. Any predetermination amount estimated is subject to continued eligibility of the patient. We may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with Your Plan in effect and remaining program Maximum dollars on the date of service.

BENEFITS

Schedule of Benefits

Your benefits are shown on the attached Schedule of Benefits. The Schedule of Benefits shows:

- the classes and groupings of dental services covered, shown with a “Plan Pays” percentage greater than “0%”.
- the percentage of the Maximum Allowable Charges the Plan will pay.
- any Waiting Periods that must be satisfied for particular services before the Plan will pay benefits. Waiting Periods are measured from date of enrollment in the Plan.
- any Deductibles You and/or Your family must pay before any benefits for Covered Services will be paid by the Plan, and the Covered Services for which there is no deductible. The Deductible is applied only to expenses for Covered Services and on either a calendar year or contract year basis (yearly period beginning with the Effective Date of the Group Policy).
- any Maximums for Covered Services for a given period of time; for example, annual for most services and lifetime for orthodontics. Annual Maximums are applied on either a calendar or contract year basis.

Your Out-of-Pocket Costs

In order to keep the Plan affordable for You and Your Group, the Plan includes certain cost-sharing features. If the class or service grouping is not covered under the Plan, the Schedule of Benefits will indicate either "not covered" or "Plan Pays -- 0%". You will be responsible to pay Your dentist the full charge for these uncovered services.

Classes or service groupings shown with "Plan Pays" percentages greater than 0% but less than 100% require you to pay a portion of the cost for the Covered Service. For example, if the Plan pays 80%, Your share or Coinsurance is 20% of the Maximum Allowable Charge. You are also responsible to pay any Deductibles, charges exceeding the Plan Maximums or charges for Covered Services performed before satisfaction of any applicable Waiting Periods.

Services

The general descriptions below explain the services on the Schedule of Benefits. The descriptions are not all-inclusive – they include only the most common dental procedures in a class or service grouping. Specific dental procedures may be shifted among groupings or classes or may not be covered depending on Your Group's choice of Plan. Check the Schedule of Benefits attached to this Certificate to see which groupings are covered ("Plan Pays percentage greater than "0%"). Also, have Your provider call Us to verify coverage of specific dental procedures or log on to *My Dental Benefits* or *My Patients' Benefits* at *www.unitedconcordia.com* to check coverage. Services covered on the Schedule of Benefits are also subject to Exclusions and Limitations. Be sure to review the Schedule of Exclusions and Limitations also attached to this Certificate.

- Exams and X-rays for diagnosis – oral evaluations, bitewings, periapical and full-mouth x-rays
- Cleanings, Fluoride Treatments, Sealants for prevention
- Palliative Treatment for relief of pain for dental emergencies
- Space Maintainers to prevent tooth movement
- Basic Restorative to treat caries (cavities, tooth decay) – amalgam and anterior composite resin fillings, stainless steel crowns, crown build-ups and posts and cores
- Endodontics to treat the dental pulp, pulp chamber and root canal – root canal treatment and retreatment, pulpotomy, pulpal therapy, apicoectomy, and apexification
- Non-surgical Periodontics for non-surgical treatment of diseases of the gums and bones supporting the teeth – periodontal scaling and root planing, periodontal maintenance
- Repairs of Crowns, Inlays, Onlays, Bridges, Dentures – repair, recementation, re-lining, re-basing and adjustment
- Simple Extractions – non-surgical removal of teeth and roots
- Surgical Periodontics for surgical treatment of the tissues supporting and surrounding the teeth (gums and bone) – gingivectomy, gingivoplasty, gingival curretage, osseous surgery, crown lengthening, bone and tissue replacement grafts
- Complex Oral Surgery for surgical treatment of the hard and soft tissues of the mouth – surgical extractions, impactions, excisions, exposure, root removal; alveoplasty and vestibuloplasty
- Anesthesia for elimination of pain during treatment – general or nitrous oxide or IV sedation
- Inlays, Onlays, Crowns when the teeth cannot be restored by fillings
- Prosthetics – fixed bridges, partial and complete dentures
- Orthodontics for treatment of poor alignment and occlusion – diagnostic x-rays, active treatment and retention for eligible dependent children

Exclusions and Limitations

Services indicated as covered on the Schedule of Benefits are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations. The existence of a Limitation on the Schedule of Exclusions and Limitations does not mean the service is covered under the Plan. Before reviewing the Limitations, You must first check the Schedule of Benefits to see which services are covered. No benefits will be provided for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations.

Payment of Benefits

If You have treatment performed by a Participating Dentist, We will pay covered benefits directly to the Participating Dentist. Both You and the dentist will be notified of benefits covered, Plan payment and any amounts You owe for Coinsurance, Deductibles, charges exceeding Maximums or charges for services not covered. Payment will be based on the Maximum Allowable Charge the treating Participating Dentist has contracted to accept.

If You receive treatment from a Non-Participating Dentist, We will send payment for covered benefits to You. You will be notified of the services covered, Plan payment and any amounts You owe for Coinsurance, Deductibles, charges exceeding Maximums or charges for services not covered. The Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the dentist any difference between the Plan's payment and the dentist's full charge for the services.

The Company does not disclose claim or eligibility records except as allowed or required by law and then in accordance with federal and state law. The Company maintains physical, electronic, and procedural safeguards to guard claims and eligibility information from unauthorized access, use, and disclosure.

Overpayments

When We make an overpayment for benefits, We have the right to recover the overpayment either from You, from the person to whom it was paid, or from the dentist to whom the payment was made on behalf of the Member. We will recover the overpayment either by requesting a refund or offsetting the amount overpaid from future claim payments. Recovery will be done in accordance with any applicable state laws or regulations.

Coordination of Benefits (COB)

If You or Your Dependents are covered by any other dental plan and receive a service covered by this Plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

    A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.
    B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.
    C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of $100 per day or less.
    D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.
    E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.
    F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.

3. In order to determine which plan is primary, this Plan will use the following rules.

   A) If the other plan does not have a provision similar to this one, then that plan will be primary.
   B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
   C) Dependent Child/Parents Not Separated or Divorced -- The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
      1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
      2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
      3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
      4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
   D) Dependent Child/Separated or Divorced Parents -- If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
      1) First, the plan of the parent with custody of the child.
      2) Then, the plan of the spouse of the parent with the custody of the child; and
      3) Finally, the plan of the parent not having custody of the child.
      4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
      5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.
   E) Active/Inactive Member
      1) For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
      2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.
   F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.
   G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

4. Right to Receive and Release Needed Information -- Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.

5. Facility of Payment -- A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Company may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan, and the Company will not pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Company.

6. Right of Recovery -- If the payment made by the Company is more than it should have paid under this COB provision, the Company may recover the excess from one or more of the following: (1) persons it has paid or for whom it has paid; or (2) insurance companies; or (3) other organization. Members are required to assist the Company to implement this section.

Workers' Compensation

When a Member is eligible for Workers' Compensation benefits through employment, the cost of dental treatment for an injury which arises out of and in the course of Member's employment is not a covered benefit under this Plan. Therefore, if the Company pays benefits which are covered by a Workers' Compensation policy, the Company has the right to obtain reimbursement for those benefits paid. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Company to receive the reimbursement.

Review of a Benefit Determination

If You are not satisfied with the Plan's benefit, please contact Our Customer Service Department at the toll-free telephone number in the Introduction section of this Certificate. If, after speaking with a Customer Service representative, You are still dissatisfied, refer to the Appeal Procedure Addendum attached to this Certificate for further steps You can take regarding Your claim.

TERMINATION -- WHEN COVERAGE ENDS

Your coverage and/or Your Dependents' coverage will end:

- on the date You lose eligibility under Your Group's eligibility requirements; or
- on the date Premium payment ceases for You and/or Your Dependents, as specified by your Group; or
- on the date Your Dependent(s) cease to meet the requirements in the definition of Dependent in the Definitions section of this Certificate;

If Your coverage or Your Dependents' coverage is terminated as described above, coverage for completion of a dental procedure requiring two or more visits on separate days will be extended for a period of 90 days after the Member's Termination Date in order for the procedure to be finished. The procedure must be started prior to the Member's Termination Date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed. For orthodontic treatment, if covered under the Plan, coverage will be extended through the end of the month of the Member's Termination Date.

If Your coverage ends, Your Dependents' coverage will end on the same date unless otherwise specified in a State Law Provisions Addendum to this Certificate. If the Group Policy is cancelled, Your coverage and Your Dependents' coverage will end on the Group Policy Termination Date.

In the event of a default in Premium payment by the Policyholder, coverage will remain in effect for the Grace Period extended for payment of the overdue Premium. If the Premium is not received by the end of the Grace Period, the Group Policy will be cancelled and coverage will terminate the first day following the end of the Grace Period.

The Company is not liable to pay any benefits for services, including those predetermined, which are performed after the Termination Date of a Member's coverage or of the Group Policy.

CONTINUATION COVERAGE

Federal law may require certain employers to offer continuation coverage to Members for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact Your employer to find out whether or not this requirement applies to You and Your employer. Your employer will advise You of Your rights to continuation coverage and the cost. If this requirement does apply, You must elect to continue coverage within 60 days from Your qualifying event or notification of rights by Your employer, whichever is later. You may elect to extend Dependent(s') coverage, or the Dependent(s) may elect to continue coverage under certain circumstances or qualifying events. Dependent(s) must elect to continue coverage within 60 days from the event or notification of rights by Your employer, whichever is later. You must pay the required premium for continuation coverage directly to your employer. The Company is not responsible for determining who is eligible for continuation coverage.

GENERAL PROVISIONS

This Certificate includes and incorporates any and all riders, endorsements, addenda, and schedules and together with the Group Policy represents the entire agreement between the parties with respect to the subject matter. The failure of any section or subsection of this Certificate shall not affect the validity, legality and enforceability of the remaining sections.

Except as otherwise herein provided, this Certificate may be amended, changed or modified only in writing and thereafter attached hereto as part of this Certificate.

The Company may assign this Certificate and its rights and obligations hereunder to any entity under common control with the Company.

This Certificate will be construed for all purposes as a legal document and will be interpreted and enforced in accordance with pertinent laws and regulations of the state indicated on the State Law Provisions Addendum.

ADDENDUM TO CERTIFICATE

APPEAL PROCEDURE

This Addendum is effective on the Effective Date stated in the Group Policy. It is attached to and made part of the Certificate.

If You are dissatisfied with Our benefit determination on a claim, You may appeal Our decision by following the steps outlined in this procedure. We will resolve Your appeal in a thorough, appropriate, and timely manner to ensure that You are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the Plan documents and consistently among claimants. You or Your authorized representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by Us required under these procedures will be supplied to You or Your authorized representative.

DEFINITIONS

The following terms when used in this document have the meanings shown below.

"Adverse benefit determination" is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational or not Dentally Necessary or appropriate.

"Authorized representative" is a person granted authority by You and the Company to act on Your behalf regarding a claim for benefit or an appeal of an adverse benefit determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

"Relevant" A document, record, or other information will be considered "**relevant**" to a given claim:

a) if it was relied on in making the benefit determination;
b) if it was submitted, considered, or generated in the course of making the benefit determination (even if the Plan did not rely on it);
c) if it demonstrated that, in making the determination, the Plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;
d) or if it is a statement of the Plan's policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

PROCEDURE

You or Your authorized representative may file an appeal with Us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed in Your Certificate of Coverage or on Your ID card.

We will review the claim and notify You of Our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

a) the specific reason for the appeal decision;
b) reference to specific plan provisions on which the decision was based;
c) a statement that You are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
d) a statement of Your right to bring a civil action under ERISA; and
e) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

PENNSYLVANIA STATE LAW PROVISIONS ADDENDUM

TO

CERTIFICATE OF INSURANCE

This addendum is effective on the Effective Date as stated in the Certificate of Insurance "Certificate" and attached to and made part of the Certificate.

The following provision is substituted for the Dependents definition in the section entitled DEFINITIONS in this Certificate:

Dependent(s*)* - Certificate Holder's spouse and any unmarried child or stepchild of a Certificate Holder or unmarried member of the Certificate Holder's household resulting from a court order or placement by an administrative agency, enrolled in the Plan:

(a) until the end of the contract year which he/she reaches age 19; or
(b) until the end of the contract year which he/she reaches age 23 if he/she is a full-time student at an accredited educational institution and chiefly reliant upon the Certificate Holder for maintenance and support; or
(c) when an enrolled full-time student's education is interrupted by military service, until the end of the period beyond the above-stated student age limit, equal to the duration of the enrolled full-time student's service of 30 or more consecutive days on active duty for any reserve component of the United States armed forces or the Pennsylvania National Guard, including State duty or until said enrollee is not longer a full-time student, whichever is sooner; or
(d) to any age if he/she is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Certificate Holder for maintenance and support.

The following provision is added to the <u>Enrollment Changes</u> sub-section of the <u>ELIGIBILITY AND ENROLLMENT</u> section of this Certificate:

Adoptive children may be enrolled up to 60 days from placement.

When an enrolled, full-time student's education is interrupted by military service as detailed in the Definition of Dependent of this Certificate, enrollment may be extended beyond the limiting age for full-time students. To qualify for the extension, the Member must submit the required Department of Military and Veterans Affairs (DMVA) forms to notify Us of placement on active duty, of completion of active duty and of re-enrollment as a full-time student for the first term or semester starting 60 or more days after release from active duty. The DMVA forms are available online at *<u>www.dmva.state.pa.us</u>*.

The restriction on enrolling new Dependents only during open enrollments when the Member fails to enroll them within 31 days of a life change event does not apply to Dependent children of a Member subject to a court or administrative order of support relating to the provision of health care coverage.

The following sub-sections are added to the section entitled HOW THE DENTAL PLAN WORKS in this Certificate:

Notice of Claim

Written notice of claim must be given to the Company within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Member to the Company, or to any authorized agent of the Company, with information sufficient to identify the Member, shall be deemed notice to the Company.

Claim Forms

The Company, upon receipt of a notice of claim, will furnish to the Member such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the Company received notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

The Company will provide claim forms to and accept claims for filing proof of loss submitted by a custodial parent of an eligible Dependent child who is the subject of a court or administrative order relating to provision of health care coverage. If services are provided by a Non-Participating Dentist, the Company will make payments directly to such custodial parent or to the Department of Public Welfare if benefits are payable under Medical Assistance.

Proof of Loss

Written proof of loss must be furnished to the Company at its said office in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Company is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

The acknowledgment by the Company of the receipt of notice given or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the Company in defense of any claim arising under such policy.

Time Payment of Claims

All benefits payable under this Policy for any loss other than loss for which this Policy provides any periodic payment will be paid no later than 30 days from receipt of due written proof of such loss. The Company may extend this 30-day period by no more than 15 days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Company. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid quarterly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims

All benefits under this policy shall be payable to the Participating Dentist or the Insured Person, or to his designated beneficiary or beneficiaries, or to his estate, except that if the Member be a minor or otherwise not competent to give a valid release, such benefits may be made payable to his custodial parent, guardian, or other person actually supporting him. All or a portion of any indemnities provided by this Policy on account of dental services may, at the option of the Company and unless the Member requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the dental office rendering such services.

Physical Examinations

The Company at its own expense shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been filed in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

The following provisions are added to the GENERAL PROVISIONS section of this Certificate:

The pertinent laws and regulations for interpretation and enforcement of the Certificate are the laws and regulations of Commonwealth of Pennsylvania.

All statements made by the Policyholder or applicant or Member shall, in the absence of fraud, be deemed representations and not warranties. No statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in a written instrument and signed by the Policyholder, a copy of which has been furnished to the Policyholder or the Certificate Holder or his/her beneficiary.

Schedule of Benefits

Concordia Flex[sm]

Group Name: Teamsters Joint Council 53
Group Number: 256916000, 256916001 Effective Date: March 1, 2008

	Plan Pays
Class I Services	
• *Exams*	**100%**
• *All X-Rays*	**100%**
• *Cleanings & Fluoride Treatments*	**100%**
• *Sealants*	**100%**
• *Palliative Treatment (Emergency)*	**100%**
Class II Services	
• *Space Maintainers*	**100%**
• *Basic Restorative (Fillings, etc.)*	**100%**
• *Endodontics*	**100%**
• *Simple Extractions*	**100%**
• *General Anesthesia*	**100%**
Class III Services	
• *Non-surgical Periodontics*	**0%**
• *Repairs of Crowns, Inlays, Onlays*	**0%**
• *Repairs of Bridges*	**0%**
• *Denture Repair*	**0%**
• *Surgical Periodontics*	**0%**
• *Complex Oral Surgery*	**0%**
• *Inlays, Onlays, Crowns*	**0%**
• *Prosthetics (Bridges, Dentures)*	**0%**
Orthodontics	
• *Diagnostic, Active, Retention Treatment*	**0%**

Deductibles & Maximums

- *$0 Deductible per Member*
- *$1,000 per Calendar Year Maximum per Member*

All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed.

Participating Dentists accept the Maximum Allowable Charge as payment in full.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

Exclusions and limitations may differ by state. Some exclusions and/or limitations may be waived depending on the Member's medical condition. Only American Dental Association procedure codes are covered.

EXCLUSIONS – The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (e.g. multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (e.g. facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

   For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

   For Group Policies issued and delivered in Maryland, this exclusion does not apply.
4. For prescription and non-prescription drugs, vitamins or dietary supplements.

   For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

   For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
6. Which are Cosmetic in nature as determined by the Company (e.g. bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

   For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

   For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
7. Elective procedures (e.g. the prophylactic extraction of third molars).
8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

   For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

   For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

   For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

   For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Certificate.

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.

    For Group Policies issued and delivered in Minnesota, this exclusion does not apply.

11. For treatment of fractures and dislocations of the jaw.

    For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

12. For treatment of malignancies or neoplasms.

13. Services and/or appliances that alter the vertical dimension (e.g. full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.

15. Preventive restorations.

16. Periodontal splinting of teeth by any method.

17. For duplicate dentures, prosthetic devices or any other duplicative device.

18. For which in the absence of insurance the Member would incur no charge.

19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.

20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

    For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.

21. For treatment and appliances for bruxism (e.g. night grinding of teeth).

22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

    For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.

23. Incomplete treatment (e.g. patient does not return to complete treatment) and temporary services (e.g. temporary restorations).

24. Procedures that are:

    - part of a service but are reported as separate services
    - reported in a treatment sequence that is not appropriate
    - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (e.g. precision attachments, copings and intentional root canal treatment).

26. Fees for broken appointments.

27. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays – one (1) every 36 month(s).
2. Bitewing x-rays – one (1) set(s) per 6 months under age fourteen (14) and one (1) set(s) per 12 months age fourteen (14) and older.
3. Oral Evaluations:
    - Comprehensive and periodic – two (2) of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
    - Limited problem focused and consultations – one (1) of these services per dentist per patient per 12 months.
    - Detailed problem focused – one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Prophylaxis – two (2) per 12 months. One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment – two (2) per 12 months under age nineteen (19).
6. Space maintainers – one (1) per three (3) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants – one (1) per tooth per 3 year(s) under age sixteen (16) on permanent first and second molars.
8. Prefabricated stainless steel crowns – one (1) per tooth per lifetime for Members under age fifteen (15).
9. Periodontal Services:
    - Full mouth debridement – one (1) per lifetime.
    - Periodontal maintenance following active periodontal therapy – two (2) per 12 months in addition to routine prophylaxis.
    - Periodontal scaling and root planing – one (1) per 24 months per area of the mouth.
    - Surgical periodontal procedures – one (1) per 24 months per area of the mouth.
    - Guided tissue regeneration – one (1) per tooth per lifetime.
10. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations – not within 12 months of previous placement.
    - Single crowns, inlays, onlays – not within 5 year(s) of previous placement.
    - Buildups and post and cores – not within 5 year(s) of previous placement.
    - Replacement of natural tooth/teeth in an arch – not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.
11. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 3 year(s) thereafter.
12. Pulpal therapy – one (1) per eligible tooth per lifetime. Eligible teeth limited to primary anterior teeth under age six (6) and primary posterior molars under age twelve (12).
13. Root canal retreatment – one (1) per tooth per lifetime.
14. Recementation – one (1) per 12 months. Recementation during the first 12 months following insertion of the crown or bridge by the same dentist is included in the crown or bridge benefit.
15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
16. Payment for orthodontic services shall cease at the end of the month after termination by the Company.

    This limitation does not apply to Group Policies issued and delivered in Maryland.

TEAMSTERS JOINT COUNCIL #53
RETIREE H&W FUND

Managed Vision Care Option 1

$35.00 COPAYMENT PROGRAM

FREQUENCY OF SERVICE: **STUDENT AGE: 25**

	Member	Spouse	Children (to age 19)
Vision Exam	24 Months	24 Months	12 Months
Lenses	24 Months	24 Months	12 Months
Frames	24 Months	24 Months	24 Months

BENEFITS:

	VBA Participating Doctor OR (13,000 Nationwide)	**Non-Participating Doctor**
	Amount Covered *(Less Co-pay)*	Amount Reimbursed *(Zero Co-pay)*
Vision Exam	100% (after $10 co-pay)	$ 30.00
Clear Standard Lenses *(Pair)*:	(after $25 co-pay)	
Single Vision	100%	$ 30.00
Bifocal	100%	40.00
Trifocal	100%	60.00
Lenticular	100%	80.00
Polycarbonate Lens Material	100%	N/A
Frame	100%	$ 40.00

Frames are covered 100% within the program's $50 wholesale allowance *(approximately $100 to $135 retail)* when obtained from a VBA Participating Provider.

Note: Only one $25 co-pay applies to lenses, frames, or frames and lenses,

- OR -

Contacts *(Includes the vision exam allowance)*:		
Selected In Lieu of Glasses	$125.00	$ 125.00
Medically Required	UCR	250.00

Note: Contact exam is included in the contact lenses allowance of $125. There is no co-pay for contact lenses and the associated exam.

To locate a participating doctor or to obtain a Vision Claim voucher, call VBA at 1-800-432-4966.