Road Carriers Local 707 Welfare Plan H

Dear Plan Participant:

Enclosed you will find a new Summary Plan Description ("SPD"). This SPD reflects the terms of the plan as of January 1, 2023.

If you have any questions, please call the Plan Office at 516-560-8500.

Thank you.

Sincerely,

The Board of Trustees

ROAD CARRIERS

LOCAL 707 WELFARE PLAN

Plan H

SUMMARY PLAN DESCRIPTION

EFFECTIVE AS OF JANUARY 1, 2023

ROAD CARRIERS LOCAL 707 WELFARE PLAN

BOARD OF TRUSTEES

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INTRODUCTION

We are pleased to provide you with this updated Summary Plan Description ("SPD") describing the benefits available to you and your dependents under the Road Carriers Local 707 Welfare Fund's plan of benefits ("Plan"). This SPD includes all changes to the Plan through 1/1/2023 It replaces and supersedes all previous SPDs that you may have received in the past. Please be sure that this book matches the Plan in which you are enrolled. Because the Plan benefits you and your family, we urge you to read this SPD carefully and share it with your family so that you will understand the Plan, the eligibility rules and the procedures for filing claims.

The Road Carriers Local 707 Welfare Fund ("Fund"), which holds the assets of the Plan, is a self-insured, jointly administered labor-management trust, established pursuant to the Taft-Hartley Act and the Employee Retirement Income Security Act ("ERISA"). The Board of Trustees, half of which are designated by employer representatives and half by Local 707, serves as Plan Administrator.

Changing economic conditions require constant assessment of the Plan to maintain its financial stability. Our goal is to continue providing cost effective coverage that contributes to the security, health and wellbeing of you and your Dependents. The Board of Trustees specifically reserve the right to modify, eliminate, or add benefits for participants and their dependents. Nothing in this SPD or elsewhere should be construed to mean that the Plan's benefits are guaranteed. We will, of course, notify you when we make significant changes in the rules, regulations or the schedule of benefits.

Only the Board of Trustees is authorized to interpret the rules and regulations set forth herein. No representative of any employer or union has authority to speak on behalf of the Board of Trustees, nor can any person act as an agent for the Trustees with respect to questions of Plan interpretation. The Trustees have the exclusive power to determine whether the conditions for payment of benefits have been met and the benefits payable on a claim. The Trustees also have the discretionary authority to determine eligibility for benefits and to construe and interpret the terms of the Plan.

You are encouraged to contact the Plan Office with any questions you may have concerning the Plan or its administration. Plan Office personnel will help you understand the rules of the Plan and will refer you to pertinent provisions in this SPD. Matters that require interpretations will be referred to the Board of Trustees.

Sincerely,

Board of Trustees

GRANDFATHERED HEALTH PLAN

The Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

EXTENSION OF CERTAIN DEADLINES DUE TO THE COVID-19 NATIONAL EMERGENCY

Effective March 1, 2021, the Plan was amended to disregard certain deadlines due to the COVID-19 outbreak, consistent with guidance issued by the Employee Benefits Security Administration. The Plan will continue to disregard the deadlines until 60 days after the federal government announces the end of the COVID-19 National Emergency.

The extension applies to the following deadlines:

- Special Enrollment Dates
- Date to elect COBRA Continuation Coverage
- Date to pay COBRA Premiums
- Date to Notify the Plan of a Qualifying Event that Would Trigger a Beneficiary's Loss of Coverage
- Date to File a Benefit Claim
- Date to File an Appeal of a Claim Denial

For example, you are ordinarily required to elect COBRA continuation coverage within 60 days of your loss of Plan coverage. The Plan will extend this deadline. Your election of COBRA coverage will be valid if made no later than 60 days after the federal government announces the end of the COVID-19 National Emergency. We will advise when the government announces the end of the COVID-19 National Emergency.

TABLE OF CONTENTS

PART A.

PART A. QUESTIONS & ANSWERS

PLAN ADMINISTRATION

1. Who contributes to the Plan?
Employers under collective bargaining agreements with Local Union No. 707, I.B.T. (the "Union") or participation agreements with the Board of Trustees contribute to the Plan for employees covered by those agreements. In some cases, employees also contribute to the cost of coverage under the Plan.

2. How are the Plan funds managed?
The Trustees of the Plan hold all the Plan funds in trust for the Participants in the Plan and their Dependents. The Trustees have the ultimate responsibility for the management of Plan funds.

3. Who is responsible for interpreting the Plan and for making determinations under the Plan?
The Trustees are responsible for interpreting the Plan and making all determinations under the Plan. In order to carry out their responsibility, the Trustees, or their designee, shall have the sole discretion and exclusive authority to determine whether an individual is eligible for any benefits under the Plan, determine the amount of benefits (if any) an individual is entitled to from the Plan, interpret all of the provisions of this SPD, and interpret all of the terms used in this SPD.

All such determinations and interpretations made by the Trustees or their designee shall be final and binding upon any individual claiming benefits under the Plan, be given deference in all courts of law to the greatest extent allowed by applicable law, and not be overturned or set aside by any court of law unless found to be arbitrary and capricious.

4. May I pledge the claim money owed to me for the purposes of obtaining a loan?
Plan Participants and their Dependents may not assign or transfer any of their benefits under the Plan. Any attempted assignment is null and void and will not be recognized. The Plan's Trustees, in their sole and absolute discretion, may decide to pay benefits due to a Participant or Dependent from the Fund directly to a healthcare provider. When this happens, it is done solely for the Participant's or Dependent's convenience. Nothing in this SPD obligates the Fund to pay any benefits directly to any healthcare provider or alters the Fund's prohibition on assigning rights and benefits under the Plan. Nor does the payment of benefits directly to a healthcare provider constitute an acceptance of any assignment.

5. If the Plan is discontinued, what will happen to the assets of the Plan?
The assets of the Plan must be used only for the benefits of Plan Participants and their Dependents. If the Plan ends, Plan assets will be applied to provide benefits in accordance with the applicable provisions of Federal Law. Under no circumstances may money, which has been properly contributed to the Plan, ever be returned to any employer or to the Union.

COVERAGE AND ELIGIBILITY

6. Who is eligible to participate in the Plan?

An "Eligible Employee" is an individual who is employed by an employer that contributes to the Plan and meets the eligibility requirements to become covered by the Plan set forth in Question 7. In addition, certain Dependents of an Eligible Employee may be eligible for coverage under the Plan. See Questions 22 through 24 for more detailed information regarding Dependent eligibility and participation in the Plan.

7. How do I become covered by the Plan?

Eligibility under the Plan is determined using a monthly method, a quarterly method or such other method as is provided for in a collective bargaining agreement between your employer and the Union or a participation agreement between your employer and the Trustees. Please contact the Plan Office to determine the eligibility method applicable for you and your Employer.

Under the monthly eligibility method, Eligible Employees who have contributions made to the Plan on their behalf by a contributing employer for a calendar month are eligible for coverage for the second calendar month following their first day of work. For example, under the monthly method, if a contributing employer makes contributions to the Plan on your behalf for January, you will be eligible for Plan coverage for the month of March.

Under the quarterly eligibility method, Eligible Employees who complete fifty-two 8-hour days, or 416 hours, of covered employment with a contributing Employer during the three consecutive months (the "Eligibility Quarter") ending one month before June 1, September 1, December 1, or March 1 (the "Quarterly Determination Date") are eligible for coverage from the Plan for the four-month period that commences on the next Quarterly Determination Date (the "Coverage Period").

For initial eligibility only, any participant under the quarterly eligibility who is credited with 416 contribution hours in any consecutive three-month work period shall become eligible for benefits on the first day of the second month after the month in which contributions were made for the participant's 416th contribution hour. Ongoing eligibility shall be determined by the existing quarterly eligibility formula.

The following summarizes coverage eligibility and termination:

Eligibility Quarter (52 8-hour days, or 416 hours, must be worked during these months)	Quarterly Determination Date	Coverage Period (covered months for benefits)
Feb., March, April	June 1st	June, July, Aug., Sept.
May, June, July	Sept. 1st	Sept., Oct., Nov., Dec.
Aug., Sept., Oct.	Dec. 1st	Dec., Jan., Feb., March
Nov., Dec., Jan.	March 1st	March, April, May, June

Under either eligibility method, you will be credited for days as an Eligible Employee only after your employer has submitted the required report and contributions. Timely processing of your benefits claims is dependent upon your employer's making its required contribution to the Plan. No claim for benefits will be processed if your Employer is delinquent in making its required contribution. Once your employer has made the payments required under the terms of its collective bargaining agreement or participation agreement, your claims will be processed.

Under the terms of the collective bargaining or participation agreement with your employer, you may be required to make an election to enroll in the Plan. At the time you enroll, you must also enroll your Dependents if you want them to be covered by the Plan. You cannot enroll your Dependents in the Plan unless you are also enrolled in the Plan. Please contact the Plan Office for details. Enrollment is effective as of the first day on which you are eligible for coverage under the Plan, as described above.

If you are not required to elect to enroll in the Plan, your enrollment in the Plan is automatic once you satisfy the requirements for eligibility.

8. Are there other times to enroll in the Plan?

If you were not required to enroll in the Plan when you first became eligible and chose not to enroll in the Plan at that time, you may elect to enroll yourself and your Dependents during any subsequent open enrollment period of the Plan, as long as you are still an Eligible Employee. If you are already enrolled (automatically or by election), but your Dependents are not, you may elect to enroll your Dependents during any subsequent open enrollment period. The Plan's open enrollment period begins on November 15th and continues to December 31st of each year, for medical coverage starting on February 1st. However, if the collective bargaining or participation agreement with your Employer specifies a different open enrollment period, then you may elect to enroll yourself and your Dependents during the period indicated in that agreement. Ask the Plan Office about the open enrollment period, if any, which applies to you.

If you decline enrollment in the Plan for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage because (1) the other coverage was COBRA continuation coverage which was exhausted, or (2) there has been a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or (3) the employer stops contributing toward your or your Dependents' other coverage. You must request this enrollment within 30 days after you or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in this Plan, effective as of the date of such event. In the case of a birth or adoption of a child, your spouse may also enroll at this time. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Office.

You and your Dependents, if eligible for, but not covered under the Plan, are also permitted to enroll in the Plan upon:

- losing eligibility for coverage under Medicaid or a state Children's Health Insurance Program ("CHIP") or
- becoming eligible for premium assistance under Medicaid or CHIP.

You or your Dependents must request coverage under this Plan within 60 days of being terminated from Medicaid or CHIP coverage as a result of loss of eligibility, or within 60 days of being determined to be eligible for premium assistance.

You can call this toll-free number: 1-800-698-4KIDS (1-800-698-4543), to find out about Child Health Plus and Children's Medicaid in New York State (TTY number: 1-877-898-5849).

Special Exception for Employees of New Employers

Eligible Employees who (1) become Participants in the Plan due to a change in jurisdiction or (2) whose coverage is transferred by their employer from another plan and who were eligible for full welfare plan benefits in the other jurisdiction or under the Employer's plan on the date of change or transfer shall become eligible for full benefits from the Plan on the date that their eligibility in the other jurisdiction or coverage under the other plan terminates.

An Eligible Employee who was not yet eligible for benefits in the other jurisdiction or under an employer's plan on the date of transfer shall become eligible for benefits from the Plan in accordance with the applicable initial eligibility rule above. However, days worked for the employer prior to the date of transfer shall be added to days worked in the jurisdiction of the Plan to meet the one-day threshold under the monthly eligibility method or the 52-day threshold under the quarterly eligibility method.

9. What is "covered employment"?
Covered employment means work for which your employer is required to contribute to the Plan because of its collective bargaining agreement or because it has a special agreement with the Board of Trustees.

10. Does self-employment count as covered employment?
No. Under no circumstances will you receive any credit, for any purpose, under the Plan for work in self-employment.

11. Can my employer (or I) contribute to the Plan even though not required to do so under a collective bargaining agreement or participation agreement?
No. Unless your participation is provided for in a written agreement between your Employer and the Union or between your Employer and the Trustees no credit can be given to you (even if you or your Employer contributes to the Plan) for any work you do.

12. When will my coverage end?
Termination of coverage may be provided for in your Employer's collective bargaining agreement or participation agreement. If so, the terms of the agreement will determine when your coverage ends.

If your coverage is subject to the monthly eligibility method, coverage under this Plan terminates at the end of the second calendar month following the month in which you last worked. For example, if you work at all in January, but not in February, you are covered under the Plan for all of March, but not April.

If you are under the quarterly eligibility method, coverage under this Plan terminates at the end of the first month of a Coverage Period if you work less than fifty-two 8-hour days, or 416 hours, during the prior Eligibility Quarter. For example, a covered Participant who worked a total of less than fifty-two 8-hour days, or 416 hours, during the employment months of February, March and April would not be covered after June 30th.

There is an exception to this termination rule for Participants who become disabled. See Question 17 for an explanation of the special disability rules. There is also an exception to this termination rule for Participants who are entitled to severance benefits that provide for a continuation of health coverage under an applicable collective bargaining agreement. See Question 13 for an explanation of the special severance rule.

Your coverage may also end on the date you engage in fraud or intentional misrepresentation of a material fact with regard to your coverage or benefits under the Plan or when your Employer ceases to participate in the Plan.

13. Can I continue coverage if I am entitled to severance benefits that provide for a continuation of health coverage under the terms of my collective bargaining agreement?
If you are entitled to severance benefits that provide for a continuation of health coverage under the terms of your collective bargaining agreement and your employer makes contributions to the Plan to pay for the continuation of health coverage, your Medical, Dental, and Vision benefits under the Plan will continue for the number of months provided by the terms of the collective bargaining agreement. Your right to COBRA continuation coverage will begin after the continuation of your Medical, Dental, and Vision benefits pursuant to the severance benefit under the collective bargaining agreement ends.

14.What happens to my coverage if I take a leave of absence from work under the Family and Medical Leave Act (FMLA)?
If eligible, you may take up to 12 weeks (or in some cases involving military personnel up to 26 weeks) of family and medical leave in a 12-month period under the FMLA as permitted by your Employer to: care for a child following his or her birth, adoption, or placement for adoption or foster care; care for a seriously ill child, parent or spouse; or recover from your own serious illness. You may also be eligible to take a leave of absence during a military "qualifying exigency" related to the fact that an active duty family member has been called in support of a "contingency operation;" or to care for a family member who is a seriously injured service member.

Coverage under the Plan will not terminate while you are on FMLA leave, provided that you apply and are approved for FMLA leave by your employer. If FMLA leave is approved, your employer must remit the required contributions to the Plan during your FMLA leave. For purposes of Continuation Coverage under COBRA, a reduction in hours caused by FMLA leave is not a qualifying event that gives rise to a COBRA right because such leave does not result in a loss of coverage.

If you are on leave beyond the allowed period under the FMLA, coverage under the Plan will not be immediately reinstated upon your return to work. Instead, you will be treated as a new employee for purposes of determining eligibility for coverage or benefits and must satisfy the Plan's eligibility requirements.

15. What happens to my coverage if I must take a leave of absence to serve in the military?
If you terminate Covered Employment due to Military Service for the time period allowed by the Uniformed Services Employment and Reemployment Rights Act ("USERRA") and you are reemployed by a participating employer when you return, you will immediately resume coverage under the Plan as if you never left.

If you terminate Covered Employment due to Military Service beyond the period allowed under USERRA and are reemployed by a participating employer, you will not immediately resume coverage under the Plan. You will be treated as a new employee for purposes of determining eligibility for coverage or benefits, and you must satisfy the Plan's eligibility requirements again.

Under USERRA, when an active employee leaves employment for full-time Military Service for more than 31 days, that employee and his/her eligible Dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under applicable law. This coverage lasts for up to 24 months beginning on the date of the employee's absence from employment. However, the coverage will terminate before the end of the 24-month period if the employee entering military service fails to pay the monthly premiums, is dishonorably discharged, is court-marshaled, participates in undesirable conduct during Military Service, or is discharged before the end of the 24-month period and fails to make a timely application for reemployment.

In addition to the Military Service continuation coverage described in this Section, active employees who are called to duty also are entitled to COBRA Continuation Coverage. The COBRA and Military Service continuation coverages run concurrently, and an employee (and his/her Dependents) are entitled to whichever coverage provides the longer period of continuation coverage.

To elect Military Service continuation coverage, contact the Plan office as soon as you are notified of your military obligation to obtain the necessary enrollment information for you and your Dependents.

16. Does the Plan provide coverage when I am a retiree?
No, this plan does not provide retiree medical coverage.

DISABILITY CREDIT

17. Can I continue coverage if I become disabled?

If you become disabled and receive disability benefits under one of the following:

- workers' compensation,
- Weekly Accident and Sickness Benefits from the Plan,
- the disability plan of your Employer who is participating in the Plan, or
- if you would have been eligible for Weekly Accident and Sickness Benefits from the Plan if coverage had not been provided under the provision of a no-fault automobile coverage,

you will continue to have working days credited towards your eligibility for coverage provided that:

- your disability lasts 29 days or longer, and
- you were continuously covered by the Plan through *active work in covered employment* during the four Coverage Periods prior to the quarter in which you were disabled (if the quarterly eligibility method applies to your Employer), or during the 12 months prior to the month in which you were disabled (if the monthly eligibility method applies for your Employer).

If the quarterly eligibility method applies for your Employer, you will receive 6.40 hours per day of disability up to 32 hours per week credit for each week of disability. For disabilities not related to workers' compensation, the maximum allowable credit is 26 weeks. For disabilities related to workers' compensation, the maximum allowable credit is 18 months in a five-year period. If you have already met the quarterly working requirement for coverage in the quarter in which you were disabled, your disability credit will be applied to the next Coverage Period.

If the monthly eligibility method applies to your Employer, you will receive credit for one working month for each month during which you are disabled during all or a portion of such month. The maximum allowable credit is six months, to cover up to 26 weeks of disability. If you have already met the monthly working requirement for coverage in a month in which you were disabled, you will not receive additional credit for that month but the month will not count against the six month limit.

If your disability is due to an accident on the job or to an occupational disease for which you are receiving workers' compensation benefits, you will continue to be covered for full benefits up to 18 months from the date of the onset of your disability, or until the date of your recovery, whichever is sooner. You will not be eligible for more than 18 months of such coverage in any five-year period, as calculated from the date of the onset of the first disability for which you received coverage under this section.

In addition, there is a special provision for Life Insurance coverage in the Plan for Totally Disabled Participants. Life Insurance will be continued for up to two years for a fully covered Participant who incurs a Total Disability, subject to the requirements stated above.

REINSTATEMENT OF COVERAGE

18. How will my coverage be reinstated once it has stopped?

In general, you will need to satisfy the eligibility requirements as discussed in the Coverage and Eligibility section. However, your coverage may be reinstated when you return from military leave as described in question number 15 above.

WELFARE BENEFITS AND MEDICARE

19. What happens if I am also eligible for Medicare?

If you are actively employed and eligible for benefits from the Plan, the Plan (not Medicare) will continue to be responsible for your hospital, medical, and surgical claims until you or your spouse reach age 65. Thus, even when you become eligible for Medicare, your benefit coverage under the Plan will be continued and the Plan will be your primary insurer as long as you remain a Participant under the terms of the Plan. In many cases, Medicare will pay the portion of the bill the Plan does not cover. Consequently, you and your eligible spouse should first submit your claims to the Plan Office and then to Medicare.

PENSIONERS

20. Are pensioners covered under the plan?

Pensioners are covered only until their active participant coverage runs out, as follows:

(a) If the quarterly eligibility method applies for your Employer and you were covered by the Plan during the Eligibility Quarter in which your retirement effective date occurred, you will continue to be covered by the Plan as an active Participant until the last day of the Coverage Period following the Eligibility Quarter in which your retirement effective date occurred, provided you met the requirements to qualify for eligibility in that Quarter.

(b) If the monthly eligibility method applies for your Employer and you were covered by the Plan during the month in which your retirement effective date occurred, you will continue to be covered by the Plan as an active Participant until the end of the second calendar month following the month in which your retirement effective date occurred.

DEPENDENTS

21. Are my Dependents eligible for coverage under this Plan?

Yes. Dependents of Participants generally are eligible for coverage under the Plan. A detailed explanation of who is an eligible Dependent is provided in the Definitions section.

22. What benefits does my Dependent receive?

In general, your Dependent will be covered for the same benefits as you except for the Life Insurance Benefit, Accidental Death and Dismemberment Benefit, and the Weekly Accident and Sickness Benefit.

23. When does coverage for my Dependent end?

Your Dependent's coverage will end on the earliest of the following:

- the date your coverage terminates;
- the date your Dependent no longer qualifies as a Dependent, as defined by the Plan;

- the date a change in the Plan terminates your Dependent's coverage;
- the date you or your Dependent engages in fraud or intentional misrepresentation of a material fact with regard to his/her coverage or benefits under the Plan; or
- in the case of a spouse, the last day of the month in which divorce is finalized.

Eligibility for benefits for each Dependent will be determined by the Trustees. The Trustees shall be the sole judge of the standards of proof required in any case and shall have the full and exclusive power and authority, in their sole discretion, to determine all questions of coverage and eligibility for benefits.

KEEP THE PLAN OFFICE INFORMED OF ADDRESS CHANGES

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

PART B.

DESCRIPTION OF BENEFITS IN THE PLAN

When reviewing the benefits provided under the Plan, please note that each benefit in the Plan may have different conditions and maximum amounts associated with the particular benefit.

SCHEDULE OF PLAN BENEFITS

The following is a summary of the benefits provided by the Plan.

The payment of benefits from the Plan is subject to the conditions and exclusions of the Plan as set forth in this SPD.

Please refer to the specific provisions of the SPD for details regarding a particular benefit.

Please note that the term "Allowed Amount" is defined differently for In-Network and Out-of-Network benefits. To find out how the Plan defines the "Allowed Amounts" for each, go to the paragraph "Medical Benefits" below or the definitions at page 44.

Type of Benefit		
Medical Benefits	**In-Network Coverage**	**Out-of-Network Coverage**
Hospital	80% of Anthem's Allowed Amount Covers up to a maximum of 25 days per plan year.	70% of Anthem's Allowed Amount
Emergency Room	$100 copayment then 100% of Anthem's Allowed Amount if the visit was due to an Emergency as defined herein	$100 copayment then 100% of Anthem's Allowed Amount if the visit was due to an Emergency as defined herein
Office Visits	$20 copayment then 80% of Anthem's Allowed Amount	$600 deductible individual, $1,200 family; 70% of Anthem's Allowed Amount
Rehabilitation Services-Outpatient Therapies	$20 copayment then 100% of Anthem's Allowed Amount (maximum limits on visits may apply)	$600 deductible individual, $1,200 family; 70% of Anthem's Allowed Amount (maximum limits on visits may apply)
Specialists	$20 copayment then 80% of Anthem's Allowed Amount (maximum limits on visits may apply)	$600 deductible individual, $1,200 family; 70% of Anthem's Allowed Amount (maximum limits on visits may apply)
Inpatient & Ambulatory Surgery (including physician's fees)	80% of Anthem's Allowed Amount; Precertification is required for nonemergency surgery.	$600 deductible individual, $1,200 family; 70% of Anthem's Allowed Amount; Precertification is required for nonemergency surgery.
Preventative Care (e.g., well visit, immunization, lab, colonoscopy, etc.)	100% of Anthem's Allowed Amount	$600 deductible individual, $1,200 family; 70% of Anthem's Allowed Amount

Lab/X-Ray (non-preventative)	$15 copayment than 80% of Anthem's Allowed Amount	$600 deductible individual, $1,200 family; 70% of Anthem's Allowed Amount
MRI/CAT Scan/PET Scan	$25 copayment then 80% of Anthem's Allowed Amount; Precertification is required	$600 deductible individual, $1,200 family; 70% of Anthem's Allowed Amount; Precertification is required
Ambulance Services	80% of In-Network or Out-of-Network Anthem's Allowed Amount.	
Prescription Drugs Purchased at Pharmacy (30 Day Supply) (only covered In-Network) (may be subject to limitations; Precertification is required for certain drugs; Specialty drugs may only be obtained through OptumRx)	Generic $10 Copayment	
	Brand Preferred (no generic available) $25 copayment	
	Brand Non-Preferred (generic available) $50 plus price spread. Specialty Drugs are limited to one prescription per plan year.	
Prescription drugs purchased through mail order pharmacy (90 day supply) (may be subject to step therapy or quantity limitations; Precertification is required for certain drugs)	Generic $20 Copayment	
	Brand Preferred and Specialty (no generic available) $50	
	Brand Non-Preferred (generic available) $100 plus price spread. Specialty Drugs are limited to one prescription per plan year per individual	
	Semaglutide medications are excluded from the Plan for any off-label use, such as weight loss. Certain factors must be met to obtain medications in this classification.	
Maximum Out of Pocket expense for medical (excluding deductible)	In Network: $2,000 individual; $4,000 family	
	Out-of-Network: $2,500 individual; $5,000 family	
Dental Benefits	$50 deductible individual/ $100 family per plan year/plan schedule. Panel dentists accept schedule in full. Out of Network: charges covered up to scheduled amount for covered services on Appendix A	
	Orthodontics lifetime maximum of $2,500 per eligible dependent child	
Vision Benefits	In-Network: exam, frame, one pair single, standard, bifocal or trifocal lens, 100% from provider selection every two years.	
	Out-of-Network: examination $15; eyeglasses (frames and/or lenses) $50; contact lenses $75; maximum benefit of $75 every two years.	
Life Insurance, Accidental Death and Dismemberment Insurance	$10,000	

If you have questions about your benefits, contact the Plan Office. You may also visit our website at www.roadcarriers707.com.

MEDICAL BENEFITS

The Plan provides comprehensive Medical Benefits that cover most Hospital, surgical, and medical expenses. In order to be covered, the medical expenses must be deemed Medically Necessary. The determination of coverage is at the sole discretion of the Trustees. For In-Network claims, the Allowed Amount is based on the provisions of that provider's network payment agreement. You pay your copayment, if applicable. For Out-of-Network claims, the Allowed Amount is based on Anthem's Allowed Amount. You pay your deductible and coinsurance and any amount above the Allowed Amount. For further details regarding coverage, refer below to the applicable SPD sections, or you may call the Plan Office for further information regarding coverage. The maximum out-of-pocket expense for in-network medical coverage is $2,000 per individual and $4,000 per family per Plan Year. The maximum out-of-pocket expense for out-of-network medical coverage is $2,500 individual: and $5,000 family (excluding any applicable deductible) per Plan Year.

IN-NETWORK PROVIDERS (PPO PROGRAM)

A network of physicians and medical service providers is available through the Plan's PPO network and other direct provider arrangements so that you have access to experienced and qualified family doctors, specialists, surgeons, laboratories, x-ray and other medical service providers. It is the sole responsibility of the PPO network to ensure that all physicians and other providers participating in the network are properly credentialed.

When you use an In-Network provider for covered services that require a copayment, there are no other out-of-pocket expenses for the covered services. When you use an In-Network provider for covered services that do not require a copayment, you must pay 20% of the Allowed Amount. There are limitations to certain coverage such as dermatology, physical therapy, podiatry, and chiropractic services. In addition, certain other services may require pre-certification as discussed herein.

If your In-Network provider leaves the Plan's PPO Network, you may continue to receive care from the provider under the same in-network terms and conditions for up to 90 days after the provider leaves the network if you are a "Continuing Care Patient".

A Continuing Care Patient is an individual who is: (1) receiving a course of treatment from the provider for a "serious and complex condition," defined as an acute illness requiring specialized treatment to avoid the reasonable possibility of serious harm or in the case of a chronic illness or condition, that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time, and which requires treatment over a prolonged period of time; (2) scheduled to undergo non-elective surgery (including any post-operative care) from the provider; (3) pregnant and being treated by the provider for the pregnancy; or (4) terminally ill and receiving treatment from the provider for the illness.

The procedure for the use of the Plan's PPO network is as follows: You may locate a provider by calling one of the Plan's PPO administrators listed in the back of this SPD. The PPO

network provides you with a choice of doctors near your home or work. You may then make an appointment with the doctor that you have selected.

It is recommended that you choose a family Primary Care Physician ("PCP") who will provide routine care and can recommend you to any network specialist or surgeon.

- You do not need a claim form when using an In-Network provider. Just show the doctor's office your Plan identification card.

- You will be responsible for the copayment and/or 20% coinsurance associated with your visit or treatment.

NOTE: To obtain assistance with finding and obtaining treatment from an appropriate, accredited mental health facility or substance abuse provider, please call the Plan's Mental Health and Substance Abuse Administrator, Teamsters Center Services (TCS). TCS's phone number is listed in the back of this booklet.

OUT-OF-NETWORK PROVIDERS

When you receive Out-of-Network care, you must pay the first $200 of covered expenses for yourself and each Dependent until you reach the family deductible of $400. Once the deductible is met, the Plan pays 70% of the Anthem Allowed Amount for covered medical expenses. You only need to meet the deductible once in a Plan Year even though you may have several different injuries or diseases. If you have covered charges during the last three months of a Plan Year (June, July, August) that are applied to the deductible for that Plan Year, and the deductible is not yet met, these charges will carry over and apply toward meeting the deductible for the next Plan Year.

OTHER TREATMENT ALTERNATIVES

In certain circumstances, the use of an alternative treatment may be approved by the Trustees, in their sole discretion, to provide cost-effective benefits other than those specifically provided in this SPD, as recommended by the Plan's Medical or Hospital Case Management Organizations or Medical Consultant and agreed to by the patient and/or treating physician.

COVERED SERVICES

The Plan provides benefits for Medically Necessary Covered Services for treatment of bodily injury or sickness. Benefits are subject to the deductibles, copayments, and coinsurance set forth in this SPD. Unless otherwise noted, for In-Network providers, a copayment and/or coinsurance applies for all covered expenses. For Out-of-Network providers, the Plan covers 70% of the Anthem Allowed Amount after you pay a deductible of $200 per individual or $400 per family. Covered Services include the following: ALLERGY AND CLINICAL IMMUNOLOGY;

ANESTHESIA EXPENSES – In-Network anesthesia claims are paid at 80% of the Allowed Amount (no copayment is required). Out-of-Network anesthesia claims of $2,000 or less are paid at the amount that would have been allowed if the claims were for In-Network services. The Plan will pay 70% of the Anthem Allowed Amount for Out-of-Network claims for covered anesthesia services that exceed $2,000, subject to the deductible. Participants should be aware that the selection of an anesthesiologist generally is at the discretion of the medical facility providing the service and that many anesthesiologists do not choose to participate in the PPO network. Therefore, it is likely that anesthesia expenses will be classified as an Out-of-Network claim;

ACUPUNCTURE **-** The Plan will cover up to six visits per year for medically necessary services that are rendered by a licensed provider within the scope of their profession;

ANNUAL PHYSICAL DIAGNOSTIC SCREENING & EXAM – Participants are covered for one physical exam per year (In-Network paid at 100% of Allowed Amount; Out-of-Network, subject to deductible and coinsurance);

CENTRAL NERVOUS SYSTEM ASSESSMENTS/TESTS**;**

CHEMOTHERAPY ADMINISTRATION**;**

CHIROPRACTIC TREATMENT – In addition to the normal coinsurance and deductibles, the maximum annual benefit for chiropractic treatment is limited to 24 treatments per Plan Year, including x-rays. Diagnostic tests other than x-rays are not covered. There are no chiropractic benefits for Dependents under age 12;

DERMATOLOGICAL PROCEDURES –Dermatological procedures are limited to $500.00 per Plan Year (cosmetic procedures are not covered). The Plan year annual limit for participants who have been diagnosed with skin cancer shall be $1,500.00.

DIAGNOSTIC SERVICES **–**The following preventative and diagnostic procedures are *not* subject to coinsurance: routine infant/child check up; general medical exam; gynecological exam/ special screening for malignant neoplasm; comprehensive metabolic panel; lipid panel; urinalysis; complete blood count; immunization administration; immunizations; hearing test; screening test for visual acuity; preventative examination (annual exam); mammography screening; blood, occult, for colorectal neoplasm screening; PSA screening, pap smear, electrocardiogram, chest, x-ray; sigmoidoscopy, and colonoscopy; All other diagnostic services are subject to In-Network or Out-of-Network coinsurances;

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC ORTHOTIC SUPPLIES (DMEPOS) – The purchase or rental of DMEPOS In-Network is paid at 80% of the Allowed Amount. Out-of-Network benefits are payable at the Anthem Allowed Amount and are subject to coinsurance and deductibles. Coverage for orthotic devices for the feet is limited to two pairs per lifetime. This benefit requires precertification prior to receiving services;

HEARING AIDS – – Benefits are provided for In-Network purchase of one hearing aid every 60 months; The Plan pays $400 per standard aid or up to $800 per programmable aid, for a maximum of one hearing aid total per 60 months.

HEMODIALYSIS FOR KIDNEY FAILURE – Benefits are provided for hemodialysis or peritoneal dialysis while a registered bed patient in a Hospital. Benefits are also provided for outpatient dialysis as follows:

- At home – The Plan pays the Allowed Amount of all appropriate Medically Necessary supplies required for home dialysis treatment, as well as the reasonable rental cost of the required equipment.
- At a Hospital or free-standing facility – The Plan pays the Allowed Amount of Medically Necessary treatment if the facility's dialysis program is approved by the appropriate governmental authorities.

This benefit is available for the first 30 months only. Thereafter, Medicare will be the primary and coverage under the Plan will be secondary. Benefits are subject to the normal copayments, deductibles and coinsurance;

IMAGING;

MRIs, CAT scans and PET scans. These scans require precertification through the Plan's Medical Management provider.

IMMUNIZATIONS AND INJECTIONS;

MAMMOGRAMS – The Plan covers one "routine" In-Network mammogram per year for women age 40 and older without copayments or coinsurance. Non-routine mammograms, In and Out-of-Network, are subject to copayments, deductibles and coinsurance; Digital mammograms are a covered service subject to plan limitations.

NEUROLOGY AND NEUROMUSCULAR SERVICES AND SUPPLIES;

NON-INVASIVE VASCULAR DIAGNOSTIC STUDIES;

OPHTHALMOLOGICAL SERVICES AND SUPPLIES;

OTORHINOLARYNGOLOGICAL SERVICES AND SUPPLIES**;**

PAIN MANAGEMENT **–** The Plan covers up to 3 treatments without prior approval. Additional treatments must be pre-certified by the Plan's Medical Consultant or Medical Case Management Organization. Contact information for the Medical Consultant and Medical Case Management Organization is found at the back of this SPD;

PODIATRY – Benefits for podiatry services are limited to 24 visits per Plan Year. Podiatry benefits are subject to copayments, coinsurance, and deductibles;

PROFESSIONAL FEES, OFFICE VISITS, HOSPITAL VISITS, HOME VISITS;

PULMONARY SERVICES AND SUPPLIES;

THERAPEUTIC OR DIAGNOSTIC INFUSIONS- in-home infusion therapy for prescribed medical treatment requiring intravenous application must be pre--certified by the Plan's Medical Case Management Organization; and

X-RAYS.

HOSPITAL EXPENSES

PRE-CERTIFICATION

Hospital admissions and services must be pre-certified with the Plan's Medical Case Management Organization (listed in the back of this SPD) prior to incurring any Hospital expenses except in cases of emergency. If you do not pre-certify with the Medical Case Management Organization prior to admission, you will be responsible for 50% of covered expenses up to a maximum of $2,500. Emergency admission requires certification with the Medical Case Management Organization within 72 hours of admission or, if later, the first business day following admission.

Pre-certification may be required for certain other expenses as specifically provided in this SPD. For example, precertification is required for organ transplants, gastric procedures, and mammoplasty. Please refer to the specific provisions of the SPD for details regarding these expenses.

COVERED EXPENSES

The following expenses are covered during a period of hospitalization:

- general nursing care;
- use of extensive or special care facilities;
- x-ray examinations including CAT scans, but not dental x-rays;
- use of operating room and related facilities;
- magnetic resonance imaging;
- drugs, medications, biologicals;
- cardiography/encephalography;
- laboratory testing and services;
- casts and dressings;
- pre- and post-operative care;
- special tests;
- nuclear medicine;
- physical and rehabilitation therapy;
- oxygen and oxygen therapy;

- anesthesia and anesthesia services;
- administration and processing of whole blood, blood plasma and blood derivatives;
- intravenous injections and solutions (in -home infusion therapy is covered for prescribed medical treatment requiring intravenous application), subject to pre-certification by the Plan's Medical Case Management Organization or Medical Consultant;
- surgical, medical and obstetrical services provided by the participating Hospital;
- special duty nursing when certified as Medically Necessary by the participating specialist Physician in concurrence with your or your Dependent's Primary Care Physician ("PCP") and approved and coordinated in advance by the Plan's Medical Case Management Organization; and
- reasonable ambulance services.

A visit to a Hospital clinic is treated as a basic medical expense, not a Hospital expense, and is subject to a $50 copay.

The Plan covers up to a maximum of 25 days of Hospitalization per plan year.

EMERGENCY ROOM CARE

After the applicable copay, the Plan will cover Hospital services and supplies when you are not admitted as a bed patient but receive care in a Hospital's emergency room or operating room. An Emergency is an illness, medical condition or injury that arises with symptoms of sufficient severity that a reasonably prudent person would believe that absence of emergency medical evaluation or treatment could seriously jeopardize his/her life or health or his/her ability to regain maximum function.

A $100 copay applies for each covered emergency room treatment, if you are not admitted as a bed patient. If you are admitted, you will not have to pay the $100 copay.

Charges made by an emergency room physician or any other licensed health care professional while you are in the Hospital or emergency room are covered under the major medical portion of your plan and the full amount of Medically Necessary and reasonable charges are reimbursable at 100%.

In order for emergency room care to be covered, the following conditions must be met:

- there must be a sudden, unexpected onset of a serious illness or medical condition, or an accidental injury occurs; and
- immediate medical care must be necessary to prevent what a prudent layperson possessing an average knowledge of health and medicine could reasonably expect would put the patient's health in serious jeopardy, absent immediate care.

ORGAN TRANSPLANTS

The Plan will cover organ transplants that have been approved as safe and effective by the U.S. Food and Drug Administration ("FDA") and the National Institutes of Health ("NIH") for

specific diseases and which the Plan's Medical Case Management Organization deems Medically Necessary and not experimental. The Plan will cover 80% of the Allowed Amount In-Network and 70% of Allowed Amount Out-of-Network for medical and Hospital services and related organ acquisition costs for approved organ transplants. All transplants must be ordered by the PCP and participating specialist Physician and pre-certified by the Plan's Medical Case Management Organization in advance of the surgery. If you do not pre-certify with the Medical Case Management Organization prior to the start of transplant services, you will be responsible for 50% of covered expenses up to a maximum of $2,500. The following may also be covered if related to the transplant:

- blood products, except when participation in a volunteer blood replacement program is available to the Participant or Dependent;
- ambulance services;
- tests (laboratory, x-ray, etc.) necessary to confirm a diagnosis prior to Hospital admission, if obtained in a licensed Hospital up to two weeks prior to admission before elective surgery; and
- surgery charges, if the transplant is performed in a licensed Hospital or outpatient surgical center.

Copayments, deductibles, and coinsurance apply to these expenses.

The Plan provides access to an organ transplant network of facilities that provide organ transplant services in a cost-effective manner. You may pay less for transplant services if you use this network. Please contact the Plan Office for information regarding the organ transplant network.

GASTRIC WEIGHT LOSS PROCEDURES

Gastric procedures must be approved by the Plan's Medical Case Management Organization and Medical Consultant in accordance with the following NIH guidelines: Patients seeking therapy for severe obesity from the Plan for the first time will be considered for treatment in a nonsurgical program integrating components of a dietary regimen, appropriate exercise, and behavioral modification and support. Gastric restrictive or bypass procedures may be considered for well-informed and motivated patients with acceptable operative risks. Candidates for surgical procedures shall be selected carefully and only after evaluation by a multidisciplinary team with medical, surgical, psychiatric, and nutritional expertise. The operation must be performed by a surgeon substantially experienced with the appropriate procedures and in a clinical setting with adequate support for all aspects of management and assessment. The normal copays, deductibles, and coinsurance apply to these procedures.

Gastric procedures for weight loss must be pre-certified by the Plan's Medical Case Management Organization and Medical Consultant. If you do not pre-certify with the Medical Case Management Organization, you will be responsible for 50% of covered expenses up to a maximum of $2,500.

Copayments, deductibles, and coinsurance apply to these procedures.

MASTECTOMY/MAMMOPLASTY

The Plan covers Medically Necessary mastectomy and the following medical services in connection with the mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses; and
- treatment of physical complications in all stages of mastectomy, including lymphedema.

In addition, the Plan will cover reduction or enhancement mammoplasty that the has been pre-certified by the Plan's Medical Case Management Organization as Medically Necessary. If you do not pre-certify with the Medical Case Management Organization prior to undergoing breast reduction or enhancement, you will be responsible for 50% of covered expenses up to a maximum of $2,500. Copayments, deductibles, and coinsurance apply to these expenses.

GENETIC TESTING

All Genetic testing must be approved in advance by the Plan's Medical Consultant.

SKILLED NURSING

Treatment at a Skilled Nursing Facility is covered at 80% of the Anthem Allowed Amount for an In-Network facility or 70% of the Anthem Allowed Amount for an Out-of-Network facility when Medically Necessary and prescribed by a Physician for patients who have been Hospitalized in acute inpatient status. Skilled nursing benefits must be pre-certified by contacting the Medical Case Management Organization. If you do not pre-certify with the Medical Case Management Organization prior to the start of services, you will be responsible for 50% of covered expenses up to a maximum of $2,500. Skilled nursing benefits are limited to 60 days per Plan Year.

HOME AND HOSPICE CARE

Occasionally, necessary services can be arranged in a home or hospice, rather than a Hospital. These include, but are not limited to: nursing care, rehabilitation services, intravenous antibiotics, monitors, pain management, oxygen, and psychiatric, and substance abuse treatments. These services will only be covered if they are pre-certified through the Plan's Medical Case Management Organization before they begin. Failure to pre-certify will result in you being responsible for 50% of covered expenses up to a maximum of $2,500. Copayments, deductibles, and coinsurance apply to services provided in home or in a hospice, except as otherwise stated in this SPD.

HOME CARE BENEFITS IN LIEU OF HOSPITALIZATION

Home care benefits are available under a Physician-approved plan of treatment when the necessary services are rendered through a state licensed Home Health Agency. Benefits will be provided only if hospitalization or confinement in a Skilled Nursing Facility would otherwise have been required.

When care through an In-Network provider begins within seven days of discharge from a Hospital, the Plan will pay 80% of the In-Network Maximum Allowed Amount for up to 100 home care visits per Plan Year. When care through an Out-of-Network provider begins within seven days of discharge from a hospital, the Plan will pay 70% of the Anthem Maximum Allowed Amount after the deductible is met. for up to 100 home care visits per Plan Year. When care is rendered without prior hospitalization or through a non-certified agency (a non-certified agency is one that is not certified by the state or by Medicare), a $150 deductible must be met, and then the Plan will pay 70% of the Anthem Maximum Allowed Amount, up to a maximum of 40 home care visits per Plan Year. In no event will coverage be provided for more than 100 visits in any Plan Year.

Covered services include:

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

When home care begins within seven days following discharge from a Hospital, these additional services are covered following discharge:

- medical social worker visits;
- x-ray and EKG services; and
- ambulance or ambulette to the Hospital.

HOSPICE CARE

In each lifetime, Plan Participants and Dependents have coverage for up to 210 days of inpatient hospice care in a hospice or Hospital, as well as home care and outpatient services provided by the hospice as described below if:

- The patient has been certified by his primary attending physician as having a life expectancy of six months or less; and
- The hospice care is provided by a hospice organization certified by the state in which the hospice organization is located.

Covered hospice and outpatient services include the following:

- bed patient care either in a designated hospice unit or in a Hospital;
- day care services provided by the hospice organization;
- home care and outpatient services which may include the following;
- intermittent care by a RN, LPN, or home health aide;
- physical therapy;
- speech therapy;
- occupational therapy;
- respiratory therapy;
- social services;
- nutritional services;
- laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of systems;
- medical supplies;
- drugs and medications prescribed by a physician and which are considered approved under the U.S. Pharmacopoeia and/or National Formulary (not covered when the drug or medication is experimental in nature);
- medical care provided by the hospice physician;
- a total of five visits for bereavement counseling are available at any time for the family members of the patient;
- durable medical equipment; and
- transportation between home or Hospital and hospice organization when Medically Necessary.

When hospice care is provided by an In-Network hospice facility or Hospital, benefits will be provided at 80% of the Allowed Amount. When the facility that provides hospice care is Out-of-Network, coverage is limited to 70% of the facility's charges for services, but in no event will payment to such a facility exceed 70% of the Anthem Allowed Amount.

SURGICAL EXPENSES

Inpatient and Ambulatory Surgical expenses are covered at 80% of the Allowed Amount for In-Network treatment. Out-of-Network surgical expenses are covered at 70% of the Anthem Allowed Amount and are subject to the Plan's deductible of $600 per individual or $1,200 per family.

PRE-CERTIFICATION

Coverage for inpatient surgical expenses requires pre-certification by the Plan's Medical Case Management Organization (listed in the back of this SPD) prior to admission for surgery. If you do not pre-certify with the Plan's Medical Case Management Organization prior to admission, you will be responsible for 50% of covered expenses up to a maximum of $2,500.

Pre-certification is also required for certain other expenses as specifically provided in this SPD. For example, pre-certification is required for organ transplants, gastric procedures, and

mammoplasty. Please refer to the specific provisions of the SPD for details regarding these expenses.

MANDATORY SECOND MEDICAL OPINION PROGRAM FOR NON-EMERGENCY SURGERY- INPATIENT AND AMBULATORY SERVICES

Coverage for the non-emergency surgery and ambulatory services listed below requires pre-certification with the Plan's Medical Case Management Organization prior to admission for surgery. Prior to scheduling your surgery, please call the Plan's Medical Case Management Organization listed in the back of this booklet for pre-certification.

The surgical procedures for which you must obtain a second opinion are as follows:

Back Surgery	Disc surgery, including injection therapy
Eye Surgery	Eyelid surgery; Blepharoplasty
Lipectomy	Removal of fatty tissue
Nose Surgery	Rhinoplasty
Scar Revision	All surgeries
Vein Surgery	Sclerotherotherapy; agent injections

For further information please contact the Fund Office

REHABILITATION SERVICES

The Plan covers inpatient and outpatient rehabilitation services as follows:

INPATIENT TREATMENT

The Plan will cover up to 30 days in a rehabilitation facility accredited by the Joint Commission on Accreditation of Health Care Organizations. The patient must notify the Plan prior to transfer to any rehabilitation facility. The attending Physician must send a letter of Medical Necessity and a written treatment plan in order to obtain prior approval from the Plan's Medical Case Management Organization or Medical Consultant. This benefit is available only for Participants and Dependents who have initially been hospitalized and would be transferred from an acute Hospital to a recognized approved rehabilitation Hospital, or alternative care setting approved by the Medical Consultant or Medical Case Manager. Coverage includes speech therapy, physical therapy, occupational therapy, cardiac rehabilitation, pulmonary rehabilitation, and cognitive therapy.

OUTPATIENT TREATMENT

The Plan will cover charges incurred for outpatient rehabilitation treatment, subject to the limitations below. Except as set forth below, a $15 copayment applies to In-Network covered services. For Out-of-Network services, the Plan covers 70% of the Allowed Amount after you satisfy the deductible of $200 per individual or $400 per family.

SPEECH THERAPY. The Plan will provide benefits for speech therapy for the following purposes:

- Restore speech function lost through injury or illness - two years maximum treatment limitation;
- Correct the maldevelopment of proper speech patterns in a child - maximum 30 treatments per Plan Year. **This benefit is only available after benefits provided by a government program are exhausted;** or
- Correct impairment due to a congenital defect for which corrective surgery has been performed.

PHYSICAL/OCCUPATIONAL THERAPY. The benefit is limited to 24 visits per Plan Year per patient per injury. If you receive therapy for an injury and then suffer another injury (whether related or not related to the original injury) during the Plan Year, the combined number of visits covered by the Plan for both the original injury and the subsequent injury will be limited to 24 visits, unless the subsequent injury occurs at least 60 days after your complete recovery from the initial injury. Physical therapy claims involving multiple modalities (or treatments) are covered at 100% of the In-Network or Out-of-Network Allowed Amounts, subject to applicable copayments.

CARDIAC REHABILITATION. The Plan will cover cardiac rehabilitation services if the services are prescribed by a Physician to restore a maximum level of recovery, and the patient:

- recently had a myocardial infarction (heart attack), coronary artery bypass graft surgery (CABG), coronary angioplasty or coronary stent insertion; or
- has a history of debilitating angina pectoris, or symptomatic left ventricular dysfunction, which has failed to respond to standard medical or surgical treatment.

The Plan will initially cover one month of cardiac rehabilitation, after which the Plan's Medical Consultant will assess the Medical Necessity for an additional month of cardiac rehabilitation. The Plan's Medical Consultant will evaluate approval requests beyond two months prior to the end of the two-month treatment period.

MATERNITY

Maternity benefits are provided for expenses incurred in a Hospital for all females covered by the Plan, except children born of Dependent children under the Plan. Regular hospitalization benefits will be provided for Hospital stays involving any pregnancy-related condition, whether or not pregnancy is terminated.

In accordance with Federal law, the Plan does not restrict benefits for any covered Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law,

require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Plan will cover charges by a certified nurse-midwife working under the direction of a Physician in conjunction with an approved Hospital or other approved facility. Benefits are paid on the same basis as if services were performed by a Physician. Charges for an In-Network midwife are not subject to the Plan's deductible.

Benefits are available from birth for newborn children for:

- routine nursery care during the mother's covered Hospital stay;
- the treatment of illness or injury;
- nursery care in an approved premature unit for an infant weighing less than 5.5 pounds;
- incubator care, regardless of the infant's weight; or
- circumcision other than ritual circumcision.

PRESCRIPTION DRUG PROGRAM

RETAIL PHARMACY PROGRAM

The Plan covers the costs of prescription drugs, subject to a copayment. Generic prescription drugs are subject to a $10 copayment. Brand-name prescription drugs that have no generic equivalent are subject to $25 copayment. Brand-name prescription drugs that have a generic equivalent are subject to $50 copayment plus the price spread. Drugs must be obtained through an In-Network pharmacy. To find out which pharmacies are In-Network, please contact Allegiant RX at the number in the back of this SPD or visit www.myallegiantrx.com.

Certain narcotic painkillers require precertification for quantities in excess of specified limits.

The maximum quantity of prescription drugs filled at a retail pharmacy is 30 days.

MAIL-ORDER PROGRAM

In addition to the above coverage, the Plan offers a prescription maintenance drug plan that covers prescriptions used by you on a steady year-round basis for up to a 90 day supply. This maintenance program applies to the management of disease and illnesses or any other physical or mental conditions, which would require constant regular medication. The program utilizes a mandatory generic drug substitution and a copayment of two times the retail pharmacy copay. Not all prescriptions may be provided through the program. Generic prescription mail order drugs are subject to a $20 copayment for a 90 day supply. Mail order brand name prescription drugs that have no generic equivalent are subject to a $50 copayment for a 90 day supply. Mail order brand name prescription drugs that have a generic equivalent are subject to an $100 copayment plus the price spread for a 90 day supply.

The Mail Order program is administered by the Plan's Prescription Drug Mail Order Administrator, Allegiant RX. You can call the Allegiant RX at the number given in the back of this SPD to request forms and information or call the Plan Office at 516-560-8500. The

benefits under this program are limited only to those maintenance drugs available through the Plan's Prescription Drug Mail Order Administrator.

SPECIALTY DRUG PROGRAM

Specialty or injectable drugs must be obtained exclusively through our Specialty Pharmacy, Optum Specialty Pharmacy 855-427-4682 (some limited distribution drugs may be not available through Optum Specialty Pharmacy and are excluded from this requirement).

NOTE:
Specialty Drugs are limited to one prescription per plan year per individual.

Certain drugs require preauthorization:

- Narcotic painkillers require preauthorization for quantities in excess of specified limits; and
- Compound drugs costing $250 or more.
- Semaglutide medications are excluded from the Plan for any off-label use, such as weight loss. Certain factors must be met to obtain medications in this classification.

To obtain preauthorization for these drugs the prescribing healthcare professional must contact our Pharmacy Benefit Manager

Certain drugs are subject to limits:

- Drugs prescribed for Erectile Dysfunction may be subject to limits; and
- Smoking cessation drugs are limited to 180 days of medication in a lifetime.

PRESCRIPTION DRUG ABUSE

If the Trustees determine, in their sole discretion, that you are abusing your prescription drug benefits, the Trustees reserve the right to take any actions they deem necessary to end such abuse, including but not limited to the following:

- discontinuing your prescription drug card, thereby requiring you to submit any prescription drug benefits directly to the Plan office for reimbursement; and
- terminating your prescription drug benefits in the Plan.

MENTAL HEALTH AND SUBSTANCE ABUSE COVERAGE (MH/SA)

The Plan provides benefits for mental health and substance abuse treatments to Participants and Dependents. You may obtain information concerning the programs and the facilities in which this coverage is offered by calling the Plan's Mental Health/Substance Abuse ("MH/SA") Administrator, Teamsters Center Services, at the phone number listed in the back of this SPD.

INPATIENT BENEFITS

The Plan will pay 80% of the Allowed Amount for MH/SA inpatient treatment in an accredited non-governmental general Hospital, non-governmental Psychiatric Hospital, or state licensed chemical dependency treatment facility. All inpatient care, other than an emergency admission, must be pre-certified by the Plan's MH/SA Administrator. In cases of emergency admissions, you or someone acting on your behalf must contact the Plan's MH/SA Administrator for certification no later than 72 hours after the admission, or, if later, the first business day after the admission. If you fail to pre-certify a nonemergency admission to an inpatient facility, you will be responsible for 50% of covered expenses up to a maximum of $2,500.

OUTPATIENT BENEFITS

Claims for Out-of-Network providers who agree to accept the In-Network Allowed Amount as full payment will be subject to copayment only. The charges will not be subject to the deductible normally applicable to Out-of-Network claims.

Outpatient benefits are otherwise provided in accordance with the following schedule:

	In-Network	***Out-of-Network***
Outpatient Care	100% of Allowed Amount; subject to $20 copayments	70% of Anthem Allowed Amount; subject to $600 single/$1,200 family deductible per Plan Year.

*No copayment is required for attendance at group session appointments.

MEDICAL BENEFIT EXCLUSIONS

The following medical expenses are not covered under the Plan's Medical Benefits:

- all charges not specifically listed as covered expenses;
- charges for services performed on or to the teeth, gingival or alveolar processes, except to tumors or cysts or except as required because of accidental injury to natural teeth occurring while covered hereunder;
- charges for eye refractions, eyeglasses, or the fittings thereof, except as provided for under the Vision Care Program;
- services by an Optometrist;
- charges for transportation, except local ambulance service, or as permitted under the Hospital Expenses section;
- expenses incurred as a donor in a transplant procedure, unless the recipient of the transplant is a Participant or Dependent in the Plan (in the event that a Participant or

Dependent is the transplant recipient, coverage will be provided under this Plan for a live donor to the extent benefits are unavailable from any other source);

- except as provided in the Hospital Expenses section, all experimental organ transplants and procedures and services associated with the preparation of such transplants;
- expenses in excess of the Allowed Amount;
- expenses for weight reduction programs or surgical operations or procedures for treatment of obesity, including but not limited to gastric procedures or balloon procedures, unless Medically Necessary as determined by the Plan's Hospital Case Management Organization or Medical Consultant in accordance with NIH guidelines;
- private duty or special nursing care, except as specifically provided in this SPD;
- reversal of voluntary sterilization;
- transsexual surgery or services;
- in-vitro fertilization procedures and related services;
- infertility procedures, services and supplies, including injectables;
- immunizations obtained for the sole purpose of travel or immunizations required as conditions of employment;
- breast reduction surgery, unless deemed Medically Necessary or reconstruction after surgery;
- orthopedic shoes or arch supports;
- convenience items, such as canes, commodes, etc.;
- charges for prescription drugs that the Trustees determine are being abused; and
- any other exclusions listed in General Exclusions.

Determinations regarding the denial of benefits are at the sole discretion of the Trustees.

DENTAL BENEFITS

The Plan provides comprehensive Dental Benefits that permit you to choose the dentist of your choice.

If you choose to use one of the many dentists who have agreed to accept the allowances of the Plan as payment in-full for their services, you will receive all covered benefits subject only to any Plan limits. The participating dentists are located throughout the covered area, so that you may select one close to your home. A list of participating dentists is on file with the Plan's Dental Plan Administrator, DDS, Inc. Contact information for the Dental Plan Administrator is listed in the back of this SPD.

You may choose to use a non-participating dentist. Non-participating dentists may charge more than the amount stated in the Plan's Schedule of Dental Benefits listed on Appendix A.
If the non-participating dentist charges the amount stated in Appendix A, you will continue to be covered for 100% of the charges for the full program of Dental Benefits, subject to any Plan limits. If the non-participating dentist charges more than that amount, you will be responsible for paying the additional amount.

COVERED EXPENSES

Benefits for both In-network and Out-of-Network Dental coverage is as follows:

Deductible	No Deductible
Basic Services	Exams, cleanings, fluoride treatments and perio scalings are covered once every six months; perio scaling and prophylaxis may not be provided on the same day; sealants and fluoride treatments are limited to dependents up to age 26.
Crowns/Bridges	Maximum of six units in each three-year period; stainless steel crowns are limited to dependents up to age 12 and for primary teeth only; no coverage for bridges where there are two or more missing teeth on both sides of the same arch; coverage includes crowns and bridges on dental implants. Please note that there is a waiting period (four consecutive eligibility quarters) prior to being covered for crown and bridge work. Maximum allowance of $400 for each crown over implants.
Dentures	Payable once every five years
Orthodontia	See below
Periodontal	$1,100 maximum per 12 month period
Dental Implants	$100 towards the actual dental implant

No payment will be made until the required dental claim forms have been completed by the attending dentist and approved by the Plan.

ORTHODONTIA

A Dependent child is eligible for orthodontia coverage if bands are inserted prior to his or her 19th birthday, provided the Participant remains eligible for Plan coverage during the course of treatment. Orthodontia benefits will be paid in accordance with the following schedule:

- Diagnosis & Appliance Insertion $500
- Active Monthly Treatments (up to a maximum of 23 months) $87
- Orthodontic lifetime maximum per Dependent $2,500

Allowances of a maximum of $87 are made monthly, dependent on the severity of the malocclusion. If you are not eligible for benefits in any month, you will be responsible for that payment.

NOTE: Only a select group of participating dentists will accept the Plan's maximum allowance as payment in full. The Participant is responsible for all expenses beyond the Plan's maximum allowance. All orthodontia claims must be radiographically evident and must be accompanied by x-rays.

PRE-CERTIFICATION

Pre-certification is required for all dental treatments exceeding $300 for a 12-month period and all prosthetics, crowns, periodontics and inlays. A treatment plan and all necessary x-rays must be submitted to the Plan's Dental Administrator when you or your dentist requests pre-certification. The Plan will pay only for the cost of the treatment approved by the Dental Administrator. If you choose a different course of treatment, you will not receive benefits in excess of those that would have been paid for the approved course of treatment. If there is a difference between the cost of the approved treatment and the treatment you select, you must pay the difference in cost yourself.

EXCLUSIONS

The following are excluded from coverage under the Dental Benefit:

- restoration with crown or bridges that are cosmetic or splints for periodontal treatment;
- free end or cantilever fixed bridges;
- TMJ, except as provided under the Medical Benefit and for occlusal guards and adjustments;
- any other general exclusion listed under General Exclusions.

VISION BENEFITS

The Plan participates in the Davis Vision network. You may use a Davis Vision provider or a Provider of your choice for your Vision Benefits. Your out-of-pocket expenses will differ depending on your choice. To set up an appointment with a Davis Vision provider, call Davis Vision at 800-999-5431.

COVERED EXPENSES

If you choose to receive services from a provider that is not part of the Davis Vision network, you must pay the provider directly, and submit the completed claim form and paid receipt to Davis Vision for reimbursement. Out-of-Network benefits are limited to $75 per individual. The Plan will provide the following vision benefits:

Benefit	***In-Network***	***Out-of-Network Reimbursement***
Eye Examination	100%	$15
Eyeglasses (frames and/or lenses)	100% for basic (see below for other options)	$50
Contact lenses (exclusive of an examination)	100% for basic (see below for other options)	$75
Vision Training	See below	See below

In-Network Providers will provide the following annual services at no cost to you:

- a comprehensive eye examination;
- a frame from the Provider's selection of basic frames;
- one pair of single vision, standard (or blended) bifocal or trifocal lenses, in your choice of either plastic or glass, in any prescription;
- solid, gradient or sun-tinted plastic lenses; glass, grey #3 prescription sunglass lenses; and
- post-cataract (lenticular) lenses.

With an additional copay, the following may be selected at an In-Network Provider:

Polycarbonate lenses	$30.00
Single vision scratch protection plan	$20.00
Multifocal scratch protection plan	$40.00
Ultraviolet (UV) coating	$12.00
Intermediate-vision lenses	$30.00
Glass photochromic lenses	$20.00
Standard ARC (anti-reflective coating)	$35.00
Premium ARC coating	$48.00
Ultra ARC coating	$60.00
Polarized lenses	$75.00
Plastic photosensitive lenses	$65.00
High index (thinner and lighter) lenses	$55.00
Standard progressive addition multifocal lenses	$50.00
Premium progressive addition multifocal lenses	$90.00
Ultra progressive addition multifocal lenses	$140.00

Selection	***Additional Copay***
One pair of standard, soft, daily-wear contact lenses (which are available for most prescriptions) in lieu of receiving eyeglasses. A care kit and all necessary visits for proper lens fitting will be provided	$25
Vision Training	See Below

VISION TRAINING

Vision training must be pre-certified by the Plan's Medical Consultant. In order to request precertification, the provider must submit a written treatment plan including diagnosis, estimated number of visits, significant clinical findings and symptomatology. The Plan will not provide benefits for vision training that is not pre-certified.

If approved, payment will be made subject to the following limitations:

Maximum reimbursement for initial work-up	$35
Maximum reimbursement for training sessions	$25
Maximum number of sessions per occurrence	10 sessions
Lifetime maximum for vision training period	$285

Providers are not obligated to accept these fees as payment in full. Reimbursement will be made to the Participant only. Participants are responsible for expenses not covered under the Plan.

CLAIMS

Services rendered by an optometrist must be submitted to the Plan's Vision Care Administrator, Davis Vision, as listed in the back of this SPD. This includes charges for comprehensive eye examinations, eyeglasses and contacts. (Claims for services rendered by an Ophthalmologist must be submitted through the Plan's PPO Provider listed in the back of this SPD.)

EXCLUSIONS

The following are NOT covered under the Plan's Vision Benefits:

- vision training without prior approval by the Plan's Medical Consultant;
- any other exclusion listed in the General Exclusions section; and
- services by an Ophthalmologist (benefits may be available for these services through the Plan's medical coverage)

LIFE INSURANCE

If you die while you are an eligible Participant in the Plan, your named beneficiaries will receive a Life Insurance Benefit of $10,000. The benefit is payable in the event of your death from any cause, on the job or off, while you are insured.

EXCLUSIONS

The Life Insurance Benefit is subject to the exclusions listed under the General Exclusions section.

BENEFICIARY

You may designate anyone you wish as your beneficiary and you may change your designated beneficiary at any time by filling out the proper enrollment card available at the Fund Office. If, at the time of your death, there is no designated beneficiary on file, or if the designated beneficiary does not survive you, the insurance will be paid to your surviving relatives in the following order: spouse, children, parents, or to the executors or administrators of your estate.

CONVERSION PRIVILEGE FEATURE

If your Life Insurance Benefit terminates, you may convert it to an individual policy of life insurance within 31 days of the date of termination without medical examination. The coverage amount of such policy shall not exceed the amount provided under the Plan. You may choose any type of individual policy then being written by the Plan's Life Insurance Administrator listed in the back of this SPD. The premium cost to you will be based upon your class of risk and your age at the time of conversion.

If you die within 31 days of the date your Life Insurance Benefit terminates, your Life Insurance Benefit will be paid as though you were still insured under the Plan.

IN THE EVENT OF PERMANENT AND TOTAL DISABILITY

If you become Totally Disabled while insured for the Life Insurance Benefit and before age 60, your Life Insurance Benefit will remain in force for a period of up to two years, provided you remain Totally Disabled and proof of disability is furnished as required. Notice of your claim must be given to the Fund Office within 12 months from the date you cease active work due to your disability. The first proof of disability must be filed with the Fund Office within three months after your total disability has lasted nine months. Subsequent proof of disability must be furnished each year thereafter.

CLAIMS

In order to file a claim for Life Insurance Benefits, an official copy of the death certificate or proof of Total Disability must be submitted to the Fund Office.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

If you are an eligible Participant in the Plan, you or your named beneficiaries will receive an Accidental Death and Dismemberment Benefit (AD&D) in the event of a covered accidental death or bodily injury in the amount of $10,000.

The AD&D Benefit provided to you under the Plan is underwritten by the Plan's Accidental Death and Dismemberment Administrator listed in the back of this SPD.

COVERED LOSSES

You or your named beneficiaries are entitled to an AD&D Benefit if you have a loss that: (a) is caused by an accidental injury; (b) is the result of an injury, directly and independently of all other causes; or (c) occurs within ninety days after the injury.

You or your named beneficiary will be entitled to the full amount of the AD&D benefit if the loss is one of the following:

- Life;
- Both hands or both feet
- Sight of both eyes; or
- Any combination of two or more of the following
    - One foot,
    - One hand, or
    - Sight of one eye.

You will be entitled to half the full benefit if the loss is one of the following:

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

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means total loss that cannot be recovered.

EXCLUSIONS

No AD&D benefits will be paid for losses from or caused directly or indirectly by:

- bacterial infection (except phylogenic infections resulting solely from injury);
- medical or surgical treatment (except medical or surgical treatment made necessary solely by injury); or
- injury sustained while engaged in or taking part in aeronautics and/ or aviation of any description or resulting from being in an aircraft except while a fare-paying passenger in an aircraft licensed to carry passengers.

In addition, AD&D benefits are subject to the exclusions listed under the General Exclusions section.

BENEFICIARY

You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out the proper enrollment card available at the Plan Office. If, at the time of your death, there is no designated beneficiary, or if the designated beneficiary does not survive you, the insurance will be paid to your surviving relatives, in the following order: spouse, children, parents, or to the executors or administrators of your estate.

CLAIMS

In order to file a claim for Accidental Death Benefits, an official copy of the death certificate and proof of the accident must be submitted to the Plan Office. In order to file a claim for Dismemberment Benefits, proof of the loss must be submitted to the Plan Office.

GENERAL EXCLUSIONS

The Plan does provide benefits for the following:

- Expenses for care that is not Medically Necessary;
- Expenses that are not specifically listed in the SPD as covered expenses;
- Expenses that exceed any Plan limit or maximum;
- Expenses incurred during confinement in a Hospital or facility owned or operated by a federal, state or local government, unless there is a legal obligation to pay charges without regard to the existence of any health coverage;
- Charges for injuries, illness, or losses resulting from war or an act of war, declared or undeclared or participation in a felony, riot or insurrection;
- Charges for injuries, illness, or losses resulting from accidental bodily injury arising out of and in the course of the individual's employment, except as provided for under the Subrogation of Benefits section in this SPD;
- Charges for injuries, illness, or losses that are compensable under any workers' compensation law, occupational disease law, or similar legislation, except as provided for under Subrogation of Benefits;
- Charges for plastic or cosmetic surgery (including, but not limited to, ear piercing, rhinoplasty, gynecomastia and reduction mammoplasty) and surgery or treatment relating to the consequences as a result of plastic surgery, except as specifically provided in this SPD;
- Expenses or losses which are the result of self-inflicted injuries, except as a result of a medical condition (including mental health conditions);
- Charges for any loss or portion thereof, for which mandatory automobile no-fault benefits are covered or recoverable;
- Charges for which a third party would otherwise be liable, except as provided for under Subrogation of Benefits;
- Charges for experimental treatments, services, drugs, supplies or procedures. A treatment, service, drug, supply or procedure is experimental if it is determined to be:
    - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or
    - not approved by the U.S. Food and Drug Administration (the "FDA") or other appropriate regulatory agency to be lawfully marketed for the proposed use; or
    - the subject of review or approval by an Institutional Review Board for the proposed use; or
    - the subject of an ongoing phase I, II or III research trial; or
    - a drug, treatment, service, supply or procedure for which reliable evidence indicates that the prevailing opinion amount experts is that further study or clinical trials are needed to compare it with standard means of treatment;

- Charges for benefits for which Medicare or Medicaid is the primary payor (the Plan will provide benefits as a secondary payor only for eligible participants under the age of 65);
- Charges for the provision of blood, blood plasma, blood derivative, or the cost of receiving the service of professional blood donors (only administration and processing of blood is covered when participation in a volunteer blood replacement program is available to the Member);
- Charges for durable medical equipment and supplies, except as specifically provided in this SPD;
- Expenses for personal convenience items or services such as: telephones, barber services, guest meals, radio and television rentals, and other like items and services;
- Expenses for any type of care which is primarily provided to attend to daily living activities that do not entail or require attention of trained medical personnel;
- Confinements for custodial or convalescent care, rest cures, or long-term care;
- Hospital confinements or any period of Hospital Confinement primarily for diagnostic studies;
- Services performed at veteran's facilities for care in connection with a military service related illness or injury;
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available;
- Expenses for any type of care where the primary purpose of the total care provided is to attend to daily living activities that do not entail or require attention of trained medical personnel;
- Drugs and medicine, except as specifically provided in this SPD;
- Special medical reports not directly related to treatment of the Participant (e.g., employment or school physicals);
- Payment for services that are eligible for payment under the provisions of an automobile insurance contract, or pursuant to any federal or state law that mandates indemnification for such service to persons suffering bodily injury from motor vehicle accidents, where permitted by state law;
- Payment for services for an illness or injury to which a contributing cause was the Participant's commission of or attempt to commit a felony, or to which a contributing cause was the Participant's being engaged in an illegal occupation;
- Costs related to any court appearance, proceeding or hearing or to any court ordered treatment;
- Speech, physical, occupational or rehabilitation therapies, except as specifically provided in this SPD;
- Orthoptics (a technique of eye exercises designed to correct the visual axes or eyes not properly coordinated for binocular vision), except as specifically provided in this SPD;
- Claims submitted more than 12 months from the date the cost was incurred;
- Long-term physical, occupational, or speech therapy;
- Cosmetics, dietary supplements, food supplements, health or beauty aids regardless of physician authorization; and
- Over-the-counter medication.

PART C.
DEFINITIONS

Allowed Amount – The charge that is used to calculate payment of your benefits. The Allowed Amount depends on the type of health care provider that furnishes a covered service to you.

For BlueCard PPO providers that have a network payment agreement with the local BlueCross and/or BlueShield plan, the Allowed Amount is based on the provisions of that provider's network payment agreement. You pay your copayment and/or coinsurance if it applies.

For all Out-of-Network providers that do not have a payment agreement with the local BlueCross and/or BlueShield Plan, the allowed amount for services other than services covered by the No Surprises Act is based on Anthem's allowed amount of 150% of the National Medicare Fee Schedule. For services not reflected on the National Medicare Fee Schedule the allowed amount will be determined under an applicable schedule. You pay the deductible and coinsurance and any amount above the Allowed Amount.

For No Surprises Act services, the Maximum Allowed Amount is the "Qualifying Payment Amount" ("QPA"), as defined under regulations to the No Surprises Act, and is based on the median of the in-network rates payable for the same or similar service in the same geographic region, adjusted for inflation.

Child – The natural child of the Participant or the Participant's spouse; a child legally adopted by the Participant (from the time the Participant assumes the legal duty to support the child, irrespective of whether the adoption is final); or a child for whom the Participant has been declared the legal guardian by a court.

Coinsurance – A portion of covered benefits required to be paid by a Participant or Dependent in connection with benefits set forth in this Plan.

Copayment – An amount required to be paid by a Participant or Dependent in connection with benefits set forth in this Plan.

Dependent – Any person in a Participant's family who is the Participant's: lawful spouse; Child from birth up to the last day of the month in which the Child attains age 26.

In order for an individual to be considered the Participant's "spouse," the Participant and spouse must have been legally married under the laws of the state in which their marriage was entered into and the participant and spouse must continue to be married during the period for which coverage is provided. The Plan does not cover a Participant's domestic partner. Marriage between a Participant and his or her spouse ends on the date that a judgment of divorce is signed. Coverage will terminate for the spouse at the end of the month in which the divorce occurred. The Participant is responsible for notifying the Plan of the divorce. Until you are divorced, your spouse remains covered under the Plan's terms. A subsequent marriage is invalid if you have not divorced. **Failure to notify the Plan that a former spouse is no longer**

eligible for benefits will be considered an act of fraud upon the Plan and the Participant will be responsible for any claims that the Plan pays for the former spouse.

Aside from you and your Dependents, no one else is entitled to benefits from the Plan. If you submit claims or you allow someone to submit claims for a person who is not entitled to benefits, you will be responsible to repay the Plan for any benefits provided for that person and any other losses the Plan sustains.

Diagnostic Services – All diagnostic services are covered, including laboratory and x-ray services, laboratory specimen collecting, EKGs, and radiation/chemotherapy. MRIs, CAT scans and PET scans require preauthorization with Med-Care at 1-800-367-1934.

Durable Medical Equipment and Prosthetic Orthotic Supplies (DMEPOS) -
Therapeutic apparatuses that are used in the treatment of medical illness or injury or support that treatment. "Durable Medical Equipment" includes items that withstand repeated use, are generally reusable, and serve a specific medical purpose. They generally are not useful to a person in the absence of illness or injury and are appropriate for use in the home. Please call the Plan Office for a list of covered and excluded items.

Eligible Employee – Any individual who is employed by an Employer and is covered by a collective bargaining agreement between the Employer and the Union, or a written participation agreement between the Employer and the Trustees, that provides for contributions to the Plan for "Plan H" benefits.

Employer – An employer making Contributions to the Welfare Plan for its Eligible Employees under a collective bargaining agreement with the Union or a participation agreement.

Essential Health Benefits – Health-related items and services that fall into the following categories, as defined in section 1302 of the Affordable Care Act, and further determined by the Secretary of Health and Human Services.

For purposes of determining whether a benefit or service is an Essential Health Benefit for purposes of permissible annual or lifetime limits under the Affordable Care Act, the Plan has chosen the State of New Mexico as its benchmark state.

Home Health Agency – Any organization that is certified as a home health agency under the Medicare laws or is otherwise state licensed.

Hospital – A legally constituted institution that meets all of the following requirements:

- it is licensed as a hospital (if hospital licensing is required where it is located);

- it is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under the supervision of a staff of legally qualified physicians;

- it continuously provides 24-hour-a-day nursing service by or under the supervision of registered graduate nurses and is operated continuously with organized facilities for operative surgery; and

- it is not, other than incidentally, a clinic, a place of rest or convalescence, a place for the aged, a nursing home, or a similar establishment.

The following are not considered Hospitals: ambulatory surgery centers; free-standing diagnostic and treatment centers; nursing homes; Skilled Nursing Facilities; school, college or camp infirmaries, rehabilitation facilities, and places for the care and treatment of alcoholism, substance abuse, mental illness, and tuberculosis.

Medicaid –Title XIX of the federal Social Security Act and all amendments and successors thereto.

Medical Case Management/Medical Case Manager– Medical Case Management is a voluntary program administered by the Plan's Medical Case Management Organization. A Medical Case Manager is a registered professional nurse that assures you are receiving optimal medical care, obtains information to assist you in making decisions about health care choices, and can discuss alternatives with you on a confidential basis. The Medical Case Manager can help reduce your confusion and anxiety, can arrange for certain services and care and can suggest ways to maximize your coverage.

Medical Case Management Organization – An organization retained by the Plan to determine requests for precertification of services or supplies as provided for in this SPD. The Medical Case Management Organization also provides Medical Case Management to Participants and Dependents.

Medical Consultant – A Physician or other qualified or licensed professional employed or contracted by the Plan who is designated as "Medical Consultant."

Medically Necessary or Medical Necessity – Medical Necessity is a need for a particular item or service for the diagnosis or treatment of disease, injury, or defect. The need for the item or service must be documented in the patient's records. Medically Necessary services or items are: appropriate for the symptoms and diagnosis or treatment of the condition, illness, disease, or injury; provided for the diagnosis or the direct care of the condition, illness, disease, or injury; in accordance with current standards of good medical practice; not primarily for the convenience of the patient or provider; not Experimental, clinically appropriate in terms of type, frequency, extent, site and duration, and the offer the most appropriate supply or level of service that can be safely provided to the patient.

Medicare – Title XVIII of the federal Social Security Act and all amendments and successors thereto.

No Surprises Services
The following services, to the extent covered under the Plan, are "No Surprises Services": (1) out-of-network Emergency Services; (2) out-of-network air ambulance services; (3) services

ancillary to non-Emergency Services (such as anesthesiology, pathology, radiology and diagnostic services and other services defined as ancillary under the No Surprises Act and its implementing regulations) when performed by out-of-network providers at in-network facilities; and (4) other out-of-network non-Medical Emergency services performed at in-network facilities with respect to which the provider does not comply with federal notice and consent requirements.

Outpatient Care – The provision of medical, nursing, counseling, or therapeutic services to a Participant who does not require an overnight stay in a Hospital or non-Hospital facility on a regular and predetermined schedule, according to an individualized treatment plan.

Participant – An Eligible Employee who is receiving benefits under the terms and conditions of the Plan.

Physician – A duly licensed member of a medical profession practicing within the scope of such license.

Plan – The Road Carriers Local 707 Welfare Plan H.

Plan Year –September 1st through August 31st.

Primary Care Physician (PCP) – A Physician who supervises and coordinates initial care and basic medical services as a general or family care practitioner, or in some cases, as an internist or a pediatrician to members, initiates their referral for specialist care and maintains continuity of patient care.

Provider – A Physician, Hospital, Skilled Nursing Facility, Home Health Agency, certified nurse midwife who is licensed by the state (if required by law), or other entity or person providing services to the Plan's Participants and Dependents.

Psychiatric Hospital – An acute care general Hospital that is certified or licensed to provide psychiatric services, or a facility that meets the definition of a Psychiatric Hospital as determined by the Trustees.

Skilled Nursing Facility –An institution or a distinct part of an institution that is licensed and approved by Medicare and by appropriate state law, regulation or agency or as otherwise determined by the Plan to meet the reasonable standards applied by any of the aforesaid authorities. The institution must be primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care facility, or nursing care facility. It must be: (a) approved by the Joint Commission on Accreditation of Health Care Organization or (b) as a certified skilled nursing facility under Medicare law.

Surgical Expenses – Expenses directly associated with the performance of surgical procedures or treatment on behalf of Plan Participants and their Dependents for illness or injury covered by the Plan.

Totally Disabled or Total Disability –A Participant has a Total Disability and is considered Totally Disabled if he or she is permanently prevented, solely because of disease or accidental bodily injury, from continuing his or her job and from engaging in any other type of gainful employment covered by any collective bargaining agreement between the Union and an Employer and when it is determined that such disability will continue for the remainder of his or her life.

Union -Teamsters Local Union No. 707

PART D.
CLAIMS AND APPEAL PROCEDURE

TRUSTEE DISCRETION

The Trustees shall have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply, construe and interpret the provisions of the Plan, this document and the terms used therein, as well as the Trust Agreement and to decide all matters arising in connection with the operation or administration thereof. The authority of the Trustees includes, without limitation, the sole and absolute discretion to:

- take all actions and make all decisions with respect to the eligibility for, and the amount of benefits payable;
- formulate, interpret and apply rules, regulations and policies necessary to administer this Plan and the Trust Agreement;
- decide questions, including legal or factual questions, relating to the determination and payment of benefits;
- resolve and clarify any ambiguities, inconsistencies or omissions arising under this Plan and the Trust Agreement; and
- process, and approve or deny benefit claims, and rule on any benefit exclusions or limitations.

All determinations made by the Trustees with respect to any matter shall be final, conclusive, and binding upon the Employers, Employees, Participants, and their Dependents. The Trustees shall be the sole judges of the standard of proof required in any matter. Any decision of the Trustees shall only be reversed by a court if such decision is determined to be arbitrary and capricious. Benefits under the Plan will be paid only if the Trustees determine, in their sole discretion, that the applicant is entitled to them.

The Trustees reserve the right to alter the benefit plan design in those instances wherein a more cost effective positive outcome can be achieved by the use of alternative plans of treatment recommended by the Plan's Medical Consultant, and agreed to by the patient, and the patient's attending and/or treating Physician.

The Trustees will have the right and opportunity to examine any claimant (while living) when and so often as it may reasonably require and also the right and opportunity to require an autopsy where it is not forbidden by law.

TYPES OF CLAIMS

Urgent Care Claims
An Urgent Care claim is any claim for upcoming medical care or treatment, without which:

- the life or health of you or your Dependent or the ability of you or your Dependent to regain maximum function could be seriously jeopardized; or
- in the opinion of the treating physician with knowledge of the medical condition, you or your Dependent would suffer severe pain that cannot be otherwise adequately managed. This type of claim generally includes those situations commonly treated as Emergencies.

The Plan will defer to the judgment of a treating physician as to whether a claim is an Urgent Care claim.

Pre-Service Claims
A pre-service claim is a claim for a benefit which requires approval (usually referred to as Precertification) of the benefit in advance of obtaining medical care.

Post-Service Claims
A post-service claim is a claim for a benefit, normally a request for payment, under the Plan which is not a pre-service claim. A claim for vision, life insurance or accidental death & dismemberment benefits is always a post-service claim.

Concurrent Claims
A concurrent claim is a claim for an extension of the duration or number of treatments previously approved by the Plan. This type of claim should be filed at least twenty-four (24) hours before the expiration of any course of treatment for which an extension is being sought.

Note that simple inquiries about the Plan provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. Your interactions with physicians, the staff of a Hospital, medical office or outpatient facility, pharmacists or any other health care provider will not be treated as a claim for benefits. In addition, a request for Pre-certification of a benefit that does not require Pre-certification, a general inquiry about Plan benefits, or an inquiry about eligibility to participate is not a claim for benefits.

When Claims Must Be Filed

- An *Urgent Care claim* must be filed as soon as possible;
- A *concurrent care claim* must be filed at least twenty-four (24) hours before the expiration of any course of treatment for which the claim/extension is being sought;
- A *pre-service care claim* must be filed at least fifteen (15) days before the start of the service in question; and
- A *post-service care claim* should be filed within 90 days following the date the charges were incurred.

SUBMITTING A CLAIM – TIMELY FILING

Claims should be filed with the Administrator that administers claims for that type of benefit, or the Plan Office if there is no specifically named Administrator in this SPD. **Claims must be submitted no later than 6 months from the date on which they were incurred.** A claim that is submitted after this period will not be covered by the Plan and benefits will not be

provided, regardless of whether benefits would have been provided if the claim had been timely submitted.

The Plan's current Administrators include:

- Blue Cross Blue Shield (BCBS): BCBS administers medical, Hospital benefit claims and in network claims for mental health and substance abuse services;
- Plan Office: The Plan Office administers claims for some mental health and substance abuse services;
- Allegiant RX administers prescription drug benefit claims;
- Davis Vision: Davis Vision administers vision benefit claims;
- Dentcare Delivery Systems, Inc (DDS).: DDS administers dental benefit claims;
- Amalgamated Life administers the Plan's life insurance and AD&D claims;
- Amalgamated Life administers disability claims.

A list of the Administrators and their contact information can be found at the end of this SPD. Your claim will be considered to have been filed as soon as it is received by the appropriate claims Administrator.

CLAIM DENIAL

If a claim is wholly or partially denied, the Plan Office will notify you within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Claim Determination	Extension Permitted
Medical, Dental, Vision	72 hours	None
• Urgent Claims (as medically determined)		
• Pre-Service Claims	15 days	15 days
• Post-Service Claims	30 days	15 days
• Concurrent Claims (claims for ongoing course of treatment)	Prior to termination of care (if sufficient notice)	None
Accidental Death and Dismemberment, Life Insurance	90 days	90 days
Weekly Accident and Sickness	45 days	Two 30 day extensions

If your claim lacks information required by the Plan Office to make a determination, you will be notified within a reasonable period of time. Extensions are permitted if the Plan Office determines that special circumstances beyond its control require an extension of time for processing the claim. In such case, you will be provided with written notice of the extension prior to the termination of the time for responding.

The Plan Office's notification of a claim denial will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA after you have exhausted the appeals process;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

APPEALING A CLAIM

If your claim is denied, you or your duly authorized representative may appeal the denial to the Board of Trustees within the following timeframe:

Type of Claim	Time Limit for Appealing Denial
Medical, Dental, Vision	180 days
Accidental Death & Dismemberment, Life Insurance	60 days
Weekly Accident and Sickness	180 days

You may submit written comments, documents, records, and other information relating to the claim for benefits. In addition, upon request and free of charge, you may have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits and, in the case of a disability claim, a listing of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the benefit determination.

DETERMINATION ON APPEAL

The Board will make a determination of your appeal within a reasonable period of time, but not later than the following:

Type of Claim	Time Limit for Appeal Determination	Extension Permitted
Medical, Dental, Vision • Urgent Claims	72 hours	None

• Pre-Service Claim • Post Service Claims • Concurrent Claims (claims for ongoing course of treatment)	30 days Regularly scheduled Board meeting (if claim received 30 days prior) Prior to termination of care (if sufficient notice)	None Next Board meeting None
Accidental Death & Dismemberment, Life Insurance	Regularly scheduled Board meeting (if claim received 30 days prior)	Next Board meeting
Weekly Accident and Sickness	Regularly scheduled Board meeting (if claim received 30 days prior)	Next board meeting

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

If the denial of a claim for Medical, Dental, or Vision Benefits was based in whole or in part on a medical judgment, the Board will consult with a health care professional who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual and who has appropriate training and experience in the field of medicine involved in the medical judgment. In addition, the determination on appeal will not afford deference to the initial claim denial.

The Board will provide a written notification of the benefit determination on review. In the case of denial, the notification will set forth the following:

- the specific reason or reasons for the denial;
- specific reference to Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the specific rule, guideline, protocol, or other similar criterion relied upon in making the determination; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- a statement of your right to sue under section 502(a) of ERISA.

EXTERNAL REVIEW OF NO SURPRISES ACT CLAIMS

For No Surprises Services claims, you may request external review once the appeals procedure has been exhausted, provided your claim involves medical judgment. The Plan will refer your appeal to an Independent Review Organization (IRO). You must file a request for external review of a denial of No Surprises Services claims within four months of the date you received the final adverse benefit determination. You will receive a decision from the IRO within 45 days of the IRO's receipt of your request for review.

AUTHORIZED REPRESENTATIVES

You may authorize someone, such as your legal spouse, to complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act as authorized representative on your behalf. A health care professional with knowledge of your medical condition may also act as an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

NO ASSIGNMENT OF CLAIMS

A Participant or Dependent cannot assign, transfer, or convey any of the benefits provided by the Plan. Similarly, no Participant or Dependent may assign, transfer, or convey any rights that he has or may have under ERISA. This prohibition on assignments of rights specifically includes any legal right a Participant or Dependent has or may have to bring claims for benefits, breaches of fiduciary duty, prohibited transactions, statutory violations and statutory penalties. Any attempt to assign any benefits provided under the Plan, or legal rights to any third party, including, but not limited to, a healthcare provider, shall be immediately invalid, void, and unenforceable. The purported assignments a Participant or Dependent may be asked to sign by a healthcare provider, at or around the time of service, do not invalidate, alter or supersede these prohibitions. The Plan's Trustees, in their sole and absolute discretion, may decide to pay benefits due to a Participant or Dependent from the Plan directly to a healthcare provider. When this happens, it is done solely for the Participant's or Dependent's convenience. Nothing in this SPD obligates the Plan to pay any benefits directly to any healthcare provider or alters the Plan's prohibition on assigning rights and benefits under the Plan. Nor does the payment of benefits directly to a healthcare provider constitute an acceptance of any assignment.

STATUTE OF LIMITATIONS

Any lawsuit brought to recover a benefit or enforce the terms of the Plan under Section 502(a) of ERISA must be filed within one year from the date the Trustees render a final decision on an appeal of a denied claim.

INCOMPETENCE

If it is determined that a claimant is unable to care for his affairs because of illness, accident, or incapacity, either mental or physical, any payments due may, unless claim has been made therefore by a duly appointed guardian, committee, or other legal representative, be paid to the

spouse or adult child of the claimant or such person having care custody of the claimant, as the Trustees will determine in their sole discretion.

COOPERATION

Every claimant must furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying or denying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulae, methods, and procedures as they consider advisable.

MAILING ADDRESS OF CLAIMANT

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last recorded by the Trustees and a letter sent by first class mail to such claimant is returned, any payments due the claimant will be held without interest until payment is successfully made.

RECOVERY OF CERTAIN PAYMENTS

The Trustees have the right to recover any overpayment or mistaken payment made to a claimant or to a third party on the claimant's behalf. Such a recovery may be made by reducing other benefit payments made to or on behalf of the claimant, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate.

REIMBURSEMENT AND SUBROGATION OF BENEFITS

If you or your Dependent receives benefits from the Plan for bodily injuries or illnesses caused by or resulting from, in whole or in part, the acts or omissions of any third party, and you or your Dependent receives any funds or monies based on the third party's actions, (including but not limited to tortfeasors, workers compensation programs, uninsured or underinsured motorist programs, no fault or school insurance programs, any other insurance policy or other plan of benefits, and/or any other third party (cumulatively referred to herein as" third party")) by insurance claim payment, legal action, settlement, judgment, or otherwise, the Plan shall have the right to first-dollar reimbursement from any recovery from the third party for the benefits paid by the Plan for such illness or injury, up to the amount of the recovery, regardless of whether such benefits were paid by the Plan prior to or after the date of any such recovery, regardless of legal fees, costs or expenses incurred by you or your Dependent, and regardless of whether the third party recovery is designated for medical costs or expenses. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence", "collateral source rule", "attorney's fund" doctrine, regulatory diligence or any other defenses or doctrines that may affect the Plan's right to subrogation or reimbursement. You or your Dependent will not be entitled to receive any benefits for any such illnesses or injuries under the Plan unless you or your Dependent, and your or your Dependent's attorney (if retained), signs the Plan's Subrogation Agreement and agrees to the following conditions:

- to hold in constructive trust any payment, amount, or recovery recovered on your or your Dependent's behalf from a third party, whether by action of law, settlement or otherwise, related to the injury or illness that gave rise to the claim for benefits from the Plan, including an insurance company or a workers' compensation carrier. The amounts held in constructive trust shall be promptly repaid to the Plan for the benefits extended by the Plan, up to the amount of recovery. You, your Dependent, or your or your Dependent's attorney (if the attorney is holding the monetary recovery), shall be fiduciaries with respect to the monies held in constructive trust.

- That the Plan has an equitable lien by agreement upon any payment, amount, or recovery received or recovered by you or your Dependent, or by anyone acting on behalf of you or your Dependent, from a third party, including amounts recovered by you or your Dependent's attorney, as a result of an insurance claims payment, legal action, settlement, judgment, or otherwise. Any such payment, amount, or recovery must be used to reimburse the Plan for the amounts of benefits paid by the Plan to or on behalf of you or your Dependent. The recovery subject to the equitable lien by agreement shall be promptly repaid to the Plan for the benefits extended by the Plan, up to the amount of the recovery.

- To irrevocably assign to the Plan all rights to recover monetary compensation from a third party, including the right to bring suit in your or your Dependent's name, or to intervene in any action brought by you or your Dependent to the extent of all benefits paid by the Plan and to give notice of this assignment directly to such third parties, their agents or insurance carriers, or to any agent or attorney who may represent you or your Dependent. The assignment shall entitle the Plan to reimbursement from any sums held or received by the following third parties which are due to you or your Dependent prior to any distribution of benefits to you or your Dependent, and shall provide that such parties shall hold such sums, which are subject to the constructive trust and/or equitable lien by agreement described above, in trust as a fiduciary for the benefit of the Plan. The parties who shall be bound by such assignment are:

    - any individual, or entity, including, but not limited to an insurance carriers making payments to or on behalf of you or your Dependent; or
    - any agent or attorney receiving payments for or on behalf of you or your Dependent.

- To notify the Plan of any claim or legal action asserted against any third party or any insurance carrier(s) for such injuries or illnesses, as well as the name and address of such third parties, insurance carrier(s), any agent or attorney who is representing or acting on behalf of you or your Dependent or the estate of you or your Dependent, or any person claiming a right through you or your Dependent, on a form to be supplied by the Plan.

- To cooperate fully with the Trustees in the exercise of any assignment or right of subrogation, and not to take any action or refuse to take any action that would prejudice the rights of the Plan.

- To acknowledge that the Plan shall have the right of recovery by withholding future benefits should you or your Dependent fail to execute an assignment, subrogation agreement or any other documents required herein, or breach any of the terms of this section.

If you or your Dependent fail or refuse to execute the required assignment, subrogation agreement, or any other documents, required herein, the Plan may withhold future benefits until you execute the required agreement or documents. Your acceptance or your Dependent's acceptance of benefits from the Plan for any illness or injury caused by or resulting from an act or omission by a third party, in whole or part, shall constitute agreement to the Plan's right to reimbursement, and your agreement or your Dependent's agreement to a constructive trust, and/or equitable lien by agreement in favor of the Plan on any payment, amount, or recovery that you or your Dependent recovers from any third party.

If there is any reasonable cause to believe that the injuries or illnesses sustained by you or your Dependent were in any way the result of the acts or omissions of one or more third parties, but you or your Dependent disclaims any third party involvements, the Plan shall have the right to require you or your Dependent to sign a declaration, under penalty of perjury, regarding such disclaimer as a pre-condition to the payment of any benefits.

PART E.
COBRA COVERAGE

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of your group health coverage (i.e., medical, dental, and vision benefits, but not life insurance or disability benefits) under the Plan.

THIS SECTION GENERALLY EXPLAINS COBRA CONTINUATION COVERAGE, WHEN IT MAY BECOME AVAILABLE TO YOU AND YOUR FAMILY, AND WHAT YOU NEED TO DO TO PROTECT THE RIGHT TO RECEIVE IT. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Fund Office.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a" qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Proof of good health is NOT required for COBRA coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse becomes eligible for Medicare;

- your spouse's employment ends for any reason other than his or her gross misconduct; or
- you become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parents become divorced;
- the parent-employee becomes eligible for Medicare, or
- the child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, your Employer must notify the Fund Office of the qualifying event.

FOR THE OTHER QUALIFYING EVENTS (DIVORCE OF THE EMPLOYEE AND SPOUSE OR A DEPENDENT CHILD'S LOSING ELIGIBILITY FOR COVERAGE AS A DEPENDENT CHILD), YOU MUST NOTIFY THE PLAN OFFICE WITHIN 60 DAYS AFTER THE QUALIFYING EVENT OCCURS.

Once the Plan Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways that this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, the disabled family member may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. This notice must be provided to the Plan Office within 60 days of the disability determination by the Social Security Administration.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or the covered employee and spouse are divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. This notice must be provided to the Fund Office within 60 days of the occurrence of the second qualifying event.

OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

NEWBORN AND ADOPTED CHILDREN

If you have a newborn child, adopt a child, or have a child placed with you for adoption while continuation coverage under COBRA is in effect and you are eligible for family coverage, you

may add the child to your coverage. To add coverage for the child, notify the Plan Office within 31 days of the child's birth, adoption or placement for adoption. Legal proof of your relationship to the child must also be provided.

PAYING FOR COBRA COVERAGE

You will be charged the full cost of continued coverage under COBRA, plus a 2% administrative fee. (If you are eligible for 29 months of continued coverage due to disability, the law permits the Plan to charge 150% of the full cost of the plan during the 19th to 29th months of coverage.)

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

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

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

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

WHEN COBRA COVERAGE ENDS

You or your Dependent's continued coverage under COBRA may end for any of the following reasons:

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

An individual whose disability is determined by the Social Security Administration to have ended must notify the Plan Office within 30 days of this determination.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PART F. MISCELLANEOUS

This SPD and the personnel at the Plan Office are authorized sources of Plan information for you. The Trustees of the Plan have not empowered anyone else to speak for them with regard to the Plan. No Employer, Union official, business agent, or shop steward is in a position to discuss your rights under the Plan with authority.

Because it is not intended that the Plan duplicate reimbursement that you receive under certain other health care programs, no reimbursement will be made under this Plan for health care costs if such costs are covered under any workers' compensation or occupational disease law. No benefits will be payable with respect to hospital, surgical, or medical expenses that are included or includible in any claim or lawsuit instituted by a Participant or his Dependent against any third party to the extent any judgment is awarded or payment is made in settlement of such claim or lawsuit. Any benefit paid by the Plan prior to such award or settlement will be reimbursed to the Plan.

Further, reimbursement for health care costs will be integrated with Medicare, state "no-fault" benefits, and any coverage under any other employer-sponsored health care plans, or health care plans provided under the auspices of an educational institution.

PLAN CONTINUANCE

It is Trustees intention to maintain this Plan indefinitely. However, the Trustees retain the right to amend or terminate the Plan at any time for any reason, subject to the terms of any collective bargaining agreement. No Participant or Dependent has the right to any benefits from the Plan following its termination.

PLAN IS NOT A CONTRACT OF EMPLOYMENT

Participation in the Plan is not intended or meant to be construed as a contract of employment between you and your Employer. Your Employer retains the right to address employment issues, including dismissal or other termination of employment, in accordance with applicable collective bargaining agreements and separate from the participation of its Eligible Employees and their Dependents in the Plan. The Plan provides specific guidance with regard to a Participant's rights to Plan benefits following termination of employment.

PRIVACY AND SECURITY OF HEALTH INFORMATION

NOTICE OF ROAD CARRIERS LOCAL 707 WELFARE FUND'S PRIVACY PRACTICES

Your Information – Your Rights – Our Responsibilities

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

Contact Information
The Plan: Road Carriers Local 707 Welfare Plan, 14 Front Street, Hempstead, NY 11550
Website: www.roadcarriers707.com
Privacy Official**:** Mr. Kevin McCaffrey, Road Carriers Local 707 Welfare Plan, (516) 560-8500, kmccaffrey@ibt707.com.

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Matters

We never market or sell personal health information.
We never contact you, or use personal health information, for fundraising purposes.
We do not create or manage a hospital directory.
We do not create or maintain psychotherapy notes.

Effective Date

This notice is effective as of September 23, 2013.

PRIVACY

Effective April 14, 2003, the receipt, use and disclosure of protected health information ("PHI") by the Fund is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Trustees, certain Fund employees and the Fund's Business Associates may receive, use and disclose PHI in order to carry out payment, treatment and health care operations under the Plan. These entities and individuals may use PHI for such purposes without your consent or written authorization. In general, if your PHI is used or disclosed for any other purpose, your written authorization for such use or disclosure will be required. All Plan Participants will receive a Notice of Privacy Practices that explains the Fund's obligation to protect PHI and also describes certain rights you have with regard to your PHI.

Under this new law, the Fund (or health insurance issuer or HMO with the Fund's permission) may disclose PHI, as defined in HIPAA, to the Trustees to carry out administrative functions related to the Plan. The Trustees' administrative functions include the responsibility to control and manage the operation and administration of the Fund, in accordance with ERISA. Such administrative functions include, but are not limited to, the responsibility to determine appeals of benefit claims. The Trustees may use and disclose the PHI provided to it from the Fund (or health insurance issuer or HMO) only for these purposes.

The Trustees are subject to the following limitations and requirements related to their use and disclosure of PHI received from the Fund:

(1) The Trustees shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to HIPAA.

(2) The Trustees shall require any agents, including subcontractors, to whom they provide PHI received from the Fund to agree to the same restrictions and conditions that apply to the Trustees with respect to such information.

(3) The Trustees shall not use PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan.

(4) The Trustees shall promptly report to the Fund any improper use or disclosure of PHI of which they become aware.

(5) The Trustees shall provide adequate protection of PHI and separation between the Fund and the Trustees by:

(a) ensuring that only the following Fund employees will have access to the PHI provided by the Fund:

- •Fund Manager (Privacy Officer)
- •Office Manager
- •Manager of Information Systems ("MIS")
- •Medical Claims Supervisor (HIPAA Contact Person)
- •Medical Claims Auditors
- •Member Services Representatives
- •Contribution Coordinator
- •Eligibility Coordinator
- •COBRA Coordinator
- •Pension Assistants
- •Pension Supervisor
- •Those employees substituting for any of the positions listed above

(b) restricting access to and use of PHI to only the employees listed above for limited purposes related to their job responsibilities, and only for the administrative functions performed by the Trustees on behalf of the Fund that are described above; and

(c) using the following procedures to resolve issues of noncompliance by the employees listed above: The Fund has a zero tolerance policy regarding the improper use or disclosure of PHI by any employee. Any employee who violates the Fund's Policies and Procedures and/or the HIPAA privacy rules will be subject to sanctions at the Fund's discretion, which may include oral counseling, write-ups, suspension, and/or termination.

(6) The Trustees shall:

(a) make PHI available for access purposes in accordance with 45 C.F.R. § 164.524;

(b) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526; and

(c) make available the information required to provide an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

(7) The Trustees shall make their internal practices, books, and records relating to the use and disclosure of PHI received from the Fund available to the Secretary of the Department of Health and Human Services for audit purposes.

(8) If feasible, the Trustees shall return or destroy all PHI received from the Fund that the Trustees retain in any form when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Trustees shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Fund shall disclose PHI to the Trustees only upon receipt of a certification by the Trustees that the Plan documents have been amended in accordance with 45 C.F.R. § 164.504(f), and that the Trustees shall protect the PHI as described herein.

Please contact the Fund Office if you have any questions regarding your privacy rights or if you need to obtain an authorization form.

SECURITY

The Trustees will reasonably and appropriately safeguard the electronic PHI the Trustees receive, create or maintain by, or on behalf of, the Fund in the Trustees' capacity as the sponsor of the Plan. The Trustees shall:

(1) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the Trustees create, receive, maintain or transmit on behalf of the Fund;

(2) implement reasonable and appropriate security measures for the purpose of ensuring that there is adequate separation as described in paragraph (5) of the Privacy section above between the Trustees and the Fund;

(3) ensure any agent, including a subcontractor, to whom the Trustees provide electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

(4) report to the Fund any security incident of which the Trustees become aware; including attempted or successful unauthorized access, use, disclosure or destruction of information or interference with system operations, that involve electronic PHI provided to the Trustees by, or on behalf of, the Fund.

COORDINATION OF BENEFITS

Under the terms of the Plan, you are not entitled to be paid more than 100% of your covered expenses (for all benefits other than Life Insurance and Accidental Death and Dismemberment) from this Plan and any other plan combined.

When benefit payments are coordinated between two or more plans, one of the plans is designated as the "primary" plan and all other plans are "secondary." The Trustees will determine which plan is primary. If a plan has no coordination of benefits provision, it is automatically considered as the primary plan. The primary plan pays full benefits as if there were no other plans.

In instances where this Plan is the secondary plan, it will pay those expenses not covered by the primary plan including co-payments and deductibles, but not more than it would have paid if it were the primary plan. If the primary plan pays benefits equal to or greater than that paid by this Plan, this Plan will not pay any benefits. The total payments from both the primary and secondary plans will never exceed the total allowable expenses under this Plan.

In determining whether this Plan or another plan is primary, the following shall apply:

(1) This Plan covers you as an employee in active service before a plan that covers you as a dependent, retired employee, disabled employee, or before your coverage under this Plan's continuation of benefits provision or under another plan's COBRA provisions.

(2) The plan covering a person as an employee or in which the person is a participant (regardless of whether such plan deems the person covered for the particular benefit) will be the primary plan.

(3) Where two or more plans cover a person as a dependent child, the plan of the parent who has a birth date earlier in the year (regardless of age) will be primary over the plan of a parent that has a birth date later in the year. If both plans do not have this birthday rule, the coverage of the employee who has participated in his or her plan for the longest time will be primary except as follows:

(a) Coverage of children of divorced or separated parents is as follows: the child is covered under the plan of the parent that was given financial responsibility for the child's medical, hospitalization, dental and health care by court decree. In the absence of a court decree, the plan of the parent who has custody of the child will pay first if that parent has not remarried.

(b) If the parent who has custody of the child has remarried, his or her plan would pay before the plan of the new step-parent or the parent without custody. If the parent with custody remarried, but does not have coverage, and the plan of the new step-parent permits coverage of the child, the step-parent's plan would pay before the plan of the parent without custody.

(4) When rules (1)–(3) do not establish an order of benefit determination, the plan which has covered the person for the longer period of time shall be primary over the plan which has covered such person the shorter period of time, provided that:

(a) A plan covering a person as a laid-off or retired employee or as the dependent of such person shall be secondary to a plan covering such person as an employee other than as a laid-off or retired employee or a dependent of such person. This provision will only apply where the plan that is to be coordinated with this Plan also contains this provision.

(b) If both parents are eligible for Plan benefits as Participants, the benefits shall be calculated first as if this Plan were the primary plan and then as if this Plan were the secondary plan. This will give them the same coverage as if they had been covered as employees in two different plans.

If the primary plan denies coverage because of the application of a rule that is unique to the plan and which is not a rule of this Plan, then this Plan will provide only that coverage which it would have provided if the primary plan had granted primary coverage.

Some school insurance policies do not pay medical benefits if a child who is injured is eligible for other medical coverage. The Plan will not provide primary coverage for injuries sustained on school property or under the supervision of school personnel if such injuries would have been covered by the school's insurance in the absence of such a provision. The Plan will cover such claims as the secondary plan.

Copayments required by a primary plan when this Plan is the secondary plan are eligible for reimbursement under this Plan.

Where not specifically noted, the Plan may utilize NAIC guidelines for Coordination of Benefits.

COORDINATION WITH MOTOR VEHICLE NO-FAULT BENEFITS

In some states it is possible for residents to obtain a small savings in their auto insurance premiums by electing a deductible of up to $2,500 for the medical coverage section of their auto insurance policies, the personal injury protection section. If you elect such a deductible, medical expenses up to the amount will not be paid by your auto insurance carrier. This means that deductible amount you select will have to be borne by you unless you have other medical insurance that will cover the deductible amount. If a valid automobile policy is not in force, no benefits will be payable under this Plan.

THIS PLAN WILL CONTINUE TO EXCLUDE THE DEDUCTIBLE FROM ITS SELF-INSURED COVERAGE FOR MEDICAL EXPENSES ARISING FROM OR RELATED TO AUTO ACCIDENTS.

Covered Expenses incurred for the treatment of injuries arising out of the maintenance or use of a Motor Vehicle shall be eligible for coverage only to the extent that such benefits are in excess of, and not in duplication of, benefits paid or payable:

- under a policy of Motor Vehicle insurance (including the mandatory part of any insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law), provided that non-duplication as contained herein is not prohibited by law; or
- through a program or other arrangement of qualified or certified self-insurance.

The Plan will be secondary to any motor vehicle insurance which provides for medical benefits, including coverage provided under any personal injury protection ("PIP") or "no-fault" coverage, even if you selected coverage under the Motor Vehicle insurance as secondary. The Plan's coverage does not include any deductibles for which you may be liable under PIP motor vehicle coverage. In no event will the Plan pay more as the secondary Plan than it would have paid for the motor vehicle related injury if it were the primary plan.

If you live in a state that requires PIP, you must buy the maximum PIP coverage offered. If you do not, the Plan will only provide benefits for medical expenses that exceed the PIP maximum coverage limits.

Not all expenses incurred in the treatment of injury arising out of the maintenance or use of a Motor Vehicle are covered by the Plan. Please refer to the other sections of this SPD for additional provisions regarding Motor Vehicle related injuries.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

A QMCSO is a judgment, decree or court order issued by a court or state administrative agency pursuant to state domestic relations law which specifically creates or recognizes the right of a child to health benefit coverage under the Plan. The Plan will comply with a valid QMCSO to provide health coverage for any child of a Participant named in a QMCSO, even if such child is not in the custody of the Participant.

Once it is determined that a child of a Participant is eligible for health benefit coverage pursuant to a QMCSO, that child will be treated as any other Dependent under the Plan. In addition, the child will be treated as a Participant with respect to ERISA's reporting and disclosure requirements, so that the Plan will provide such child or the child's designated representative any information that is required to be distributed to Participants, such as the summary plan description. The Plan will determine who meets the requirements for this coverage, on a case by case basis.

Please contact the Plan Office if you have any questions regarding QMCSOs.

PAID FAMILY LEAVE (NEW YORK)

You will be covered under New York State's Paid Family Leave ("PFL") and for New York State disability benefits through the Plan, if:

● your work is localized in New York State (that is, most of your work is performed in New York State), and
● your employer elects to participate in the Plan for these benefits.

Under the PFL law, you are required to pay for your coverage through the Plan. Contributions will be collected from your pay by your employer, in the amounts required by the law, and remitted to the Plan in payment for your coverage. If your employer remits those payments to the Fund our carrier Amalgamated Life provides PFL benefits for you.

ELIGIBILITY

If you are normally scheduled to work at least 20 hours per week, you are eligible to take PFL after 26 consecutive weeks of employment. If your regular work schedule is less than 20 hours per week, you are eligible to take PFL after you have worked for at least 175 days.

However, you cannot take PFL if you:

● are collecting New York State disability benefits;
● are not working or are on administrative leave;
● are collecting sick pay or paid time off from your employer; or
● are working the same hours for which the paid leave would be taken.

PFL BENEFITS

For 2020, you are permitted to take up to ten weeks of PFL per year. Your weekly PFL benefit for 2020 will equal the lesser of (a) 60% of your average weekly wage ("AWW") or (b) $840.70 which is 50% of the New York State average weekly wage ("SAWW"). The SAWW may change each year. Benefits may increase in subsequent years.

You may take PFL for the following reasons:

● To care for or bond with a child during the first 12 months following the child's birth, adoption, or placement for foster care (but not before the birth, adoption or placement);
● To provide physical or mental care for a spouse, domestic partner, child, parent, parent in-law, grandparent or grandchild with a "serious health condition." A "serious health condition" is an illness, injury, impairment, or physical or mental condition that involves: (i) inpatient care in a hospital, hospice, or residential health care facility, or (ii) continuing treatment or continuing supervision by a health care provider; or
● To address certain emergencies, specified in the federal Family and Medical Leave Act, when a spouse, child, domestic partner or parent is on, or has been notified of an impending call or order to, active military duty.

APPLYING FOR PFL

In order to apply for PFL, you must submit a completed PFL-1 form to Amalgamated Life. You must use the form that applies to the type of PFL that you are seeking and provide all of the information and documents noted on the form. You will need to get information from your employer for the form. The PFL-1 form will reference other PFL forms that you may also have to submit. You can obtain forms from Amalgamated Life at the following address:

33 Westchester Avenue
White Plains, NY 10604-2910
You can also obtain the PFL forms on the New York State Paid Family Leave website: https://www.ny.gov/new-york-state-paid-family-leave/paid-family-leave-employer-and-employee-forms-0.

The completed PFL forms and documents must be submitted before the date that you wish to take leave if your leave is foreseeable. You must also notify your employer at least 30 days before your leave if it is foreseeable. If your leave is not foreseeable, the form and documents must be provided to Amalgamated Life as soon as practicable. You should also notify your employer that you wish to take leave as soon as practicable. If your request for PFL is not timely received or your documents are incomplete, your benefits may be delayed.

DENIALS OF PFL

If Amalgamated Life denies your request for PFL, its denial letter will give you the reason for the denial and an explanation of why your request was denied. You can refile your request for PFL at least 30 days before the date on which your leave is to begin if your request is denied because the information and documents you provided are incomplete. If Amalgamated Life denies your request for any other reason, you can have a neutral arbitrator review the denial. The denial letter will include instructions on how to submit your denial to the arbitrator by mail or online. Amalgamated Life will also give you a Request for Arbitration Form which you must complete if you want to request arbitration by mail. There is a $25 fee for arbitration that you must pay. However, if the arbitrator decides that your claim is valid, you will be reimbursed for the arbitration fee.
You must initiate arbitration of a denied PFL request within six months of the date on which your request was denied.

MAINTAINING YOUR HEALTH BENEFITS

Your Welfare Plan benefits will continue during your paid leave unless the Plan suspends or terminates medical benefits for all employees of your employer during your leave.

PART G. INFORMATION REQUIRED UNDER ERISA

PLAN NAME: Road Carriers Local 707 Welfare Plan.

EFFECTIVE DATE: This SPD is effective as of September 1, 2020.

PLAN SPONSOR: Board of Trustees of the Road Carriers Local 707 Welfare Plan.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 11-2159859.

PLAN NUMBER: 501.

TYPE OF PLAN: Welfare Plan.

PLAN YEAR ENDS: August 31st.

PLAN ADMINISTRATOR: Board of Trustees, Road Carriers Local 707 Welfare Plan, 14 Front Street, Suite 301, Hempstead, NY 11550-3602. Phone: (516) 560-8500. The contributing Employers and the Union are equally represented on the Board of Trustees.

AGENT FOR SERVICE OF LEGAL PROCESS: Kevin McCaffrey, CEBS,
Plan Manager, 14 Front Street, Suite 301, Hempstead, NY 11550. Phone: (516) 560-8500. In addition to the person designated as agent for legal process, service of legal process may also be made upon any Plan Trustee.

TYPE OF PLAN ADMINISTRATION: Self-administered by the Board of Trustees.

TYPE OF FUNDING: All benefits are self-insured except for Life Insurance and Accidental Death & Dismemberment benefits. Life Insurance and Accidental Death & Dismemberment benefits are provided through contracts of insurance with third parties.).

SOURCES OF CONTRIBUTIONS TO PLAN: Employers are required to contribute to the Road Carriers Local 707 Welfare Plan.

COLLECTIVE BARGAINING AGREEMENTS: This Plan is maintained in accordance with collective bargaining agreements. You may obtain a copy of the agreement applicable to

your employer upon written request to the Plan Manager. A copy of the agreement is also available for examination by you at the Plan Office.

PARTICIPATING EMPLOYERS: You may receive from the Plan Manager, upon written request, information as to whether a particular employer participates in the Plan. You may also receive the employer's address if the employer is a participating employer.

PLAN BENEFITS PROVIDED BY: Medical, Dental and Vision Benefits are provided on a self-insured basis. Life Insurance Benefits and Accidental Death and Dismemberment Insurance Benefits are provided on an insured basis. All other benefits are provided on a self-insured basis. See Part H, Key Contacts, for information regarding insurers and administrators.

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

- 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 summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500) 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, including the Trust Agreement under which the Plan is governed, collective bargaining agreements, financial reports, the latest annual report (Form 5500) and updated summary plan descriptions. The Plan 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 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 SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision 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 Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the 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 NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NO INSURANCE BY THE PBGC: Since this Plan is not a defined benefit pension plan, it is not covered by the Pension Benefit Guaranty Corporation.

TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the Road Carriers Local 707 Welfare Plan. The following are the individual Trustees that make up the Board. The Union and the Employers who contribute to the Plan are equally represented on the Board of Trustees.

Union Trustees:
Kevin McCaffrey
I.B.T. Local 707
14 Front Street, Ste 300
Hempstead, NY 11550

Daniel Pacheco
I.B.T. Local 707
14 Front Street, Ste. 300
Hempstead, NY 11550

Charles White
I.B.T Local 707
14 Front Street, Ste 300
Hempstead, NY 11550

Employer Trustees:
Michael Day
YRC Freight
100 Roadway Dr.
Carlisle, PA 17015

Steven Dusko
ABF Freight System
8051 Center Point 70 Blvd.
Huber Heights, OH 45424

John Yancigay
DiCarlo Foods
1630 North Ocean Avenue
Holtsville, NY 11742

PART H. KEY CONTACTS

Dental Plan Administrator
DDS, Inc.
265 Post Avenue, Suite 340
Westbury, NY 11590
800-255-5681
www.ddsinc.net

Disability Carrier
Amalgamated Life
PO Box 5463
White Plains, NY 10602-5453
914-367-5113

Life Insurance/ AD&D Claims Administrator
Amalgamated Life
333 Westchester Avenue
White Plains, NY 10604-2910
914-367-5000

Prescription Drug Program ~ Retail and Mail Order Drug Administrator
Allegiant RXP.O. Box 4604 |
Manchester, NH 03108
1-866-888-0103
www.Allegiantrx.com

Medical Case Management Organization
Med-Care Management
2090 Palm Beach Lakes Blvd.
West Palm Beach, FL 33409
800-367-1934

PPO Provider
Empire Blue Card Program
1-800-810-BLUE
www.BCBS.com

Vision Care Administrator
Davis Vision
Customer Service
Capital Region Health Park, Suite 301
711 Troy-Schenectady Road
Latham, NY 12110
1-800-999-5431
www.davisvision.com

Mental Health & Substance Abuse Administrator
Teamsters Center Services
121 W 27 Street, Suite 1100
New York, NY 10001
1-800-433-4827
1-212-235-5003

APPENDIX A:
Schedule of Dental Benefits

The following is a partial listing of covered dental procedures and charges. For any procedure, which has an allowance that is different for members or dependents over the age of 12, and for dependent children between the ages of 0-12, the description indicates "adult" or "child." Comprehensive oral examinations are allowed every 12 months. Some areas may have a higher reimbursement rate.

0140 Emergency Oral Exam 10.00
0150 Comprehensive Oral Exam 20.00
0210 X-rays ~ Complete Series 40.00
0220 X-Rays ~ Periapical 1st Film 10.00
0230 X-Rays ~ Periapical Each Additional 7.00
0240 X-Rays ~ Occlusal Film 12.00
0250 X-Rays ~ Extraoral 1st Film 20.00
0270 X-Rays ~ 1 Bitewing 10.00
0272 X-Rays ~ 2 Bitewings 12.00
0274 X-Rays ~ 4 Bitewings 20.00
0290 X-Rays ~ Post/Anter Survey Film 50.00
0310 X-Rays ~ Sialography Film 40.00
0320 X-Rays ~ Temporomandibular Joint 120.00
0330 X-Rays ~ Panoramic Film 30.00
0340 X-Rays ~ Cephalometric Film 40.00
0415 Bacterial Exam/Biopsy 5.00
0460 Pulp Vitality Test 20.00
0470 Diagnostic Casts 25.00
1110 Dental Prophylaxis ~ Adult 30.00
1120 Dental Prophylaxis ~ Child 20.00
1203 Fluoride Treatment ~ Child 12.00
1351 Sealant Per Tooth ~ Under age 19 .....25.50
1510 Space Maintainer ~ Fixed Unilate 97.50
1515 Spacer Maintainer ~ Fixed Bilater 1 .....46.25
1520 Space Maintainer ~ Removable Uni 97.50
1525 Re-cement Space Maintainer – Removable Bil 146.25
1550 Re-cement Space Retainer 19.50
2140 Amalgam ~ 1 Surface, Prim., Post 40.00
2150 Amalgam ~ 2 Surfaces, Prim., Post 60.00
2160 Amalgam ~ 3 or more Surfaces, Prim., Post 75.00
2161 Amalgam ~ 4+ Surfaces, Prim., Post 75.00
2330 Composite ~ 1 Surface, Anterior 40.00
2331 Composite ~ 2 Surface, Anterior 60.00
2332 Composite ~ 3 Surfaces, Anterior 70.00

2335 Composite ~ 4 or more/Incisal 80.00
2391 Composite ~ 1 Surface, Posterior 40.00
2392 Composite ~ 2 Surfaces, Posterior 60.00
2393 Composite ~ 3 Surfaces, Posterior 70.00
2394 Composite ~ 4+ Surfaces, Posterior 80.00
2410 Gold Foil ~ 1 Surface 50.00
2420 Gold Foil ~ 2 Surfaces 60.00
2430 Gold Foil ~ 3 Surfaces 70.00
2510 Inlay ~ Metallic ~ 1 Surface 100.00
2520 Inlay ~ Metallic ~ 2 Surfaces 200.00
2530 Inlay ~ Metallic ~ 3 or more Surfaces 300.00
2610 Inlay ~ Porcelain/Ceramic ~ 1 Surface 100.00
2710 Crown ~ Resin 250.00
2720 Crown ~ Resin High Noble Metal 340.00
2721 Crown ~ Resin Predom Base Metal 340.00
2722 Crown ~ Resin Noble Metal 340.00
2740 Crown ~ Porcelain/Ceramic 340.00
2750 Crown ~ Porcelain High Noble Metal 400.00
2751 Crown ~ Porcelain Predom Base Metal 400.00
2752 Crown ~ Porcelain Noble Metal 400.00
2780 Crown ~ ¾ Cast High Noble Metal 280.00
2790 Crown ~ Full Cast High Noble Metal 300.00
2791 Crown ~ Full Cast Predom Base 300.00
2792 Crown ~ Full Cast Noble Metal 300.00
2910 Recement Inlay 30.00
2920 Recement Crown 30.00
2930 Stainless Steel Crown ~ Primary 80.00
2940 Sedative Filling 10.00
2950 Core Buildup Including Pins 45.00
2951 Pin Retention ~ Per Tooth 25.00
2952 Cast Post and Core 100.00
2954 Prefab Post and Core 100.00
2960 Veneer Labial-Resin Laminate 40.00
3110 Pulp Cap ~ Direct 10.00
3120 Pulp Cap ~ Indirect 10.00
3220 Therapeutic Pulpotomy 51.00
3310 Root Canal ~ Anterior 210.00
3320 Root Canal ~ Bicuspid 320.00
3330 Root Canal ~ Molar 400.00
3346 Re-treatment of root canal ~ Anterior 450.00
3347 Re-treatment of root canal ~ Bicuspid 550.00
3348 Re-treatment of root canal ~ Molar 650.00
3352 Apexifi cation/Recalcification 60.00
3410 Apicoectomy ~ Anterior 140.00
3421 Apicoectomy ~ Bicuspid, 1st Root 160.00
3425 Apicoectomy ~ Molar, 1st Root 160.00

3426 Apicoectomy ~ Each Addl. Root 100.00
3430 Retrograde Filling ~ Per Root 40.00
3450 Root Amputation ~ Per Root 85.00
3460 Endodontic Implant ~ Endosseous 150.00
3920 Hemisection 110.00
4210 Gingivectomy/Plasty ~ Per Quad 90.00
4211 Gingivectomy/Plasty ~ 1-3 Teeth 25.00
4240 Gingival Flap Procedure ~ Quad 90.00
4260 Osseous Surgery ~ Per Quad 300.00
4261 Osseous Surgery 1-3 Teeth 275.00
4263 Bone Replacement Graft ~ 1st Site 190.00
4264 Bone Replacement Graft ~ Each Additional 190.00
4270 Pedicle Soft Tissue Graft 90.00
4271 Free Soft Tissue Graft 90.00
4320 Provisional Splinting ~ Intracor 30.00
4321 Provisional Splinting ~ Extracor 35.00
4341 Perio Scaling ~ Rt Planning ~ Quad 40.00
4910 Periodontal Maintenance 40.00
4920 Unscheduled Dressing Changes 15.00
5110 Complete Denture ~ Maxillary 400.00
5120 Complete Denture ~ Mandibular 400.00
5130 Immediate Denture ~ Maxillary 400.00
5140 Immediate Denture ~ Mandibular..... 400.00
5211 Partial Dent ~ Max W/Clasps ~ Resin 300.00
5212 Partial Dent ~ Mand W/Clasps ~ Resin 300.00
5213 Partial Dent ~ Max W/Clasps ~ Cast 400.00
5214 Partial Dent ~ Mand W/Clasps ~ Cast 400.00
5281 Removable Unilateral Prtl ~ 1 Tooth 150.00
5410 Adjust Complete Denture ~ Max..... 25.00
5411 Adjust Complete Denture ~ Mand 25.00
5421 Adjust Partial Denture ~ Max 25.00
5422 Adjust Partial Denture ~ Mand 25.00
5510 Repair Brkn Complete Dent Base 60.00
5520 Replace Miss/Brkn Tth ~ Comp Dnt 60.00
5610 Repair Partial Resin Denture Base 60.00
5620 Repair Cast Framework 120.00
5630 Repair or Replace Broken Clasp 120.00
5640 Replace Broken Teeth ~ Per Tooth 60.00
5650 Add Tooth to Partial Denture 60.00
5660 Add Clasp to Partial Denture 100.00
5710 Rebase Complete Denture ~ Max 160.00
5711 Rebase Complete Denture ~ Mand..... 160.00
5720 Rebase Partial Denture ~ Max 160.00
5721 Rebase Partial Denture ~ Mand 160.00
5730 Reline Complete Dent-Max ~ Chair 100.00

5731 Reline Complete Dent-Mand ~ Chair 100.00
5740 Reline Partial Dent-Max ~ Chair 85.00
5741 Reline Partial Dent-Mand ~ Chair 85.00
5750 Reline Complete Dent-Max ~ Lab 160.00
5751 Reline Complete Dent-Mand ~ Lab 160.00
5760 Reline Partial Dent-Max ~ Lab 120.00
5761 Reline Partial Dent-Mand ~ Lab 120.00
5820 Interim Partial Denture ~ Max 112.50
5821 Interim Partial Denture ~ Mand 112.50
5850 Tissue Conditioning ~ Maxillary 50.00
5851 Tissue Conditioning ~ Mandibular 50.00
5860 Overdenture Complete 235.00
5861 Overdenture Partial 250.00
5931 Obturator ~ Surgical 140.00
5932 Obturator ~ Definitive 140.00
6010 Surg. Placement Implant-Endoste 100.00
6020* Abut. Placement Implant-Endoste 100.00
6040* Surg. Placement Eposteal Implan 100.00
6050* Surg. Placement Transosteal Imp 100.00
6240 Pontic ~ Porcelain High Noble 300.00
6545 Retainer ~ Cast Metal Resin 250.00
6600 Abut. Inlay ~ Porce/Ceramic - 2 Sur 63.00
6601 Abut. Inlay ~ Porce/Ceramic – 3+Sur 100.00
6608 Abut. Onlay ~ Porce/Ceramic – 2 Sur 100.00
6720 Abutment ~ Resin High Noble Metal 340.00
6721 Abutment ~ Resin Predom Base Metal 340.00
6722 Abutment ~ Resin Noble Metal 340.00
6740 Abutment ~ Porcelain/Ceramic 200.00
6750 Abutment ~ Porcelain High Noble 400.00
6751 Abutment ~ Porcelain Predom Base Metal 400.00
6752 Abutment ~ Porcelain Noble Metal 400.00
6780 Abutment ~ ¾ Cast High Noble 280.00
6790 Abutment ~ Full Cast High Noble 300.00
6791 Abutment ~ Full Cast Predom Base 300.00
6792 Abutment ~ Full Cast Noble Metal..... 300.00
6930 Recement Bridge 35.00
6940 Stress Breaker 40.00
6973 Core Buildup For Retainer 70.00
7140 Extraction, Erupted TTH, Exposed 60.00
7210 Surgical Removal Erupted TTH 80.00
7220 Removal Impacted TTH ~ Soft Tiss 80.00
7230 Removal Impacted TTH ~ Partial Bony 120.00
7240 Removal Impacted TTH ~ Full Bony 200.00
7250 Surgical Removal Residual Root 75.00
7260 Oroantral Fistuala Closure 250.00

7270 Tooth Reimplantation 155.00
7272 Tooth Transplantation 165.00
7280 Surgical Access Unerupted TTH 215.00
7281 Surgical Exposure Impacted-Aid 140.00
7285 Biopsy of Oral Tissue ~ Hard 183.00
7286 Biopsy of Oral Tissue ~ Soft 133.00
7310 Alveoloplasty W/Ext~Quad 70.00
7320 Alveoloplasty W/Out Ext~Quad 100.00
7340 Vestibuloplasty 464.00
7410 Radical Excision Lesion < 1.25 .....130.00
7411 Radical Excision Benign Lesion > 1.25 .....170.00
7450 Removal Odont Cyst/Tumor < 1.25 .....220.00
7451 Removal Odont Cyst/Tumor > 1.25 .....250.00
7460 Removal Nonodont Cyst/Tumor < 1.25 .....220.00
7461 Removal Nonodont Cyst/Tumor > 1.25 .....250.00
7471 Removal of Exostosis ~ Per Site 225.00
7510 Incision & Drainage ~ Intraoral 75.00
7520 Incision & Drainage ~ Extraoral 120.00
7530 Removal of Foreign Body 1,060.00
7550 Partial Ostectomy 200.00
7970 Excision Hyperplastic~Tis-Arch 200.00
7971 Excision Pericoronal Gingiva 50.00
8220 Appliance Insertion/Diagnostic 500.00
8670 Ortho- Monthly Treatments x 23 months 87.00
9110 Palliative Treatment 15.00
9210 Local Anesthesia..... 15.00
9220 Deep Sed/Gen Anesth-1st 30 min 150.00
9241 IV Sed/Analgesia – 1st 30 min 110.00
9310 Consultation by Specialist 60.00
9410 House/Extended Care Call 60.00
9420 Hospital Call 60.00
9430 Office Visit for Observation 12.00
9440 Office Visit after Regular Hours 20.00
9940 Occlusal Guard 100.00
9951 Occlusal Adjustment ~ Limited 15.00
9952 Occlusal Adjustment ~ Complete 70.00
9974 Internal Bleaching ~ Per Tooth 25.00
Updated 9/04

Participant is responsible for paying the difference between the scheduled allowance for implants and the treating dentist's normal charge.