

Southwestern Teamsters Security Fund

Retired Employee Plan

Rules and Regulations

Effective September 1, 2004

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QUICK REFERENCE CHART

Information Needed	Whom to Contact
<p>Claims Administrator (also called the Administrative Office or Fund Office)</p> <ul style="list-style-type: none"> • Claims Processing for Medical Benefits • Medical Claim Appeals • Eligibility and Plan Benefit Information • Certificate of Creditable Coverage 	<p>Southwest Service Administrators, Inc. 2400 W. Dunlap Ave Suite 250 Phoenix, AZ 85021-2811 Phone: 602-249-3582 or 800-474-3485 Fax: 602-249-3795</p> <p>Hours: Monday through Friday, except holidays 8:30 a.m. to 5:00 p.m.</p>
<p>Prescription Drug Program Administrator</p> <ul style="list-style-type: none"> • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Direct Member Reimbursement for non-network retail pharmacy claims. 	<p>NMHC RX 11523 S Nandina Avenue Jenks, OK 74037 Phone: 1-800-324-2200 Mail Order 1-800-881-1966</p>
<p>Employee Assistance Program (EAP)</p> <ul style="list-style-type: none"> • EAP counseling and referral services 	<p>CONTACT Behavioral Health Services 1400 E. Southern, Suite 800 Tempe, AZ. 85282 Phone: 480-730-3023 or 800-888-1477 Fax: 480-730-5528 www.contactbhs.com</p>
<p>Behavioral Health Program</p> <ul style="list-style-type: none"> • Mental Health and Substance Abuse Services and Providers • Behavioral Health Claims and Appeals 	<p>CONTACT Behavioral Health Services 1400 E. Southern, Suite 800 Tempe, AZ. 85282 Phone: 480-730-3023 or 800-888-1477 Fax: 480-730-5528 www.contactbhs.com</p>
<p>COBRA Administrator</p> <ul style="list-style-type: none"> • Information About COBRA Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments 	<p>Southwest Service Administrators, Inc. 2400 W. Dunlap Ave Suite 250 Phoenix, AZ 85021-2811 Phone: 602-249-3582 or 800-474-3485 Fax: 602-249-3795</p>
<p>Plan Administrator/Plan Sponsor</p> <ul style="list-style-type: none"> • Claim Appeals. 	<p>Board of Trustees for the Southwestern Teamsters Security Fund 2400 W. Dunlap Ave Suite 250 Phoenix, AZ 85021-2811 Phone: 602-249-3582 or 800-474-3485 Fax: 602-336-0895</p>
<p>HIPAA Privacy Officer</p>	<p>Southwest Service Administrators, Inc. 2400 W. Dunlap Ave Suite 250 Phoenix, AZ 85021-2811 Phone: 602-249-3582 or 800-474-3485 Fax: 602-336-0895</p>

INTRODUCTION

This booklet is designed to provide detailed information about the health and welfare benefits available to participants in the Retired Employee Plan of the Southwestern Teamsters Security Fund.¹ The booklet includes:

- A brief overview of the form of the Fund and the responsibility of its Board of Trustees. To understand everything that follows, you should understand the structure of the Fund and its Board of Trustees;
- A brief summary of the benefits available under the Retired Employee Plan. The Schedule of Benefits included in this summary is an overview of the benefit coverage available and the allowances that an individual might expect with respect to covered medical expenses that are incurred;
- The formal Rules and Regulations of the Retired Employee Plan, as amended by the Trustees to the date of printing;
- Information about the Plan and its operation, the disclosure of which is required by the governing federal (ERISA - the Employee Retirement Income Security Act); and
- An Appendix which specifies how an individual can obtain benefits and how an individual can secure review of adverse benefit determinations.

The Trustees urge participants to review this information and to share it with covered family members so that they will be familiar with the benefits available to them. Obviously, not all questions can be answered in the booklet, so participants are also urged to call or write the Fund Office, when necessary, to secure help in understanding and obtaining the benefits to which they are entitled.

A BRIEF OVERVIEW OF THE FUND

The Southwestern Teamsters Security Fund was formed in the collective bargaining process in the early 1950's by and between various Teamster local unions in the southwestern United States and various employers in the grocery, delivery and warehouse industries. Due to economies of scale and a mobile work force, the collective bargaining parties designed the Fund as a "multi-employer" Fund so that workers for all the unionized employers in the industry could be covered by one health benefits program.

Under the multi-employer trust fund arrangement, industry employers make contributions to the Fund, in amounts required by the Collective Bargaining Agreements, on behalf of employees working under those agreements. Some of those contributions are dedicated to the Retired Employee Plan. Eligible retirees may also be required to contribute toward the Retired Employee Plan benefits. The Fund's Board of Trustees, which consists of industry labor and management leaders, receives all the contributions, holds them in trust to pay benefits and administrative expenses, and invests the reserves for the future. The Fund is not an insurance company that returns profits to its investors. The Fund uses all contributions and earnings either to provide benefits to employees, retirees and their dependents or to pay necessary expenses. At a time when securing retiree health coverage has become more and more difficult, participants in the Southwestern Teamsters Security Fund Retiree Employee Plan should feel fortunate to have the benefits that the Fund provides.

¹ The Fund also provides the Class 3 and the Class 4 Plans to actively employed individuals and their dependents whose Collective Bargaining Agreement specifies their coverage under those Plans.

To clarify the work history necessary for an employee to be eligible for Retired Employee Plan benefits, and to specify the benefits available, the Board of Trustees has adopted Rules and Regulations governing the provision of benefits. These Rules and Regulations represent the efforts of the Trustees to provide the best benefits possible to the largest number of retirees and their dependents. The Rules and Regulations for the Retired Employee Plan are reproduced in this booklet.

RESPONSIBILITY OF THE BOARD OF TRUSTEES

Under the Collective Bargaining Agreements, the Agreement and Declaration of the Trust for the Fund, and the Rules and Regulations of the Retired Employee Plan, the Board of Trustees has full and exclusive authority to determine all questions of coverage and eligibility, the methods of providing or arranging for benefits and any other related matters. The Trustees have full power to construe the provisions of the Trust Agreement and the Rules and Regulations of the Plan. Any such determination and any such construction adopted by the Trustees in good faith are binding on the employers, the Unions, and any participant or beneficiary of the Fund.

Most of the benefits in this booklet are not insured by any contract of insurance, and the responsibility for those benefits is limited to the amount in the Trust Fund collected and available for benefits purposes.

A Word About Privacy: In conformance with federal law, the Trust Fund has adopted policies and procedures concerning the confidentiality of protected health information (P.H.I.) You will receive, separate and apart from this booklet, a “Notice of Privacy Practices” that summarizes how the Trust Fund uses and discloses P.H.I.

SUMMARY OF BENEFITS AVAILABLE

The following pages contain highlights of the Plan of benefits in chart form, followed by a brief summary of each of the Articles of the formal Rules and Regulations of the Plan. The Rules and Regulations, and the specific language of any benefit provision contract will control over the highlights expressed in this summary.

SCHEDULE OF RETIREE BENEFITS

Pre-Medicare Eligible

Retirees and their Eligible Dependents who are NOT eligible for Medicare:

Deductible.....	\$500 per calendar year per person; Maximum 3 per family
Lifetime Maximum.....	\$125,000 per person; \$2000 annual restoration

Medicare Eligible

Retirees and their Eligible Dependents who are eligible for Medicare (benefits will be coordinated with Medicare regardless of whether or not the Medicare Eligible Individual has enrolled in Part A and Part B or is a participant in a federally approved substitute.

Deductible.....	None
Lifetime Maximum.....	\$125,000 per person; \$2,000 annual restoration

NOTE: The total lifetime maximum for a retiree participant is \$125,000 combined Pre-Medicare Eligible and Medicare Eligible.

Pre-Medicare and Medicare Retirees and their Eligible Dependents:

Coinsurance

Medical Benefits.....	70% of allowable expenses
Hospital Room and Board.....	Semi-private; maximum of 70 days per confinement ²
Extended Care Facility.....	\$12 per day; maximum of 90 days per disability
Home Health Care.....	\$15 per day; maximum of 70 days per calendar year ³

² 70-day combined maximum

³ 70-day combined maximum

SCHEDULE OF BEHAVIORAL HEALTH BENEFITS

Coverage	In-Network (if you call the Behavioral Health Program)	Out-of-Network (if you <u>do not</u> call the Behavioral Health Program)
Deductible	None	None
Employee Assistance Program (EAP) • (1-6 visits/year)	No Charge	Not available
Inpatient Care (Mental Nervous) • Hospital expenses, room and board, drug, x-ray and lab, physician charges, detoxification, residential and partial hospital (paid at 2 partial days to 1 inpatient day).	100% coverage to the calendar year limit.	50% coverage per day for facility and professional fees combined to the calendar year limit.
Inpatient Calendar Year Limit:	30 days/year	3 days/year
Outpatient Care (Mental Nervous)		
• Visits 1-6:	100%, no copay for EAP visits 1-6	60% coverage to the calendar year limit.
• Visits 7 - 45	100% after a \$5 copay per visit for visits 7-45	60% coverage to the calendar year limit.
Outpatient Calendar Year Limit:	45 visits/year	3 visits/year
Substance Abuse (Alcoholism/Drug Abuse) Lifetime Limit	60 days/lifetime; (2 inpatient substance abuse treatments per lifetime, including detoxification)	6 days/lifetime
• Inpatient:		
• Outpatient:	180 visits/lifetime	12 visits/lifetime
Utilization Review	<p>Pre-authorization is required for all in-network benefits.</p> <p>Failure to obtain pre-authorization will result in payment at the out-of-network benefit levels.</p> <p>Emergency: For emergency admission, notification must be received by the next scheduled workday.</p>	Not Required

MEDICAL REVIEW PROGRAM & CASE MANAGEMENT SERVICES

Most people do not know whether the medical advice they receive represents the only, or even the best, alternative treatment plan for their situation. To help educate Fund participants, as health care consumers, the Fund is pleased to offer a comprehensive Case Management and Medical Review Program.

There is a team of Registered Nurses available to you at the Fund Office. The nursing staff can provide important health care information services to help participants decide on their best treatment options. This will help you understand your health care choices and in turn will allow the Fund the ability to preserve the Fund's benefit dollars for future benefit use.

HOW DO I USE THESE SERVICES?

The Fund Trustees understand that the relationship between the medical provider and patient is crucial to improving medical outcomes, therefore our program is voluntary. Accordingly, the program is designed to compliment the treatment recommendations your medical provider has recommended.

HAVE YOU EVER WONDERED IF YOUR CARE WILL BE COVERED?

We have created a program that will assist you and your provider to determine if services will be covered prior to a procedure being performed. We ask that for all **Non-Emergency Hospital Stays** (planned hospital admissions) that your provider call the Fund Office at least 10 days prior to admission.

The Fund will screen your request to ensure the procedure being requested meets the Fund's description of an eligible expense. The nurse will also evaluate the request to see if you may benefit from additional support and teaching to assist you with your recovery process before and/or after your discharge.

For **Urgent and Emergency Admissions** we request you or the facility contact the Fund Office within 48 hours of the admission to the hospital. This allows the nurse time to work with your providers to evaluate discharge-planning needs and assist with the coordination of services prior to your discharge home. It will also allow the Fund the ability to assist you with selecting providers that are in your network. This in turn will minimize your chance of incurring unnecessary out-of-pocket costs.

You or your provider may also request to have certain **Outpatient Services** reviewed for a predetermination of benefits. This may include high dollar durable medical equipment requests, questionable experimental or investigational services, review of services that may be considered cosmetic in nature and services that may have a question regarding medical necessity.

Remember that these services are provided on a voluntary basis and are not required by the Fund. This program has been designed with you in mind.

CASE MANAGEMENT SERVICES

The Board of Trustees recognizes that working through the complexities of health care and coverage issues can be difficult. This task becomes even more difficult when a participant is faced with unexpected medical complications. To assist you through these times, the Fund has recognized the importance of providing eligible participants with a Registered Nurse that specializes in Case Management services.

The program is *voluntary* and is available to any covered individual. This service may be initiated through claims review, pre-service screening or during the predetermination process. You and/or your provider may call the Fund Office and request to access the Case Management program.

Case Management specializes in the coordination of care for those that require individualized care that involves multiple providers. It is the belief of the Fund that by utilizing Case Management services, it will likely “improve your rehabilitation, quality of life, coordination of palliative care, client satisfaction compliance with medical care, and the reduction of healthcare costs”. (CMSA Standard of Practice for Case Management, 2002)

Questions?

Call the Fund Office: (602) 249-3582 or Arizona Toll Free: 1-800-474-3485
FAX: (602) 249-3795

**Southwest Service Administrators, Inc.
2400 West Dunlap Ave., Suite 250
Phoenix, AZ 85021**

RULES AND REGULATIONS SUMMARY

DEFINITIONS - ARTICLE I

Article I of the Retired Employee Plan Rules and Regulations contains the definitions used in the Plan. Many of the word and phrases used in the Rules and Regulations, and otherwise in this booklet, have a particular meaning assigned to them by these definitions. The Fund Office staff and other benefit professionals use these words and phrases regularly, and have become accustomed to their meaning. Plan participants, on the other hand, do not have occasion to talk about Plan benefits on a regular basis, and can be unsure of the meaning of some of these defined terms. To fully understand the Plan benefits available to you, you should review the defined words and phrases. Communication with the Fund Office will be easier if you familiarize yourself with the definitions that the Plan uses.

ELIGIBILITY - ARTICLE II

Retired Employee and Dependent Eligibility

Under Article II of the Retired Employee Plan Rules and Regulations, Retired Employees earn the right to benefits under the Retired Employee Plan of the Southwestern Teamsters Security Fund by working in the industry covered by the collective bargaining agreements calling for contributions to the Fund and its Retired Employee Fund. To be eligible, a Retired Employee must not be covered by any group health plan as an active employee and must:

- 1) Be retired from a Contributing Employer to the Fund and the Retired Employee Fund;
- 2) Have been covered by the Southwestern Teamsters Security Fund as an Active Employee for 24 of the most recent 36 months prior to retirement;
- 3) Have completed and submitted a written application for coverage to the Administrative Office;
- 4) Be receiving a monthly retirement or disability benefit under a Teamsternegotiated Pension Program or the Federal Social Security Act; and
- 5) Timely tender to the Administrative Office any self-payment for the Retired Employee Plan required by the Board of Trustees; and
- 6) Has completed the necessary written application and submitted it to the Administrative Office within 60 days of retirement. If the application is not submitted within 60 days of the retirement date, then eligibility begins the first day of the month subsequent to the date the application is received.

Note: Timely payment is by the 10th of the month preceding the eligibility month, and no payments will be accepted after the 20th of the month preceding the eligibility month.

Eligibility is effective on the date of retirement or, if later, the date Active Employee or Self-Pay Employee eligibility under the Southwestern Teamsters Security Fund terminates. Eligibility for Dependents (as Dependents are defined by the Retired Employee Plan) is coextensive with eligibility for the Retired Employee.

Retired Employee eligibility terminates under Article II on the earliest of the following dates:

- 1) The date on which the benefits provided under this Plan are terminated by the Board of Trustees;
- 2) The date the Retired Employee ceases to be eligible according the Rules and Regulations;

- 3) The first of the month following the month the Retired Employee becomes covered under any group health plan as an active employee. (If such person returns to eligible status as a Retired Employee within 12 months of his/her loss of eligibility, benefits will be effective on the first day of the month coinciding with or next following the date of return. However, if the Retired Employee remains ineligible for 12 consecutive months, he/she must again qualify as described above.);
- 4) The end of the second month following the month the Retired Employee's former Employer ceases being a Contributing Employer under this Plan unless the Employer has ceased operation or has sold the operation to another Contributing Employer, or unless the Trustees specifically authorize continued eligibility.

Dependent Self-Pay Provisions

If any Dependent of a Retired Employee loses coverage for the benefits of this Trust Fund because of:

- 1) The death of an Eligible Retiree;
- 2) The divorce from an Eligible Retiree; or
- 3) In the case of a Dependent child, ceasing to be a Dependent child as defined under the Plan,

He or she may continue eligibility by making self-payments directly to the Administrative Office.

Notice: Dependents whose coverage under this Retiree Plan is affected by death, divorce or a Dependent child ceasing to be a Dependent child as defined under the Retiree Plan are responsible for notifying the Administrative Office in writing of those facts within 60 days of the affecting event. The Administrative Office will then notify the Dependents of their rights under these provisions within 14 days.

The Dependents will have until the later of 60 days from the date of the notice from the Administrative Office, or 60 days from the date eligibility is lost, to notify the Administrative Office of their election to continue eligibility by making self-payments.

The amount of the monthly self-payment premium for Dependents will be established by the Board of Trustees. Dependents can choose continuation of medical benefits being provided for those Dependents as of the date eligibility would have otherwise ended.

The right of Dependents to make self-payment shall be continued until the end of the month in which the earliest of the following events occur:

- 1) The Trust Fund ceases providing any benefits to any Participant;
- 2) Coverage ceases by reason of the failure of the Dependents to make timely self-payments required by the Trustees;
- 3) The Dependents become covered under any group health plan, including, without limitation, this Retiree Plan and Medicare (for the exception to this when the other plan has limitations and/or pre-existing conditions, see the Rules and Regulations); or
- 4) 36 months have passed since the initial loss of eligibility under this Retiree Plan.

The initial self-payment premium (retroactive to the date of loss of eligibility) must be paid no later than the 45th day after the date the Administrative Office is notified of the person's election to make self-payments. Each subsequent self-payment is due on the first day of the month for which coverage is intended. **Self-payments received at the Administrative Office later than 30 days after the due date will not be accepted, and rights to self-payment will terminate. There will be no waivers granted.**

The Board of Trustees reserves the right to request and receive from self-pay Dependents any pertinent information bearing on the eligibility of such persons for the benefits provided under the self-payment provision of this Trust Fund. The failure of any such person to promptly respond to the Trustees' request for such information may lead to the self-payment rights described herein being suspended or terminated by the Trustees, at their discretion.

Notwithstanding anything to the contrary in the Retiree Plan, no person may enjoy any one continuous self-pay coverage extension under the Trust Fund and Retiree Plan beyond 36 months from the end of the month in which the first event giving rise to self-payment rights with respect to that person occurred.

Note: You must elect your self-payment choice in writing on the form provided by the Administrative Office. Once you make the election to self-pay, the Administrative Office will not send you a bill or notice for the self-payment premium. It is your responsibility to make timely payment under these self-payment provisions.

BENEFIT PROVISIONS - ARTICLE III

Employee and Dependent Medical Benefits (Excluding Mental Nervous/Substance Abuse)

Generally

The Plan's medical, hospital and surgical expense benefits are set forth in Article III of the Rules and Regulations. They can be briefly summarized as follows. After the deductible and within the Plan maximums, the Plan will pay the percentages specified in the Schedule of Benefits (usually 70%) of "Allowable Expenses" incurred by Eligible Individuals for medical services provided for the diagnosis and treatment of bodily illness and injury. "Allowable Expense" is defined in Article III of the Rules and Regulations, and generally will not equal expense incurred.

Article III, Sections 1 through 4 of the Rules and Regulations specify the kinds of medical, hospital and surgical expenses that are covered by the Plan. Please review these provisions, or contact the Fund Office, if you have questions about the medical benefits of the Plan.

Limitations and Exclusions

The Plan has a number of strict limitations and exclusions for medical services that are detailed in Article III, Section 5 and 6 of the Rules and Regulations. Please review these provisions or contact the Fund Office to ascertain whether a particular procedure or service is limited or excluded by the Plan.

Mental Nervous/Substance Abuse Benefits

The days when a stigma was attached to seeking help for emotional, mental health or substance abuse problems are hopefully drawing to a close. Many individuals in today's fast-paced society experience difficulties with stressful life situations. In many of these situations, a few simple counseling sessions would be of immense help.

In order to make such counseling (and to make treatment for more severe mental health/substance abuse conditions) readily available to Eligible Individuals under the Plan, the Fund has entered into an agreement with an independent Behavioral Health Provider to provide care for Plan participants. To utilize these benefits, Eligible Individuals must contact the Provider's coordinator at its telephone numbers. Benefits provided, exclusions and limitations are summarized in the Provider's brochure, which will be provided to Retired Employees.

Please Note: Eligible Individuals and providers of Mental Nervous/Substance Abuse services must receive pre-certification for all inpatient and outpatient care or benefits will be reduced. Failure to obtain preauthorization from the Behavioral Health Program will result in payment at the out-of-network benefit level. Request for pre-certification must be directed to the Provider's telephone numbers set forth in the brochure.

GENERAL EXCLUSIONS - ARTICLE IV

Article IV notes some general exclusions of the Plan, including the notation that the Plan does not cover occupational illnesses or injuries. If you have an occupational illness or injury, you should secure benefits under applicable workers' compensation laws.

COORDINATION OF BENEFITS - ARTICLE V

In recognition that families in today's society may have group health care coverage under more than one plan, the Trustees have adopted Plan provisions that allow individuals to take advantage of duplicate coverage, yet prevent payments in excess of the amount of the claims incurred. These "coordination of benefits" (COB) provisions are set forth in Article V of the Rules and Regulations.

Under the COB rules, one plan is assigned "primary" status and pays first. The other plan is assigned "secondary" status and pays (up to as much as a total of 100% of the incurred charges) after the primary plan. Medicare is a "plan" for these purposes, and has its own coordination rules which complement the rules of this Plan.

When filing a claim where other benefits are available, you should read Article V to determine if your claim will be covered by this Plan first or by your other plan first.

- A. If this Plan should pay first, file your claim as described in the Appendix.
- B. If this Plan should pay second, file your claim with the other plan first. When the other plan has paid its benefits, file your claim with this Plan as described above and include a copy of the other plan's payment worksheet/explanation of benefits (EOB).

Under the COB provision, it is necessary that you file a claim for any benefits you are entitled to receive from any source. Whether or not you file a claim to these other sources, the COB provision assumes that you have.

It is sometimes necessary for information to be furnished to other plans and for other plans to furnish information to this Fund under the operation of the COB provision. The right to release necessary information to other sources and to receive such information is reserved to the Trustees so that this Fund may be operated in an efficient, equitable and proper manner.

Sometimes, in the operation of a COB provision, delays occur in the receipt of necessary information for the proper processing of a claim.

In the event that another plan has paid first when this Fund should have paid first, this Fund may pay directly to the other plan the benefits it would have normally paid so as to satisfy this provision.

GENERAL PROVISIONS - ARTICLE VI

Generally

There are several important matters set forth in the Plan's General Provision. For a full understanding of these provisions, you should review Article VI of the Rules and Regulations.

Participants are generally responsible for notifying the Fund of changes in family circumstances. Benefits are not assignable, although the Fund will honor qualified medical child support orders, and will make its procedures for treatment of such orders available to participants and beneficiaries.

The Plan may be subrogated to your rights against third parties responsible for Illness and/or Injury. Article VI of the Rules and Regulations details the Fund rights the Trustees may choose to enforce.

The Board may secure such information as it needs to process claims, and may conduct individual examinations, if necessary.

Section 12 of Plan Article VI specifies when and how the Board of Trustees can use and otherwise deal with confidential medical information.

Appeals

While the Plan covers many routine and catastrophic health care expenses likely to be incurred, the Plan cannot pay every claim related to an Eligible Individual's health. The Fund Office, hired by the Trustees to perform routine claims payment tasks, uses the information submitted by a participant to determine whether, under the Rules and Regulations, a claim is payable and what amounts should be paid. Other providers make initial determinations about other claims.

The Trustees recognize that a participant can disagree with the determinations made by the Fund Office or other initial decision maker. Accordingly, they have developed informal review and formal appeal procedures to allow the Trustees (or their designee) to review claim determinations. The procedures are referenced in Article VI of the Rules and Regulations and are detailed in the Appendix to this booklet. The Appendix specifies what should be done by a participant (and when it must be done), to secure review of a claim which has been denied in whole or in part. There are time limits on informal review and formal appeals, so if you disagree with the action taken by the Fund Office or other initial decision maker on your claim, you should review the procedures in the Appendix and promptly file any review request or appeal.

AMENDMENT AND TERMINATION - ARTICLE VII

In Article VII, it is noted that the Board of Trustees generally has the power to amend the Plan's Rules and Regulations.

MAXIMUM LIABILITY OF THE PLAN - ARTICLE VIII

In Article VIII, it is noted that the benefits of the Plan are limited to the amounts collected and available in the Trust Fund for benefit purposes.

SOUTHWESTERN TEAMSTERS SECURITY FUND
RESTATED
RULES AND REGULATIONS
PROVIDING HEALTH AND WELFARE BENEFITS FOR RETIRED EMPLOYEES

Effective September 1, 2004

ARTICLE I. DEFINITIONS

Section 1. The term “**Trust Agreement**” means the Trust Agreement establishing the Southwestern Teamsters Security Fund and any modification, amendment, extension or renewal thereof.

Section 2. The term “**Fund**” means the Southwestern Teamsters Security Fund; the term “**Fund**” also means the Board of Trustees established by the Trust Agreement where applicable.

Section 3. The terms “**Board of Trustees,**” “**Trustees**” and “**Board**” mean the Board of Trustees established by the Trust Agreement.

Section 4. The terms “**Retiree,**” “**Retired Employee**” and “**Eligible Retiree**” mean any person who meets the eligibility requirements hereunder as established by the Fund and as amended from time to time.

Section 5. The term “**Dependent**” means:

- A. The Eligible Retiree’s lawful spouse;
- B. The Eligible Retiree’s unmarried natural child who is less than 19 years of age;
- C. An unmarried stepchild, foster child or legally adopted child who lives with the Eligible Retiree in regular parent- child relationship and who is **less than 19 years of age;** and
- D. An unmarried natural child, stepchild, foster child, or legally adopted child **over the age of 19, but less than 23,** who is a full-time student (at least 12 credit hours, or for a graduate student, 9 credit hour) in attendance at a high school, college, university, vocational, technical or trade school. (Spring full-time student certification grants coverage through August 31.)

The term “**Foster Child**” shall mean and include a child who:

- A. Resides with the Eligible Retiree on a permanent, full-time basis;
- B. Depends upon the Eligible Retiree fully and solely for support and maintenance; and
- C. Is reported as a Dependent by the Eligible Retiree which the Eligible Retiree files a return under the Internal Revenue Code.

The term “**Legally Adopted Child**” shall include a child placed for adoption and as to which the Eligible Retiree assumes and retains a legal obligation for total or partial support in anticipation of adoption of the child.

If a Dependent, prior to attaining the applicable maximum age for Eligible Dependent, is chiefly dependent upon the Eligible Retiree for support and maintenance and is continuously unable to obtain self-sustaining employment because of physical handicap or mental retardation, the Dependent shall remain eligible for the medical coverage provided for Dependents until the Dependent either recovers from the physical handicap or mental retardation, or no longer chiefly depends upon the Eligible Retiree for support and maintenance.

In no event shall any Dependent other than a lawful spouse be eligible under the Plan both as an Eligible Dependent and as an Eligible Retiree. However, if a spouse is eligible as a Retiree, Dependent children will be covered as Dependents of both parents and benefits will be coordinated in accordance with Article V of the Rules and Regulations.

Section 6. The term “**Eligible Individual**” means each Eligible Retiree and each of his/her Dependents, if any.

Section 7. The term “**Physician**” means a person legally licensed as a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Section 8. The term “**Health Care Practitioner**” means a Physician, Chiropractor, Dentist, Nurse, Nurse Practitioner, Nurse Midwife, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master’s prepared Audiologist, Optometrist, or Optician who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Section 9. The term “**Hospital**” means only an institution which meets all the following tests:

- A. Maintains permanent and full-time facilities for the bed care of 5 or more patients;
- B. Has a Physician (M.D. and/or D.O.) in regular attendance;
- C. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics, or a place for drug addicts;
- D. Is operated lawfully in the jurisdiction where it is located;
- E. Continuously provides 24-hour-a-day nursing services by Registered Nurses; and

The term “Hospital” will also include a hospital-based or free-standing outpatient surgical facility or urgent care facility.

Section 10. The term “**Extended Care Facility**” or “**Skilled Nursing Facility**” means only an institution that meets all the following tests:

- A. Provides skilled nursing care to sick and injured persons as registered inpatients under 24-hour-a-day supervision of a Physician (M.D. and/or D.O.) or Registered Nurse;
- B. Has available at all times the services of a Physician (M.D. and/or D.O.) who is a staff member of a Hospital;
- C. Has on duty, 24 hours a day, a Licensed Vocational Nurse or Skilled Practical Nurse and has on duty at least 8 hours a day a Registered Nurse;
- D. Is operated lawfully in the jurisdiction where it is located;
- E. Maintains a daily medical record for each patient; and
- F. Is not a place used by the Eligible Individual for rest or custodial care or is not for the aged, for drug addicts, for alcoholics, or a hotel.

Skilled Nursing Facility includes but is not limited to a long term care facility, extended care facility or subacute care facility.

Section 11. The term “**Hospice**” shall mean a public agency or private organization constituted and operated pursuant to law, engaged primarily in providing palliative, supportive and related care for the

Covered Person diagnosed as terminally ill with a medical prognosis that life expectancy is 6 months or less; and

- A. Provides hospice care on a 24-hour basis including control of symptoms associated with terminal illness; and
- B. Has an interdisciplinary medical team consisting of at least 1 Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.), at least 1 Registered Nurse, at least 1 social worker, at least 1 volunteer and a volunteer program; and
- C. Maintains central clinical records on all patients; and
- D. Provides appropriate methods for dispensing and administering drugs and medicines; and
- E. Is not an institution or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, a hotel or similar institution.

Section 12. The term “**Registered Nurse**” means a Registered Nurse who does not ordinarily reside in the Eligible Retiree’s home and is not the spouse, child, brother, sister or parent of the Eligible Retiree or the Eligible Retiree’s spouse.

Section 13. The term “**Schedule of Allowances**” means the description of surgical procedures and professional services and the amounts allowable for each, as set forth in these Rules and Regulations.

Section 14. The term “**Reasonable Charges**” means the customary charges in the area in which they are incurred, but not exceeding such charges as would have been made in the absence of the benefits provided under these Rules and Regulations. A “customary charge” as used herein means the usual charge made by a Hospital, Extended Care Facility, Physician, or other professional person, or other person or firm having rendered or furnished the service, treatments or supplies which do not exceed the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred for bodily injuries or sicknesses comparable in severity and nature to the bodily injuries or sicknesses treated or being treated. The term “area” as it would apply to any particular item for which a covered charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross-section of entities furnishing such items. A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained.

Section 15. The term “**Medicare**” as used herein means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it as presently constituted or may hereafter be amended.

Section 16. The term “**Plan**” means these Rules and Regulations as adopted and thereafter amended by the Board of Trustees.

Section 17. The term “**Contributing Employer**” means a person or entity bound by a Collective Bargaining Agreement or other agreement to make Contributions to the Fund on behalf of employees for the purpose of providing those Regular Employees with the health and welfare benefits of the Fund.

Section 18. The term “**Calendar Year**” means January 1 through December 31 or each year.

Section 19. The term “**Home Health Agency**” means an organization or agency that meets the requirements for participation as a Home Health Agency under Medicare. Care provided by a Home Health Agency is limited to the home health benefit maximum described in this Plan.

Section 20. “Experimental and/or Investigational”: The Board of Trustees or their designee have the discretion and authority to determine if a service or supply is or should be classified as Experimental

and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Board of Trustees or their designee, based on the information and resources available at the time the service was performed or the supply was provided, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- A. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Practitioner that performs the service or prescribes the supply;
- B. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
- C. In the opinion of the Board of Trustees or their designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
- D. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is:
 - approved by the FDA as an “investigational new drug for treatment use”; or
 - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease” as that term is defined in FDA regulations; or
 - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
- E. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Board of Trustees or their designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided or considered:

- A. Medical or dental records of the covered person;
- B. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
- C. Protocols of the Health Care Practitioner that renders the prescribed service or prescribes or dispenses the supply;
- D. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including, but not limited to “United States Pharmacopeia Dispensing Information”; and “American Hospital Formulary Service”;
- E. The published opinions of the American Medical Association (AMA), such as “The AMA Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health

(NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.

- F. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
- G. The latest edition of “The Medicare Coverage Issues Manual.”

Section 21. Medically Necessary:

- A. A medical or dental service or supply will be determined to be “Medically Necessary” by the Board of Trustees or their designee if it:
 - 1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
 - 2. is determined by the Board of Trustees or their designee to be necessary in terms of generally accepted American medical and dental standards; and
 - 3. is determined by the Board of Trustees or their designee to meet all of the following requirements:
 - it is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
 - it is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Practitioner, or health care facility; and
 - it is an “Appropriate” service or supply given the patient’s circumstances and condition; and
 - it is a “Cost-Efficient” supply or level of service that can be safely provided to the patient; and
 - it is safe and effective for the illness or injury for which it is used.
- B. A medical or dental service or supply will be considered to be “**Appropriate**” if:
 - 1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
 - 2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
- C. A medical or dental service or supply will be considered to be “**Cost-Efficient**” if it is no more costly than any alternative Appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
- D. The fact that a Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.
- E. A Hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient’s illness or injury could safely and Appropriately be diagnosed or treated while not confined.
- F. A medical or dental service or supply that can safely and Appropriately be furnished in a Physician’s or Dentist’s office or other less costly facility will not be considered to be medically necessary if it is furnished in a Hospital or health care facility or other more costly facility.
- G. The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other health care facility is medically necessary.

- H. A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or health care facility.

ARTICLE II. ELIGIBILITY FOR BENEFITS

Section 1. Establishment and Maintenance of Eligibility:

- A. Any Retired Employee shall be eligible for benefits under these Rules and Regulations if he/she is not covered by any other group health plan as an Active Employee, and:
1. Retires from the employ of an Contributing Employer that is a continuing contributor to the Southwestern Teamsters Security Fund and the Retired Employee Fund thereunder; and
 2. Was covered under an Active Employee Plan of benefits by the Southwestern Teamsters Security Fund for at least 24 of the 36 months immediately preceding his/her retirement date. Self-payment participation shall not be considered for these purposes. (For good cause shown, the Trustees in their discretion may waive the requirements of this provision); and
 3. Has completed the necessary written application and submitted it to the Administrative Office within 60 days of retirement. If the application is not submitted within 60 days of the retirement date, then eligibility begins the first day of the month subsequent to the date the application is received; and
 4. Is receiving a monthly retirement or disability benefit under the Federal Social Security Act, the Western Conference of Teamsters Pension Trust or another bona fide pension plan which is provided to employees by virtue of a Teamster-negotiated collective bargaining agreement with the Retired Employee's former Employer; and
 5. Timely tenders to the Trust any self-payments the Trustees may require in order for such individual to be considered eligible for benefits. To be considered timely, such self-payments must be made by the 10th of the calendar month preceding the month of eligibility. No such payments will be accepted after the 20th of the month preceding the month of eligibility; i.e., there is only a 10-day grace period, and no waivers or exceptions will be granted.
- B. A Retired Employee's eligibility shall commence on the later of the following dates:
1. The first day of the month for which said pension or disability benefits become payable to such Retired Employee;
 2. The date on which his/her eligibility as an Active Employee under the active Employee Plan terminates if, in fact, he/she is eligible as a Retired Employee as of such date;
 3. The date on which his/her eligibility as a Self-Pay Employee under the Active Employee Plan terminates if, in fact, he/she is eligible as a Retired Employee as of such date.
- C. A Retired Employee's Dependent becomes eligible on the later of the following dates:
1. The date the Retired Employee's eligibility is effective;
 2. The date the Retired Employee acquires the Dependent;
 3. In the case of a newborn infant, the date of birth.

Section 2. Termination of Eligibility.

- A. A Retired Employee's eligibility will terminate on the earlier of the following dates:
1. The date on which the benefits provided herein are terminated by the Board of Trustees;

2. The date on which the Retired Employee ceases to be eligible according to these Rules and Regulations;
3. The first day of the month next following the month in which the Retired Employee becomes covered under any group health plan as an Active Employee. If such person returns to an eligible status as a Retired Employee within 12 months of his/her loss of eligibility as a Retired Employee, benefits will be effective on the first day of the month coinciding with or next following the date of return.

However, if the Retired Employee remains ineligible for 12 consecutive months, he/she must again qualify as previously described in Section I of this Article II, to regain his/her eligibility;

4. The end of the second calendar month following the calendar month in which the Retired Employee's former Employer ceases being a Contributing Employer under this Plan except if such Contributing Employer ceases doing business or sold the business to another Contributing Employer as of the date the Retired Employee's insurance would otherwise terminate because of this provision.

Notwithstanding this subsection (4), a Retired Employee whose former Employer is not a Contributing Employer may, on such terms and conditions as the Trustees may authorize, and for such time periods as the Trustees may authorize, continue eligibility for themselves and their Eligible Dependents by making self-payments, in such amounts as the Trustees may approve directly to the Administrative Office.

- B. The eligibility of a Dependent of a Retired Employee will terminate on the earlier of the following dates:
 1. The date on which the benefits provided herein are terminated by the Board of Trustees;
 2. The date on which he/she no longer qualifies as a Dependent, as defined in Section 5 of Article 1;
 3. The date on which the Retired Employee's eligibility terminates;
 4. On the date he/she enters full-time military service of any country.

Section 3. Retiree Dependent Self-Payments.

- A. If any Dependent(s) lose(s) coverage for the benefits of this Trust Fund because of:
 1. The death of an Eligible Retiree;
 2. The divorce from an Eligible Retiree; or
 3. In the case of a dependent child, ceasing to be a dependent child as defined under the Retiree Plan; they may continue eligibility by making self-payments directly to the Administrative Office.
- B. Dependents whose coverage under this Plan is affected by death, divorce, or a dependent child ceasing to be a dependent child as defined under the Retiree Plan are responsible for notifying the Administrative Office of those facts within 60 days of the affecting event. **Such notice must be in writing and should contain enough information for the Administrative Office to determine who is affected by the event or the contact information for the person who has that information.** The Administrative Office will then notify the Dependent(s) of their rights under these provisions within 14 days. The Dependent(s) will have until the later of 60 days from the date of the notice from the Administrative Office, or 60 days from the date eligibility is lost, to notify the Administrative Office of their election to continue eligibility by making self-payments.

- C. **Coverage Available - Self-Payment Premium.** The amount of the monthly self-payment premium(s) for Dependent(s) will be established by the Board of Trustees. The Self-payment charged represents continuation of those medical benefits being provided for those Dependents as of the date eligibility would have otherwise ended.
- D. **Maximum Period of Self-Payments.** The right of Dependent(s) to make timely self-payments shall be continued until the end of the month in which the earliest of the following events occurs:
1. The Trust Fund ceases providing any benefits to any Participant;
 2. Coverage ceases by reason of the failure of the Dependent(s) to make timely self-payments required by the Trustees;
 3. The Dependent(s) become covered under any group health plan;
Note: If the other plan contains lawful limitations or exclusions for any pre-existing conditions, any individual so limited or excluded by the other plan may continue coverage under the Fund until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by this Subsection (D).
 4. The Dependent(s) become entitled to Medicare; or
 5. 36 months have passed since the initial loss of eligibility under this Plan.
- E. **Payment of Self-Payment Premium for Dependents.** The initial self-payment premium(s) (retroactive to the date of loss of eligibility) must be paid no later than the 45th day after the date the Administrative Office is notified of the person's election to make self-payments. Each subsequent self-payment is due on the first day of the month for which coverage is intended. Self-payments received at the Administrative Office later than 30 days after the due date will not be accepted, and rights to self-payment will terminate.

ARTICLE III. MAJOR MEDICAL EXPENSE BENEFITS

Section 1. Allowable Expense. For the purpose of this Article, an expense or charge shall be an Allowable Expense only if the Trustees in their sole discretion determine that:

- A. Except for items/services specified in Section 4(T) of this part, it is Medically Necessary for the care and treatment of non-occupational accidental bodily injury or sickness of a person who is an Eligible Individual at the time the expense is incurred;
- B. It is recommended and approved by a Physician and is for a valid course of medical treatment which is not experimental and which is recognized as valid by an established medical society in the United States, provided that the Plan may obtain and rely upon independent medical advice to determine whether services or supplies are Medically Necessary, are consistent with professionally recognized standards of care with regard to quality, frequency and duration; and are provided in the most economical and medically appropriate site for treatment;
- C. It is a Covered Charge as described in Section 4 below;
- D. It is a Reasonable Charge as defined in Article 1, Section 14;
- E. It is not otherwise excluded or limited by provisions under this Article.

Section 2. Benefits.

- A. Benefits other than Behavioral Health Benefits (mental nervous/alcoholism and drug abuse benefits):

If an Eligible Individual receives therapeutic treatment for an injury or sickness, the Fund will, subject to the terms and conditions hereafter stated, pay an amount equal to 70% of all Allowable Expenses which exceed the Deductible Amount during the Calendar Year, up to the maximum specified in Section 7 of this Article III. Benefits as set forth in this Article shall be coordinated with Medicare in accordance with the provisions of Article V of these Rules and Regulations.

Note: Prescription Drugs may be provided either through retail pharmacies or by mail order under the Fund's prescription benefit manager network with a 30% co-payment by the Eligible Individual. When Prescription Drugs are secured in-network, the Plan Deductible is waived; Prescription Drugs secured out-of-network are subject to the Plan Deductible.

- B. Behavioral Health Benefits (mental nervous/alcoholism and drug abuse benefits): Behavioral health benefits for mental health, substance abuse, and counseling for stress, depression, family matters, marital problems and financial issues are provided through

CONTACT Behavioral Health Services
1400 East Southern Avenue, Suite 800
Tempe, Arizona 85282
(For precertification call 1-800-888-1477)

The Fund will make the Behavioral Health Services brochure available to Retired Employees and their Dependents. See also the Schedule on the next page:

SCHEDULE OF BEHAVIORAL HEALTH BENEFITS		
Coverage	In-Network (if you call the Behavioral Health Program)	Out-of-Network (if you <u>do not</u> call the Behavioral Health Program)
Deductible	None	None
Employee Assistance Program • (EAP)(1-6 visits/year)	No Charge	Not available
Inpatient Care (Mental Nervous) • Hospital expenses, room and board, drug, x-ray and lab, physician charges, detoxification, residential and partial hospital (paid at 2 partial days to 1 inpatient day).	100% coverage to the calendar year limit.	50% coverage per day for facility and professional fees combined to the calendar year limit.
Inpatient Calendar Year Limit:	30 days/year	3 days/year
Outpatient Care (Mental Nervous) • Visits 1-6:	100%, no copay for EAP visits 1-6	60% coverage to the calendar year limit.
• Visits 7-45:	100% after a \$5 copay per visit for visits 7-45	60% coverage to the calendar year limit.
Outpatient Calendar Year Limit:	45 visits/year	3 visits/year
Substance Abuse (Alcoholism/Drug Abuse) Lifetime Limit • Inpatient:	60 days/lifetime; (2 inpatient substance abuse treatments per lifetime, including detoxification)	6 days/lifetime
• Outpatient:	180 visits/lifetime	12 visits/lifetime
Utilization Review	<p>Pre-authorization is required for all in-network benefits.</p> <p>Failure to obtain pre-authorization will result in payment at the out-of-network benefit levels.</p> <p>Emergency: For emergency admission, notification must be received by the next scheduled workday.</p>	<p>No pre-authorization required. No penalties apply.</p>

Note: Prescription drugs, blood tests and other physical diagnostic measures medically necessary for the treatment of mental nervous/alcoholism and drug abuse conditions are provided under this Subsection A.

Section 3. Deductible Amount. The Deductible Amount of the Plan is \$500 per year for each Eligible Individual NOT eligible for Medicare (the deductible is waived for all Eligible Individuals who ARE covered by Medicare or a federally approved substitute). However,

- A. Any Allowable Expenses incurred during the last three months of a Calendar Year which are applied against a Eligible Individuals's Deductible Amount will also reduce his/her Deductible Amount for the next Calendar Year.
- B. After Deductible Amounts totaling \$1,500 have been applied during any Calendar Year to any combination of Eligible Individuals within a family, no further Deductible Amounts will be

applicable to the Eligible Retiree or any of his/her Dependents for the remainder of the Calendar Year.

- C. If an Eligible Retiree and one or more of his/her Eligible Dependents, or if two or more of his/her Eligible Dependents, are injured in the same accident, all Allowable Expenses arising out of such accident will be combined and only one Deductible Amount will be applied to all such expenses incurred. This combined Deductible Amount will also apply to future reapplication of the Deductible Amount for such common accident.

Section 4. Covered Charges. Covered Charges are as follows:

- A. Charges made by a **Hospital** on its own behalf for:

1. Room, board and other necessary services and supplies provided during **Hospital confinement**. Hospital room and board expenses will be paid at the average semi-private room rate; except room and board expenses in special care units will be paid at the rate for such units. **Note: The plan maximum is 70 days per confinement.**
2. **Routine newborn hospital care** (including elective newborn circumcision).
3. **Emergency Room (ER).**
4. **Urgent Care facility** in a hospital-based or free-standing urgent care facility.
5. **Ambulatory Surgery** in a hospital-based or free-standing outpatient surgical facility.
6. **Hospital Length of Stay for Childbirth:** This Trust complies with federal law that prohibits restricting benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a Physician or Health Care Practitioner to obtain authorization from the Trust for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending Physician or Health Care Practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).

- B. Charges made by a **Physician or Health Care Practitioner** for professional services performed within the scope of their license/specialty;

1. Charges for the surgeon for surgical procedures and postoperative treatment; **(See Note, below.)**
2. Charges for the **assistant surgeon** (payable to a maximum of 20% of the allowed fee payable to the surgeon); **(See Note, below.)**
3. Charges for **anesthesia** and its administration by a Physician or Certified Registered Nurse Anesthetist (CRNA); **(See Note, below.)**

Note: For surgical procedures, post-operative treatment, anesthesia and its administration, the amount allowed shall be the product of the appropriate Relative Value stated in the 1964 California Relative Value Schedule multiplied by a Unit Value of \$13.00. The allowance for an assisting Physician for an operation is 20% of the 1964 California Relative Value Schedule for the surgical procedure. Benefits shall not be payable for the attendance of two Physicians on the same case at the same time except where it is warranted by medical necessity.

For medical services not shown in the 1964 California Relative Value Schedule, and which are not expressly excluded by the terms of this Plan, the Plan will determine the Relative Value of the service. A service comparable to the enumerated service of closest similarity will be used as a basis for the determination.

4. **Allergy testing**, desensitization shots and allergy antigen.
 5. **Elective newborn circumcision** is payable when performed by a Physician in the hospital or Physician's office up to 10 weeks of age, thereafter only if medically necessary.
 6. **Surgery Allowance:** The Board of Trustees or their designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Reasonable Charges will be allowed as the Plan's benefit:
 - a) Allowances for multiple surgeries through the same incision or operational field is 100% for the primary procedure and 50% for all other procedures;
 - b) Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session is 100% for the first site primary procedure and 50% for the first site secondary and additional procedures and 50% for the second site primary and additional procedures.
- C. **Acupuncture** is payable when performed by a Physician who is properly licensed by the state in which he/she is practicing and must be performing services within the scope of that license.
- D. Charges for **Ambulance** transportation. Benefits are payable for ground vehicle transportation to the nearest appropriate facility as Medically Necessary for treatment of a medical emergency, acute illness or inter-health care facility transfer. Air/sea transportation only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.
- E. Charges for **Blood transfusions** and blood products and supplies for administration;
- F. Charges for **Chemotherapy**.
- G. Charges for **Dialysis**.
- H. Charges for the rental of necessary **Durable Medical Equipment (DME)** (means equipment that is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness, is not disposable or non-durable and is appropriate for the patient's home). Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds (with safety rails), electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. Equipment is payable for rental up to the purchase price of the item, repair, adjustment or servicing of the item or Medically Necessary replacement due to a change in the covered person's physical condition or if the item cannot be satisfactorily repaired.
- I. Charges for **Home Health/Home Infusion Therapy Services** using nursing service furnished by a Registered nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN), provided in any case that such nurse is one who does not ordinarily reside in the home of the Retiree and is not a member of the Retiree's immediate family (for purposes of this coverage "immediate family" consists of the Retiree, the Retiree's spouse, children, brothers, sisters and parents). Home health home infusion therapy services are limited to \$15 per day and are in lieu of, and not in addition to, Hospital care. Each day of Home Health Care payable under the Plan shall count as a day of Hospital confinement.
- J. Charges for **Hospice Care**.
- K. Charges for **Laboratory Services**.
- L. Charges for the **Non-durable supplies** listed below:
 1. Sterile surgical supplies used immediately after surgery;

2. Supplies needed to operate or use covered Durable Medical Equipment or Orthotics devices;
 3. Supplies needed for use by skilled home health or home infusion therapy personnel but only during the course of their required services;
 4. Colostomy/ostomy supplies;
 5. Diabetic Supplies (such supplies are also payable under the Prescription Drug Program).
- M. Charges for **Orthotic devices** (means items used to support a weakened body part) including but not limited to leg braces or crutches.
1. Orthopedic shoes and related items such as wedges, cookies and foot orthotics are payable if custom made for the Eligible Individual and are payable once in a 12-month period for adults and once in a 6-month period for children under age 19 when replacement is needed due to growth.
- N. **Prescription Drugs:** are payable for medically necessary drugs which may be lawfully dispensed, as provided under the Federal Food and Drug Administration (FDA), including any amendment thereto, only upon a written or oral prescription of a Physician or Health Care Practitioner licensed to prescribe such drug.
1. Covered drugs include insulin, diabetic supplies (including syringes, needles and blood glucose test supplies), prescription contraceptives, and prenatal vitamins.
 2. The Trust may contract with an independent Prescription Drug Program to administer outpatient drugs through contracted retail pharmacies and a mail order home delivery service.
 3. Some drugs have a quantity limit (such as those to treat migraines and sexual dysfunction) or may require prior authorization by contacting the Prescription Drug Program.
 4. Section 5A of this Article describes the drugs that are not payable by the Plan.
- O. Charges for **Prosthetic appliances** (items used to replace a missing body part) including but not limited to an artificial limb. Note that one pair of contact lenses is payable when used as a prosthetic device following the surgical removal of the lens of the eye, such as after cataract surgery.
- P. Charges for **Radiology and Nuclear Medicine** services including radiation therapy;
- Q. **Reconstructive Services:**
1. The Plan provides coverage for an Eligible Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy as follows:
 - Reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.
 2. Reconstructive Surgery is payable if used to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital anomaly that causes a functional defect.
- R. **Rehabilitation Services:** The following charges are payable by the Plan for **short-term, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician when the patient actively participates in this rehabilitation, as follows:
1. **Outpatient rehabilitation** includes any combination of **Physical, Occupational and/or Speech Therapy, Respiratory Therapy or Cardiac Rehabilitation** and is payable to a maximum of \$5,000 per person per calendar year. Speech therapy is covered for the purpose

of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation, laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease.

2. **Inpatient Rehabilitation** services are payable in an acute hospital, rehabilitation unit or freestanding rehabilitation facility or Skilled Nursing Facility for short term, active, progressive Rehabilitation Services that cannot be provided in an outpatient or home setting. Inpatient rehabilitation is payable to a maximum of 60 days per person per calendar year.
 3. **Maintenance rehabilitation** is not payable. Maintenance therapy refers to therapy that is provided after a person has met the functional goals of the rehabilitation therapy program so that no continued significant and measurable improvement is reasonably and medically anticipated and that further therapy serves primarily to maintain, support, and/or preserve the patient's functional level.
- S. Charges for **Prescription Contraceptives** administered by a Physician or Health Care Practitioner in their office.
- T. Charges for **Preventive (Wellness) Services** are payable as follows:
1. **Routine Preventive Care Childhood Immunizations** are payable to age 2 yrs.;
 2. **Mammography breast cancer screening** as follows:
 - (a) 1 baseline screening mammogram payable for women from age 30 to 39.
 - (b) 1 screening mammogram every year for women age 40 and over, or more frequently based on the recommendation of a Physician.
 3. **Annual cervical cancer screening gynecological exam and pap smear for women age 18 and over to a maximum of \$125 per year.**
- U. **Sexual dysfunction drugs** (payable under the outpatient prescription drug benefit of this Plan) or medically necessary surgical treatment.
- V. **Skilled Nursing Facility (SNF), Long Term Care Facility, Extended Care or Sub-Acute Care Facility** is payable to a maximum of **\$12 per day up to a maximum of 90 days per person, per calendar year, but only if such confinement commences within 7 days after a period of at least five days of Hospital confinement.**
- W. **Spinal manipulation** and related services (by a Physician or Chiropractor) are payable to a maximum of **one treatment per day, 50 treatments per Calendar Year, and \$1,500 per person per Calendar Year.** This limit does not include radiology services performed by the Health Care Practitioner or Medically Necessary supplies.
- X. Charges for elective **Sterilization**, such as tubal ligation or vasectomy.
- Y. Charges for the **medical** or surgical treatment of **Temporomandibular joint dysfunction syndrome (TMJ)** is payable to a maximum of \$1,500 per person per lifetime.
- Z. Charges for Medically Necessary human organ and tissue **Transplants**, including an artificial heart or ventricular assistive device when used as a temporary bridge to a heart transplant.

Section 5. Limitations and Exclusions.

- A. This Plan does not cover expenses for the following:
1. Treatment in a **United States Government Hospital**, or elsewhere, at federal government expense unless required by law.
 2. Treatment or **expenses incurred outside of the United States** unless in an emergency.

3. Expenses for injury or illness during or arising out of a period of employment for which **Workers' Compensation** benefits are payable or arising from or sustained in the course of any gainful occupation or employment;
4. Expenses determined to be **investigational or experimental** including any diagnostic or treatment measures which are not recognized as generally accepted medical practice as determined by the Board of Trustees or their designee;
5. As a result of the commission or the attempt to commit an **assault or felony**.
6. As the **result of war**, whether declared or undeclared, or insurrection.
7. **Services that are not Medically Necessary:** Services, supplies or treatment, including any period of Hospital confinement, which were not recommended, approved and certified by a Physician as necessary for the therapeutic treatment of the Eligible Individual or **medically unnecessary confinement** in skilled nursing facilities, nursing homes, institutions, convalescent facilities, Hospitals or other qualified health care facilities.
8. **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses, charges for broken/missed appointments, telephone calls, late fees and/or photocopying fees, administrative fees, state taxes, state surcharges, interest, or penalties.
9. Expenses resulting from an **abortion** unless continuation of the pregnancy to a viable birth creates a life-threatening situation for the mother or unless for complications of an elective abortion;
10. Benefits for Inpatient and Outpatient **Behavioral Health** (Mental, Nervous, Alcoholism and Drug Abuse) treatment are not covered by **Sections 4 and 5 of this Article III**, but are covered by **Section 2(B)** of this Article III. Prescription drugs, blood tests and other physical diagnostic measures medically necessary for treatment of Mental Nervous/Alcoholism and Drug Abuse conditions are provided under **this Article**.
11. **Cosmetic surgery** unless it is necessary for the repair of damage resulting from an injury received or illness, if incurred within one year of the injury or the commencement of the illness. This time limit may be extended up to two additional years if necessary repair is not medically feasible within one year. Notwithstanding the foregoing, in the case of an Eligible Individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the Plan will provide coverage for:
 - Reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - Prosthesis and physical complications of all stages of mastectomy, including lymphedemas;
12. **Custodial** care services.
13. In connection with **dental care**, treatment or surgery unless necessitated by non-occupational accidental bodily injury to sound natural teeth. Sound natural teeth refers to natural teeth (not dentures, bridges, pontics or artificial teeth) that are free of active or chronic clinical decay; and have at least 50% bony support; and are functional in the arch; and have not been excessively weakened by previous dental procedures. Injury to the teeth refers to damage to sound natural caused by trauma from an external source and does not include an injury caused by any intrinsic force, such as the force of biting or chewing.
14. Certain **drugs** as follows:
 - Non-prescription (over the counter) drugs such as aspirin;
 - Vitamins, except prenatal vitamins are payable;
 - Food supplements, except when these supplements are the sole source of nutrition;
 - Fertility drugs;

- Weight loss/appetite suppressants, fat inhibitors;
 - Smoking/tobacco cessation products;
 - Drugs to treat a work-related illness, injury/accident;
 - Growth hormones;
 - Products used for unapproved cosmetic indications.
15. **Education related services:** Services rendered for remedial reading and recreational, visual and behavioral modification therapy, hypnosis, pain rehabilitation control and dietary or educational instruction for any disease, illness, or condition.
 16. **Eye refractions,** eyeglasses and contacts (except one pair of contact lenses used as a prosthetic device following surgical removal of the lens of the eye such as after cataract surgery), surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, radial keratotomy (RK) and automated keratoplasty (ALK), or laser assisted in situ keratomileusis (LASIK).
 17. Services, supplies, or treatment in connection with or related to **gender dysphoria** or any attempts of these procedures.
 18. **Genetic tests,** including obtaining specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, including pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are determined by the Board of Trustees or their designee to be likely to be transmitted to a child of that parent or parents, and prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of genetic disease or disorder.

However, in pregnant women, the Plan will allow genetic testing associated with amniocentesis, chorionic villus sampling (CVS) and alphafetoprotein (AFP). Expenses for **genetic counseling** to educate the patient about issues related to chromosomal abnormalities, genetically transmitted characteristics, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman are excluded.
 19. Charges for and related to **hair removal or hair transplants** and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis.
 20. **Hearing aids** and batteries, except a medically necessary cochlear implant for individuals with profound hearing loss.
 21. Expenses for the **diagnosis and treatment of infertility** including but not limited to drugs, invitro fertilization, artificial insemination, reversal of elective sterilization, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services.
 22. **Maternity-related expenses for other than Employees or Dependent Wives.**
 23. Inpatient Hospital expense benefits for **non-emergency admissions** beginning on Friday or Saturday unless surgery is performed on the same day or the day following admission.
 24. **Non-medical supplies/equipment:** Air conditioners and/or filters, dehumidifiers, air purifiers, heating pads, batteries, home enema equipment, rubber gloves, swimming pools, saunas, whirlpool baths, home pregnancy test, and any other items not normally considered medical supplies.
 25. Services, supplies, or treatment in connection with or related to **obesity** (except as noted below for morbid obesity), surgery for excess fat in any area of the body (unless due to a condition unrelated to obesity and not otherwise treatable); or resection of excess skin or fat

following weight loss or pregnancy. Surgical treatment of morbid obesity is payable if the morbid obesity has lasted for at least 5 yrs., defined as either:

- a.) body mass index (BMI) exceeding 40; or
 - b.) BMI greater than 35 in conjunction with ANY of the following severe comorbidities: coronary heart disease; or type 2 diabetes mellitus; or clinically significant obstructive sleep apnea; or high blood pressure/hypertension (BP > 140 mmHg systolic and/or 90 mmHg diastolic) and
 - 1) The patient has completed growth (18 years of age or documentation of completion of bone growth); and
 - 2) The patient has participated in a physician supervised nutrition and exercise program (including dietitian consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:
 - a. Participation in nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dietitians and/or nutritionists; and
 - b. Nutrition and exercise program must be 6 months or longer in duration; and
 - c. Nutrition and exercise program must occur within the two years prior to surgery; and
 - d. Participation in physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who does not perform bariatric surgery. Note: A physician's summary letter is not sufficient documentation.
26. **Personal convenience items** including, but not limited to, hospital admission kits, bedside kits, telephone and television, guest meals and beds and similar items.
27. Routine **Physical Examinations** and screening x-rays and laboratory services (except as covered under Preventive Services in Section 4 of this Article), physical examinations and testing for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party.
28. **Speech Therapy**, except when ordered by a Physician for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation, laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease.
29. **Temporomandibular Joint Dysfunction/Syndrome (TMJ)** Medical and dental treatment except as noted in Section 4 of this Article.
30. **Transplantation of tissue or organs.**
- a.) Expenses for the transportation of Physicians or Health Care Practitioners or family members of either the patient or the donor in connection with a transplant.
 - b.) An artificial organ implant is excluded (except an artificial heart or ventricular assistive device is payable when used as a temporary bridge to a heart transplant).
 - c.) Donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan.
31. **Work hardening**, weight training, strength training, massage therapy or similar services or exercise equipment.
32. **Internet/Virtual Office Visit:** Expenses related to an online internet consultation with a Physician or other Health Care Practitioner, also called a virtual office visit/consultation, physician-patient web service or physician-patient e-mail service, including receipt of advice,

treatment plan, prescription drugs or medical supplies obtained from an online internet provider.

Section 6. Maximum Benefit. In no event shall an Eligible Individual receive benefits in excess of \$125,000 total under the Retiree Plan.

If Major Medical Expense Benefits have been paid for an Eligible Individual, an amount equal to the benefits paid up to \$2,000 will be automatically reinstated on January 1 of each Calendar Year.

ARTICLE IV. GENERAL EXCLUSIONS

Section 1. Exclusions. The Fund shall not provide benefits for:

- A. Any bodily injury or sickness for which the eligible Individual is not under the care of a Physician;
- B. Any disability covered by any Worker's Compensation or occupational disease law;
- C. Any injury or sickness arising from or sustained in the course of any gainful occupation or employment;
- D. Conditions caused by or arising out of an act of war (whether declared or undeclared), armed invasion, aggression, or riot;
- E. Any supplies or services:
 - 1. For which no charge is made;
 - 2. For which the Eligible Individual is not required to pay;
 - 3. Which are furnished by a Hospital or facility operated by the United States Government or any authorized agency thereof or furnished at the expense of such Government or Agency unless required by law;
 - 4. Which are provided without cost by any municipal, county, or other political subdivision;
- F. Charges for services received by an Eligible Retiree or Dependent which are performed by the spouse, child, brother, sister or parent of the Eligible Retiree or of the Eligible Retiree's spouse;
- G. Any services or procedures which are experimental in nature or are not within generally accepted standards;
- H. Care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision.

Section 2. Reasonable Charges. The Fund shall not be liable to provide benefits for medical services or supplies not reasonably necessary for the care or treatment of bodily injuries or sicknesses. Furthermore, the Fund will not provide benefits for services, treatments or supplies for the care and treatment of bodily injuries or sicknesses which are in excess of Reasonable Charges.

ARTICLE V. COORDINATION OF BENEFITS

Section 1. Benefits Subject to this Provision. All benefits provided under these Rules and Regulations are subject to the following additional provisions and limitations.

Section 2. Definitions.

- A. **Plan.** The "Plan" means, for purposes of this Article V only, any plan providing benefits or services for or by reasons of medical care which benefits or services are provided by:
 - 1. Group, blanket or franchise insurance coverage;

2. Service plan contracts, group practice, individual practice and other pre-payment coverage;
3. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; or
4. Any coverage under governmental programs and any coverage required or provided by any statute.

The term “Plan” shall be construed separately with respect to that portion of each benefit or service which reserves the right to take the benefits or services of any other plan into consideration in determining its benefits and that portion which does not.

- B. **This Plan.** For purposes of this Article V only, the term “This Plan” means that portion of the Rules and Regulations providing Hospital and medical benefits.
- C. **Allowable Expense.** The term “Allowable Expense” means any necessary, reasonable, and customary item of medical expense incurred, a portion of which is covered under one of the plans covering the Eligible Individual for whom claim is made.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

The Fund shall not be required to determine the existence of any other plan, or the amount of benefits payable under any plan other than This Plan. The payment of benefits under This Plan shall be affected by the benefits payable under other plans only if the Fund is furnished with information concerning the existence of such other plans by the Eligible Individual or insurance company, organization, agency of government or person.

- D. **Claim Determination Period.** The term “Claim Determination Period” means a period commencing with any January 1 and ending at 12:00 midnight on the next succeeding December 31, or that portion of such period during which the Eligible Individual has been covered under This Plan.

Section 3. Effect on Benefits.

- A. This provision shall apply in determining the benefits due an Eligible Individual under This Plan for any Claim Determination Period if, for the Allowable Expense incurred as to such Eligible Individual during such period, the sum of the benefits that would be payable under all other plans in the absence of this provision, and the benefits that would be payable under all other plans in the absence in them of provisions of similar purpose to this provision, would exceed such Allowable Expenses.
- B. As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under This Plan in the absence of this provision for the Allowable Expenses **incurred** as to such Eligible Individual during such Claim Determination Period shall be reduced to the extent necessary so that the sum of:
1. such reduced benefits, and
 2. all the benefits payable for such Allowable Expenses under all other plans, except as provided in Subsection (C) of this Section 3, shall not exceed the total of such Allowable Expenses. Benefits payable under another plan include the benefits that would have been paid had claim been duly made for them.
- C. If another plan covering the Eligible Individual covered by This Plan contains a similar nonduplication of benefits provision which coordinates its benefit with those of This Plan and would, according to its rules, determine its benefits after the benefits of This Plan have been determined, and the rules set forth in Subsections D of this Section 3 would require This Plan to

determine its benefits before such other plan, then the benefits of such other plan will not be considered for the purposes of determining the benefits due under This Plan.

- D. For the purpose of Subsection C of this Section 3, the rules establishing the order of benefit determination are:
1. The plan which covers you as other than a Dependent will pay before the plan which covers you as a Dependent;
 2. The plan which covers you other than as a Retiree pays before the plan which covers you as a Retiree;
 3. The plan which covers your child as a Dependent of the parent whose birthday (excluding year of birth) occurs earlier in the Calendar Year pays first. If both parents have the same birthday (month and day), the plan which has covered the Dependent for the longer period of time pays first. However, if the parents are divorced or are separated, the plan covering the parent who has custody will pay first. If the parent with custody remarries, the "order of payment" is as follows:
 - (a) Natural parent with whom the child resides;
 - (b) Step-parent with whom the child resides; or
 - (c) Natural parent not having custody of the child.

This order of payment can change if the divorce decree directs one of the parents to be financially responsible for the medical, vision or other health care expenses of the child.

4. A plan which covers a Dependent as other than a Dependent of a Retiree pays before a plan which covers such Dependent as a Dependent of Retiree;
5. When the above-mentioned rules do not apply, the benefits of the plan which covered the Eligible Individual for the longest period of time will pay before any other plan. If an Eligible Individual's other plan has no duplication of benefits provision, it will pay first.

Section 4. Right to Receive and Release Necessary Information. The Fund may, with the consent of the Eligible Individual, release to or obtain from an insurance company or other organization or person any information, with respect to the person, which the Fund deems to be necessary for the purpose of implementing this provision. Any Eligible Individual claiming benefits under This Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Section 5. Facility of Payment. Whenever payments which should have been made under This Plan in accordance with this provision have been made under any other plan, the Fund shall have the right in its sole discretion to pay to any organization making such payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under This Plan and, to the extent of such payments, the Fund shall be fully discharged from liability under This Plan.

Section 6. Right of Recovery. Whenever payments have been made by the Fund with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Fund shall determine:

- A. The Eligible Individual;
- B. Any person to, or for, or with respect to, such payments were made;
- C. Insurance companies, service plans or any other organizations.

Section 7. Like Benefits. This Plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or

programs. Therefore, when This Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits.

Section 8. Medicare Coordination. Notwithstanding the foregoing Section, This Plan will honor all Medicare as Secondary Payer (MSP) rules promulgated under federal law. Coordination with Medicare will assume the enrollment of the Eligible Individual for both Parts A and B.

ARTICLE VI. GENERAL PROVISIONS

Section 1. Proof of Claim. All benefits will be paid by the Fund to the Eligible Retiree as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character, and extent of the event for which the claim is made.

Section 2. Assignment. Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, any Eligible Retiree may direct that benefits due him/her, be paid to an institution in which he/she or his/her Eligible Dependent is hospitalized, or to any provider of medical care services or supplies in consideration for Hospital or medical care services rendered or to be rendered.

Notwithstanding the foregoing, the Fund will honor any “qualified medical child support order” as defined by ERISA Section 609, received with respect to the Fund, and will make any payment required by ERISA Section 609 to a State which has acquired rights under that Section.

Section 3. Time Limit for Claims. Benefits will be paid by the Fund only if proof of claim is made within 90 days from the date on which expense with respect to which claim is made was incurred, unless it shall be shown by the Eligible Retiree not to have been reasonably possible to provide proof within such time limit, but in no event shall benefits be allowed if proof of claim is made beyond one year from the date on which the expense was incurred.

Section 4. Facility of Payment. In the event the Fund determines that the Eligible Retiree is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Retiree has not provided the Fund with an address at which he/she can be located for payment, the Fund may, during the lifetime of the Eligible Retiree, pay any amount otherwise payable to the Eligible Retiree, to the spouse, or to a relative by blood of the Eligible Retiree, or to any other person or institution determined by the Fund to be equitably entitled. In the event of the death of the Eligible Retiree, before all amounts payable under Article III have been paid, the Fund may pay any such amount to any person or institution determined by the Fund to be equitably entitled. The remainder of such amount shall be paid to one or more of the following surviving relatives of the Eligible Retiree: lawful spouse, child or children, mother, father, brothers or sisters, or to the Eligible Retiree’s estate, as the Board of Trustees in its sole discretion may designate. Any payment made in accordance with this provision shall discharge the obligation of the Fund hereunder to the extent of such payment.

Section 5. Claim to Benefits.

A. No Eligible Retiree, Eligible Dependent, beneficiary or other person shall have any right or claim to benefits under this Plan or any right or any claim to payments from the Fund other than as specified in these Rules and Regulations, the Rules of the Fund and the provisions of the Trust Agreement. Any dispute as to eligibility, type, amount or duration of such benefits or any right or claim to payments from the Fund shall be resolved by the Board of Trustees, under and pursuant to the Fund and the Plan and its decision on the dispute, right or claim shall be final and binding upon all parties, subject only to such judicial review as may be in harmony with its federal labor policy.

B. Each individual whose claim for benefits under the Plan has been denied shall be provided adequate notice in writing setting forth the specific reasons for such denial and written in a

manner calculated to be understood by the claimant. A claimant aggrieved by such decision may request review. The Trustees shall establish and publish to Eligible Individuals Fund rules and procedures for review of denied claims. Such rules and procedures shall comply with federal law.

- C. The Trustees have full and exclusive authority to determine all questions of coverage and eligibility, the method of providing or arranging for benefits and any other related matters. The Trustees are authorized to construe the Trust Agreement and the Rules and Regulations of the Plan. The Trustees may delegate all or a portion of their authority hereunder to a Claims Committee, or to such other appropriate named fiduciary as the Trustees may determine, in order to provide individuals with a full and fair review of claims.
- D. Any legal action or suit to secure judicial review of a claim determination must be filed within one year of the date of the final determination of the Trustees or their claim-review delegate, or judicial review is time barred. The provisions of this Section shall be applied to include any and every claim or right asserted under the Plan or against the Fund, regardless of whether or not the claimant was a “participant” or “beneficiary” or the Plan within the meaning of those terms as defined in ERISA.

Section 6. Examination. The Fund, at its own expense, shall have the right and opportunity to examine the person of any Eligible Individual when and as often as it may reasonably require during the time a claim is pending, and also the right and opportunity to make an autopsy, in case of death, if not forbidden by law. Proof of claim forms, as well as other forms and methods of administration and procedure, will be solely determined by the Fund.

Section 7. Workers’ Compensation. The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by Workers’ Compensation insurance laws or similar legislation.

Section 8. Conflicts. The provisions of these Rules and Regulations are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of these Rules and Regulations and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

Section 9. Claim Evaluation. In determining the benefits payable under this Plan, the Board may use, on a consistent basis, such claims evaluation information as is generally available in the health care benefits field.

Section 10. Subrogation. This provision may be applied by the Trustees in an equitable manner if an Eligible Individual has an injury, illness, accident or condition resulting from or caused by the act or omission of a third party. In the event that an Eligible Individual has an injury, illness, accident or condition due to the act or omission of a third party:

- A. The Plan shall be subrogated, to the extent of any payments by the Plan on account of a claim, to all rights of recovery of an Eligible Individual against any person, organization, or other entity in connection with the injury, illness, accident or condition to which the claim relates;
- B. The Plan shall be entitled, to the extent of payments made on account of the claim, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery by the Eligible Individual against any person, organization, or other entity responsible in connection with the injury, illness, accident or condition to which the claim relates;
- C. The Plan shall require the Eligible Individual to complete a Subrogation Agreement, in a form acceptable to the Trustees, **prior** to payment of any benefits in relation to the injury, illness, accident or condition; and, in the event that an Eligible Individual fails or refuses to execute such Subrogation Agreement requested by the Plan to the contrary, the Plan shall, notwithstanding any other provision of the Plan to the contrary, be relieved of any and all legal, financial, or

contractual obligation contained in the Plan to pay for any benefits or otherwise eligible charges incurred by the Eligible Individual;

- D. The Plan shall have the right, if so desired by the Trustees, to request the Eligible Individual in writing to take such action as may be necessary or appropriate to recover payments made by the Plan from any individual, organization, or other entity responsible in connection with the injury, illness, accident or condition;
- E. The Eligible Individual shall not do anything to release, discharge or prejudice the rights referred to in this Section, and shall assist and cooperate with the Plan to recover damages, and shall do everything necessary to enable the Plan to exercise its subrogation rights as described herein; and
- F. In any event, the Plan may offset future benefit payments against the obligation of an Eligible Individual to the Plan under these rules.

Section 11. Notifying the Plan. Eligible Retirees are required to notify the Fund in writing when a Dependent ceases to meet the Plan's definition of Dependent in Article 1. This notice is required when:

- A. The Eligible Retiree's marriage is dissolved (all marriage certificates and divorce decrees are required to be submitted to the Fund).
- B. A Dependent child marries.
- C. A Dependent child who is not a full-time student attains the age of 19.
- D. A Dependent child age 19 to 23 ceases to be full-time student.
- E. A Dependent child who is a full-time student turns 23 years of age.
- F. A Dependent step-child or foster child ceases to reside with or depend upon the Eligible Retiree.
- G. A Dependent disabled child over the Plan age limitations ceases to be disabled or ceases to be dependent upon the Eligible Retiree.

The Notice must contain the name and the Social Security number of the Eligible Retiree and the name and address (if different from the Eligible Retiree) of the Dependent whose status has changed. At the discretion of the Board of Trustees, an Eligible Retiree who fails to comply with this Section may be required to repay to the Fund any benefits provided to persons not eligible, where their status would have been apparent from the Notice required by this Section.

Section 12. Privacy. The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan's Board of Trustees (the "Trustees") for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

- A. Disclosure of PHI to the Trustees.
 - 1. Disclosures by Plan. The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.
 - 2. Disclosures by Business Associates. The Plan's Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.
 - 3. Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:

- (a) The Plan's Payment activities,
 - (b) Those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and
 - (c) All of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.
- B. Uses and Disclosures of PHI by the Trustees. The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or Health Care Operations.
- C. Privacy Safeguards. The Trustees agree to:
1. Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;
 2. Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;
 3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;
 4. Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;
 5. Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;
 6. Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;
 7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
 8. Make available the information required to provide and accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
 9. Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;
 10. If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and
 11. Ensure that adequate separation between the Plan and the Trustees is established, as described below.
- D. Adequate Separation: The Trustees may use PHI only for Plan administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.

ARTICLE VII. AMENDMENT AND TERMINATION

Section 1. Reduction or Cessation of Benefits. In order that the Fund may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible

benefits for all Eligible Individuals, the Board of Trustees expressly reserves its right, in accordance with the Trust Agreement and Collective Bargaining Agreements, to:

- A. Terminate or amend either the amount of benefits or the eligibility requirements with respect to any benefits, even though such termination or amendment affects claims which have already accrued;
- B. Alter or postpone the method of payment of any benefit;
- C. Amend or rescind any other provision of these Rules and Regulations.

ARTICLE VIII. LIMITATION OF LIABILITY

Section 1. Maximum Liability of the Fund. Most of the benefits provided in these Rules and Regulations are paid directly from the assets of the Fund and there is no liability on the Fund, the Board of Trustees or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for the purpose of providing Retiree benefits paid directly by the Fund.

The restated Rules and Regulations of the Retired Employee Plan are hereby adopted effective **September 1, 2004**, by the Board of Trustees of the Southwestern Teamsters Security Fund by motion duly made and seconded.

(George Scovill)
Chairman

Date

12/7/04

(Douglas Finkelmyer)
Secretary

Date

12/7/04

157557/00741

**INFORMATION REQUIRED BY ERISA
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974**

The following information concerning the Retired Employee Plan is being provided to you in accordance with government regulations:

A. The name and type of administration of the Plan

The Southwestern Teamsters Security Fund Retired Employee Plan is a welfare benefit plan providing medical expense and behavioral health benefits to participants and beneficiaries who have retired from the industry. It is administered by a joint Board of Trustees consisting of three Union representatives and three Employer representatives.

The benefits described in this plan document are self-funded and administered by the independent Claims Administrators whose names are listed on the Quick Reference Chart in the front of this document.

B. The name and address of the Plan Administrator is:

Board of Trustees for the Southwestern Teamsters Security Fund

Southwest Service Administrators Inc.
2400 W. Dunlap Ave., Suite 250
Phoenix, AZ 85021-2811
Phone: 602-249-3582 or 800-474-3485

C. Name and business addresses of the Trustees are:

Labor

Mr. Andrew Marshall
Teamsters Local No. 104
1450 South 27th Avenue
Phoenix, AZ 85009

Mr. George Scovill
Teamsters Local No. 104
1450 South 27th Avenue
Phoenix, AZ 85009

Mr. Paul Willsher
Teamsters Local No. 104
1450 South 27th Avenue
Phoenix, AZ 85009

Management

Mr. James Nygren
Director of Labor Relations, Fry's Food Stores, Inc.
P. O. Box 6016
Phoenix, AZ 85005

Terrence L.Clark
Labor Relations, Safeway Stores, Inc.
2750 South Priest
Tempe, AZ 85353

Trustee pending appointment

D. In addition to the Board of Trustees, the following person has been designated as agent for the service of legal process:

David L. Niederdeppe, Esq.
107 N. Cortez St, Suite 201
Prescott, Arizona 86301

E. **The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 86-6052021. The Plan number assigned by the Board of Trustees is 501.**

F. **For purposes of maintaining the Fund's fiscal records, the year-end date is November 30.**

G. **Funding Medium.**

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

H. **Financial Information.**

Contribution Sources: All contributions to the Plan other than self-payment contributions are made by Employers in accordance with collective bargaining agreements between Unions affiliated with the Southwestern Teamsters Security Fund and participating employers. The collective bargaining agreements require contributions to the Plan at fixed rates per hour. The Administrative Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the collective bargaining agreement. See the paragraph of this section entitled "Plan Documents" if you wish to obtain additional information about the collective bargaining agreement.

Organizations Accumulating Fund Assets: The Fund's assets and reserves are held in custody by Wells Fargo Bank and invested by NWQ Investment Management Company. See the paragraph of entitled "Plan Documents" if you wish to obtain additional information concerning the Fund's investment of assets and checking accounts.

I. **Plan Information.**

Eligibility: The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of any benefits are fully described in the Plan Document contained in this booklet.

Plan Regulations: All types of benefits provided by the Plan are set forth in the Plan Document contained in this booklet.

J. **Statement of ERISA Rights.**

Rights of Plan Participants

As a Participant in the Southwestern Teamsters Security Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office (as noted on the Quick Reference Chart in the front of this document) and at other specified locations, such as worksites, all documents governing the Plan including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

Obtain, upon written request to the Plan Administrator, copies of the documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan descriptions. The Administrator may make reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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 summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-Existing Condition exclusion for twelve months after your Eligibility date.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

K. Newborns' and Mothers' Health Protection Act.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing the length of stay not in excess of 48 hours (or 96 hours). Of course a longer stay will be allowed if the needs are such that a longer stay is medically necessary.

L. Women's Health and Cancer Rights Act.

Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas. This coverage is subject to the plan's annual co-payments, annual deductibles and co-insurance provisions.

M. Claim Procedures.

The procedures to follow for filing a claim for benefits are set forth in the Appendix to this booklet. All claims for benefits must be submitted on claim forms made available by the Administrative Office or other provider. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

N. Review and Appeals Procedures.

The procedures to follow for appealing an adverse claim determination are also set forth in the Appendix to this booklet.

O. Plan Documents and Reports.

You may examine the following documents at the Administrative Office during regular business hours, Monday through Friday, except holidays:

1. Trust Agreement;
2. Collective Bargaining Agreement;
3. Plan Documents, policies and all amendments;

4. Form 5500 or full Annual Report filed with the Internal Revenue Service and Department of Labor; and
5. List of Contributing Employers.

You may also obtain copies of the documents by writing for them and paying the reasonable cost of duplication. You should find out what the charges will be before requesting copies. If you prefer, you can arrange to examine these reports, during business hours, at your local Union office. To make such arrangements, call or write the Administrator at the Administrative Office. A summary of the annual report that gives details of the financial information about the Fund's operation is furnished free of charge to all Participants.

P. Spanish Language Assistance.

Pongase en contacto con la oficina de administracion si no entiende los beneficios del Plan al numero 800-622-8780.

This booklet contains a summary in English of your Plan rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Administrative Office.

Q. Privacy.

Effective April 14, 2004, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, requires that health plans like the Southwestern Teamsters Security Fund (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term "**Protected Health Information**" (**PHI**) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by your employer or your union in its role as an employer or bargaining unit, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), life insurance, drug testing, etc.

A description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices which is provided to new participants and is also available from the Administrative Office.

R. Authority.

Nothing in this booklet is meant to interpret or change in any way the provisions expressed in the Rules and Regulations of the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.

APPENDIX

Dear Retiree:

This Appendix to the benefit booklet of the Southwestern Teamsters Security Fund is designed to provide information to participants and beneficiaries of the Fund concerning:

- A. How to secure benefits, file benefit claims or pose other benefit issues to the Fund for initial determination ; and
- B. How to secure review of initial determinations that are adverse.

The rules set forth in this Appendix are intended to comply with applicable regulations, which specify time frames and other procedural safeguards for benefit determinations. The rules are complex, since they address a number of different circumstances. For assistance in understanding the rules please contact the Fund Office.

Sincerely

Board of Trustees

PREFACE

Regulations developed by the United States Department of Labor⁴ express minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries. This Appendix sets forth the Fund's rules, developed to conform to the Regulations and any applicable state regulations.

The "How to Obtain Benefits" section of this Appendix explains what steps a participant or beneficiary of the Fund must follow to present various kinds of benefit claims for initial determination. Some claims are presented directly to the Administrative Office of the Fund. Others are presented directly to service providers hired by the Fund.

The "Rules" Section defines the various kinds of claims that can be submitted, and sets forth the federal rules that apply to those claims. Additional sections contain claim and appeal procedures from various service providers who have developed specific rules of their own.

The "How to Obtain Benefits" section of the Appendix identifies what kind of claim a specific benefit request is; when such a claim is considered filed for purposes of the time frames; which rules from the "Rules" Section and/or which specific service provider procedures are applicable; who makes the initial determination on the claim; and which fiduciary is "named" by the Fund Trustees for review of that kind of claim.

Hopefully, the process set forth in this Appendix will allow the prompt initial determination of benefit claims and the full and fair review of adverse claim determinations for which review is requested.

AUTHORIZED REPRESENTATIVES

The Regulations contemplate that claimants may pursue benefit claims through authorized representatives. They also contemplate that a benefit plan may establish procedures for determining whether an individual has been authorized to act on behalf of a claimant. This Fund will recognize the following individuals as representatives for claims and claim review requests:

1. An adult participant or beneficiary may speak on their own behalf.
2. A participant or participant's spouse may speak on behalf of any claimant residing, according to Fund records, in the same household.
3. A parent (natural or adoptive) may speak on behalf of a child - beneficiary.
4. A provider to whom the benefits in question have been assigned may speak on its own behalf.
5. A health care professional may speak on behalf of a claimant with respect to a claim involving urgent care.

All other purported representatives must supply evidence that they are authorized to speak on behalf of an individual. For the Fund to recognize such a representative, the representative must present to the Administrative Office a court order, a "Power of Attorney" or a similar document, signed by the claimant, or otherwise expressing the representative capacity.

If an individual does not believe that another speaks on behalf of a specific participant or beneficiary, that individual should notify the Administrative Office of the Fund, and the Trustees will make a determination as to whether such an individual is an authorized representative.

PLEASE NOTE: If at any time during the pendency of a claim or other issue, a claimant feels that the rules expressed in this Appendix are not being honored by the Fund Office or other decision-maker, that claimant should contact the claim committee of the Board of Trustees. This claim committee is authorized (but is not required) to suspend these rules, policies and procedures and to move the pending claim or issue directly to their attention for final determination. The claim committee maybe contacted at:

⁴ Department of Labor Regulations, ERISA § 503, 29 CFR § 2560.503-1.

Claim Committee of the Southwestern Teamsters Security Fund
Southwest Service Administrators, Inc.
2400 W. Dunlap Ave., Suite 250
Phoenix, AZ 85021-2811
Phone: 602-249-3582 or 800-474-3485 Fax: 602-249-3795

HOW TO FILE FOR REIMBURSEMENT OF MEDICAL EXPENSES OR MEDICATIONS OBTAINED OUTSIDE OF THE PBM NETWORK

A claim form should be obtained from the Administrative Office, completed and returned along with itemized Hospital, Physician or other health care provider bills as soon as you or one of your Dependents has accumulated Covered Medical Expenses in excess of the Deductibles.

It is necessary to keep separate records of expenses with respect to each of your Dependents, as well as yourself, because the provisions of the Plan operate separately for each covered family member. The following data is important and should be carefully kept to be submitted with your claim:

1. The name and address of your Physician, Surgeon or Health Care Provider;
2. The date you incurred each expense; and
3. Copies of all itemized statements, such as bills from Physicians, Hospitals and laboratories. A bill from a druggist should always give the date of the purchase, prescription number, name of the drug and name of the Physician who issued the prescription. Each of these statements should indicate clearly the name of the member of your family involved.

If You Need Assistance.

If at any time you have questions concerning the filing of a claim or eligibility, write or call the Administrative Office. They will promptly advise you of the answer to your questions. Your correspondence and calls should be directed to:

Southwest Service Administrators, Inc.
2400 W. Dunlap Ave., Suite 250
Phoenix, AZ 85021-2811
Phone: 602-249-3582 or 800-474-3485
or Fax: 602-249-3795

Claims for reimbursement of medical expenses are “Post-Service Claims”. The definitions and federal rules pertaining to such claims are described in this Appendix.

A claim for reimbursement of medical expenses is “filed” when both a completed claim form and the itemized bill(s) are received by the Administrative Office. The Administrative Office makes the initial determination on the claim.

The “named fiduciary” for review of adverse determinations with respect to claims for reimbursement of medical expenses is the Board of Trustees. The Board of Trustees can be contacted through the Administrative Office.

HOW TO OBTAIN A BENEFIT “PROJECTION”

To accommodate participants and beneficiaries, the Fund will “project”, i.e., predict whether post-service claims will be allowed under the Plan, assuming benefit eligibility. **Requesting and securing a claim projection of benefit payments is not the filing of a Post-Service Claim or a Pre-Service Claim under these rules and procedures, and there is no right to review of these projections made by the Fund as post-service claims or pre-service claims.**

To request a benefit “projection”, a participant should contact the Fund Office in writing with as much information as possible about the medical care, treatment or procedure that is contemplated. The Fund Office will “project” benefits in writing to the participant or beneficiary based on the information supplied, assuming benefit eligibility.

An adverse determination on a benefit “projection” is not subject to the “Post-Service Claim” rules, since there can be no “claim” within the meaning of those rules until the actual care, service or procedure is provided and a billing for that care, service or procedure is received. An adverse “projection” determination is not subject to the Pre-Service Claim Rules either, since the Fund is not pre-approving care. Additionally, an adverse determination on a benefit “projection” that is provided only to a health care provider is not subject to any review, since there is no “assignment” of the claim which might give the health care provider appeal rights.

A benefit “projection” is an “Other Claim”. The definitions and federal rules pertaining to such issues are described in this Appendix. The Administrative Office makes the initial determination on benefit “projections”.

The “named fiduciary” for review of adverse determinations on benefit “projections” is the Board of Trustees. The Board of Trustees can be contacted through the Administrative Office.

HOW TO OBTAIN PRESCRIPTION DRUGS THROUGH THE PBM PROGRAM

The Trust Fund has contracted with a Prescription Benefit Management (PBM) program to manage outpatient prescription drugs. The PBM program offers substantial discounts on prescription drugs purchased through affiliated network pharmacies and, when part of the PBM program, a mail order service. Participating pharmacies are identified in the PBM’s brochure.

Your ID Card will identify you or a family member as a PBM member. When you need to fill a prescription, go to one of the participating pharmacies and present your card along with the prescription. You must present your ID Card because it entitles you to purchase FDA approved eligible prescription drugs for a co-payment.

Claims for PBM Network prescription drug benefits are “Post-Service Claims”. The definition and federal rules pertaining to such claims are described in this Appendix.

Because the PBM Network is designed to allow speedy prescription drug service at participating pharmacies, a claim for PBM Network drug benefits is not considered “filed” until a pharmacy refuses to fill a prescription and the circumstances surrounding that refusal are presented in writing to the Administrative Office. The Administrative Office makes the initial determination on such a claim.

Medications filled at a retail pharmacy that is not part of the PBM network (non-network) can be submitted to the PBM for reimbursement. A bill from a druggist should always give the date of the purchase, prescription number, name of the drug and name of the Physician who issued the prescription.

The “named fiduciary” for review of adverse determinations with respect to claims for PBM Network and non-network outpatient prescription drug benefit claims is the Board of Trustees. The Board of Trustees can be contacted through the Administrative Office.

HOW TO OBTAIN MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

Benefits for mental health, substance abuse and counseling for stress, depression, family matters, marital problems and financial situations are provided through CONTACT Behavioral Health Services, 1400 East Southern Avenue, Suite 800, Tempe, Arizona 85282. (For pre-certification call (800) 888-1477.)

Mental Nervous and Substance Abuse claims are “Pre-Service Claims”. The definition and federal rules pertaining to such claims are described in this Appendix. A claim for mental/nervous or substance abuse care is “filed” when CONTACT is provided with sufficient information to identify the individual involved and the nature of the care requested. CONTACT makes the initial determination on the claim.

The “named fiduciary” for review of adverse determinations with respect to mental/nervous or substance abuse claims is CONTACT. CONTACT’s procedure for review of claims are set forth in this Appendix.

RULES REGARDING CLAIM AND CLAIM REVIEW

Definitions and Rules Relating to Different Kinds of Claims, Including Rules on How to Secure Review of Initial Claim Determinations

HEALTH BENEFIT CLAIMS

All medical claims, mental nervous/substance abuse claims, and prescription claims are health benefit claims and will fit into one or more of the subcategories of health claims identified in this Appendix. Please take note of these subcategories because the “How to Obtain Benefits” portion of this Appendix identifies the category into which specific claims fall.

A. Pre - Service Health Claims

Definition: By definition, a “pre-service claim” is any claim for a benefit under the Fund with respect to which the Fund conditions its receipt, in whole or in part, on approval of the benefit in advance of obtaining care.

Initial Determination - Notice

Pre-service claims are required to be initially determined by the Fund’s decision-maker, and notice of the determination given to the claimant, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the receipt of the claim. This period may be extended one time for up to 15 days, provided that the Fund decision-maker both: (1) determines that such an extension is necessary due to matters outside the control of the Fund; and (2) notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to make the determination. If an extension is necessary due to the claimant’s failure to submit necessary information, the notice of extension is required to describe the missing information, and the claimant will have at least 45 days from receipt of the notice to provide the information. The time periods for making determinations under this provision are tolled from the date the claimant is notified of missing information until the date the claimant responds to the notice.

If a claimant fails to follow the Fund procedures for filing a pre-service claim, the claimant must be notified of the failure and of the proper procedure. This notice is required to be provided to the claimant as soon as possible, but not later than 5 days after the failure. This notification may be oral, unless written notice is requested by the claimant.

This paragraph only applies where a claimant communicates with the Fund Office or other provider customarily responsible for handling benefit matters and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

Form of Notice of Initial Determination

If an adverse determination is made by the Fund with respect to a pre-service claim, the Fund is required to provide written notification to the claimant setting forth, in a manner calculated to be understood by the claimant:

- (1) The specific reason(s) for the determination;
- (2) Reference to the specific plan provision(s) on which the determination is based;
- (3) A description of any additional material or information necessary to perfect the claim and an explanation of why the additional material or information is necessary;
- (4) A description of the Fund's review/appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to sue under Section 502(a) of ERISA; and
- (5) (a) If the determination was based on an internal rule, guideline, protocol or similar criterion, notice that the rule, guideline, protocol or similar criterion will be provided free of charge to the claimant on request.

(b) If the determination was based on a finding that the service was not medically necessary, was experimental, or was subject to some similar exclusion or limit, notice that an explanation of the scientific or clinical judgment for the determination, taking into account the terms of the plan and the claimant's medical circumstances, will be provided free of charge to the claimant on request.

Time Frame To Request Review

A claimant has 180 days following receipt of notification of an adverse benefit determination on a pre-service claim to file a request for review. Any request for review received by the Fund after this time frame is untimely and subject to denial on review on that basis alone.

Request for Review to the Appropriate Named Fiduciary

A claimant may request review of an adverse benefit determination on a pre-service claim by filing a written review request with the fiduciary named by the Board of Trustees for hearing such request (the "appropriate named fiduciary").

Full and Fair Review

A claimant will be given the opportunity to submit written comments, documents, records and other information relating to the claim. The Fund will provide a claimant, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim. The named fiduciary's review of the claim will take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Any expert whose advice was obtained in connection with the initial determination will be identified, whether or not such advice was used in making the determination.

The review process will not afford deference to the initial determination. The named fiduciary conducting the review will not be the same individual who made the initial determination nor the subordinate of such individual. The named fiduciary conducting the review will consult with a health care professional who has appropriate training and expertise with respect to any review involving a

medical judgment, and such health care professional will not be an individual who was consulted with respect to the initial determination nor the subordinate of such individual.

Determination on Review - Notice

A determination on review of a pre-service claim is required to be made by the appropriate named fiduciary, and notice of that determination given to the claimant, within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the receipt of the request for review.

Form of Notice of Determination on Review

The Fund will provide a claimant with written notification of the determination on review. If the determination is adverse, the Fund is required to provide written notice to the claimant setting forth, in a manner calculated to be understood by the claimant:

- (1) The specific reason(s) for the determination;
- (2) Reference to the specific plan provision(s) on which the determination is based;
- (3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information related to the claim;
- (4) (a) If the determination was based on an internal rule, guideline, protocol or similar criterion, notice that the rule, guideline, protocol or similar criterion will be provided free of charge to the claimant on request;

(b) If the determination was based on a finding that the service was not medically necessary, was experimental, or was subject to some similar exclusion or limit, notice that an explanation of the scientific or clinical judgment for the determination, taking into account the terms of the Plan and the claimant's medical circumstances, will be provided free of charge to the claimant on request.
- (5) A statement of the claimant's right to sue under Section 502(a) of ERISA, and a statement that the claimant and the Fund may have other voluntary alternative dispute resolution options, such as mediation, and that the claimant may contact the local United States Department of Labor Office or State Insurance Department to explore such options.

B. Claims Involving Urgent Care

Definition

By definition, a "claim involving urgent care" is a pre-service health claim with respect to which the application of the time periods for making pre-service claim determinations:

- (a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- (b) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain which cannot be adequately managed without the care or treatment that is the subject of the claim.

Any claim that a physician with knowledge of a claimant's medical condition determines is a "claim involving urgent care" as defined above, shall be treated as a "claim involving urgent care" by the Fund for this purpose. Otherwise, the determination of whether a claim is a "claim involving urgent care" is made by a Fund representative applying the judgment of a prudent person who possesses at least an average knowledge of health and medicine.

Special Rules

Only claims that are “pre-service health claims” can be “claims involving urgent care”. Claims involving urgent care are subject to the normal pre-service health claim rules and procedures noted above, except that:

- A health care professional (a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law) shall be permitted to act as the claimant’s authorized representative.
- Such claims are required to be initially determined by the Fund’s decision-maker, and notice of the determination given to the claimant as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless the claimant fails to provide sufficient information to the decision-maker to determine whether, or to what extent, benefits are available under the Fund. In the case of such failure, the decision-maker is required to notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. In such a case, notice of the Fund’s benefit determination will be provided as soon as possible, but in no event later than 48 hours after the earlier of:
 - (a) The Fund’s receipt of the specified information; or
 - (b) The end of the period afforded the claimant to provide the specified additional information.
- Notice of the initial benefit determination will include a description of the expedited review process applicable to such claims.
- A request for review of such claims may be submitted orally or in writing by the claimant, and all necessary information shall be transmitted between the Fund and the claimant by telephone, facsimile, or other available similarly expeditious methods.
- A determination on review of a claim involving urgent care is required to be made, and notice of such determination given to the claimant, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant’s request for review of an adverse benefit determination.

C. Concurrent Claims

Definition

Concurrent claims involve pre-service care already approved by the Fund as an ongoing treatment to be provided for a period of time or number of treatments, and either -

- (a) A request by a claimant to extend the course of treatment beyond the period of time or number of treatments approved; or
- (b) A reduction or termination by the Fund of such course of treatment before the end of the approved period of time or number of treatments.

Special Rules

Because they involve treatment approved before it is received, concurrent care claims are pre-service health claims that are generally subject to the normal pre-service health claim rules and procedures noted above, except that

- Reductions or terminations of pre-approved care are adverse benefit determinations that are required to be made, and notice of such determinations given to the claimant, at a time sufficiently

in advance of the reduction or termination to allow the claimant to obtain a determination on review before the benefit is reduced or terminated.

- If a claimant requests an extension of a course of treatment beyond the period of time or number of treatments, and, the underlying claim is a “claim involving urgent care”, as defined above, the Fund decision-maker is required to make a determination as soon as possible, taking into account the medical exigencies, and to notify the claimant of the determination within 24 hours after receipt of the request, provided that such request is made to the Fund at least 24 hours before the expiration of the approved period of time or number of treatments.

D. Post-Service Health Claims

Definition

By definition, a post-service claim is any health benefit claim that is not a “pre-service health claim”.

Initial Determination - Notice

Post-service claims are required to be initially determined by the Fund’s decision-maker, and notice of any decision given to the claimant, within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Fund for up to 15 days, provided that the Fund decision-maker both (1) determines that such an extension is necessary due to matters outside the control of the Fund; and (2) notifies the claimant, prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Fund expects to make the determination. If an extension is necessary due to the claimant’s failure to submit necessary information, the notice of extension is required to describe the missing information, and the claimant will have 45 days from receipt of the notice to provide the information. The time periods for making determinations under this provision are tolled from the date the claimant is notified of missing information until the date the claimant responds to the notice.

If a claimant fails to follow Fund procedures for filing a post-service claim, the claimant will be notified as soon as possible of the proper procedure.

Form of Notice of Initial Determination

If an adverse determination is made by the Fund with respect to a post-service claim, the Fund is required to provide written notification to the claimant setting forth, in a manner calculated to be understood by the claimant:

- (1) The specific reason(s) for the determination;
- (2) Reference to the specific plan provision(s) on which the determination is based;
- (3) A description of any additional material or information necessary to perfect the claim and an explanation of why the additional material is necessary;
- (4) A description of the Fund’s review/appeal procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to sue under Section 502(a) of ERISA; and
- (5) (a). If the determination was based on an internal rule, guideline, protocol or similar criterion, notice that the rule, guideline, protocol or similar criterion will be provided free of charge to the claimant on request.

(b). If the determination was based on a finding that the service was not medically necessary, was experimental, or was subject to some similar exclusion or limit, notice of that explanation of the scientific or clinical judgment, taking into account the terms of the plan and the claimant’s medical circumstances, will be provided free of charge to the claimant on request.

Time Frame to Request Review

A claimant has 180 days following receipt of notification of an adverse benefit determination on a post-service claim to file a request for review. Any request for review received by the Fund after this time frame is untimely and subject to denial on review on that basis alone.

Informal Review

A claimant may request an informal review of a claim by the Fund Office. Such a request for informal review may be in writing or presented orally, and need only specify the claim in question and why the claimant feels the adverse benefit determination was erroneous. Upon presentation of a request for informal review, the Fund Office will reexamine the claim that is the subject of the request and will notify the claimant in writing of the results of the informal review within 30 days. If the result of the informal review is to uphold the original adverse determination, the notice to the claimant will set forth the right of the claimant to pursue a formal request for review.

Request for Formal Review to the Appropriate Named Fiduciary

As an alternative to the informal review described above, or after completion of an informal review, a claimant may request review of an adverse benefit determination on a post-service claim by filing a written review request with the fiduciary named by the Board of Trustees for hearing such request (“the appropriate named fiduciary”).

A claimant will be given the opportunity to submit written comments, documents, records and other information relating to the claim. The Fund will provide a claimant, free of charge, reasonable access to and copies of all documents, records or other information relevant to the claim. The named fiduciary’s review of the claim will take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Any expert whose advice was obtained in connection with the initial determination will be identified, whether or not such advice was used in making the determination.

The review process will not afford deference to the initial determination. The named fiduciary conducting the review will not be the same individual who made the initial determination nor the subordinate of such individual. The named fiduciary conducting the review will consult with a health care professional who has appropriate training and expertise with respect to any review involving a medical judgment, and such health care professional will not be an individual who was consulted with respect to the initial determination nor the subordinate of such individual.

Determination on Review - Notice

- If the “named fiduciary” is other than the Board of Trustees:

A determination on review of a post-service claim is required to be made by the appropriate named fiduciary, and notice of that determination given to the claimant, within a reasonable period of time, but in no event later than 60 days after the receipt of the request for review.

- If the “named fiduciary” is the Board of Trustees:

A determination on formal review of a post-service claim is required to be made by the Board of Trustees no later than the date of the meeting of the Board of Trustees that immediately follows receipt of the request for review, unless the request for review was filed within 30 days preceding the date of such meeting. In such a case, a benefit determination may be made by no later than the date of the second meeting following the receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Board of Trustees following the receipt of the

request for formal review. If special circumstances require such an extension, the Fund will notify the claimant in writing of the extension, describing the special circumstances and the date on which the benefit determination will be made. Notice of the benefit determination on formal review will be given not later than 5 days after such a determination is made.

Form of Notice of Determination on Review

The Fund will provide a claimant with written notification of the determination on review. If the determination is adverse, the Fund is required to provide written notice to the claimant setting forth, in a manner calculated to be understood by the claimant:

- (1) The specific reason(s) for the determination;
- (2) Reference to the specific plan provision(s) on which the determination is based;
- (3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information related to the claim;
- (4) (a). If the determination was based on an internal rule, guideline, protocol or similar criterion, notice that the rule, guideline, protocol or similar criterion will be provided free of charge to the claimant on request;

(b). If the determination was based on a finding that the service was not medically necessary, was experimental, or was subject to some similar exclusion or limit, notice of that explanation of the scientific or clinical judgment, taking into account the terms of the Plan and the claimant's medical circumstances, will be provided free of charge to the claimant on request.
- (5) A statement of the claimant's right to sue under Section 502(a) of ERISA, and a statement that the claimant and the Fund may have other voluntary alternative dispute resolution options, such as mediation, and that the claimant may contact the local United States Department of Labor Office or State Insurance Department to explore such options.

OTHER CLAIMS

Definition

"Other claims" are claims for eligibility issues unrelated to a specific claim, and any other issue which a participant or beneficiary may have with the Fund.

Initial Determination - Notice

"Other claims" are required to be initially determined by the Fund's decision-maker, and notice of any decision given to the claimant, within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Fund for up to 90 days, provided that the Fund decision-maker both: (1) determines that special circumstances require the extension, and (2) notifies the claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Fund expects to make the determination. Notwithstanding the foregoing, any notice to a claimant of the unavailability of Continuation Coverage (COBRA) from the Fund will be provided within timeframes specified by the COBRA regulations.

Form of Notice of Initial Determination

If an adverse determination is made by the Fund with respect to "other claims", the Fund is required to provide written notification to the claimant setting forth, in a manner calculated to be understood by the claimant:

- (1) The specific reason(s) for the determination;
- (2) Reference to the specific plan provision(s) on which the determination is based;
- (3) A description of any additional material or information necessary to perfect the claim and an explanation of why the additional material is necessary; and
- (4) A description of the Fund's review/appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to sue under Section 502(a) of ERISA.

Time Frame to Request Review

A claimant has 60 days following receipt of notification of an adverse benefit determination on "other claims" to file a request for review. Any request for review received by the Fund after this time frame is untimely and subject to denial on review on that basis alone.

Informal Review

A claimant may request an informal review of "other claims" by the Fund Office. Such a request for informal review may be in writing or presented orally, and need only specify the claim in question and why the claimant feels the adverse benefit determination was erroneous. Upon presentation of a request for informal review, the Fund Office will re-examine the claim that is the subject of the request and will notify the claimant in writing of the results of the informal review within 30 days. If the result of the informal review is to uphold the original adverse determination, the notice to the claimant will set forth the right of the claimant to pursue a formal request for review.

Request for Formal Review to the Appropriate Named Fiduciary

As an alternative to the informal review described above, or after completion of an informal review, a claimant may request review of an adverse benefit determination on "other claims" by filing a written review request with the fiduciary named by the Board of Trustees for hearing such request ("the appropriate named fiduciary").

Formal Review

A claimant will be given the opportunity to submit written comments, documents, records and other information relating to the claim. The Fund will provide a claimant, free of charge, reasonable access to and copies of all documents, records or other information relevant to the claim. The named fiduciary's review of the claim will take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Any expert whose advice was obtained in connection with the initial determination will be identified, whether or not such advice was used in making the determination.

Determination on Review - Notice

- If the "named fiduciary" is other than the Board of Trustees:

A determination on review of an "other" claim is required to be made by the appropriate named fiduciary, and notice of that determination given to the claimant, within a reasonable period of time, but in no event later than 60 days after the receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than 60 days after the expiration of the initial period. If special circumstances require such an extension, the Fund will notify the claimant in writing of the extension, describing the special circumstances and the date on which the benefit determination will be made.
- If the "named fiduciary" is the Board of Trustees:

A determination on formal review of “other claims” is required to be made by the Board of Trustees no later than the date of the meeting of the Board of Trustees that immediately follows receipt of the request for review, unless the request for review was filed within 30 days preceding the date of such meeting. In such a case, a benefit determination may be made by no later than the date of the second meeting following the receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the Board of Trustees following the receipt of the request for formal review. If special circumstances require such an extension, the Fund will notify the claimant in writing of the extension, describing the special circumstances and the date on which the benefit determination will be made. If the extension is due to the claimant’s failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the notification of extension is sent to the claimant until the date on which the claimant responds to the request for additional information. Notice of the benefit determination on formal review will be given not later than 5 days after such a determination is made.

Form of Notice of Determination on Review

The Fund will provide a claimant with written notification of the determination on review. If the determination is adverse, the Fund is required to provide written notice to the claimant setting forth, in a manner calculated to be understood by the claimant:

- (1) The specific reason(s) for the determination;
- (2) Reference to the specific plan provision(s) on which the determination is based;
- (3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information related to the claim; and
- (4) A statement of the claimant’s right to sue under Section 502(a) of ERISA.

BEHAVIORAL HEALTH CLAIMS

Behavioral Health Claims and Claim Appeals are managed by:

Contact Behavioral Health

1400 East Southern Ave., Suite 800 Tempe, AZ 85282
1-800-888-1477

This section describes the procedures for filing claims on or after January 1, 2003, for behavioral health benefits and for appealing adverse benefit determinations in connection with those claims in compliance with 29 CFR §2560.503-1. Claims covered by these procedures include those claims filed under your behavioral health program benefits.

CONTACT takes steps to assure that behavioral health benefits are applied consistently with respect to you and other similarly situated member eligible for behavioral health benefits. The claims procedures outlined in this document will afford you a full, fair and fast review of the claim to which it applies. This section also discusses the process CONTACT undertakes on certain appealed claims, to consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not medically necessary, is experimental or investigational).

Time Limit For Filing Behavioral Health Claims

All post-service claims must be submitted to CONTACT within TWO YEARS from the date of service. No Behavioral health benefits will be paid for any claim not submitted within this period.

Additional Information Needed: There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. CONTACT is not legally required to consider information submitted after these stated time frames.

When You Must Get Plan Approval In Advance Of Obtaining Behavioral Health Care: Some Behavioral health benefits are payable without a financial penalty only if CONTACT approves payment before you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification).

Key Definitions

Days: For the purpose of the claim and appeal procedures outlined in this document, “days” refers to calendar days, not business days.

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit or a beneficiary’s eligibility to participate in CONTACT; and
- a reduction in a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual or that individual’s authorized representative (as defined later in this document) in accordance with CONTACT’s claims procedures, described in this document.

There are four types of claims covered by the procedures in this document: Pre-service, Urgent, Concurrent, and Post-service, described later in this document. The type of claim is determined as of the time the claim or review of denial of the claim is being processed. A claim must include the following elements to trigger CONTACT’s claims processing procedures:

- a. be written or electronically submitted (oral communication is acceptable only for urgent care claims),
- b. be received by CONTACT, as defined in this document,
- c. name a specific individual,
- d. name a specific medical condition or symptom,
- e. name a specific treatment, service or product for which approval or payment is requested, and
- f. made in accordance with CONTACT’s benefit claims filing procedures described in this document.

A claim is NOT:

- a. a request made by someone other than the individual or his/her authorized representative;
- b. a request made by a person who will not identify him/herself (anonymous);
- c. a casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- d. a request for prior approval of behavioral health benefits where prior approval is not required by CONTACT;
- e. an eligibility inquiry that does not request behavioral health benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;

Pre-Service Claim: A pre-service claim is a request for behavioral health benefits where CONTACT conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. CONTACT may determine, in its sole discretion, to pay benefits for the services needing

precertification (that were obtained without prior approval) if you were unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (precertification) procedure could have seriously jeopardized the patient's life or health.

Urgent Care Claim: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification:

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

Concurrent Care Claim: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

Post-Service Claim: A post-service claim is a claim for behavioral health benefits under CONTACT that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims.

Health Care Professional: Means a Physician or other behavioral health care professional licensed, accredited or certified to perform specified behavioral health services consistent with State law.

Tolled: Means stopped or suspended, particularly as it refers to time periods during the claims process.

Authorized Representative: CONTACT recognizes an authorized representative as the person who can act on your behalf to file a claim under CONTACT (because of your death, disability or other reason acceptable to CONTACT) and to appeal an adverse benefit determination. An authorized representative includes a health care professional. Subject to the written statement requirement discussed below, the following individuals may be recognized as your authorized representative: a health care professional, legal spouse, dependent child age 18 or over, parents or adult siblings, grandparent, other adult, court ordered representative, such as an individual with power of attorney for health care purposes or legal guardian conservator.

CONTACT requires a written statement from the individual that he/she has designated one of the above individuals as the authorized representative along with the representative's name, address and phone number. Where the individual is unable to provide a written statement, CONTACT will require written proof (*e.g.* notarized power of attorney for health care purposes, court order of guardian/conservator) that the proposed authorized representative satisfies one of the relationships listed above. To designate an authorized representative, you must submit a completed authorized representative form.

Once CONTACT receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. CONTACT will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A designated authorized representative may be revoked by submitting a completed change of authorized representative form available from and to be returned to CONTACT.

In the case of an urgent care claim, if a health care professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such health care professional will be considered by CONTACT to be your authorized representative bypassing the need for completion of CONTACT's written authorized representative form.

CONTACT reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

How To File A Post-Service Claim For Benefits Under CONTACT

1. A claim for post-service benefits is a request for behavioral health benefits (that is not a preservice claim) made by you or your authorized representative, in accordance with CONTACT's claims procedures, described in this document.
2. Behavioral health benefits for post-service claims are considered for payment on the receipt of a written proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim, but sometimes additional information or records may be required.
3. Generally behavioral health benefits for a Hospital or Health Care Facility will be paid directly to the facility. At the time you submit your claim you must furnish acceptable evidence that you or your covered dependent paid some or all of those charges.
4. Behavioral health benefits will be paid to you up to the amount allowed by CONTACT for those eligible expenses. Do not send balance due statements, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.
5. **Claim Forms:** Occasionally a health care provider will send a claim directly to you. In this case you should contact CONTACT.
 - Complete the employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
 - The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or Behavioral Health Care Practitioner can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains all of the following information:
 - A description of the services or supplies provided.
 - Details of the charges for those services or supplies including CPT/CDT codes.
 - Diagnosis including DSM IV codes.
 - Date(s) the services or supplies were provided.
 - Patient's name, (social security or ID number), address and date of birth.
 - Provider's name, address, phone number, professional degree or license, and federal tax identification number.
 - Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to CONTACT. This can reduce costs to you and CONTACT.
 - Complete a separate claim form for each person for whom behavioral health benefits are being requested.
 - If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to CONTACT.
 - Mail the claim form and a copy of the provider's actual claim to CONTACT.
6. In all instances, when deductibles, co-insurance or co-payments apply, you are responsible for paying your share of the charges.
7. CONTACT will review your post-service claim within a reasonable period of time but not later than 30 calendar days from the date CONTACT receives the claim. You will be notified if you did not properly follow the post-service claims process.

- This 30-day period may be extended one time by CONTACT for up to 15 additional calendar days if CONTACT determines that an extension is necessary due to matters beyond their control, the date by which they expect to make a decision and they notify you prior to the expiration of the initial 30 day period using a written Notice of Extension.
 - The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
 - If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date on which the Notice of Extension was sent.
 - CONTACT will then make a claim determination within a reasonable period but not later than 15 calendar days from the date CONTACT receives the additional information or the date displayed in the Notice of Extension on which CONTACT will make a decision if no additional information is received.
8. If the post-service claim is denied in whole or in part, a notice of this initial denial will be provided to you in writing or electronically, as applicable. This notice of initial denial will:
- give the specific reason(s) for the denial;
 - reference the specific behavioral health benefits on which the denial is based;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of CONTACT's appeal procedure along with time limits;
 - contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed; and
 - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request; and
 - if the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
9. If you disagree with a denial of a post-service claim, you or your authorized representative may ask CONTACT for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. CONTACT will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of A Post-Service Claim

1. CONTACT maintains a 2 level appeals process for post-service claims. Appeals must be in writing to CONTACT for the first and second levels. You will be provided with:
- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of CONTACT who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
 - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental,
 - investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
 - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained on behalf of CONTACT in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
2. Under CONTACT's 2 level appeal process, CONTACT will make the first level determination on the post-service appeal within a reasonable period of time but not later than 30 calendar days from receipt of the appeal.
 - There is no extension permitted in the first or second level of the appeal review process.
 - You will be sent a written notice of the appeal determination as discussed below.
 - If still dissatisfied with the initial appeal level determination you will have a reasonable period of time (90 calendar days under CONTACT) from receipt of the first level review determination to request a second level appeal review by writing to CONTACT. CONTACT will make a second level determination within a reasonable period of time but not later than 30 calendar days from receipt of the second level appeal.
 3. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during CONTACT's review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
 4. If the claim was denied due to a medical judgment (medical necessity, experimental or investigational) CONTACT will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
 5. A written notice of the appeal determination will be provided to you at each level of the appeal review that includes:
 - the specific reason(s) for the adverse appeal review decision;
 - reference the specific behavioral health benefits on which the denial is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;

- if the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - the statement that “You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency.”
 - in the notice of first level appeal review determination, the notice will describe the process to proceed to a second level appeal review and time frames if still dissatisfied with the determination. If still dissatisfied with the initial appeal level determination you will have a reasonable period of time (90 calendar days under CONTACT) from receipt of the first level review determination to request a second level appeal review by writing to CONTACT.
6. This concludes the post-service appeal process under CONTACT. CONTACT does not offer a voluntary appeal process.

How To File An Urgent Care Claim For Benefits Under CONTACT

1. If your claim involves urgent care (as defined earlier in this document), you may file the claim or CONTACT will honor a health care professional as your authorized representative in accordance with CONTACT’s urgent care claims procedures described below.
2. Urgent care claims (as defined previously in this document) may be requested by you orally or by writing, as appropriate, to CONTACT.
3. In the case of an urgent care claim, if a health care professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the health care professional will be considered by CONTACT to be the authorized representative bypassing the need for completion of CONTACT’s written authorized representative form.
4. You will be notified of CONTACT’s benefit determination as soon as possible but not later than 72 hours after receipt of an urgent care claim by CONTACT. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under CONTACT.
5. If you fail to provide sufficient information to decide an urgent care claim, you will be notified as soon as possible, but not later than 24 hours after receipt of the urgent care claim by CONTACT, of the specific information necessary to complete the urgent care claim and you will be allowed a reasonable amount of time, but not less than 48 hours, to provide the information. You will then be notified of CONTACT’s benefit determination on the urgent care claim as soon as possible but not later than 48 hours after the earlier of CONTACT’s receipt of the needed information or the end of the period of time allowed to you in which to provide the information.
6. If the urgent care claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided not later than 3 calendar days after the oral notice.
7. If the urgent care claim is denied in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided not later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
 - give the specific reason(s) for the denial;
 - reference the specific behavioral health benefits on which the denial is based;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

- provide an explanation of CONTACT's appeal procedure along with time limits;
 - contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
 - if the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
 - you will be provided a description of the expedited appeal review process for urgent care claims.
8. If you disagree with a denial of an urgent care claim, you or your authorized representative may ask CONTACT for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. CONTACT will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of An Urgent Care Claim

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to CONTACT.
2. You will be provided with:
 - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, CONTACT will:
 - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
3. CONTACT will make a determination on the appeal (without the opportunity for an extension) as soon as possible but not later than 72 hours after receipt of the appeal.
4. The notice of appeal review of an urgent care claim will be provided orally with written (or electronic, as appropriate). A written notice of the appeal determination will be provided to you that includes:
 - the specific reason(s) for the adverse appeal review decision;
 - reference the specific behavioral health benefits on which the denial is based;

- a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
 - if the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - the statement that “You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency.”
5. This concludes the urgent care claim appeal process under CONTACT’s behavioral health care program. CONTACT does not offer a voluntary appeal process.

How To File A Concurrent Claim For Benefits Under CONTACT

1. If your claim involves concurrent care (as that term is defined earlier in this document), you may file the claim by writing (orally for an expedited review) to CONTACT.
2. If a decision is made to reduce or terminate an approved course of treatment, CONTACT will provide notification of the termination or reduction to you at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.
3. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this document.
4. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Preservice or Post-service claim sections of this document.
5. If the concurrent care claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
 - give the specific reason(s) for the denial;
 - reference the specific behavioral health benefits on which the denial is based;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of CONTACT’s appeal procedure along with time limits;
 - contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
 - if the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

6. If you disagree with a denial of a concurrent claim, you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. CONTACT will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of A Concurrent Care Claim

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to CONTACT.
2. You will be provided with:
 - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
 - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained on behalf of CONTACT in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
3. CONTACT will make a determination on the appeal (without the opportunity for extension) as soon as possible before the benefits is reduced or treatment is terminated.
4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. A written notice of the appeal determination will be provided to you that includes:
 - the specific reason(s) for the adverse appeal review decision;
 - reference the specific behavioral health benefits on which the denial is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
 - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
 - if the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

- the statement that “You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency.
5. This concludes the concurrent claim appeal process under CONTACT. CONTACT does not offer a voluntary appeal process.

How To File A Pre-Service Claim For Benefits Under Contact

1. A claim for pre-service (as defined in this document) must be made by a claimant or the claimant’s authorized representative (as described in this document) in accordance with CONTACT’s claims procedures outlined in this document.
2. A pre-service claim (claim which requires pre-certification) must be submitted (orally or in writing) as follows:
 - to CONTACT at least 7 days before the expected date of service for those behavioral health services outlined that necessitate precertification.
3. The pre-service claim will be reviewed within a reasonable period of time but not later than 15 calendar days from the date the pre-service claim is received by CONTACT (If you did not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.)
 - The 15 calendar day review period may be extended one time for up to 15 additional calendar days if the CONTACT determines that an extension is necessary due to matters beyond their control, the date by which they expect to make a decision and notify you prior to the expiration of the initial 15 day period using a written Notice of Extension.
 - If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed from the date on which the Notice of Extension was sent.
 - The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
 - You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
 - The CONTACT will then make a claim determination within a reasonable period of time but not later than 15 calendar days from the earlier of the date CONTACT receives the additional information or 60 days has elapsed from the date on which the Notice of Extension was sent.
4. If the pre-service claim is approved you will be notified orally and in writing (or electronic, as applicable).
5. If the pre-service claim is denied in whole or in part, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
 - give the specific reason(s) for the denial;
 - reference the specific behavioral health benefits on which the denial is based;
 - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
 - provide an explanation of CONTACT’s appeal procedure along with time limits;

- contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed; and
 - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request; and
 - if the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
6. If you disagree with a denial of a pre-service claim, you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. CONTACT will not accept appeals filed after this 180-calendar day period.

Appeal Of A Denial Of A Pre-Service Claim

1. CONTACT maintains a 2 level appeals process. Appeals must be in writing to CONTACT for the first and second levels of appeal review.
 - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
 - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
 - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
 - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
 - consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
 - provide the identification of medical or vocational experts whose advice was obtained on behalf of CONTACT in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
2. Under CONTACT's 2 level appeal process, CONTACT will make the first level determination on the pre-service appeal within a reasonable period of time but not later than 15 calendar days from receipt of the appeal.
3. There is no extension permitted in the first or second level of the appeal review process. You will be sent a written notice of the appeal determination as discussed below.
4. If still dissatisfied with the initial appeal level determination you will have a reasonable period of time (90 calendar days under CONTACT) from receipt of the first level review determination to request a second level appeal review by writing to the Board of Trustees whose address is listed on the Quick Reference chart in the front of this document.
5. CONTACT then will make a second level determination within a reasonable period of time but not later than 15 calendar days from receipt of the second level appeal.
6. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during CONTACT's review of the denial. Your claim

will be reviewed by a person at a higher level of management than the person who originally denied the claim.

7. If the claim was denied due to a medical judgment (medical necessity, experimental or investigational) CONTACT will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
8. A written notice of the appeal determination will be provided to you at each level of the appeal review that includes:
 - the specific reason(s) for the adverse appeal review decision;
 - reference the specific behavioral health benefits on which the denial is based;
 - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
 - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
 - if the denial was based on an internal rule, guideline, protocol or similar criterion a statement will be provided that such rule, guideline, protocol or criteria will be provided free of charge to you, upon request;
 - if the denial was based on a medical judgment (medical necessity, experimental or investigational), a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
 - the statement that “You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency.”
 - in the notice of first level appeal review determination, the notice will describe the process to proceed to a second level appeal review and timeframes if still dissatisfied with the determination.
9. This concludes the post-service appeal process under CONTACT. CONTACT does not offer a voluntary appeal process.

The following chart outlines the timeframes for the claim filing and claim appeal process:

Overview of Claims and Appeals Timeframes				
	Urgent	Concurrent	Pre-service	Post-service
Plan must make Initial Claim Benefit Determination as soon as possible but not later than:	72 hours	Before the benefit is reduced or treatment terminated.	5 days	30 days
Extension permitted during initial benefit determination?	No ¹	No	15 days	15 days
Appeal Review must be submitted to CONTACT within:	180 days	180 days	180 days	180 days
Plan must make Appeal Claim Benefit Determination as soon as possible but not later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days for each level of his 2 level appeals process.	30 days for each level of his 2 level appeals process.
Extension permitted during appeal review?	No	No	No	No

1: No formal extension for urgent care claims but if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

Limitation on When A Lawsuit May be Started

You may not start a lawsuit to obtain benefits until after you have exhausted CONTACT's Claims and Appeals procedures or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. No lawsuit may be started more than 3 years after the end of the year in which health care services were provided.

157557/00741

**AMENDEMENT NO. 1
TO THE
SOUTHWESTERN TEAMSTERS SECURITY FUND
RESTATED RULES AND REGULATIONS
PROVIDING HEALTH AND WELFARE BENEFITS
FOR RETIRED EMPLOYEES**

Effective September 1, 2005, Article VI, Section 12(A)(1) is amended and restated to read as follows:

Section 12. Privacy/Disclosures

* * *

A. Disclosure of PHI to the Trustees.

1. Disclosures by Plan. The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administrative functions that qualify as Payment or Health Care Operations. The Plan may, pursuant to 42 C.F.R. § 423.884(b), provide to the Trustees and/or the Centers for Medicare and Medicaid Services and/or its contractors, including but not limited to the Retiree Drug Subsidy Center, in the manner and in the form directed by the Trustees, the information required for the Trustees to comply with their obligations, if any, under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and its implementing regulations, including subpart R of Part 423 of Title 42 of the Code of Federal Regulations.

The Rules and Regulations are amended as stated above this 9 day of ^{MARCH}~~December~~, 2006.



Chairman



Secretary

**AMENDMENT NO. 2
TO THE
SOUTHWESTERN TEAMSTERS SECURITY FUND
RESTATED RULES AND REGULATIONS
PROVIDING HEALTH AND WELFARE BENEFITS
FOR RETIRED EMPLOYEES**

1. Effective September 1, 2006, ARTICLE VI, Section 10 is amended and restated to read as follows:

Section 10. Acts of Third Parties. This provision applies when an Eligible Individual has an Injury or Illness caused by the act or omission of another person or party. In such a case, to the extent of any benefit payments provided by the Trust, the Eligible Individual must reimburse the Trust from any and all recoveries made by the Eligible Individual. It is the intent of this provision to establish a constructive trust/equitable lien on the recoveries made by the Eligible Individual at the time the recoveries come into the hands of the Eligible Individual or that person's representative.

The term "recoveries made by the Eligible Individual" includes any amount received by way of judgment, arbitration award, settlement or any other arrangement from any third party or third party insurer, or from the Eligible Individual's uninsured or underinsured motorist coverage. It includes all monies received regardless of how held, and includes monies directly received by the Eligible Individual as well as any monies held in any account or trust on their behalf. The Trust's share of any recovery will not be reduced because the Eligible Individual has not received the full damages claimed from the third party, unless the Trust agrees in writing to a reduction.

The Plan may require the Eligible Individual to complete, in a form acceptable to the Trustees and prior to the payment of any benefits in relation to the Injury or Illness, a Reimbursement Agreement and other appropriate documentation. In the event that an Eligible Individual fails or refuses to execute such an Agreement/Document, the Trust shall, notwithstanding any other provision to the contrary, be relieved of any obligation to provide benefits to the Eligible Individual.

The Eligible Individual shall take such action as may be necessary or appropriate to recover payments made by the Trust from any responsible third party or insurer in connection with the Injury or Illness. Further, the Eligible Individual shall not do anything to release, discharge or prejudice the rights of the Trust as set forth in this provision, and the Eligible Individual and/or that person's representative shall assist and cooperate with the Trust hereunder, doing everything necessary and appropriate to enable the Trust to enforce its rights as described herein. In this regard, the Eligible Individual shall promptly respond to inquiry from the Trust concerning the status of any such action

and shall direct any legal representative retained to comply with and facilitate the reimbursement contemplated by this provision.

2. Effective September 1, 2006, a Section 13 is added to ARTICLE VI to read as follows:

Section 13. No Right to Assets. No person other than the Trustees of the Trust shall have any right, title or interest in any of the income, property or funds received or held by or for the account of the Plan, and no person shall have any right to benefits provided by the Plan except as expressly provided herein. Amounts paid erroneously to any person, including any Eligible Individual, whether through the misconduct of the recipient or the mistake or oversight of the Trustees or their representatives, shall be held in trust by the recipient, and the Trust and its Trustees shall have an equitable lien thereon in addition to any other remedy provided by the Plan, by law, or otherwise.

The Rules and Regulations are amended as stated above this 14TH day of SEPTEMBER, 2006.



Chairman



Secretary

**AMENDMENT NO. 3
TO THE
SOUTHWESTERN TEAMSTERS SECURITY FUND
RESTATED RULES AND REGULATIONS
PROVIDING HEALTH AND WELFARE BENEFITS
FOR RETIRED EMPLOYEES**

Effective July 1, 2008, the above plan is amended as follows:

Article III, Section 1, is amended to delete the text in strike-through and add the text in italics as noted below:

Section 1. Allowable Expenses. For the purpose of this Article, an expense or charge shall be an Allowable Expense only if the Trustees in their sole discretion determine that:

- A. Except for items/services specified in Section 4 (T) of this part, it is Medically Necessary for the care and treatment of non-occupational accidental bodily injury or sickness of a person who is an Eligible Individual at the time the expense is incurred;
- B. It is recommended and approved by a Physician and is for a valid course of medical treatment which is not experimental and which is recognized as valid by an established medical society in the United States, provided that the Plan may obtain and rely upon independent medical advice to determine whether services or supplies are Medically Necessary, are consistent with professionally recognized standards of care with regard to quality, frequency and duration; and are provided in the most economical and medically appropriate site for treatment;
- C. It is a Covered Charge as described in Section 4 below;
- D. It is a Reasonable Charge as defined in Article 1, Section 14;
- E. It is not otherwise excluded or limited by provisions under this Article.

The Trust may enter into Preferred Provider Organization (PPO) arrangements in order to access discounted fees for medical services, and these discounted PPO fees, if otherwise recognized under subsections A through E of this Section, shall constitute Allowable Expenses.

Article III, Section 4, (B) (3), is amended to delete the text in strike-through and add the text in italics as noted below:

Section 4. Covered Charges

- B. Charges made by a **Physician or Health Care Practitioner** for professional services performed within the scope of their license/specialty;
 1. Charges for the surgeon for surgical procedures and postoperative treatment; (**See Note, below.**)
 2. Charges for the **assistant surgeon** (payable to a maximum of 20% of the allowed fee payable to the surgeon); (**See Note, below.**)
 3. Charges for **anesthesia** and its administration by a Physician or Certified Registered Nurse Anesthetist (CRNA); (**See Note, below.**)

~~Note: For surgical procedures, post-operative treatment, anesthesia and its administration, the amount allowed shall be the product of the appropriate Relative Value stated in the 1964 California Relative Value Schedule multiplied by a Unit Value of \$13.00. The allowance for an assisting Physician for an operation is 20% of the 1964 California Relative Value Schedule for the surgical procedure. Benefits shall not be payable for the attendance of two Physicians on the same case at the same time except where it is warranted by medical necessity.~~

~~For medical services not shown in the 1964 California Relative Value Schedule, and which are not expressly excluded by the terms of this Plan, the Plan will determine the Relative Value of the service. A service comparable to the enumerated service of closest similarity will be used as a basis for the determination.~~

*Note: For surgical procedures, post-operative treatment, anesthesia and its administration, the charge means the allowed amount for medically necessary services or supplies and will be determined by the Plan Administrator or its designee to be the **lowest** of:*

1. *With respect to a PPO Health Care Practitioner/Facility, the fee set forth in the agreement between the Provider/Facility and the PPO Network or the Plan; or*
2. *For non-PPO Practitioners/Facilities, no more than the product of the appropriate Relative Value stated in the 1964 California Relative Value Schedule multiplied by a Unit Value of \$13.00. The allowance for an assisting Physician for an operation is 20% of the 1964 California Relative Value Schedule for the surgical procedure. Benefits shall not be payable for the attendance of two Physicians on the same case at the same time except where it is warranted by medical necessity. For medical services not shown in the 1964 California Relative Value Schedule, and which are not expressly excluded by the terms of this Plan, the Plan will determine the Relative Value of the service. A service comparable to the enumerated service of closest similarity will be used as a basis for the determination; or*
3. *The Practitioner/Facility's actual billed charge.*

The Rules and Regulations are amended as stated above this 11th day of September, 2008.


Chairman


Secretary

4050129v3/00741.001

AMENDMENT NO. 4
to the
SOUTHWESTERN TEAMSTERS SECURITY FUND
RULES AND REGULATIONS
restated September 2004
providing Health and Welfare Benefits for the
RETIRED EMPLOYEES PLAN

Effective January 1, 2009, the above plan is amended as follows:

Article I, Section 5, a NEW paragraph is added to this as noted by the text in italics below:

Section 5. The term “**Dependent**” means:

- A. The Eligible Retiree’s lawful spouse;
- B. The Eligible Retiree’s unmarried natural child who is less than 19 years of age;
- C. An unmarried stepchild, foster child or legally adopted child who lives with the Eligible Retiree in regular parent-child relationship and who is **less than 19 years of age**; and
- D. An unmarried natural child, stepchild, foster child, or legally adopted child **over the age of 19, but less than 23**, who is a full-time student (at least 12 credit hours, or for a graduate student, 9 credit hour) in attendance at a high school, college, university, vocational, technical or trade school. (Spring full-time student certification grants coverage through August 31.)

The term “**Foster Child**” shall mean and include a child who:

- A. Resides with the Eligible Retiree on a permanent, full-time basis;
- B. Depends upon the Eligible Retiree fully and solely for support and maintenance; and
- C. Is reported as a Dependent by the Eligible Retiree which the Eligible Retiree files a return under the Internal Revenue Code.

The term “**Legally Adopted Child**” shall include a child placed for adoption and as to which the Eligible Retiree assumes and retains a legal obligation for total or partial support in anticipation of adoption of the child.

If a Dependent, prior to attaining the applicable maximum age for Eligible Dependents, is chiefly dependent upon the Eligible Retiree for support and maintenance and is continuously unable to obtain selfsustaining employment because of physical handicap or mental retardation, the Dependent shall remain eligible for the medical coverage provided for Dependents until the Dependent either recovers from the physical handicap or mental retardation, or no longer chiefly depends upon the Eligible Retiree for support and maintenance.

In no event shall any Dependent other than a lawful spouse be eligible under the Plan both as an Eligible Dependent and as an Eligible Retiree. However, if a spouse is eligible as a Retiree, Dependent children will be covered as Dependents of both parents and benefits will be coordinated in accordance with Article V of the Rules and Regulations.

No individual will be considered a dependent under the Plan in the absence of specific documentation to substantiate dependent status, including accurate Identification Information (e.g. Social Security number, Medicare health insurance claim number, etc).

Article III, Section 6, is amended to delete the text in strike-through as noted below:

Section 6. Maximum Benefit. In no event shall an Eligible Individual receive benefits in excess of \$125,000 total under the Retiree Plan.

~~If Major Medical Expense Benefits have been paid for an Eligible Individual, an amount equal to the benefits paid up to \$2,000 will be automatically reinstated on January 1 of each Calendar Year.~~

Article VI, Section 1, is amended to add the text in italics as noted below:

Section 1. Proof of Claim. All benefits will be paid by the Fund to the Eligible Employee as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character, and extent of the event for which the claim is made. *Identification information is required for all Eligible Individuals and will need to be provided to the Fund before any claims can be considered for payment. Identification information can include but is not limited to social security number, Medicare health insurance claim number (HIC), etc.*

The Rules and Regulations are amended as stated above this 5th day of March, 2009.



Chairman



Secretary

5026926v2/00741.001

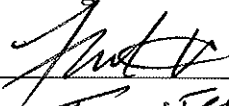
AMENDMENT NO. 5
to the
SOUTHWESTERN TEAMSTERS SECURITY FUND
RULES AND REGULATIONS
restated September 2004
providing Health and Welfare Benefits for the
RETIRED EMPLOYEES PLAN

Effective June 1, 2009, the above plan is amended as follows:

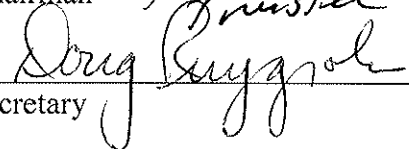
Any and all reference to the previous EAP/Behavioral Health Program vendor "CONTACT" or "CONTACT Behavioral Health" is deleted and replaced with the new EAP/Behavioral Health Program vendor Mines and Associates.

The Rules and Regulations are amended as stated above this 11th day of June, 2009.

Chairman



Secretary



5030686v2/00741.001

AMENDMENT NO. 6
to the
SOUTHWESTERN TEAMSTERS SECURITY FUND
RULES AND REGULATIONS
restated September 2004
providing Health and Welfare Benefits for the
RETIRED EMPLOYEES PLAN

Effective April 1, 2010, Article I, Section 14, is amended to read as follows:

Section 14. Recognized Charges means the expenses or charges for medical services and supplies, as described in Article III, which are:

- A. With respect to a covered PPO provider, the fee set forth in the agreement between the preferred provider organization (PPO) network and the Trust; or
- B. With respect to a non-PPO provider, the fee identified in the schedule that lists the dollar amounts the Trustees have determined the Plan will allow for covered services or supplies (or, if lower, the provider's actual billed charge).

Effective April 1, 2010, the term "Reasonable Charges" is replaced wherever it appears in the Plan with the term "Recognized Charges."

Effective April 1, 2010, the first part of Article V, Section 2, Sub-section C, is amended and restated to read as follows:

- C. **Allowable Expense.** The term "Allowable Expense" means any medically necessary item of medical expense incurred, a portion of which is covered under on the of the plans covering the Eligible Individual for whom claim is made.

Effective January 1, 2010, Article II, Section 2, is amended as noted by the addition of the following text:

- D. Notwithstanding this provision or any other provision of the plan to the contrary, the eligibility of a Dependent child will be continued at no cost if the child is enrolled in a postsecondary educational institution, enjoys Dependent status under the Plan by virtue of such enrollment, and takes a medically necessary leave of absence from such enrollment and loses such Dependent status because of the absence. Eligibility so continued will terminate the earlier of (1) the date that is one year after the first day of the medically necessary leave of absence, or (2) the date on which such eligibility would otherwise have terminated under the Plan. The Trustees will require written certification by the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary. At the conclusion of continued eligibility under this paragraph, a child will be treated as having failed to meet the definition of Dependent for purposes of the Dependent Self-Payments allowed by the Plan.

The Rules and Regulations are amended as stated above this 10th day of June 2010.

Chairman



Secretary



5073605v1/00741.001

AMENDMENT NO. 7
to the
SOUTHWESTERN TEAMSTERS SECURITY FUND
RULES AND REGULATIONS
restated September 2004
providing Health and Welfare Benefits for the
RETIRED EMPLOYEES PLAN

Effective June 1, 2010, the above Plan is amended as follows:

Article III Major Medical Expense Benefits, Section 2 Benefits, is amended as noted by the addition of the text in italics:

Section 2. Benefits.

A. Benefits other than Behavioral Health Benefits (mental/nervous/alcoholism and drug abuse benefits):

If an Eligible Individual receives therapeutic treatment for an injury or sickness, the Fund will, subject to the terms and conditions hereafter stated, pay an amount equal to 70% of all Allowable Expenses which exceed the Deductible Amount during the Calendar Year, up to the maximum specified in Section 7 of this Article III. Benefits as set forth in this Article shall be coordinated with Medicare in accordance with the provisions of Article V of these Rules and Regulations.

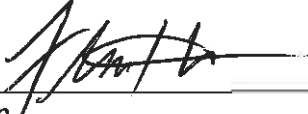
Note: Prescription Drugs may be provided either through retail pharmacies or by mail order under the Fund's prescription benefit manager network with a 30% co-payment (*Specialty Drugs are payable at 100% after a \$75 co-pay*) by the Eligible Individual. When Prescription Drugs are secured in-network, the Plan Deductible is waived; Prescription Drugs secured out-of-network are subject to the Plan Deductible.

Specialty drugs are available on an outpatient basis when ordered through and managed by the Prescription Drug Program. Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. Injectable drugs need precertification. These drugs may require special handling, are date sensitive and are generally available only in a 30-day quantity.

Article III Major Medical Expense Benefits, Section 4 Covered Charges, is amended as noted by the addition of the text in italics in N-2 below (causing renumbering of the rest of N):

- N. Prescription Drugs:** are payable for medically necessary drugs which may be lawfully dispensed, as provided under the Federal Food and Drug Administration (FDA), including any amendment thereto, only upon a written or oral prescription of a Physician or Health Care Practitioner licensed to prescribe such drug.
1. Covered drugs include insulin, diabetic supplies (including syringes, needles and blood glucose test supplies), prescription contraceptives, and prenatal vitamins.
 2. *Specialty Drugs are available on an outpatient basis when ordered through and managed by the Prescription Drug Program. Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. Injectable drugs need precertification. These drugs may require special handling, are date sensitive and are generally available only in a 30-day quantity.*
 3. The Trust may contract with an independent Prescription Drug Program to administer outpatient drugs through contracted retail pharmacies and a mail order home delivery service.
 4. Some drugs have a quantity limit (such as those to treat migraines and sexual dysfunction) or may require prior authorization by contacting the Prescription Drug Program.
 5. Section 5A of this Article describes the drugs that are not payable by the Plan.

The undersigned Chairman and Secretary of the Southwestern Teamsters Security Fund do hereby certify that the foregoing Amendment to the Rules and Regulations of the Active Employees Plan was duly adopted by the Board of Trustees at a meeting duly called and held on March 10, 2011.



Chairman



Secretary

5086289v3/00741.001

AMENDMENT NO. 8
to the
SOUTHWESTERN TEAMSTERS SECURITY FUND
RULES AND REGULATIONS
restated September 2004
providing Health and Welfare Benefits for the
RETIRED EMPLOYEES PLAN

Effective December 1, 2010, the above Plan is amended as follows:

Article II, Sections 1 and 2 are amended to add the text in italcis and delete the text in strike-through as noted below:

Section 1. Establishment and Maintenance of Eligibility.

- A. Any Retired Employee shall be eligible for benefits under these Rules and Regulations if he/she is not covered by any other group health plan as an Active Employee, and:
1. Retires from the employ of an Contributing Employer that is a continuing contributor to the Southwestern Teamsters Security Fund and the Retired Employee Fund thereunder; and
 2. Was covered under an Active Employee Plan of benefits by the Southwestern Teamsters Security Fund for at least 24 of the 36 months immediately preceding his/her retirement date. Self-payment participation shall not be considered for these purposes. (For good cause shown, the Trustees in their discretion may waive the requirements of this provision); and
 3. Has completed the necessary written application and submitted it to the Administrative Office within 60 days or retirement. If the application is not submitted within 60 days of the retirement date, then eligibility begins the first day of the month subsequent to the date the application is received; and
 4. Is receiving a monthly retirement or disability benefit under the Federal Social Security Act, the Western Conference of Teamsters Pension Trust or another bona fide pension plan which is provided to employees by virtue of a Teamster-negotiated collective bargaining agreement with the Retired Employee's former Employer; and
 5. Timely tenders to the Trust any self-payments the Trustees may require in order for such individual to be considered eligible for benefits. To be considered timely, such self-payments must be made by the 10th of the calendar month preceding the month of eligibility. No such payments will be accepted after the 20th of the month preceding the month of eligibility; i.e., there is only a 10-day grace period, and no waivers or exceptions will be granted.
- B. A Retired Employee's eligibility shall commence on the later of the following dates:
1. The first day of the month for which said pension or disability benefits become payable to such Retired Employee;
 2. The date on which his/her eligibility as an Active Employee under the active Employee Plan terminates if, in fact, he/she is eligible as a Retired Employee as of such date;
 3. The date on which his/her eligibility as a Self-Pay Employee under the Active Employee Plan terminates if, in fact, he/she is eligible as a Retired Employee as of such date.

C. A Retired Employee's **Dependent** becomes **eligible** on the later of the following dates:

1. The date the Retired Employee's eligibility is effective;
2. The date the Retired Employee acquires the Dependent (*if properly enrolled*);
3. In the case of a newborn infant, the date of birth (*if properly enrolled*).

D. **Dependent Eligibility and Enrollment.**

All existing Eligible Dependents of an Eligible Retiree can continue benefits unless they meet a termination of eligibility provision outlined in Section 2. Newly acquired Dependents are eligible on the first day of the month following their proper enrollment as described below.

1. **Enrollment Process:** *New Dependents are considered properly enrolled upon the Retirees' completion of an enrollment form and the submission of the information required under the Proof of Dependent Status Provision below.*
 - a. **Special Rule for Newly-Acquired Spouse** - - *A newly acquired spouse of an Eligible Retiree will be covered as of the date of the marriage to the Retiree, if properly enrolled within 90 days of the marriage. You will be requested to complete an enrollment form and provide proof and identification data for the Dependent Spouse (if requested). If a newly acquired Spouse is not properly enrolled within this 90-day period, then eligibility for that Dependent will begin on the first day of the month following their proper enrollment.*
 - b. **Special Rule for Newborns** - - *Newborn Dependent Children of an Eligible Retiree will be covered from the date of birth, if properly enrolled within 90 days of their birth. You will be requested to complete an enrollment form and provide proof and identification data for the Dependent (if requested). If a newborn Dependent child is not properly enrolled within this 90-day period, then eligibility for that Dependent will begin on the first day of the month following their proper enrollment.*
 - c. **Special Rule for Adopted Children** - - *Adopted Children, or children "Placed for Adoption" with an Eligible Retiree will be covered from the date of adoption, or the date of placement for adoption, if earlier, if properly enrolled within 90 days of the adoption or placement for adoption. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. You will be requested to complete an enrollment form and provide proof and identification data for the Dependent (if requested).). If an adopted child is not properly enrolled within this 90-day period, then eligibility for that Dependent will begin on the first day of the month following their proper enrollment. If a child is Placed for Adoption with you and is properly enrolled, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.*
2. **Proof of Dependent Status:** *Specific documentation to substantiate Dependent status will be required by the Plan and may include proof that the dependent is related to the Retiree and social security number of the dependent(s) you wish to add to the plan, and any of the following:*
 - **Marriage:** *copy of the certified marriage certificate.*
 - **Birth:** *copy of the certified birth certificate.*
 - **Adoption or placement for adoption:** *court order paper signed by the judge.*
 - **Foster Child:** *a copy of the foster child placement papers from a qualified state placement agency, or proof of judgment decree or court order of a court of competent jurisdiction, and any proof of any state provided health coverage.*
 - **Qualified Medical Child Support Order (QMCSO):** *Valid QMCSO document or National Medical Support Notice.*
 - **Disabled Dependent Child:** *Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently*

mentally retarded or mentally or physically disabled (as that term disabled is defined in this document) and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on you and/or your Spouse for support and maintenance. The plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.

Section 2. Termination of Eligibility.

A. **A Retired Employee's eligibility will terminate** on the earlier of the following dates:

1. The date on which the benefits provided herein are terminated by the Board of Trustees;
2. The date on which the Retired Employee ceases to be eligible according to these Rules and Regulations;
3. The first day of the month next following the month in which the Retired Employee becomes covered under any group health plan as an Active Employee. If such person returns to an eligible status as a Retired Employee within 12 months of his/her loss of eligibility as a Retired Employee, benefits will be effective on the first day of the month coinciding with or next following the date of return.

However, if the Retired Employee remains ineligible for 12 consecutive months, he/she must again qualify as previously described in Section I of this Article II, to regain his/her eligibility;

4. The end of the second calendar month following the calendar month in which the Retired Employee's former Employer ceases being a Contributing Employer under this Plan except if such Contributing Employer ceases doing business or sold the business to another Contributing Employer as of the date the Retired Employee's insurance would otherwise terminate because of this provision.

Notwithstanding this subsection (4), a Retired Employee whose former Employer is not a Contributing Employer may, on such terms and conditions as the Trustees may authorize, and for such time periods as the Trustees may authorize, continue eligibility for themselves and their Eligible Dependents by making self-payments, in such amounts as the Trustees may approve directly to the Administrative Office.

B. **The eligibility of a Dependent of a Retired Employee will terminate** on the earlier of the following dates:

1. The date on which the benefits provided herein are terminated by the Board of Trustees;
2. The date on which he/she no longer qualifies as a Dependent, as defined in Section 5 of Article 1;
3. The date on which the Retired Employee's eligibility terminates;
4. On the date ~~he/she~~ *the Dependent Spouse* enters full-time military service of any country.

C. *In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.*

D. ~~Notwithstanding this provision or any other provision of the plan to the contrary, the eligibility of a Dependent child will be continued at no cost if the child is enrolled in a postsecondary educational institution, enjoys Dependent status under the Plan by virtue of such enrollment, and takes a medically necessary leave of absence from such enrollment and loses such Dependent status because of the absence. Eligibility so continued will terminate the earlier of (1) the date that is one year after the first day of the medically necessary leave of absence, or (2) the date on which such eligibility would otherwise have terminated under the Plan. The Trustees will require written certification by the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary. At the conclusion of~~

~~continued eligibility under this paragraph, a child will be treated as having failed to meet the definition of Dependent for purposes of the Dependent Self-Payments allowed by the Plan.~~

Article I, Section 5 is amended to add the text in italics and delete the text in strike-through as noted below:

Section 5. The term “Dependent” means:

- A. ~~The Eligible Retiree’s lawful spouse as defined consistent with federal law to refer only to a person of the opposite sex who is a husband or a wife. The Plan may require proof of the legal marital relationship. A domestic partner or divorced former spouse of a retiree is not an eligible spouse under this Plan;~~
- B. ~~The Eligible Retiree’s unmarried natural child who is less than 19 years of age;~~
- C. ~~An unmarried stepchild, foster child or legally adopted child who lives with the Eligible Retiree in regular parent child relationship and who is less than 19 years of age; and~~
- D. ~~An unmarried natural child, stepchild, foster child, or legally adopted child over the age of 19, but less than 23, who is a full time student (at least 12 credit hours, or for a graduate student, 9 credit hour) in attendance at a high school, college, university, vocational, technical or trade school. (Spring full-time student certification grants coverage through August 31.)~~

The term “Foster Child” shall mean and include a child who:

- A. ~~Resides with the Eligible Retiree on a permanent, full-time basis;~~
- B. ~~Depends upon the Eligible Retiree fully and solely for support and maintenance; and~~
- C. ~~Is reported as a Dependent by the Eligible Retiree which the Eligible Retiree files a return under the Internal Revenue Code.~~

The term “Legally Adopted Child” shall include a child placed for adoption and as to which the Eligible Retiree assumes and retains a legal obligation for total or partial support in anticipation of adoption of the child.

~~If a Dependent, prior to attaining the applicable maximum age for Eligible Dependents, is chiefly dependent upon the Eligible Retiree for support and maintenance and is continuously unable to obtain self-sustaining employment because of physical handicap or mental retardation, the Dependent shall remain eligible for the medical coverage provided for Dependents until the Dependent either recovers from the physical handicap or mental retardation, or no longer chiefly depends upon the Eligible Retiree for support and maintenance.~~

- B. *For the purposes of this Plan, a Dependent Child is any of the Retiree’s children listed below who are under the age of 26 (whether married or unmarried):*
 - *Son or daughter (proof of relationship and age may be required).*
 - *Stepson or stepdaughter (proof of relationship and age will may be required).*
 - *Legally adopted child or child placed for adoption with the Retiree (proof of adoption or placement for adoption and age will may be required). The term “Legally Adopted Child” shall include a child placed for adoption and as to which the Eligible Retiree assumes and retains a legal obligation for total or partial support in anticipation of adoption of the child.*
 - *Foster child, lawfully placed with the Retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction (proof of relationship and age may be required).*
 - *An unmarried Dependent Child (as defined above) age 26 or older who is permanently and totally disabled and whose disability existed before the attainment of the Plan’s age limit under this plan and who is eligible for tax-free health coverage as a “qualifying child” or “qualifying relative” under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively and who will be claimed as a Dependent on the Retiree’s tax return for each plan year for which coverage is provided.*

- *The Plan will require initial and periodic proof of disability. To be eligible for tax-free health coverage as a “qualifying child,” an unmarried child with a permanent and total disability must have the same principal place of abode as the participant for more than half of the year and must not provide over half of his/her own support for the year.*
- *To be eligible for tax-free health coverage as a “qualifying relative,” the participant must provide over half of the child’s support, and the child must not be the “qualifying child” of any person. The Dependent shall remain eligible for the medical coverage provided for Dependents until the Dependent either recovers from the disability or no longer chiefly depends upon the Retiree for support and maintenance (a tax-qualified Dependent).*

For plan years beginning prior to January 1, 2014, a Dependent Child who is age 18 or older is not eligible for coverage under the Plan if such adult child is eligible for coverage under another employer-sponsored health plan (other than a group health plan of a parent).

In no event shall any Dependent other than a lawful spouse be eligible under the Plan both as an Eligible Dependent and as an Eligible Retiree. However, if a spouse is eligible as a Retiree, Dependent children will be covered as Dependents of both parents and benefits will be coordinated in accordance with Article V of the Rules and Regulations.

No individual will be considered a dependent under the Plan in the absence of specific documentation to substantiate dependent status, including accurate Identification Information (e.g. Social Security number, Medicare health insurance claim number, etc).

The following individuals are not eligible under the Plan: a spouse of a Dependent Child (e.g. Retiree’s son-in-law or daughter-in-law), children of a Domestic Partner, children under a legal guardianship or a child of a Dependent Child (e.g. Retiree’s grandchild).

Article III. Section 2, the following chart is added before subsection A,

*The Trustees of the Southwest Teamsters Security Fund believes the **Retiree Plan** (a group health 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 your 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 preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, expanded age for eligibility a dependent child.*

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 Administrative Office at their phone number listed on the Quick Reference Chart in the front of this document.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform/>. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Article III, Section 4, subsections (I), (R), (T), (V) and (W) are amended to add the text in italics and delete the text in strike-through:

- I. Charges for **Home Health/Home Infusion Therapy Services** using nursing service furnished by a Registered nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN), provided in any case that such nurse is one who does not ordinarily reside in the home of the Retiree and is not a member of the Retiree's immediate family (for purposes of this coverage "immediate family" consists of the Retiree, the Retiree's spouse, children, brothers, sisters and parents). Home health/home infusion therapy services are limited to ***\$15 per day-a maximum of 70 days per calendar year***, and are in lieu of, and not in addition to, Hospital care. Each day of Home Health Care payable under the Plan shall count as a day of Hospital confinement.
- R. **Rehabilitation Services:** The following charges are payable by the Plan for **short-term, progressive Rehabilitation Services** (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician when the patient actively participates in this rehabilitation, as follows:
1. **Outpatient rehabilitation** includes any combination of **Physical, Occupational and/or Speech Therapy, Respiratory Therapy or Cardiac Rehabilitation** and is payable to a maximum of ***\$5,000 50 visits*** per person per calendar year. Speech therapy is covered for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation, laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease.
- T. Charges for **Preventive (Wellness) Services** are payable as follows:
1. **Routine Preventive Care Childhood Immunizations** are payable to age 2 yrs.;
 2. **Mammography breast cancer screening** as follows:
 - (a) 1 baseline screening mammogram payable for women from age 30 to 39.
 - (b) 1 screening mammogram every year for women age 40 and over, or more frequently based on the recommendation of a Physician.
 3. **Annual cervical cancer screening gynecological exam and pap smear** for women ***age 18 and over to a maximum of \$125 per year***.
- V. **Skilled Nursing Facility (SNF), Long Term Care Facility, Extended Care or Sub-Acute Care Facility** is payable to a maximum of ***\$12 per day up to a maximum of 90 days per person per calendar year, but only if such confinement commences within 7 days after a period of at least five days of Hospital confinement***.
- W. **Spinal manipulation** and related services (by a Physician or Chiropractor) are payable to a maximum of ***one treatment per day, 50 treatments per Calendar Year, and \$1,500 per person per Calendar Year***. This limit does not include radiology services performed by the Health Care Practitioner or medically necessary supplies.

Any reference to a Lifetime Maximum of \$125,000 is deleted throughout the Plan Rules.

Article III, Section 6 is amended to add the text in italics and delete the text in strike-through:

Section 6. Maximum Benefit.

1. In no event shall an Eligible Individual receive benefits in excess of **\$125,000 per person per year total** under the Retiree Plan.

If Major Medical Expense Benefits have been paid for an Eligible Individual, an amount equal to the benefits paid up to \$2,000 will be automatically reinstated on January 1 of each Calendar Year.

2. *Waiver of the Medical Plan's Yearly Benefit Maximum.*

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. In 2011, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least \$750,000.

Your health insurance coverage, offered by Southwest Teamsters Security Fund health plan, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of \$125,000 on all covered medical plan benefits along with a \$2,000 annual restoration benefit.

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least \$750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing \$750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits.

This waiver is valid for one year, renewable upon the plan making application to the U.S. Department of Health and Human Services.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Administrative Office at (602) 249-3582 or (800) 474-3485.

Article VI, Section 11 is amended to add the text in italics and delete the text in strike-through:

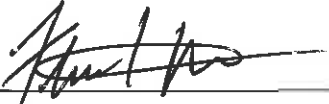
Section 11. Notifying the Plan. Eligible Retirees are required to notify the Fund in writing when a Dependent ceases to meet the Plan's definition of Dependent in Article 1. This notice is required when:

- A. The Eligible Retiree's marriage is dissolved (all marriage certificates and divorce decrees are required to be submitted to the Fund).
- B. A Dependent child ~~marries~~ *reaches age 26.*
- C. ~~A Dependent child who is not a full-time student attains the age of 19.~~
- D. ~~A Dependent child age 19 to 23 ceases to be a full-time student.~~
- E. ~~A Dependent child who is a full-time student turns 23 years of age.~~
- F. ~~A Dependent step-child or foster child ceases to reside with or depend upon the Eligible Retiree.~~

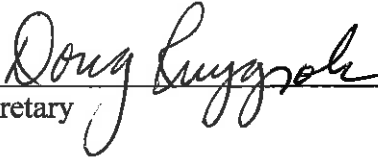
G. A Dependent disabled child over the Plan age limitations ceases to be disabled or ceases to be dependent upon the Eligible Retiree.

The Notice must contain the name and the Social Security number of the Eligible Retiree and the name and address (if different from the Eligible Retiree) of the Dependent whose status has changed. At the discretion of the Board of Trustees, an Eligible Retiree who fails to comply with this Section may be required to repay to the Fund any benefits provided to persons not eligible, where their status would have been apparent from the Notice required by this Section.

The undersigned Chairman and Secretary of the Southwestern Teamsters Security Fund do hereby certify that the foregoing Amendment to the Rules and Regulations of the Active Employees Plan was duly adopted by the Board of Trustees at a meeting duly called and held on September 8, 2011.



Chairman



Secretary

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