Ohio Conference of Teamsters
& Industry Health & Welfare Fund

YOUR HEALTH BENEFITS

Restated as of September 2017

BENEFIT PLAN 5B-PPO

OHIO CONFERENCE OF TEAMSTERS & INDUSTRY HEALTH & WELFARE FUND

Street Address:
435 South Hawley Street
Toledo, OH 43609
(419) 254-3310
1-800-523-8467

BOARD OF TRUSTEES

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To All Eligible Participants:

The Board of Trustees is pleased to provide this updated Plan and Summary Plan Description ("SPD") booklet that describes the Benefits currently available to you and your eligible dependents under the Ohio Conference of Teamsters & Industry Health and Welfare Fund ("Fund" or "Plan").

The booklet contains important information on the Plan's eligibility rules, coverage and Benefits, as well as limitations and exclusions, and information on filing claims for Benefits. It is important that you read the booklet carefully so that you understand the Plan's program of Benefits and what you must do to qualify for these Benefits.

The Fund has contracted with Medical Mutual Services, LLC ("Medical Mutual") to participate in their PPO Network program. PPO Network will provide you with comprehensive health care Benefits and services through PPO Network Providers, Hospitals, laboratories, specialists and other health care providers.

The PPO Network health Benefit plan gives you the option to choose your own personal Physicians, specialists and any Hospital facility from the comprehensive provider Network directory. For maximum Benefits, you must utilize PPO Network providers.

It is important to realize that some Physicians practice medicine in more than one facility and maximum coverage is only applicable when the service is provided at the facility (address) listed in the PPO Network Provider Directory. If treatment is sought in a facility not listed in the PPO Network Provider Directory, the Plan will pay only 60% of the Allowed Amount. FOR MAXIMUM BENEFITS ONE MUST SEEK TREATMENT FROM PHYSICIANS PRACTICING MEDICINE AT THE IN-NETWORK FACILITIES (OFFICE AND HOSPITAL.

If you choose to receive care from a Non-Network Physician or Hospital, the amount the Fund pays for COVERED SERVICES WILL BE COVERED AT A REDUCED LEVEL.

Services obtained from a Physician or other professional provider who is not part of the PPO Network and is not a Medical Mutual participating Physician will be paid based on the Allowed Amount determined by Medical Mutual. YOU WILL BE RESPONSIBLE FOR ANY DIFFERENCE BETWEEN THE ALLOWED AMOUNT AND THE PROVIDER'S NORMAL CHARGE (this is called Balance Billing), IN ADDITION TO THE 40% COINSURANCE. Services obtained from a Non-Contracting Hospital will be paid based on Covered Charges. When you go to a Non-Contracting Hospital, you will be responsible for any difference between the amount the Fund pays for Covered Charges and the billed charges, in addition to the 40% Coinsurance.

All PPO Network Hospitals have agreed to provide specific services at a guaranteed rate, so you will receive the maximum Benefit amount by having your Physician select a PPO Network Hospital. All PPO Network Physicians have admitting privileges at PPO Network Hospitals.

All inpatient care is reviewed before you go into a Hospital or other treatment facility. This procedure is called preauthorization or precertification. **All elective Hospital admissions must be reviewed and certified by Medical Mutual.** When you choose a PPO Network Provider or a Contracting Hospital, the Hospital will take care of the precertification process for you.

When using a Non-Contracting or out-of-state Hospital, you have the responsibility to contact Medical Mutual prior to an elective admission.

In emergency situations always go to the nearest Hospital for treatment. Emergency care requiring an inpatient Hospital admission, as defined in your Benefit Plan booklet, is covered in any Hospital, regardless of location or Network status. You will not be required to pay a 40% Coinsurance for an emergency inpatient admission to a non-PPO Network Hospital.

IT IS IMPORTANT TO NOTE that only the Trustees have complete authority to construe and interpret the provisions of the Plan and Trust Agreement. Any questions or interpretations about the Plan or Trust Agreement, or disputes about eligibility for or amount of Benefits, shall be resolved by the Board of Trustees. No Employer or Union, or representative of any Employer or Union, is authorized to interpret the provisions of either the Plan or Trust Agreement. Any interpretation of the Plan or Trust Agreement made by the Trustees will, subject to the claimant's right to legal action, be final and binding on the participant, the Fund and the Trustees.

If you have any questions about the Plan or need assistance in filing a claim, contact the Fund office.

Sincerely,

Board of Trustees

IMPORTANT INFORMATION ABOUT THE HEALTH AND WELFARE FUND

Besides the Benefits contained in this booklet, the following information contains facts about the Fund you may need.

The name of the Plan is the Ohio Conference of Teamsters and Industry Health and Welfare Fund - Plan 5-PPO. The address of the Fund office is 435 South Hawley Street, Toledo, OH 43609. The phone numbers for the Fund office are (419) 254-3310 and (800) 523-8467 (toll free).

The Plan is maintained pursuant to collective bargaining agreements between contributing Employers and Local Unions affiliated with the Ohio Conference of Teamsters. A copy of each such agreement may be obtained upon written request to the Plan Administrator, who may make a reasonable charge for the copies, and is available for examination by participants and Dependents at the Fund office, Ohio Conference of Teamsters and Industry Health and Welfare Fund, 435 South Hawley Street, Toledo, Ohio 43609.

Contributions to the Plan are made by participating Employers working within the jurisdiction of the collective bargaining agreement on behalf of their Employees. The amount of contributions is negotiated through the collective bargaining agreements. A list of contributing Employers is available upon request to the Fund office at no cost.

The "Plan Sponsor" and "Plan Administrator" is a joint Board of Trustees. The names and principal places of business of the Trustees are as follows:

UNION TRUSTEES:

Mr. Travis Bornstein
Teamsters Local Union 24
2380 Romig Road
Akron, Ohio 44320

Mr. Richard “Chuck” Collinson
Teamsters Local Union 20
435 South Hawley St.
Toledo, Ohio 43609

Mr. Patrick J. Darrow
Teamsters Joint Council 41
6051 Carey Dr.
Valley View, Ohio 44125

Mr. Brian Van Matre
Teamsters Local Union 908
800 St. Johns Ave.
Lima, Ohio 45804

EMPLOYER TRUSTEES:

Mr. James Gilmore
5928 Iron Court
Waterville, Ohio 43566

Mr. Edmund Szczesny
East Manufacturing Corporation
883 Bristol Dr.
Akron, Ohio 44312

Mr. David Tuttle
Spartan Nash
4067 County Rd. 130
Bellefontaine, Ohio 43311

Upon written request, participants and Dependents may receive from the Fund office information as to whether a particular employer or employee organization is a sponsor of the Plan, and if so, the entity's appropriate address.

The Administrative Manager handles the day-to-day administration of the Plan at 435 South Hawley Street, Toledo, Ohio 43609, (419) 254-3310 or (800) 523- 8467. The employer identification number ("EIN") assigned to the Plan Sponsor, the Board of Trustees, by the Internal Revenue Service is 31-6029682. The Plan number assigned by the Board of Trustees is 501.

The Plan provides Hospital, surgical, x-ray, laboratory, ambulance, hearing aids, vision, dental, and prescription drug Benefits, as well as life insurance, weekly accident and sickness coverage, and accidental death and dismemberment Benefits. The specific Benefits in this booklet are revised periodically by the Trustees, with notice of major changes being distributed to participating Employees.

The Life Insurance and Accidental Death and Dismemberment Benefit is insured by Dearborn National at 20445 Emerald Parkway, Suite 400, Cleveland, OH 44135 and is administered by the Fund office.

The Medical Benefits coverage is self-insured by the Ohio Conference of Teamsters & Industry Health and Welfare Fund. Coverage for Hospital and professional services is administered by Medical Mutual at 2060 East Ninth Street, Cleveland, Ohio 44115. Medical Mutual has agreements with area Hospitals and Physicians that allow the Fund to realize discount arrangements when its participants use the Medical Mutual Hospital and professional provider Network.

Dental and Vision Benefit coverage is insured and administered by the Fund and available only to eligible participants and their Dependents.

The prescription drug Benefit coverage is self-funded and administered by Optum Rx, PO. Box 509075, San Diego CA 92150-9075.

The agent for service of legal process is the Administrative Manager, 435 South Hawley Street, Toledo, Ohio 43609. Additionally, each Trustee may be served at their principal place of business above.

Huntington National Bank (Dover, Ohio) is the depository of funds for the provision of Benefits and the investment manager for a short-term investment fund and an intermediate-to-long-term investment fund.

The Plan year for the Fund begins on March 1st and ends on the last day of February in the following year.

YOUR PROVIDERS FOR CLAIM SERVICE

CLAIMS

For **eligibility questions** and filing **Dental and Vision claims.**	**Ohio Conference of Teamsters & Industry Health & Welfare Fund** 435 South Hawley Street Toledo, Ohio 43609 (419) 254-3310, (800) 523-8467
For filing **medical claims**.	**Medical Mutual** P.O. Box 6018 Cleveland, Ohio 44101 Attention: Group No. 800217

MANDATORY PRECERTIFICATION

General Inpatient Hospitalization	1 (800) 338-4114
Skilled Nursing Facility and Home Health	1 (800) 338-4114
Psychiatric or Substance Abuse Inpatient Hospitalization	1 (800) 258-3186

BENEFIT NETWORKS

Medical Group Number: 800217	**Medical Mutual SuperMed Plus** Customer service (including list of participating providers): www.MedMutual.com Customer Service: Ohio: 1 (888) 823-2583 All other states: First Health – 1 (800) 889-0277
Prescription Drug Group Number: OCT BIN Number: 610494 PCN Number: 9999	**Optum Rx** Customer service (including list of participating pharmacies): www.Optum.com 1 (800) 797-9791 3515 Harbor Boulevard Costa Mesa, California 92626 **Mail Order**: 1 (800) 562-6223 P.O. Box 509075 San Diego, California 92150-9075 **Hearing Impaired**: 1 (800) 498-5428
Dental	**DenteMax Network** 1 (800) 752-1547 www.dentemax.com

APPEALS

Medical – Group No. 800217	**Medical Mutual** Member Appeals Unit Medical Mutual Services P.O. Box 94580 Cleveland, Ohio 44101-4580 MZ: 01-4B-4809
All other appeals, including final voluntary appeal and appeals for Dental and Vision claims	**Claims Subcommittee** Ohio Conference of Teamsters & Industry Health & Welfare Fund 435 South Hawley Street Toledo, Ohio 43609 (419) 254-3310 (800) 523-8467

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ELIGIBILITY

You will become eligible for Benefits if you work under the jurisdiction of any participating Local Union and if the required contribution amounts are paid by participating Employers.

Eligibility of New Employees

An Employee becomes eligible for all Benefits on the first day of the week for which a contribution is due from his Employer under the terms of the applicable collective bargaining agreement (eligibility date). If you are not at work on your eligibility date due to disability, layoff or other reasons, including Hospital confinements, you will nevertheless become eligible on the first day of the week for which your Employer is obligated to contribute to the Fund on your behalf.

To receive Benefits, you must enroll by promptly returning the enrollment form and necessary documents to the Fund office. See the below section titled “Enrollments and Special Enrollments” for additional information.

Eligibility for Dependents

Your Dependents become eligible for coverage at the same time you do. Your Dependents include any of the following:

1. A spouse who is not divorced or legally separated from the Employee. The Fund will require a legal marriage certificate.

2. Each child under twenty-six (26) years of age which includes any natural child, adopted child, stepchild or child for whom you are the legal guardian. Eligibility for adult children does not depend on their marital status or other access to employer-provided healthcare. The Fund will require a birth certificate and any documents proving legal guardianship.

3. Children for whom coverage is required under a Qualified Medical Child Support Order (QMCSO).

4. Each child as defined above over twenty-six (26) years of age who is unable to perform any work for gainful employment and depends on you for your principal support because of mental or physical handicap, as certified by a Physician. The Fund will require proof of your child's dependency and handicap.

Regardless of whether your eligible Dependent is confined in a Hospital on the date your coverage becomes effective, your Dependent will be eligible for Benefits commencing on the date you first become eligible for Benefits.

If the spouse of an eligible Employee is enrolled or chooses to join a health maintenance organization (“HMO”) and then fails to use that program, this Fund will not be responsible for providing Benefits to that individual because the HMO is considered fully responsible for the health care needs of that person.

No Employee or Dependent, including a newly acquired spouse, is eligible for COBRA coverage under this Plan, unless the individual is a Qualified Beneficiary at the time of the COBRA

Qualifying Event. The rights and obligations under COBRA are detailed in the COBRA and self-pay Continuation of Coverage section of this SPD.

Enrollments and Special Enrollments

You should promptly return your enrollment form which includes your designation of Beneficiary for life insurance to the Fund office.

If you or your Dependent are eligible for coverage, but do not enroll in the Plan, you may enroll in the Plan within 30 days of losing other coverage or acquiring (or becoming) a new Dependent through marriage, birth, adoption or placement for adoption, or change in status under another plan, including termination of employer contributions towards your other coverage whether or not you also lost your other coverage as a result.

Eligibility for Transferring Employees

If you had been covered by a different Plan under the Fund and transferred employment to another participating Employer, you are covered immediately on your date of transfer provided your Employer makes the required contribution. Any condition which existed for your Dependents or yourself prior to transferring plans is covered under the previous plan.

Employees Serving in the Armed Forces

Eligibility for Benefits cease on the date you enter full-time service in the military unless you exercise your special continuation of coverage rights. If you are called into military service (active duty or inactive duty training) or certain types of service in the National Disaster Medical System, you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are called into military service for up to 31 days, your health care coverage will continue if you make the required employee contributions. If you are called into military service for more than 31 days, you and your eligible Dependents may continue coverage by paying the required monthly premiums for up to 24 month under USERRA.

Your coverage will continue until the earlier of:

- The date you or your Dependents do not make the required premium payment;
- The date you become eligible for coverage under the Fund again;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- The last day of the month after 24 consecutive months; or
- The date the Fund terminates.

You need to notify the Fund office at least 30 days prior to the date you will leave for the military. For more information about the election of USERRA coverage and payment of the required premiums, contact the Fund office.

If you do not elect to continue coverage under USERRA, your coverage will end immediately when you enter military service. Your eligible Dependents may continue coverage under the Fund by electing and making self-payment for COBRA continuation coverage.

Upon discharge from military service, you may apply for reemployment with an Employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any health insurance coverage offered under the Fund. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service and your honorable discharge from that service.

The following information outlines the deadlines that apply to your rights to reemployment and reinstatement of health care coverage. When you are discharged or released from military service that lasted:

- Less than 31 days, you have one (1) day after discharge (allowing eight hours for travel) to return to work for an Employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for an Employer;
- More than 180 days, you have up to 90 days after discharge to return to work for an Employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred during the military service, you have until the end of the period that is necessary for you to recover to return to work for a participating Employer.

If you take military leave but do not elect USERRA coverage within sixty (60) days of the receipt of the notice of your right to elect the coverage, your health insurance coverage offered under the Fund will terminate. When you meet the reemployment deadlines and return to work with an Employer, your health insurance coverage will be reinstated upon the reemployment date without regard to any waiting periods, initial eligibility periods or preexisting condition limitations.

Termination of Eligibility

Eligibility for this Plan for you and your Dependents will generally cease at the end of the last week for which your Employer is required to make contributions on your behalf under the collective bargaining agreement, except during a period of time when you are eligible for and receiving weekly **Loss of Time Benefits**.

Coverage for any Dependent will end on the date that Dependent ceases to qualify as a Dependent, unless Dependent loses eligibility because of attaining age 26. Dependents who turn 26 no longer qualify as a dependents as of the last day of the month in which they turn 26.

Qualified Medical Child Support Order (QMCSO)

Notwithstanding any other provision of this Plan to the contrary, the Plan will provide Benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as defined in ERISA section 609(a).

A Qualified Medical Child Support Order (QMCSO) is an order issued by a court or authorized administrative agency that requires an Employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or a paternity dispute. A QMCSO requires the Fund to cover an alternate recipient who might not otherwise be eligible for coverage.

Any payment for Benefits made by the Plan pursuant to a QMSCO in reimbursement for expenses paid by an alternate recipient's custodial parent or legal guardian will be made to the alternate recipient or the alternate recipient's parent or legal custodian.

Upon receipt of a QMCSO, the Administrative Manager will promptly notify the eligible participant and each alternate recipient, as that term is defined in ERISA Section 609(a), of the receipt of such Order and the Plan's procedures for determining whether the Order is a QMCSO. The Administrative Manager will then determine whether the order is a QMCSO pursuant to the Plan's procedures and notify the eligible participant and each alternate recipient of the determination. The Fund has a written procedure for processing QMCSO's which may be obtained upon request to the Fund office at no cost. As a participant in the Plan, you are entitled to pursue issues regarding your QMCSO in Federal Court.

RESCISSION OF COVERAGE

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf) perform an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission, or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") provides a framework for coordinating payment of medical expenses when you and other members of your family are covered by two or more group benefit plans. For example, if your spouse has coverage under a group benefit plan sponsored by his or her employer and is also covered under this Plan, then you and your Dependents may be eligible for Benefits under both your spouse's plan and this Plan.

COB provides complete payment of your allowable expenses while preventing duplicate payment for the same service. Although COB does not guarantee 100% reimbursement for all expenses, it does attempt to provide as close to 100% reimbursement as the plans involved in coordination allow.

The following schedule will determine which plan is the Primary plan:

When the other Plan Does Not Have Applicable COB Rules or Provisions

Primary Plan	***Secondary Plan***
Plan that does not have COB	Plan that does have COB

When Both Plans Have COB

Primary Plan	***Secondary Plan***
A. Plan covering person as an active employee	Plan covering person as a Dependent or non-active employee
B. Plan covering person other than as a laid-off or retired person or as a Dependent of such	Plan covering person as a laid-off or retired person, or as a Dependent of such person
C. Plan covering person as a Dependent of a parent whose birthday falls earlier in a year	Plan covering person as a Dependent of a parent whose birthday falls later in that Calendar year
D. (Where other plan does not have the earlier birthday" rule in (C above). Plan covering person as a Dependent of a male	(Where other plan does not have the "earlier birthday" rule in (C above). Plan covering person as a Dependent of a female

Special Rule for Plans Which Do Not Follow the Model Rules

When the Plan covers a person as a Dependent and another plan would be primary under the Plan's COB rules or the model COB regulations of the National Association of Insurance Commissioners, and the other plan contains a provision that limits, caps, excludes, reduces or eliminates coverage for the person based upon the existence of this Plan, thereby having the effect of shifting coverage liability to this Plan in a manner designed to avoid the usual operation of the COB rules, this Plan shall not be liable to provide Benefits until and unless the other plan provides the customary Benefits of a primary plan, as determined without regard to the provision

of the other plan's limits, caps, exclusions, reductions, or elimination of coverage for the person based upon the existence of this Plan.

As secondary payer, the Plan will continue to apply the Plan's Deductibles, Coinsurance, and Benefit exclusions.

None of the Above - The plan covering person for the longest time will be the primary plan.

Special Rules For Dependent Child - If a Dependent child whose parents are separated or divorced is the patient, Benefits will be paid as follows:

The plan which covers a child of a parent who has financial responsibility for health care expenses of the child through court decree will be the primary plan and pay Benefits first.
If there is no court decree:
the plan of the parent with custody pays first.
the plan of the spouse of the parent with custody (i.e., the stepparent) pays second, and
the plan of the parent without custody pays last.

If your spouse is entitled to group coverage through his or her employer, and he or she chooses a health maintenance organization (HMO), that HMO will be the primary plan for your spouse. This Plan will be the secondary plan whether or not your spouse actually uses the HMO in a particular instance.

If your spouse's HMO is determined to be the primary plan for your Dependent child(ren) according to the above schedule, then this Plan will be the secondary plan for your child(ren). This is true even if the HMO is not used in a particular instance.

This Plan's COB provision will be followed in determining all other matters regarding COB with your spouse's HMO.

Coordination with Medicare (Part A and Part B)

This Plan will pay its Benefits before Medicare ONLY for:

An active Employee who is age 65 or older;

An active Employee's Dependent spouse who is age 65 or older;

The first 30 months of treatment for end-stage renal disease received by any insured person; or

Medicare beneficiaries who are disabled and are covered as a result of their current employment status, or the current employment status of a family member.

When the rules above do not apply, this Plan will pay its Benefits only **after** Medicare has paid its Benefits.

IMPORTANT— IF YOU ARE ELIGIBLE FOR MEDICARE, THE PLAN WILL PAY BENEFITS ONLY UP TO THE AMOUNT THAT WOULD BE PAID UNDER THE ABOVE RULES, WHETHER OR NOT YOU HAVE APPLIED FOR MEDICARE BENEFITS. BECAUSE YOUR POLICY BENEFITS MAY BE AFFECTED BY

MEDICARE, YOU MAY WANT TO CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE FOR INFORMATION ABOUT MEDICARE. THIS SHOULD BE DONE BEFORE YOU OR YOUR SPOUSE'S 65TH BIRTHDAY.

Note:
If another plan is primary under this Plan's COB rules and it contains a provision capping its Benefits for an eligible individual or his Dependents having the effect of shifting primary coverage liability to this Plan in a manner designed to avoid the usual operation of the NAIC's or this Plan's COB rules, this Plan will not be liable to provide Benefits until the primary plan provides its customary Benefits determined without regard to such a cap.

COBRA AND SELF-PAYMENT CONTINUATION COVERAGE

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when any of you would otherwise lose your group health coverage. This section gives only a summary of your COBRA continuation coverage rights and obligations under the Plan and under federal law. If you have further questions concerning COBRA rights and obligations, contact the Fund office, Administrative Manager, 435 South Hawley Street, Toledo, Ohio 43609 (419) 254-3310 or (800) 523- 8467.

COBRA is not available to continue your life insurance, or weekly accident and sickness Benefits. Please contact the Fund office if you have questions.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed below. COBRA continuation coverage is offered to each person who is a “Qualified Beneficiary”. A Qualified Beneficiary is someone who will lose coverage under the Plan because of a Qualifying Event. Depending on the type of Qualifying Event, participants, spouses and Dependent children of participants may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you are an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1) Your hours of employment are reduced; or

2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1) Your spouse dies;

2) Your spouse's hours of employment are reduced;

3) Your spouse's employment ends for any reason other than his or her gross misconduct;

4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both);

5) You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1) The parent-Employee dies;

2) The parent-Employee's hours of employment are reduced;

3) The parent-Employee's employment ends for any reason other than his or her gross misconduct.

4) The parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both);

5) The parents become divorced or legally separated; or

6) The child stops being eligible for coverage under the Plan as a "Dependent."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund office has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Fund office of the Qualifying Event.

You Must Give Notice of Some Qualifying Events.

For the other Qualifying Events (divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), *you must notify* the Fund office within 60 days of the Qualifying Event. You must provide this notice to: Administrative Manager, Ohio Conference of Teamsters and Industry, Health and Welfare Plan and Trust, 435 South Hawley Street, Toledo, Ohio 43609.

If you do not choose continuation coverage, your group health insurance coverage will end. In certain instances, such as retirement and Total and Permanent Disability, however, you will be offered another self-payment option to maintain coverage under the Plan. At the time of your retirement or Total and Permanent Disability, you will be notified of any rights you may have, if you are eligible, and the choices available to you. If you reject this continuation coverage, your Dependent(s) will be given the opportunity to elect coverage independently from you.

Specific cost information will be provided to you and your Dependents when you become eligible for continuation coverage. You and/or your Dependents must pay the entire cost of continued group health coverage at the current group rates. The cost will not exceed 102% of the cost for providing health Benefits to individuals in the same Benefits election situation as yourself.

How is COBRA Coverage Provided?

Once the Fund office receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Employees may elect COBRA continuation coverage on behalf of their spouses; parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If continuation coverage is not chosen, health Benefits will end.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a Dependent child's losing

eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of **36** months.

An Employee who becomes entitled to Medicare benefits less than 24 months before the Qualifying Event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (36 months minus 8 months).

When the Qualifying Event is the end of employment or the reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for up to **24** months. There are two ways in which this **24** month period of COBRA continuation coverage can be extended.

1) **Disability Extension of 24-month Period of Continuation Coverage.** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first **60** days of COBRA continuation coverage and **you notify** the Administrative Manager in a timely fashion, you and your entire family can receive up to an additional **5** months of COBRA continuation coverage, for a total maximum of **29** months. **You must** make sure that the Administrative Manager is notified of the Social Security Administration's determination within **60** days of the date of the determination and before the end of the **24** month period of COBRA continuation coverage.

2) **Second Qualifying Event Extension of 24-month Period of Continuation Coverage.** If you or your Dependents experience another Qualifying Event while receiving COBRA continuation coverage, the spouse and Dependent children in your family can get an additional **12** months of COBRA continuation coverage, up to a maximum of **36** months. This extension is available to the spouse and Dependent children if the former Employee dies, enrolls in Medicare (Part A, Part B or both) or gets divorced or legally separated. The extension is also available to a Dependent child when the child stops being eligible under the Plan as a Dependent child. In all of these cases, **you must make sure** that the Administrative Manager is **notified** of the second Qualifying Event within **60** days of the second Qualifying Event. This notice must be sent to: Administrative Manager, 435 South Hawley Street, Toledo, Ohio 43609.

Duration Not Extended by Self-Payments or Otherwise.

The duration period of COBRA will be measured from the day of the Qualifying Event. The potential 24, 29, or 36 months duration period will include any self-payments or free coverage. See the section titled "Self-payment for Full Benefit Plan While on Temporary Layoff" for additional information.

Veterans Act.

Under the Veterans Benefits Improvement Act of 2004, coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") was amended. The new rule provides that if you are called up to military active duty you will be given an opportunity to continue health coverage for yourself and your family for 24 months. This period applies to individuals electing coverage beginning on or after December 10, 2004. Please note that coverage under USERAA is not the same as COBRA and different rules may apply in the event

of various Qualifying Events, such as divorce or death. We are simply including the recognition of the Veterans Act coverage in this COBRA notice to explain all rights to employees and potential qualified beneficiaries. See the section titled “Employees Serving in the Armed Forces” for additional information.

Early Termination of COBRA

The law provides that your continuation coverage may be cut short for any of the following five reasons:

1. The Plan no longer provides health care coverage;

2. The contribution for your continuation coverage is not paid timely;

3. You or your Dependent(s) become covered under another health care plan after you elect continuation coverage (unless there is a preexisting condition limitation that would result in denial of Benefits). If you need to show a new health plan how long you were covered under this Plan in order to reduce or avoid the new plan's preexisting coverage exclusion, you may request a written statement from the Plan office, certifying to the length of your coverage under this Plan;

4. You or your Dependent becomes enrolled in Medicare after you elect continuation coverage. If you become eligible for Medicare, your Dependents can continue COBRA coverage for up to 36 months from the initial date they became eligible for COBRA; or

5. You were divorced from an Employee and subsequently remarry and are covered under your new spouse's health care plan (unless there is a preexisting condition limitation that would result in a denial of Benefits).

CONTINUATION OF COVERAGE SUMMARY		
Coverage may continue for:	**If:**	**Maximum duration of coverage**
You and your eligible Dependents	Your employment ends for any reason (except gross misconduct, layoff, Total and Permanent Disability, or retirement) (for spouses of active Employees only)	24 months
You and your eligible Dependents	Your hours of employment are reduced	24 months
Your eligible Dependents	You die	36 months
Your eligible Dependents	You become eligible for Medicare or retire	36 months
Your eligible Dependents	You are divorced	36 months
Your eligible Dependent children	Your eligible Dependent children ceased to be qualified as eligible Dependents (for example, they reach age 26).	36 months

Notification

When a Qualifying Event occurs, the Fund office, upon notification, will give you and your Dependents all the details regarding continuation coverage, including the cost. It is your responsibility, however, to inform the Fund's Administrative Manager of a divorce, legal separation or of a child losing eligible Dependent status under the Plan. **If you do not notify the Fund's Administrative Manager within 60 days of a divorce, legal separation or, a child losing eligible Dependent status, you will lose the right to elect continuation coverage**.

While it is the responsibility of the Employee's Employer to notify the Administrative Manager within 30 days of the Employee's death, termination of employment, Total and Permanent Disability, layoff, reduction of hours, retirement or entitlement of Medicare, the Employee or other family member should notify the Administrative Manager if any of these Qualifying Events occurs in order to assure timely notification of eligibility for, and processing of, an election of continuation of coverage.

When the Administrative Manager is notified that one of these events has occurred, you will be notified within 14 days that you have the right to choose continuation of coverage. Under the law, you have at least 60 days from the later of the date (i) your coverage terminated or will terminate under the group Plan or (ii) the date of the notice advising you of your rights to continuation coverage, to inform the Administrative Manager that you want continuation of coverage.

Continuation Coverage for Newly Acquired Dependents

Continued coverage is not available to anyone who was not covered under the Plan before coverage ended. However, you may add newly acquired eligible Dependents while covered under COBRA by notifying the Fund office within 30 days after acquiring the new eligible Dependent and paying the required premium.

A child born or placed for adoption while you are on COBRA Continuation Coverage (but not a spouse you marry while you are on COBRA Continuation Coverage) will have all the same COBRA rights as your spouse or Dependent children who were covered by the Plan before the event that resulted in your loss of coverage. Otherwise, the same rules about Dependent status and qualifying changes in family status that apply to active Employees will apply to those Dependents. Adding a Dependent child may cause an increase in the amount you must pay for COBRA continuation coverage.

If You Have Questions

Questions concerning your Plan or your continuation coverage rights should be addressed to: the Fund office, Administrative Manager, 435 South Hawley Street, Toledo, Ohio 43609 (419) 254-3310 or (800) 523- 8467. For more information about your rights under the Employee Retirement Income Security Act (“ERISA”), including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor’s Employee Benefits Security Administration (“EBSA”) in your area or visit the EBSA Website at www.dol.gov/ebsa/. Addresses and telephone numbers of regional and district EBSA offices are available on the agency’s website.

Keep the Fund Office Informed of Address Changes

To protect your family's rights, you should keep the Administrative Manager informed of any changes in the addresses of family members. You also should keep for your own records a copy of any notices you sent to the Administrative Manager.

No Conversion Privilege

Because of the self-funded status of the Fund, the Benefits cannot be converted to individual coverage.

Trade Adjustment Assistance

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the tax provisions, eligible individuals can receive tax credits for 65% of the monthly premiums for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628- 4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Options if No Further Coverage is Available Under the Plan

If you are losing coverage options under the Fund, you should immediately consider:

- Any special enrollment right available to you under your spouse's health plan based on your loss of group health coverage (generally available for only 30 days after your loss of coverage under this Plan);
- Enrolling in a Marketplace Exchange
- Enrolling in an HMO;
- Purchasing a "HIPAA policy" if you are "federally eligible individual";
- Enrolling in Medicare based on your age, a Total and Permanent Disability or end-stage renal disease; or
- Purchasing Supplementary Medicare Coverage.

You may lose valuable legal rights if you delay consideration.

RETIREE AND TOTAL AND PERMANENT DISABILITY PLANS

Eligibility for Retiree Program

If you retire from active employment with a participating Employer in one of the Plans provided by the Ohio Conference of Teamsters & Industry Health and Welfare Fund which provides for retiree coverage, you are eligible for the Retiree Plan if you have met the following requirements:

1. You have completed five (5) full years of employment in a Benefit Plan (which includes retiree coverage) with a participating Employer in the Fund or have two (2) continuous year of coverage under the Fund in a Benefit Plan (which provides retiree coverage) as of your retirement date;

2. You are at least age 50;

3. You are eligible for and receiving an Early Retirement benefit from a Teamsters-negotiated industry retirement plan, or are receiving a full service pension based on thirty (30) years of contribution service from a Teamsters-negotiated industry.

4. You submit a proper application for coverage to the Fund office within one year of the date you last worked;

5. Your application is approved by the Fund office and

6. Your last Employer immediately before retirement is a participating Employer in the Plan. (You must be in the Plan at the time of retirement.)

If you retire before your 50th birthday, you may defer your participation in the Retiree Plan, until your 50th birthday by making self-payments under the COBRA Program to continue your coverage in this active Plan until you are eligible for the Retiree Plan coverage at age 50. Please contact the Fund office for information concerning the monthly costs.

Please note: the coverage provided by your employer may not include retiree coverage. Contact the Fund Office for more details.

Termination of Retiree Eligibility

Your Coverage under the Retiree Plan shall cease upon the first of the following events:

1. Your Death;

2. Your sixty-fifth (65th) birthday;

3. Your return to active employment that covers you under group health insurance;

4. You become eligible for any group health insurance coverage;

5. You become eligible for Medicare;

6. Contributions to fund this Plan are no longer made by one or a number of Employers;

7. Your Employer terminates participation in the Fund through collective bargaining;

8. The Plan terminates; or

9. You do not make the required premium payment due the first of each month for which you want coverage.

Termination of Spousal Eligibility under the Retiree Plan

Spousal coverage under the Retiree Plan shall cease upon the first of the following events:

1. The spouse's death;

2. Divorce or legal Separation from the retiree;

3. The spouse's sixty-fifth (65th) birthday;

4. The spouse becomes eligible for group coverage under another plan;

5. The spouse becomes eligible for Medicare;

6. The Retiree's coverage under the Plan ceases; or

7. You do not make the required premium payment due the first of each month for which you want coverage.

However, if the Retiree's coverage ceases because of his/her death or reaching age 65 coverage for the spouse will continue for the balance of the five year period, if any, beginning on the date the Employee retired.

If you leave active employment at age 50 or after, you will have a right to elect COBRA Continuation Coverage instead of this Retiree Plan. In order to elect this Retiree coverage, you must first waive continuation coverage rights under COBRA.

Retiree Benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such Benefits, either before or after their retirement. The Trustees may expand, reduce or cancel coverage for Retirees, change eligibility requirements or the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Retiree or any other person.

Please contact the Fund office for details.

If an Employee waives coverage because the Employee has other health coverage, the Employee may later enroll within 30 days of a change of family status resulting in a loss of coverage (other than because of failure to pay premiums). Change of family status means loss of coverage based on divorce, death, termination of employment, or reduction in the number of hours of employment.

Coverage is effective the first of the month after receipt of the required contributions. It cannot be retroactive to the date of termination. Benefits are payable only to the Retired or Totally and Permanently Disabled Employee and spouse.

The Benefits are not those shown in the Schedule of Benefits in this booklet, and are limited. Please contact the Fund office for the current schedules of retiree Benefits.

Contributions must be made on or before the first day of the month in which they are due. If contributions are not paid timely, eligibility and coverage are forever lost. They cannot be reinstated with a later payment of delinquent contributions. Monthly contributions **must be sent to Ohio Conference of Teamsters & Industry Health and Welfare Trust, Department L-492, Columbus OH 43260**. The amount is determined by the Trustees, and may be changed by the Trustees at any time. It is the participant's responsibility to make certain that required contributions are received by the Fund office in a timely manner. No billings or payment reminders will be given.

Eligibility for Total and Permanent Disability Program

For you and your Dependents to be eligible for coverage under the Total and Permanent Disability Programs, you must:

1. Apply for a Social Security Disability benefit as a result of your Total and Permanent Disability and submit such evidence to the Fund office. If you are denied a Social Security award, you must then submit other evidence of disability to the Fund for a determination of continued eligibility;

2. Have credit for five (5) years of employment with participating Employer, or have two (2) consecutive years of coverage under the Fund at the time your disability occurs; and

3. Be age 56 or less at the time your Total and Permanent Disability coverage would start; and

4. Be covered by the Fund.

Extended Benefits

If you or your Dependent is in the Hospital:

1. When your Plan coverage terminates, or

2. Within three (3) months of your coverage being terminated due to an illness or injury that existed on the day your coverage terminated, then your Hospital Benefits and surgical Benefits as described in the Schedule of Benefits will be extended for up to three (3) months from your coverage termination date. To qualify for this extension of Hospital Benefits and surgical Benefits, you or your Dependent must be totally disabled from the date coverage terminated until you are hospitalized or surgery is performed.

Benefits are payable:

1. Limited to Hospital charges for each day you or your Dependent stays in the Hospital,

2. At the daily rate in effect on the day your coverage terminated, and

3. For surgical expense.

The Benefit levels which will be extended will be those in effect on the date your eligibility terminates.

It is the intent of the Trustees to continue this Plan of Benefits for all eligible Employees. However, the Trustees reserve the right to modify or terminate the program if necessary. The Benefit Plan currently provided for retirees and Total and Permanent Disability Employees may also be modified or terminated by the Trustees if necessary.

NOTE: PAYMENT OF UNION DUES DOES NOT KEEP YOUR COVERAGE IN FORCE.

OHIO CONFERENCE OF TEAMSTERS & INDUSTRY HEALTH & WELFARE FUND

PLAN 5B-PPO SCHEDULE OF BENEFITS

EMPLOYEE ONLY	**AMOUNT**
Death Benefit	$50,000
Accidental Death and Dismemberment Benefits (maximum)	$50,000
Loss of time, Weekly Benefit	$400
(certification of disability by Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, or Midwife necessary)	
Benefits begin on the first day of a disability caused by an accident and on the eighth consecutive day of a disability caused by a sickness.*	
Maximum Number of Weeks Payable Per Disability	26
Benefits begin on eighth consecutive day of a disability caused by sickness due to mental/nervous disorder.	
Maximum Number of Weeks Payable Per Calendar year for all disabilities caused by mental/nervous disorders	4
Benefits begin on eighth consecutive day of a disability caused by sickness due to alcohol/drug addiction.	
Maximum Number of Weeks Payable Per Calendar year for all disabilities caused by alcohol/drug addiction	8

* However, the seven day waiting period also applies if the participant returns to work after an accident, but subsequently becomes disabled as the result of the initial accident.

BENEFITS		**PPO NETWORK**	
		IN-NETWORK	**NON-NETWORK**
Precertification		Required – provider completes at PPO Network Hospitals Participant must complete at Non-Contracting and out-of-state Hospitals.	
Deductible	Single Family	$100 $200	
Coinsurance Limit/ Out-of-Pocket Maximum After Deductible	Single Family	There is no coinsurance limit or maximum out-of pocket amount in this Plan.	
Annual Maximum		No annual maximum	

COMPREHENSIVE MAJOR MEDICAL SERVICES

	IN-NETWORK	**NON-NETWORK**
Room and Board	No Charge	80%
Ancillary Services	No Charge	80%
Inpatient X-ray & Lab	No Charge	80%
Outpatient X-ray & Lab	80%	60%
Outpatient Surgery	No Charge	80%
Medically Necessary Physical, Occupational & Speech Therapies (Institutional or Professional) (40-visit limit, per therapy type, per person, per year)	No Charge - Institutional 80% - Professional	80% - Institutional 60% Professional
Chemotherapy	No Charge	80%
Emergency Room – medical emergencies (no hour limit) (use of "prudent layperson")	No Charge	No Charge
Emergency Room – (All other causes)	80%	60%
Urgent Care	80%	60%
Radium Therapy	No Charge	80%
Outpatient Cardiac Rehab	No Charge	80%
Outpatient Respiratory Therapy	No Charge	80%
Outpatient Dialysis	No Charge	80%
In-Hospital Physician Service	80%	60%
Office Visits	80%	60%
Surgical Expenses	No Charge	80%
Ambulatory or Outpatient Surgery (Professional)	No Charge	80%
Inpatient Anesthesia	No Charge	80%
Outpatient Anesthesia	No Charge	80%
Maternity – Pre- and Postnatal Care	80%	60%
Maternity – Delivery and Inpatient Services	No Charge	80%
Temporomandibular Joint Disorder (TMJ) $500 Annual Maximum	50%	30%
Ambulance	1st $500 paid at 100%. After Deductible, balance paid at 80%.	1st $500 paid at 100%. After Deductible, balance paid at 60%.
Routine Mammograms	100%; Limited to one per calendar year	80%; Limited to one per calendar year
Pap Smear	100%; Limited to one routine per calendar year	80%; Limited to one routine per calendar year
Colonoscopy	80%	60%
Prostate exams	80%	60%

Well Child Care	100% up to age 9 (including immunizations)	Not Covered
Routine Physical	100% (One Exam every 24 months)	Not Covered
Allergy Testing	80%	60%
Cast Room (all causes)	80%	60%
Diagnostic Services	80%	60%
Chiropractic Services	80%	60%
	$1,000 Maximum	
Organ Transplant (includes Heart, Heart-Lung, Liver & Pancreas)	100%	80%
Hearing Aids	$1,000 Once Every 3 Years	
OTHER SERVICES		
Case Management	100%	100%
Skilled Nursing Facility	80%	60%
Private Duty Nursing	80%	80% waived specialty
Home Health Care	80%	60%
Hospice	100%	80%
Home Infusion	80%	60%
Orthotics	80%	60%
Prosthetics	80%	60%
Education: Diabetic ($100 life-time maximum) and in-home Dialysis	80%	60%
MENTAL/NERVOUS DISORDERS, ALCOHOL & SUBSTANCE ABUSE		
Inpatient Mental Health/Nervous Disorders	100%	80%
Inpatient Alcohol/Drug Abuse	100%	80%
Outpatient Mental/Nervous/Alcohol and Drug Abuse	80%	60%

Please note: There is no required co-payment for office visits. You do not need a referral to see a specialist.

This Benefit summary chart is intended to provide an overview of the Benefits provided by the Fund. Please refer to the Summary Plan Description for a detailed description of the terms, conditions and exclusions of this Plan.

Members residing outside of Ohio have only the Network levels of Benefits. The Non-Network level of Benefits does not apply to out-of-state participants.

Participants may be billed by Non-Contracting providers for the amount in excess of the Allowed Amount and the participant will be responsible for paying the difference between the Allowed Amount and the provider's Charge.

Dental Benefits – Per Person		
	Network	Non-Network
Calendar year Maximum (per covered person)	$1,500	
Deductible (Per Person and/or Family)[1]	$100	$200
Preventative Services	100% of Network Allowance	100% of UCR Schedule
Basic Services	60% of Network Allowance after Deductible	50% of UCR Schedule after Deductible
Major Services	50% of Network Allowance after Deductible	50% of UCR Schedule after Deductible
Orthodontia	50% of Network Allowance after Deductible	50% of UCR Schedule after Deductible
Orthodontia Lifetime Maximum (per covered person)	$1,000	

[1] Maximum Family Deductible

Vision Benefits – Per Person, Per Calendar Year

Professional Eye Examination
- Ophthalmologist, M.D. ..... Up to $30.00
- Optometrist, O.D. ..... Up to $30.00

Professional Lens – per pair
- Single Vision ..... Up to $50.00
- Bi-Focal ..... Up to $70.00
- Tri-Focal ..... Up to $80.00
- Lenticular ..... Up to $130.00
- Contact ..... Up to $80.00
- Frames ..... Up to $35.00

Prescription Drug Benefits ..... 80% of the Usual, Customary and Reasonable Charges

Mail order program is mandatory for maintenance drugs, which are available in 90-day supplies. If a generic drug is available, you are responsible for the cost difference between generic drug and name brand drug.

The above schedule is subject to the Plan's terms.

It is the intent of the Trustees to continue this Plan of Benefits for all eligible members and their Dependents. However, the Trustees reserve the right to modify or terminate the Plan provisions if necessary.

Please note, payment of Union dues does not keep your health coverage in force.

DEATH BENEFITS

In the event you die for any cause while covered under the Plan, the Death Benefit listed in the Schedule of Benefits becomes payable to the named Beneficiary.

If you were disabled before January 1, 1980, while covered under the Plan, your Death Benefit will continue beyond age 57 if:

- You have a Total and Permanent Disability; and
- A Physician continues to certify your disability.

If you were disabled on or after January 1, 1980, while covered under the Plan, your Death Benefit will terminate when you reach age 57.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

In the event you are involved in an accident, on or off the job, which causes the loss of life, loss of limbs or loss of sight, an Accidental Death and Dismemberment Benefit becomes payable to you or your Beneficiary. Depending on the extent of the loss, the following Benefit amounts are payable:

Loss of Life	Maximum Amount
Loss of two limbs, sight of both eyes or loss of one limb and sight of one eye	Maximum Amount
Loss of one limb or sight of one eye	One-half the Maximum Amount

The maximum amount is shown in the Schedule of Benefits.

Loss of limb means severed at or above the wrist or ankle joint, and loss of sight means the total and irrecoverable loss of sight as the direct result of an accidental injury. Any loss must occur within ninety (90) days from the date the injury first happened for Benefits to be payable.

If more than one of the losses listed above is suffered as the result of any one accident, only the maximum amount of Benefit for Accidental Death and Dismemberment will be payable.

Benefit Exclusions and Limitations

Benefits shall not be payable for any loss due to:

1. Suicide or attempted suicide;
2. Intentionally self-inflicted injury;
3. Disease or mental infirmity or from the medical or surgical treatment or diagnosis for such disease or infirmity;

4. Ptomaines;

5. Bacterial infection except pyrogenic infection which occurs through or with an Accidental cut or wound;

6. War or any act of war, whether declared or undeclared (and including resistance to armed aggression);

7. Travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft;

8. Your being under the influence of any drug, except those prescribed by a Physician, including alcohol, narcotics, hallucinogens and gas or fumes, which are taken or inhaled voluntarily; or

9. By voluntary poisoning.

LOSS OF TIME BENEFIT

Loss of Time Benefits are payments made to you on a weekly basis if you become totally disabled due to an accidental injury or illness.

The amount of payment and the maximum number of weeks payable are listed in the Schedule of Benefits.

To be eligible for these Benefits, you must be under the regular care of a Physician. To receive these Benefits, a certification from a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) or doctor of podiatric medicine (D.P.M.) or midwife is necessary if the individual is disabled. Anyone's disability certified by a D.P.M. for more than six (6) weeks is subject to review.

Successive periods of disability separated by less than two weeks of continuous employment will be considered one period of disability.

No disability, including accidents, will be considered as beginning more than three (3) days prior to the member's first visit to a Physician only as listed above.

Loss of Time Benefits will not be payable if:

- Your disability due to a sickness is covered by Workers' Compensation; or
- Your disability is due to injury arising from other employment for wages or profit.

Should an Employee be suspended or terminated from employment and is required to complete a drug or alcohol rehabilitation program in order to resume employment, and they notify the Fund in writing within thirty (30) days of the suspension or termination of employment, Benefit coverage for the Employee only will be extended for sixty (60) days for drug and alcohol addiction treatment provided by an accredited Hospital or approved rehabilitation center under the alcohol or drug abuse provisions of the Plan.

It is a requirement that we be notified in writing as we do not have any other way of knowing that the special provision is applicable. Your Employer has probably discontinued premium payments, thus terminating your and any Dependents' coverage under this Plan. Further, it is very probable that claims submitted for Employee drug and alcohol addiction treatment will be initially denied as they automatically adjudicate and the system does not know that there has been special authorization to honor those specific claims.

PPO NETWORK COMPREHENSIVE MAJOR MEDICAL BENEFIT PLAN

INTRODUCTION

Preferred Provider Organization (PPO)

The PPO Network Comprehensive Major Medical Plan is a Hospital and Physician based PPO with a select Network of providers. These providers have been chosen for their commitment to quality and cost effective care, while providing these services at special reduced rates. When a member uses one of the Network Hospitals or Physicians, eligible services are paid at the maximum level available, less any Deductible or Coinsurance amounts.

Your health Benefit Plan gives you the option to choose your own personal Physician, specialist and Hospital facility from the provider Network directory. For maximum Benefits, utilize the Network providers at the identified locations only.

If you would like, you can continue to see your current Physician or specialist if he or she is not listed in the directory. You do have the freedom to seek care outside the Network, however, the Benefits will be provided at the lower Non-Network Benefit level. Throughout this booklet you will be informed of Network and Non-Network health care Benefits available to you and your family.

The Fund pays Benefits to you and your eligible Dependents based on the Allowed Amount determined by Medical Mutual for the services received, subject to the Deductibles, Coinsurance, yearly maximum, if applicable, and other limitations described in this section and in the Schedule of Benefits.

How Claims Are Paid

Benefits are paid by the Plan for Covered Services through agreements with Contracting Providers based on the Allowed Amount. For Non-Contracting Providers, benefits are paid based on the Non-Contracting Amount. Any charges exceeding the Allowed Amount or the Non-Contracting Amount will not apply towards the Deductible, Coinsurance Limit, or maximum out-of-pocket limit.

Deductible

Each calendar year (January 1 through December 31), you must pay the Deductible before the Plan pays any Benefit. The Deductible per individual is $100.00 each calendar year and $200.00 per family. With a family of more than two members, the Deductible is limited to a maximum of $200.00 for the calendar year.

Normally, the Deductible is applied separately for each covered person under the Plan. However, if two or more covered persons from your family are injured in the same accident, only one Deductible ($200.00) will apply for the expenses to be covered for that accident.

Coinsurance

Each calendar year (January 1 through December 31), after each participant or family unit has satisfied the Deductible as specified in the Schedule of Benefits, the PPO Network Comprehensive Major Medical Plan will pay 80% of the Allowed Amount (for most services) for covered expenses for injuries or sickness that are in excess of your Deductible if they are provided by a Network provider, or

60% (for most services) of the Allowed Amount for covered expenses if the services are provided by a Non-Contracting provider. Please note, life-threatening emergency room accident and life threatening medical emergencies are always paid at 100% of the Allowed Amount.

Example

You are hospitalized for a surgical procedure and Hospital. Surgical and other medical expenses billed to you total $12,000. Your Benefits would be paid in the following manner, assuming the full $12,000 fell within the Plan's approval amount.

	NETWORK	NON-NETWORK
Total Approved Hospital and Medical Charges	$12,000	$12,000
Less: Deductible	$100	$100
Less: Coinsurance Paid by Participant (20% network / 40% non-network)	$2,380	$4,760
Total Paid by Participant	**$2,480**	**$4,860**
Balance Paid by Plan	**$9,520**	**$7,140**

Annual Maximum

Beginning March 1, 2014, there is no annual maximum paid by the Plan.

Payments Required when Using a Non-Contracting Provider or Physician.

You will receive the maximum Benefits of Physicians and Hospital care, when you choose a Network Physician or Hospital. This does not mean you cannot see your current Physician or specialist if he or she is not listed in the directory. You do have the option to seek care outside the Network and still receive part of your Benefits. Services obtained from a Physician, Hospital or other professional provider who is not part of the Network or who has an indemnity contract will be paid based on Covered Charges. You will be responsible for the Excess Charges or Balance Billed if you go to a Non-Contracting provider. A list of Network providers can be found in the Medical Mutual website at www.medmutual.com or by calling Customer Service.

Precertification

When the member receives services at an In-Network Contracting Hospital, precertification will be obtained by the provider. However, if services are performed at a Non-Network Hospital or out-of-state Hospital, the member must obtain precertification from Medical Mutual. Failure to properly precertify a service will result in the imposition of a $200 penalty. See the "Health Care Cost Management Program" section of the booklet below for further details on precertification.

HEALTH CARE COST MANAGEMENT PROGRAM

Note: All Precertification phone numbers are printed on your insurance card.

Precertification from Medical Mutual must be obtained for Inpatient admissions to a Hospital in order to receive the full Benefits specified in the Schedule of Benefits. If the Hospital does not precertify the admission, you must obtain precertification for the Inpatient admission by calling the Medical Mutual telephone number on your identification card at least two days prior to your admission to the Hospital. Failure to properly precertify a service will result in the imposition of a $200 penalty. Additionally, in the event precertification is not obtained, and your Hospital admission is determined to not be Medically Necessary, you will be responsible for all Billed Charges for that Hospital stay.

Emergency Admission

In the event of an Emergency Admission, the Hospital, you, a family member, or your representative must notify Medical Mutual within 48 hours, or two working days, of admission; or you may be responsible for all Billed Charges for that Emergency Admission.

Additionally, some Outpatient tests, procedures, and equipment also require precertification. Examples of services that may require precertification are:

- Reconstruction surgeries
- Durable medical equipment and devices
- MRI's and PET scans
- Therapy
- Home health care

Precertification for Inpatient Admission

Inpatient admissions to a Hospital must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting Hospitals in Ohio will assure this preauthorization is done, and since the Hospital is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. However, for Non-Contracting Hospitals or Hospitals outside of Ohio, you are responsible for obtaining your own preauthorization. If you do not preauthorize a Hospital admission and it is later determined that you admission was not Medically Necessary, or not covered for any reason, you will be responsible for all Billed Charges.

MEDICAL BENEFITS

Medical Benefits provide important financial protection in the event you or a covered family member needs medical care for non-occupational illness or injury. To be considered for payment, all Charges must be medically necessary. All Charges are subject to the Allowed Amount as negotiated by Medical Mutual with providers. Any payment percentages noted in this document are subject to the Allowed Amount negotiated between Medical Mutual and providers.

The Network is a group of Hospitals and doctors that have agreed to favorable pricing of their services to members of the Plan. You are not required to use a Hospital or Physician that is a member of this Network; however, if you seek care from a provider that participates in the Network or has a contract with Medical Mutual, there are important advantages to you.

After you pay your Deductible and Coinsurance, the remainder of the eligible Charges for services provided by a Network, or traditional participating doctor will be paid by the Plan, up to the Benefit maximums.

On the other hand, Charges for services provided by Non-Contracting Physicians are subject to the Non-Contracting Amount. **You may be billed by a Non-Contracting Physician for the amount in excess of the Non-Contracting Amount limits and you would be responsible for paying the difference between the Non-Contracting Amount and the provider's Charge**.

The following medical Benefits will be covered under the PPO Network Comprehensive Major Medical Plan as indicated in the Schedule of Benefits:

1. Daily Room and Board (Semi-Private Room Rate).
2. Ancillary Services.
3. Newborn Exams.
4. Hospital Outpatient Emergency Accident and Sickness.
5. Pre- and Post-Operative Testing.
6. Doctor's In-hospital Medical Charges and Consultation.
7. Charges for the Services of a Physician.
8. Private Duty Nursing.
9. Skilled Nursing.
10. Home Health Care.
11. Home Infusion.
12. Allergy Testing.

Benefit Exclusions and Limitations

Benefits shall not be payable for items listed in the booklet section entitled, "General Exclusions," and those listed below:

1. Any Charges made for television, telephone, patient care kits, barber and beauty supplies, or other items or services not necessary for medical treatment.

2. Any confinement due to sickness which is covered by a Workers' Compensation Act or other similar legislation or due to injury arising out of or in the course of any employment for wage or profit.

3. Any service for which no Charges are made.

4. Any confinement or Charges for in vitro fertilization or infertility treatment.

5. Any confinement or Charges incurred for the purpose of reversing a sterilization procedure, whether or not the reversal is successful, will not be covered nor any reimbursement made.

6. Admission charges or charges for before-hours or after-hours care.

7. Educational supplies and Charges except for outpatient diabetes training, which is coverable up to $100 per person per lifetime, or for in-home dialysis training.

AMBULANCE BENEFITS

Ambulance Charges will be paid as indicated in the Schedule of Benefits. The first $500 is paid at 100% of the Allowed Amount per trip and the balance of Charges are paid after the annual Deductible has been satisfied, at 80% of the Allowed Amount if provided by a Network provider, or 60% of the Allowed Amount for a Non-Network provider. In addition, the Allowed Amount for air ambulance services will also be covered as indicated in the Schedule of Benefits, provided all of the following conditions are met:

1. The transportation is by a vehicle designed and equipped and used only to transport the sick and injured.

2. The transportation is from the scene of an accident or medical emergency to a Hospital or between Hospitals.

3. The trip is to the closest facility that can give the appropriate services for the condition.

4. Certification by an attending Physician must be received indicating that transportation using ground facilities would not have been appropriate due to the life threatening and emergency nature of the accident or illness.

CHIROPRACTIC SERVICES

Covered services include the treatment given by a chiropractor to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of a body part. These Covered services include, but are not limited to, office visits, physical treatments, hydrotherapy, physical agents, and biomechanical or neurophysiological principles, and may include devices. Braces and molds are not covered under this Benefit.

All Charges by chiropractors for services including X-rays, lab Charges, therapy, office visits and other expenses will be covered at 80% of the Allowed Amount for In-Network or 60% of Allowed Amount for Non-Network providers up to a maximum of $1,000 per calendar year per eligible person.

DIAGNOSTIC BENEFITS

Diagnostic services and examinations will be covered at 80% of the Allowed Amount for charges in excess of your Deductible if they are provided by a Network provider, and 60% of the Allowed Amount if the services are provided by a Non-Network provider.

The following services and examinations are included in this benefit:

- Radiology
- Ultrasound
- Laboratory
- EKG
- EEG
- MRI

Benefit Exclusions and Limitations

Benefits shall not be payable for exclusions listed in the booklet section entitled, "General Exclusions"; nor for dental x-rays or x-ray therapy.

EDUCATIONAL TRAINING

Outpatient diabetes training and education services are coverable up to $100 per person per lifetime. In-home dialysis training is covered at 80% of the Allowed Amount for services provided by a Network provider, and 60% of the Allowed Amount for services provided by a Non-Network provider.

HEARING AID BENEFIT

The Hearing Aid Benefit covers Charges for fittings, approved hearing correction devices (hearing aids) and the first set of batteries. All services must be provided by an audiologist or certified hearing aid specialist and recommended or prescribed by a Physician.

The Plan covers both in-the-ear and behind-the-ear appliances at 80% of the Lesser Amount if provided by a Network provider, or 60% of the Lesser Amount for a Non-Network provider, after the Deductible. The Plan will pay up to $1,000.00 once every 3 calendar years.

Benefit Exclusions and Limitations

Benefits shall not be payable for exclusions listed in the booklet section entitled, "General Exclusions," and those listed below:

1. Replacement of lost, missing or stolen appliances;
2. Repair or replacement of broken appliances;
3. Replacement of batteries;
4. Hearing aids purchased without prescription or recommendation from a Physician; and
5. Services and supplies for which the covered individual would not legally be required to pay.

HOSPICE CARE

A Plan participant who is eligible for regular Plan Benefits will be eligible for hospice care Benefits if certified by a Physician to have a life expectancy of six months or less.

The eligible person must submit an election statement to the Fund office choosing hospice care in lieu of all other Plan Benefits. When hospice care Benefits are elected, all other Plan Benefits are waived except for the services of the patient's attending Physician, provided that Physician is not employed or compensated by the hospice. However, expenses for any illness or injury which is not related to the terminal illness will be covered under regular Plan Benefits. An election of hospice care may be revoked at any time to resume regular Plan Benefits.

Hospice services covered under this Benefit include all reasonable and necessary services for the care or management of the terminal illness as well as related conditions, including Physician services, nursing services, inpatient care, home health and homemaker services, physical and occupational therapy, medical supplies, drugs and counseling services.

The Fund will pay for the following services at 100% of the Allowed Amount if they are provided by a Network provider, or 80% of the Allowed Amount if services are received from a Non-Network provider, up to the amount of the allowance permitted for hospice care by the federal Medicare law in the geographic area in which the hospice is located:

1. Continuous home care when at least eight hours of care daily is required during crisis periods in which the patient elects not to be hospitalized;

2. Routine home care;

3. General inpatient care when continuous care is provided in the Hospital or similar facility and when less intensive care is not provided;

4. Respite inpatient care, up to a maximum of five consecutive days, when short-term inpatient care is required in a Hospital, nursing home or free-standing hospice facility in order to relieve the family from home care duties. Benefits for respite care shall be paid only when the patient does not require intensive care and when general inpatient care Benefits are not payable; and

5. Physician's services, except when the Physician renders services to the patient outside the scope of normal supervisory activities or when the expenses are those of the patient's attending Physician. Such expenses shall be covered under the applicable limits of the Plan.

The maximum Benefit payable per individual for hospice services shall be the maximum allowance under the federal Medicare law for the geographic area in which the hospice is located. To the extent that services are provided or expenses incurred by the patient which are not part of the hospice program, such services and expenses shall be considered Covered Charges under the applicable Plan of Benefits which the participant was entitled at the time he elected to waive those Benefits to become eligible for hospice Benefits.

JAW JOINT DISORDERS (TMJ)

Payment made for treatment by any method of jaw joint problems including temporomandibular joint syndrome and craniomandibular disorders, or other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the joint shall be limited to 50% of the Lesser Amount for Network providers and 30% of the Lesser Amount for Non-Network provider for such treatment, including surgery, medical care, supplies, hospitalization, major medical and dental expense, but not to exceed payment by the Fund of $500.00 during the lifetime of each covered individual.

MATERNITY HOSPITAL SERVICES

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy, and routine nursery care for a well newborn are covered.

Coverage for the inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a caesarean section. Neither the mother nor the Provider is required to obtain a preauthorization for an inpatient maternity stay that falls within these time frames.

Further, Physician-directed follow-up services are covered after discharge, including:

- Parent education
- Physical assessments of the mother and newborn
- Assessment of the home support system
- Assistance and training in breast and/or bottle feeding
- Performance of any Medically Necessary or appropriate clinical tests
- Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

Covered Services will be provided whether received in a medical setting or through home health care visits. Home health care visits are only covered if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

If requested by the mother, coverage for a length of stay shorter than the minimum period above may be permitted if the attending Physician (or the nurse midwife, as applicable) determines further inpatient postpartum care is not necessary, providing the following conditions are met:

- In the opinion of the attending Physician, the newborn child meets the criteria for medical stability that determine the appropriate length of stay based on the evaluation of:
    - The antepartum, intrapartum, and postpartum course of the mother and infant
    - The gestational stage, birth weight, and clinical condition of the infant
    - The demonstrated ability of the mother to care for the infant after discharge

- The availability of post-discharge follow up to verify the condition of the infant after discharge.

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, at-home post-delivery follow-up care visits are covered for the mother and newborn at their residence by a physician or nurse when performed no later than 72 hours following their discharge from the Hospital, to include:

- Parent education
- Physical assessments of the mother and newborn
- Assessment of the home support system
- Assistance and training in breast and/or bottle feeding
- Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or newborn, including the collection of an adequate sample for the heredity and metabolic newborn screening.

At the mother's discretion, this visit may occur at the facility of the Provider.

MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT

Some medical supplies and equipment are covered when prescribed by your Physician. These supplies and equipment must serve a specific, therapeutic purpose in the treatment of a medical condition.

Medical and Surgical Supplies - Disposable supplies which serve a specific therapeutic purpose are covered. These include:

1. Syringes and needles;
2. Oxygen;
3. Surgical dressings and other similar items; and
4. Diabetic supplies, including lancets and test strips.

Benefit Exclusions and Limitations

Benefits shall not be payable for items listed in the booklet section entitled, "General Exclusions," and items usually stocked in the home for general use. These include, but are not limited to:

1. Elastic bandages;
2. Thermometers;
3. Corn and bunion pads; and
4. Jobst stockings and support/compression stockings.

Durable Medical Equipment ("DME") - Reimbursement shall be made for the Allowed Amount cost of DME that serves only a medical purpose and that must be able to withstand repeated use. DME must be appropriate for home use. Upon request, your Physician must provide a written treatment plan that shows how the prescribed equipment is Medically Necessary for the diagnosis or treatment of a Condition or how it will improve the function of a malfunctioning body part. If you need to use this equipment for more than six months, your Physician may be required to recertify that continued use is Medically Necessary. DME must be for the exclusive use of the covered person for whom the Physician has certified that it is medically necessary.

You may rent or purchase DME; however, for each Condition, the Plan will not cover more in total rental costs than the customary purchase price. For example, if you submit claims for the monthly rental fee and by the third month the total in rental dollars meets or exceeds the customary purchase price, you will have exhausted your Benefit for that piece of Durable Medical Equipment. When it has been determined that you require DME, before you decide whether to rent or purchase, estimate what the rental cost will be for the time period during which you will use the DME. If the estimated rental cost exceeds the purchase price, then you should consider purchasing the DME.

IMPORTANT: If the cost of any durable medical equipment exceeds $1,500, the purchase must be preapproved by the Fund prior to payment being made. Therefore, if you or your Dependent needs durable medical equipment which costs more than $1,500, please contact that Fund office in order to be certain that the cost will be covered by the Plan. The Fund office can provide you with the specific information necessary for reviewing the purchase.

Covered DME includes:

- Blood glucose monitors;
- Respirators;
- Home dialysis equipment;

- Wheelchairs;
- Hospital beds; and
- Crutches.

Non-covered equipment includes, but is not limited to:
- Rental costs if you are in a facility which provides such equipment;
- Repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;
- Physician's equipment, such as a blood pressure cuff or stethoscope;
- Deluxe equipment such as specially designed wheelchairs for use in sporting events
- Items not primarily medical in nature such as exercycles, treadmills, bidet toilet seats, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters;
- Items for comfort and convenience;
- Disposable supplies and hygienic equipment;
- Self-help devices such as bedboards, bathtubs, sauna baths, overbed tables, adjustable beds, special mattresses, telephone arms, air conditioners and electric cooling units;
- Other compression devices.

Orthotic Devices - Rigid or semi-rigid supportive devices that limit or stop the motion of a weak or diseased body part, are covered. These devices can include braces for the leg, arm, neck or back, trusses, and back and special surgical corsets.

Non-covered devices include, but are not limited to:
- Garter belts, arch supports, corsets and corn and bunion pads;
- Corrective shoes, except with accompanying orthopedic braces; and
- Arch supports and other foot care or foot support devices only to improve comfort or appearance. These include, but are not limited to care for flat feet and subluxations, corns, bunions, calluses and toenails.

Prosthetic Appliances - Your coverage includes the purchase, fitting, adjustments, repairs and replacements of prosthetic devices that are artificial substitutes and necessary supplies that replace all or part of a missing body organ or limb and its adjoining tissues, or replace all or part of the function of a permanently useless or malfunctioning body organ or limb. Covered prosthetic appliances include:
- Artificial hands, arms, feet, legs and eyes, including permanent lenses; and
- Appliances needed to effectively use artificial limbs or corrective braces.

Non-covered appliances include, but are not limited to:
- Dentures, unless as a necessary part of a covered prosthesis;
- Dental appliances;
- Eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;
- Replacement of cataract lenses unless needed because of a lens prescription change;
- Taxes included in the purchase of a covered prosthetic appliance;
- Deluxe prosthetics that are specially designed for uses such as sporting events; and
- Wigs and hair pieces.

MENTAL OR NERVOUS DISORDERS, ALCOHOL OR DRUG ABUSE

Individuals covered under the PPO Network Comprehensive Major Medical Plan will receive coverage for inpatient mental/nervous disorder, alcoholism/drug abuse, payable at 100% of the Allowed Amount if services are received from Network providers; or 80% of the Allowed Amount if services are received from Non-Network providers.

Outpatient coverage for mental/nervous disorders, alcoholism/drug abuse treatment for you and your Dependents will be payable at 80% of the Allowed Amount if services are received from Network providers, or 60% of the Allowed Amount from Non-Network providers.

Precertification for Inpatient Admission

Inpatient admissions to a Hospital must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting Hospitals in Ohio will assure this preauthorization is done, and since the Hospital is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. However, for Non-Contracting Hospitals or Hospitals outside of Ohio, you are responsible for obtaining your own preauthorization. If you do not preauthorize a Hospital admission and it is later determined that you admission was not Medically Necessary, or not covered for any reason, you will be responsible for all Billed Charges.

Employee Assistance Program ("EAP")

IMPACT Solutions' Employee Assistance and Work/Life Program is designed to provide prompt, professional help for you and your eligible Dependents experiencing personal problems, marital difficulties, stress, child or adolescent concerns, death or illness of a family member, financial pressure or job stress. While these are "human problems" that anyone may experience at any time, knowing where to turn for help can be difficult. This assistance program operates on a completely confidential basis with you and your eligible Dependents. All services provided by this program are strictly confidential; no information can be released without your written permission.

IMPACT Solutions is an organization of medical doctors, social workers, counselors, psychologists, and other professionals who will arrange for consultation or treatment with appropriate clinical specialists who are located near you. Participant access to IMPACT Solutions' providers is excellent. If inpatient treatment is needed, you will be referred to an approved Medical Mutual facility in the Fund's existing Medical Mutual inpatient Network. Your care will then be directed by the Medical Mutual inpatient Network, and they will provide you with inpatient case management and any discharge planning that may be necessary.

However, if you need outpatient treatment, you will be referred to Medical Mutual's outpatient Network of providers. **The first three visits with IMPACT Solutions Network of providers are provided at no cost to you or your eligible Dependents**. From the time you contact them, they will coordinate your service or treatment and provide when necessary, outpatient precertification, case management, and after services. Be aware that not all diagnoses are covered under Medical Mutual's program or your medical benefits.

As in any emergency, if care is needed on an emergency basis, you may seek care at the nearest facility. Benefits will be paid on all emergency Hospital admissions provided that the

confinement is reviewed within 48 hours and an agreed on length of stay is determined. We believe that this health program will provide the quality of care that you and your family deserve.

ORGAN TRANSPLANT BENEFITS

The Fund will cover 100% Allowed Amount for all Network expenses and 80% of the Allowed Amount for all Non-Network expenses related to the transplantation of an organ, including patient screening, organ procurement and transportation, surgery for the patient and a life donor, follow- up care in the home or a Hospital and immunosuppressant drugs if the following conditions are met:

1. The transplantation is not considered experimental or investigational by the American Medical Association;

2. The patient is admitted to a transplant center program in a major medical center approved either by the Federal government or the appropriate state agency of the state in which the center is located; and

3. The patient utilizes "case management" services.

Organ/Tissue Transplant Pre-Certification

In order for an organ/tissue transplant to be a covered service, the proposed course of treatment must be pre-certified and approved by Medical Mutual. No Benefits will be provided for organ/tissue transplant services which have not been pre-certified.

After your Physician has examined you, he must provide Medical Mutual with:

- The proposed course of treatment for the transplant;

- The name and location of the proposed transplant center; and

- Copies of your medical records, including diagnostic reports for Medical Mutual to determine the suitability and medical necessity of the transplant services.

This determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ/tissue. You may also be required to undergo an examination by a Physician chosen by Medical Mutual. You and your Physician will then be notified of Medical Mutual's decision.

Obtaining Donor Organs or Donor Tissue

The following services will be covered services when they are necessary in order to acquire a legally obtained human organ/tissue:

- Evaluation of the organ/tissue;

- Removal of the organ/tissue from the donor; and

- The transportation of the organ/tissue to the Transplant Center.

Donor Benefits

Benefits necessary for obtaining an organ/tissue from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and

are subject to any applicable limitations and exclusions. Donor benefits include treatment of immediate post-operative complications if medically necessary as determined by Medical Mutual. Such coverage is available only so long as the recipient's coverage is in effect.

The provisions of this Fund regarding Coordination of Benefits shall be applicable to the payment of expenses for organ transplantation under this Section.

Exclusions

The Plan does not provide organ transplant benefits for services, supplies or charges:

- That are not furnished through a course of treatment which has been approved by Medical Mutual;
- For other than a legally obtained organ;
- For travel time and other travel-related expenses of the Provider; or
- That are related to other than a human organ.

PHYSICALS AND WELL-CHILD SCREENING

Well-child screenings are covered once every 12 months through age 8. Beginning at age 9, all members are eligible for a routine physical every 24 months. Sports physicals and physicals required for school, insurance or employment are not covered.

Generally, lab work and immunizations are covered as part of the physical/well-child screening. Childhood immunizations are covered as part of the well-child screening, and flu vaccines are also covered. Covered immunizations include:

- Hepatitis A (Well-child only; not covered for adults.)
- Hepatitis B
- Diphtheria/Tetanus (DT)
- Influenza
- Meningococcal Vaccine
- Rabies Vaccine
- Varicella
- Pneumococcal Polysaccharide
- Measles, Mumps and Rubella (MMR)
- Human Papillomavirus Vaccine (HPV)

ROUTINE SCREENING

Beginning at age 50, for both men and women, the Plan will cover preventative screenings based upon the following schedule:

- Annual fecal occult blood test
- Flexible Sigmoidoscopy every 5 years
- Double-contract barium enema every 5 years
- Colonoscopy every 10 years.

Additionally, these services will be covered for individual with risk factors at an earlier age and can be performed more frequently than the schedule stated above when ordered by their Physician. Risk factors include:

- A personal history of colorectal cancer or adenomatous polyps;
- A strong family history of colorectal cancer or polyps (cancer or polyps in a first degree relative (parent, child or sibling) younger than age 60, or in two first degree siblings of any age;
- A personal history of chronic inflammatory bowel disease; or
- A family history of hereditary colorectal cancer syndromes.

Prostate exams and diagnostic PAP smears and mammograms are covered at 80% after Deductible for the Allowed Amount for Network providers (60% for Non-Network providers).

Claims for the above will be paid after Plan Deductibles and Coinsurance.

Routine PAP smears and Mammograms are covered after the Deductible at 100% of the Allowed Amount for Network providers and 80% of the Allowed Amount for a Non-Network provider, but no more frequently than once per calendar year.

SURGICAL BENEFITS

If you or your Dependents require a surgical procedure or operation for a non-occupational bodily injury or sickness which is recommended by a Physician, the Plan will provide Benefits at 100% of the Allowed Amount for treatment thereafter provided your services are received by Network providers.

If Non-Network providers are utilized for the surgical procedures, the Plan will provide Benefits at 80% of the Allowed Amount. All Surgical Charges must be Usual, Customary, and Reasonable.

Coverage is provided for surgery. In addition, coverage is provided for the following specified services:

- Sterilization, regardless of Medical Necessity;
- Surgery to correct deformity which was caused by disease, trauma, birth defects, growth defect or prior therapeutic processes;
- Surgery to improve a functional deficiency; and
- Mandibular staple implants are only covered when treatment is needed:
  - for accident-related care, or
  -following surgical removal of benign or malignant lesions or tumors.

Mandibular staple implants are not a covered service when performed to prepare the mouth for prosthetics.

Diagnostic Surgical Procedures - Coverage is provided for surgical procedures to diagnose your Condition while you are in the Hospital. The diagnostic surgical procedure and Medical Care visits are covered.

Multiple Surgical Procedures - When two or more surgeries are performed through the same body opening during one operation, you are covered only for the most complex procedure. However, if each surgery is mutually exclusive of the other or the result of a multiple trauma, you will be covered for each surgery. Incidental surgery is not covered.

When two or more surgical procedures are performed through different body openings during one operation, you are covered for the most complex procedure, and the Allowed Amount for the secondary procedures will be half of the Allowed Amount for a single procedure.

If two or more foot surgeries (podiatric surgical procedures) are performed, you are covered for the most complex procedure, and the Allowed Amount will be half of the Allowed Amount for the next two most complex procedures. For all other procedures, the Allowed Amount will be one-fourth of the full Allowed Amount.

Assistant at Surgery - Another Physician's help to your surgeon in performing covered surgery when a Hospital staff member, intern or resident is not available is a covered service.

Anesthesia - Your coverage includes the administration of anesthesia, performed in connection with a covered service, by a Physician, other professional provider or certified registered nurse anesthetist who is not the surgeon or the assistant at surgery or by the surgeon in connection with covered oral surgical procedures. This Benefit includes care before and after the

administration. The services of a stand-by anesthesiologist are only covered during coronary angioplasty surgery.

Second Surgical Opinion - A second surgeon's opinion and related diagnostic services to help determine the need for elective covered surgery recommended by a surgeon are covered but are not required.

The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the surgery. This Benefit is not covered while you are an Inpatient of a Hospital.

If the first and second surgical opinions conflict, a third opinion is covered. The surgery is a covered service even if the Physicians' opinions conflict.

Benefit Exclusions and Limitations

Benefits shall not be payable for exclusions listed in the booklet section entitled, "General Exclusions," and those listed below:

4. Any Charges for dental work or treatment.

5. Any operation performed in a Hospital owned or operated by the Federal Government.

6. Any surgery or operation for sickness which is covered by a Workers' Compensation Act or other similar legislation or due to injury arising out of or in the course of any employment for wage or profit.

7. Any Charges for in vitro fertilization or infertility treatment.

8. Any services for which no Charges are made.

9. Any Charges incurred for the purpose of reversing a previous sterilization procedure, whether or not the reversal is successful, will not be covered nor any reimbursement made.

THERAPY

Physical therapy is treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. These covered services include physical treatments, hydrotherapy, heat or similar methods, physical agents, and biomechanical and neurophysiological principals, and may include devises. This benefit is limited to 40 visits per person, per year.

Occupational therapy helps those recuperating from physical or mental illness to perform the activities required in day-to-day life. This benefit is limited to 40 visits per person, per year.

Speech therapy helps with speech and language problems, in an effort to help the patient speak more clearly. This benefit is limited to 40 visits per person, per year. Only speech therapy by a licensed speech therapist is covered.

Other therapy treatments covered by the Plan include Cardiac Rehabilitation, Chemotherapy, Radiation, Repertory, Radium, and Dialysis. Therapy must be ordered by a Physician as medically necessary and follow surgery, injury, accident, or illness.

Benefit Exclusions and Limitations:

Benefits shall not be payable for exclusions listed in the booklet section entitled, "General Exclusions," and those listed below:

1. Braces and molds are not covered under this Benefit; they may be covered as Durable Medical Equipment.
2. Aquatic or massage therapy.
3. Acupuncture or acupressure.
4. Hot and cold packs.

URGENT CARE SERVICES

Health problems that require immediate attention which are not Emergency Medical Conditions are considered to be urgent care needs. Examples of urgent care are:

1. Minor cuts and lacerations;
2. Minor burns;
3. Sprains;
4. Severe earaches or stomachaches;
5. Minor bone fractures; or
6. Minor injuries.

GENERAL EXCLUSIONS

No Benefits are payable for the following:

1. Treatment or service not prescribed by, or performed by or under the supervision of, a Physician, or performed by a Physician outside the scope of his or her license.

2. Treatment received from other than a Provider.

3. Treatment or service that is not medically necessary.

4. Treatment or service which is paid for or furnished by any government agency, including care received in a military facility for a condition related to military service.

5. Treatment or service due to sickness or injury arising out of or in the course of any employment for wage or profit.

6. Treatment or service resulting from war or any act of war declared or undeclared.

7. Treatment or service on a participant's tooth or teeth, whether by a dentist or dental surgeon or otherwise, except as a result of a traumatic accident that affects the jaw or as otherwise specifically provided for in this Plan.

8. Treatment with intraoral prosthetic devices, or any other method, to alter vertical dimension.

9. Treatment for experimental or investigational drugs, devices, medical treatments, or procedures.

10. Treatment or service that is received from a member of your immediate family.

11. Treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

12. Treatment for residential care rendered by a Residential Treatment Facility, except as otherwise approved by Medical Mutual.

13. Any claims filed with the Fund office more than 365 days from date Charges were incurred.

14. Any claims incurred after you stop being eligible for coverage in the Plan.

15. Charges for or in connection with custodial care, education or training, except diabetes and in-home dialysis educational training as expressly stated.

16. Services for which the Patient has no legal obligation to pay, or services for which a Charge would not be made except as a result of this insurance being in effect.

17. Physical examinations or services required by an insurance company to obtain insurance, a governmental agency such as the FAA or a DOT, or an employer to begin or continue working.

18. Charges in excess of the Allowed Amount.

19. Charges for cosmetic services, unless necessary as a result of an accident or correction of a birth defect that impairs a bodily function or for reconstructive surgery associated with a mastectomy.

20. Charges as a result of committing or attempting to commit a criminal act.

21. Charges for non-medically necessary care or well-person care unless specifically provided for in this Plan.

22. Non-legend, patent or proprietary medicine (over-the-counter drugs).

23. Vitamins, nutrients or other nutritional supplements, including baby formula.

24. Claims for Benefits through more than one coverage of the Plan.

25. Treatment for any form of obesity, weight reduction or dietary control, including weight loss surgery and any repairs, revisions or modifications of such surgery, including weight loss device removal.

26. Dietary and/or nutritional counseling or training.

27. Treatment or service due to sickness or injury that is covered by a Worker's Compensation Act or law, even if the person does not filed a claim for Benefits, or that arises out of, or is the result of, any work for wage or profit.

28. Treatment or services for which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Covered Person had applied for Parts A, B and/or D, except as specified elsewhere in this Benefit Book or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part B, Medical Mutual will calculate benefits as if he or she had enrolled.

29. Any Charges for in vitro fertilization or infertility treatment.

30. Services incurred as a result of a Covered Person acting as or contracting to be a surrogate parent.

31. Any Charges incurred for the purpose of reversing a previous sterilization procedure, whether or not the reversal is successful, will not be covered nor any reimbursement made.

32. No Benefits are payable for treatment related to or in connection with gender dysphoria, transsexual surgery, or any treatment leading to or in connection with transsexual surgery.

33. Suicide, attempted suicide or self-inflicted injury. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

34. Charges for massage or aquatic therapy.

35. Treatment of the vertebral column unless related to a specific neuromusculoskeletal

related diagnosis.

36. Any Charges over the specified dollar limit maximum.

37. Smoking cessation.

38. Treatment for hair loss, including because of alopecia.

39. Transportation or lodging.

40. Marital counseling.

41. Genetic testing.

42. Treatment or services related to an autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems, or mental retardation.

43. Personal hygiene or convenience items.

44. Eyeglasses, contact lenses or examinations, except as detailed in the "Vision Benefits" section herein, or those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of surgery.

45. Any surgical procedure for the correction of a visual refractive problem, including, but not limited to, radial keratotomy and LASIK.

46. Hypnosis or acupuncture.

47. Topical anesthetics.

48. Specialized camps.

49. After hours care.

50. Missed appointments, completion of claim forms, or copies of medical records.

51. For any oral, written, or electronic communication by a Provider with a Covered Person or another Provider that did not involve in-person contact with the Covered Person.

52. Fraudulent or misrepresented claims.

53. In the event that a non-PPO Network Provider waives Copayments, Coinsurance, and/or the Deductible, no benefits are available for the services for which Copayments, Coinsurance, and/or the Deductible are waived.

54. Any non-covered services or services specifically excluded in the text herein.

PRESCRIPTION DRUG BENEFITS

You and your Dependents are covered for prescription drugs under the Plan. Costs for prescription drugs and medicines purchased at a retail pharmacy are reimbursable up to 80% of UCR and you are responsible for the Balance Billing. The Coinsurance for mail order prescriptions will be the lesser of 20% or a $15.00 Copay for generic drugs and the lesser of 20% or a $35.00 Copay for brand drugs. The Plan's Deductible does not apply.

Mandatory Generic Prescription Drug Program

The Prescription Drug Program is administered by Optum Rx. The program requires that generic drugs be dispensed when available. The only exception to this rule is when your Physician specifically indicates to dispense the prescription as written. If you choose a brand name prescription drug when a generic drug is available, you will be responsible for the difference between the generic drug cost and the brand name drug cost.

Coverage

The Plan will cover up to a consecutive 30-day supply prescribed by your Physician or dentist. The following prescriptions are covered:

1. Drugs requiring a written prescription by a Physician or dentist and dispensed by a licensed pharmacist for use outside of the Hospital;

2. Ointments and lotions for treatment of skin problems prepared by a pharmacist according to a Physician's prescription;

3. Prescription drug dispensed in a Physician's or dentist's office if a separate Charge is made for the drug; and

4. Prenatal vitamins that contain fluoride or folic acid with diagnosis of pregnancy.

Benefit Exclusions and Limitations

Benefits shall not be payable for exclusions listed in the booklet section entitled, "General Exclusions," and those listed below:

1. Devices, bandages, heat lamps, splints, dressings or other appliances;

2. Intrauterine devices, cervical caps or diaphragms;

3. Most injectable drugs other than insulin and antigens;

4. Blood and blood plasma;

5. Vitamins, diet pills, health and beauty aids and cosmetics (other than prescribed pre-natal vitamins);

6. Drug administered in rest homes, convalescent homes or sanitariums unless dispensed from a licensed pharmacy; and requiring a prescription;

7. Any drugs or medicines that are not necessary for treatment of any injury of illness;

8. Any Charges for in vitro fertilization or infertility treatment;

9. Oral medications for treatment of sexual dysfunction;

10. Appetite suppressants, even if medically necessary for attention deficit disorder, narcolepsy or other condition;

11. Compounded prescription medications with ingredients not requiring a Physician's authorization by state or federal law;

12. Compounded prescription medications with a cost greater than $300 are subject to prior authorization before any benefits are available;

13. Investigational or Experimental medications;

14. Medications used for Experimental indications and/or dosage regimens determined to be Experimental (e.g. Progesterone suppositories or suspension or Nystatin oral powder);

15. Medications with no approved FDA indications (e.g. yohimbine);

16. Over-the-counter (OTC) medications that do not require a Physician's authorizations by state or federal law, and any prescription medication that is available as an OTC medication;

17. Prescription refills dispensed after one year from original date of dispensing or for any drug refill if it is more than the number of refills specified;

18. Replacement prescriptions resulting from loss, theft or breakage; or

19. Devices or equipment of any type.

Using Participating Pharmacies

Should you have any questions about your pharmacy or participating pharmacies in your area, please feel free to contact Optum Rx's toll-free customer service department at 1 (800) 797-9791 or call the Fund office.

To have your prescription filled, simply present your drug identification card, and make your Coinsurance.

Using Non-Participating Pharmacies

To have your prescription filled at a Non-Participating pharmacy, you must pay for the entire cost at the time of your purchase. You should take a prescription claim form with you and have it completed by the pharmacist. Then you may seek partial reimbursement by completing your prescription claim form and mailing it to the Fund office. You must include your original receipts with the form.

After deduction of the Coinsurance, you will be reimbursed a percentage of the Charge for the drug, according to the Schedule of Benefits.

Mandatory Mail Order Program

The prescription mail order program is mandatory for maintenance medications. In other words, you will be permitted to get two fills for maintenance medications at the retail pharmacy after which you will be required to use the mail order program through Optum Rx Mail Service Pharmacy.

You will receive a 90 day supply of your medication through Mail Service, rather than just a 30 day supply from your local pharmacy. Ask your Physician to send you a new prescription for your current maintenance medications. Your Physician should prescribe a 90 day supply, plus refills. **For new medications**: Ask your doctor to write two prescriptions: one for a one month supply and one for a 3-month supply plus refills. Fill the one month prescription at your local pharmacy then, once you and your Physician are confident that you'll continue on this new medication, **mail your doctor's original prescription for a 90 day supply, along with the method of payment (check or credit card), in an envelope that will be mailed to you upon your enrollment in the prescription program**. To find out how much the Copayment for your maintenance medication is, call 1-800-562-6223. Your prescription will usually arrive within 7 working days after they receive your order. Included with your medication will be a reorder form, detailed instructions that tell you how to take the medication, possible side effects and other information. Also, you will be provided with a toll-free number that connects you to their registered pharmacists, so you can call with any questions. You can order your refill three weeks before your medication runs out. Refills are processed within 48 hours. Refills can be ordered by mail, by phone, or over the internet at www.optumrx.com.

DENTAL BENEFITS

If you or your Dependent should undergo dental treatment, the Fund will pay up to $1,500.00 for expenses incurred by each covered person during a calendar year. Covered services will be paid listed in the Dental Plan Schedule of Benefits.

You, on behalf of yourself and your Dependents, also have the right to opt not to receive Dental Benefits.

Under this Plan, orthodontia services are also payable up to a lifetime maximum of $1,000.00 for each covered person. There is no age limit for orthodontia services.

Covered services include:

Preventive Services

- Routine oral examinations, but not more than once in any period of 6 consecutive months.
- Bitewing X-rays every 6 months.
- Full mouth or panorex X-rays, but not more than once in any period of 24 consecutive months.
- Miscellaneous diagnostic X-rays, including but not limited to periapical X-rays as required.
- Routine prophylaxis (including cleaning, scaling and polishing of teeth), but not more than once in any period of 6 consecutive months.
- Topical fluoride treatment, but not more than once in any period of 6 consecutive months.
- Sealants
- Emergency oral examinations.

Basic Services

- Consultations and other exams by specialists.
- Space maintainers (not made of precious metals) that replace prematurely lost primary teeth.
- Minor restorative services including amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.
- Endodontics, including pulpotomy and root canal treatment.
- Periodontics including diagnosis and treatment planning, including periodontal examination.
- Non-surgical periodontal therapy including periodontal scaling and root planing.
- Surgical periodontal therapy.
- Periodontal maintenance and gingival inflammation cleaning procedures.
- Repair of broken crowns, inlays, onlays, or bridges.
- Adjustments, repairs, relining or rebasing of dentures more than 6 months after the insertion of an initial or replacement denture.
- Routine extractions.

- Surgical extractions of erupted and impacted teeth, except for impacted wisdom teeth.
- Surgical removal of maxillary or mandibular intrabony cysts.
- Procedures performed for the preparation of the mouth for dentures.
- Apicoectomy (surgical removal of the end of a root).
- Palliative (emergency) treatment for relief of dental pain.
- Administration of local anesthesia, nitrous oxide, or IV sedation.
- Administration of general anesthesia in connection with covered services when rendered by or under the direct supervision of a dentist other than the surgeon, assistant surgeon, or attending dentist.

Major Services

- Gold foil restorations.
- Single unconnected inlays, onlays, and crowns (none of which is part of a fixed bridge or are splinted together).
- Replacement of inlays, onlays, and crowns if at least 5 years have elapsed since the date of the insertion of the existing inlay, onlay, or crown and if the existing inlay, onlay, or crown is unserviceable and cannot be made serviceable.
- Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays).
- Initial insertion of partial or full dentures (including any adjustments during the 6-month period following insertion).
- Replacement, after adjustment or repair, of an existing partial or full denture or bridge by a new denture or a new bridge, but only if the existing denture or bridge was inserted at least 1 year prior to the replacement and if the existing denture or bridge is not serviceable and cannot be made serviceable. Replacement of denture or bridge is limited to one in 5 years in the case where the existing denture or bridge is lost or stolen.
- The addition of teeth to an existing partial denture or to a bridge, but only if satisfactory evidence is presented that the addition of teeth is required to replace one or more teeth extracted after the existing denture or bridge was inserted.

Orthodontics

- Orthodontic diagnostic services, including X-rays.
- Minor treatment for tooth guidance, including removable appliance therapy.
- Minor treatment for harmful habits, including fixed or removable appliance therapy.
- Interceptive orthodontic treatment, including fixed or removable appliance therapy.
- Comprehensive orthodontic treatment encompassing active treatment, including necessary appliances, and retention treatment following active treatment.

Benefit Exclusions and Limitations

Benefits shall not be payable for exclusions listed in the booklet section entitled, "General Exclusions," and those listed below:

1. Charges due to an occupational accident where Benefits are payable under a Workers' Compensation law or other similar law, or due to injury arising out of or in the course of any employment for wage or profit

2. A duplicate denture, replacing the existing denture, except where the original cannot be repaired or adjusted, shall be limited to one per year; lost or stolen, one every five years.

3. Payment for full series of X-rays will be provided initially and at intervals of not less than two years thereafter.

4. Payment for examination of the oral cavity and four bitewing X-rays will be provided only if the interval since the last preceding examination covered under this Plan is not less than six months.

Using Participating Providers

The Plan uses the DenteMax provider Network. Dentists in the DenteMax Network have agreed to accept fees that average 25-40% below usual costs experienced by DenteMax members. While you are not required to use DenteMax, you may be able to obtain more Benefits under the Plan using DenteMax providers:

Find a DenteMax provider online at www.dentemax.com or by calling customer service at 1-(800) 752-1547.

Make an appointment to see your DenteMax dentist and let them know you are a DenteMax member.

If your dentist is not currently a member, you can refer your dentist by calling DenteMax at 1-(800) 752-1547 or visiting www.dentemax.com and entering your dentist's information in the dentist referral section.

Payment for covered services performed by DenteMax Network dentists will be made based upon either the amount Charged, or the DenteMax Allowed Amount, whichever is less. A DenteMax dentist will accept the DenteMax allowance and not bill you for amounts that exceed the Allowed Amount. You are responsible for any Coinsurance, Deductibles, amounts exceeding maximum Plan limitations (Balance Billing), or any service not covered by the Plan.

Payment for covered services performed by Non-Network dentists will be made based upon either the amount Charged, or the UCR Schedule Allowed Amount, whichever is less. Non-Network dentists are not obligated to accept the UCR Schedule allowance and may bill you for amounts that exceed the Allowed Amount. You are responsible for any Coinsurance, Deductibles, amounts exceeding the Allowed Amount, amounts exceeding maximum Plan limitations, or any service not covered by the Plan.

Preventive
Oral Exams
Bitewing X-Rays
Diagnostic X-Rays (including Full Mouth/Panorex)
Prophylaxis
Fluoride Treatment
Sealants
Emergency Oral Exams

Basic
Consultations and Other Exams by Specialists
Space Maintainers
Minor Restorative Services
Endodontics/Pulp Services
Periodontal Services
Repairs, Relines & Adjustments of Prosthetics
Simple Extractions
Impactions
Minor Oral Surgery Services
Emergency Palliative Treatment
Local Anesthesia
General Anesthesia

Major
Gold Foil Restoration
Inlays, Onlays
Crowns
Bridgework (Pontica & Abutments)
Partial and Complete Dentures

Orthodontics
Orthodontic Diagnostic Services
Minor Treatment for Tooth Guidance
Minor Treatment for Harmful Habits
Interceptive Orthodontic Treatment
Comprehensive Orthodontic Treatment

VISION BENEFITS

You and your Dependents are covered for routine eye care under the Plan. The individual Benefit amounts payable for examination, lenses and frames are listed in the Schedule of Benefits. However, Benefits are only payable on either one set of contact lenses or one pair of glasses per calendar year.

You, on behalf of yourself and your Dependents, also have the right to opt not to receive Vision Benefits.

Benefit Exclusions and Limitations

Benefits shall not be payable for exclusions listed in the booklet section entitled, "General Exclusions," and those listed below:

1. Sunglasses;
2. Examinations your company might require for your job;
3. Examinations not performed by a licensed eye doctor; and
4. Refraction.

CLAIMS AND APPEALS PROCEDURES

Claims Procedures:

How to Obtain Inpatient Hospital Services

The Fund has adopted a special rule regarding the ability to obtain inpatient non-emergency Hospital services. You must follow the Pre-Hospital Admission Certification Program outlined in the Health Care Cost Management Program section of this Plan PRIOR to obtaining any inpatient medical treatment with the exception of emergency treatment. This includes any inpatient treatment for Mental and Nervous Disorders or the treatment of substance abuse. In the event you have an emergency admission, you or your authorized representative must notify the Pre-Hospital Admission Certification Program within 48 hours following admission.

Once you contact the Pre-Hospital Admission Certification Program, they will contact your Physician to determine the appropriateness of your hospitalization. This review will be performed as quickly as possible. The Pre-Hospital Admission Certification Program will make a decision on the request, as soon as possible, but within 15 days.

If the Pre-Hospital Admission Certification Program needs additional information from you or your Physician to make its decision, you will be notified as to what information must be submitted. You and/or your Physician will have 45 days to submit the additional information. Once the Pre-Hospital Admission Certification Program receives the information from you or your Physician, you will be notified of the decision on the claim. This decision will be made generally within 10 days after receipt of the additional information.

In the event that the Pre-Hospital Admission Certification Program does not approve the admission as requested, this would be considered a denial or "Adverse Benefit Determination." You will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- The specific reasons for the adverse Benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse Benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim, and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of the Pre-Certification Program Vendor's Appeal Procedure set forth below.

How to File Claims for Medical Benefits

When you receive health care services:

- Show your identification card to the service provider, and
- Ask the provider to file a claim for you

In the case that you and your Dependents use providers who participate in the Medical Mutual Network, the provider will submit a claim for you directly to Medical Mutual for payment.

However, if you use a Non-Participating or Non-Network provider or Physician, it is your responsibility to submit the claim form to Medical Mutual for payment. Generally, you may have to file a claim under the following circumstances:

1. Services are provided in Hospitals or other health care institutions, which do not contract with Medical Mutual;

2. When outpatient services are provided by Hospitals outside of the geographic area served by your local Medical Mutual Plan;

3. When a provider has Charged you for a service that you believe should be submitted to Medical Mutual; or

4. When you believe that the provider's claim submitted to Medical Mutual was inaccurate.

If you must submit a claim for Hospital services received you should:

- Obtain an itemized bill from the Hospital;
- Obtain a claim form from Medical Mutual;
- Complete the claim form and attach the itemized bill to the form; and
- Send the claim form and bill to the address on the claim form.

All claims for payment must include the following information:

- Name and identification number of the participant;
- Name and address of the provider of service (Physician, Hospital, etc.);
- Patient's name and relationship to the Participant;
- Date of service;
- Diagnosis codes;
- Type of service; and
- Amount Charged for each service.

Submit original itemized bills and make copies of these bills for your own records. Once submitted, itemized bills cannot be returned. When submitting an itemized bill, all information must be on the provider's preprinted letterhead or stationery. Remember: Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

Payment for these Non-participating or Non-Network providers will be made to you directly once you have met your Deductibles, and Coinsurance obligations. It is your responsibility to provide this payment to your provider.

A claim is not filed until it is received by Medical Mutual. They will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, Medical Mutual may request additional information from you or the provider. You and/or your provider will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Plan, you will be notified by Medical Mutual that the claim is denied in whole or in part with an explanation of the reasons for the denial. You

will receive a Notice of the Adverse Benefit Determination in the form of an EOB in writing which contains the following:

- The specific reasons for the adverse Benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse Benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim, and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of the Medical Mutual appeals procedure set forth below.

NOTE: Completed claim forms must be submitted to the Fund office within one year from when a covered person is discharged from a Hospital or receives the treatment or service. If additional information is needed, you will be contacted. NO CLAIMS WILL BE CONSIDERED BEYOND THIS ONE-YEAR FILING LIMITATION.

How to File Claims For Prescription Benefits Under the Optum Rx Program

You will receive a personalized Optum Rx Prescription Benefits Identification Card once you become eligible for coverage under this Plan. You must present your prescription benefits identification card along with your Physician's prescription to any participating Optum Rx pharmacy.

The pharmacist will fill the prescription and Charge you the Coinsurance, which is the amount you pay. The pharmacist will generally ask you to sign the form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase of a prescription is not a claim for Benefits. If you do not receive your prescription at the Optum Rx retail pharmacy due to a denial of coverage, you need to contact the Fund office for additional information.

If you elect to have your prescription filled by a pharmacy other than a participating pharmacy, do not use your Optum Rx Benefits Identification Card. Follow the claim reimbursement procedure described herein to obtain reimbursement of prescription expenses.

You can obtain a reimbursement form from the Fund office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach the itemized pharmacy receipt that includes the information about the drug from the pharmacy. Pay the Charge for the prescription in full to the pharmacy and mail the completed form to the Fund office. Reimbursement will be made directly to you by the Fund on the same basis as Benefits would have been paid to a participating Optum Rx's pharmacy.

If you are not eligible for Benefits at the time you contact the Optum Rx pharmacy or in the event that the prescription is not a covered drug under the Plan, you must contact the Fund office for additional information. The Fund office will review your claim for Benefits and if the claim is denied in whole or part, provide you with a "Notice of the Adverse Benefit Determination" in writing which contains the following:

- The specific reasons for the adverse Benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provision on which the adverse Benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim, and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A description of this Fund's Appeals Procedure set forth below.

How to File a Claim for Dental and Vision Benefits

When you receive dental or vision services:

- Show your identification card to the provider of service, and
- Ask the provider to file a claim for you.

If the provider of service files a claim for you, he/she will then submit all necessary claim information to the Fund office and will receive reimbursement directly.

In some cases, however, you may have to submit a claim for Benefits directly to the Fund. If you must submit a claim for health care services received, you should:

- Obtain an itemized bill from the Hospital, Physician, medical facility, dentist or vision facility;
- Obtain a claim form from the Fund offices;
- Complete the claim form and attach the itemized bill to the form; and
- Send the claim form and bill to the address on the claim form.

An itemized bill generally includes all of the following:

- Participant's name and address;
- Patient's name and address, if different;
- Date of service;
- Type of service and diagnosis, if applicable;
- Itemized Charges; and
- Provider's complete name, address, and tax identification number.

Payment for eligible Benefits will be made to the health care vendor unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not filed until it is received by the Fund office. The Fund office will process your claim within 30 days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund may request additional information from you or the provider. You and/or your Physician will have at least 45 days to submit the additional information.

When certain expenses are not eligible under the Plan, you will be notified by the Fund office that the claim is denied with an explanation of the reasons for the denial. You will receive a "Notice of the Adverse Benefit Determination" in writing which contains the following:

- The specific reasons for the adverse Benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse Benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Plan's appeals procedure set forth below.

NOTE: Completed claim forms must be submitted to the Fund office within one year of receipt of dental or vision services. If additional information is needed, you will be contacted. NO CLAIMS WILL BE CONSIDERED BEYOND THIS ONE-YEAR FILING LIMITATION.

How to File Claims for Loss of Time Benefits.

Claims should be submitted to the Fund office as soon as possible: do not delay in filing any claims. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund office to be completed by you, your Employer and your treating Physician. This documentation should be completed as soon as possible in order to begin receiving your weekly Benefits after you complete the waiting period. No photo copies will be accepted. Forms must be signed in ink, not stamped.

The Fund office will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond its control, you will be notified of the reason or the delay and when the decision will be made. This notification will occur before the expiration of the 45 day period. A decision will be made within 30 days of the time the Fund office notifies you of the delay.

In the event your claim for Benefits is denied in whole or in part because the Fund office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund office receives the information from you, you will be notified of the decision on the claims within 30 days.

If your claim is denied, the Fund office will provide you with a “Notice of the Adverse Benefit Determination” in writing which contains the following:

- The specific reasons for the adverse Benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provision on which the adverse Benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Plan's Appeals Procedure set forth below.

NOTE: Completed claim forms must be submitted to the Fund office within one year from when a covered person has lost time from work. If additional information is needed, you will be contacted. NO CLAIMS WILL BE CONSIDERED BEYOND THIS ONE-YEAR- FILING LIMITATION.

How to File Claims for Death and Accidental Death and Dismemberment Benefits

If a person covered by the Fund dies, a completed Proof of Death form, a claimant's statement, and a certified copy of the death certificate must be filed with the Fund office within 365 days from the date of death for Benefits to be payable.

When appropriate items are received at the Fund office, death Benefits will be paid in full

Claims should be submitted to the Fund office as soon as possible: do not delay in filing any claims. Claims for Death or Accidental Death and Dismemberment Benefits will be processed through an insurance provider. Your Beneficiary must contact the Fund office who will submit the completed claim form with all required documentation to the insurance provider. The claims for death Benefits will not be considered until the completed application is received by the insurance provider.

Generally, the insurance provider will notify your Beneficiary of the decision on the claim for Benefits within 90 days. In the event that the insurance provider needs additional time to review the claim for Benefits or needs additional information, your Beneficiary will be provided with the information on the status prior to the expiration of the initial 90 day period.

When the claim for life insurance Benefits falls within the Plan exclusions, your Beneficiary will be notified by the insurance provider and Fund office that the claim is denied in whole or part, with an explanation of the reasons for the denial. He/she will receive a “Notice of the Adverse Benefit Determination” in writing which contains the following:

- The specific reasons for the adverse Benefit determination;
- The sections of the Plan and/or Summary Plan Description upon which the adverse Benefit determination was based;
- A description of any additional materials or information necessary for him/her to perfect the claim, and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Plan's appeals procedure set forth below.

If seeking dismemberment Benefits, an Employee, covered by the Fund, must submit a completed "Dismemberment Benefit" claim form and any other required information (such as proof of loss) within 365 days from the date of the Employee's accidental loss of limbs or sight for Benefits to be payable. Benefits will be paid as soon as the Fund office receives and processes the required documentation.

Appeals Procedures:

Review Procedure for Claims Denied by the Pre-admission Certificate Program

If you receive notice that your Pre-Hospital Admission Certification has been denied in whole or part, you may request a review of the denied claim within 180 days of the receipt of the notice of

denial. The appeal of the denial of an inpatient procedure prior to the service being performed is called a "pre-service" claim. These claims appeals will be handled solely by the Pre-Hospital Admission Certification Program vendor and not the Board of Trustees. Since the Fund does not require Pre-Hospital Admission Certification of inpatient stays which are due to an emergency prior to admission, the Fund will not have any claims for "urgent care services."

The Pre-Hospital Admission Certification Program vendor will provide you with a complete review of your claim for pre-service inpatient admission. You can file your appeal with the vendor either in writing or orally at the address or phone number provided on the adverse Benefit determination. The appeal will be reviewed, and you will be provided with a decision within 30 days. You will receive written notice of the denial on appeal which includes the following:

- The specific reason for the denial;
- Reference to the sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- If the Claim was denied based on medical necessity, experimental treatment, or a similar Plan exclusion or limit, notice of your right to a written explanation of any such exclusion which affects your claim, if applicable;
- A notice of your right to file suit under ERISA Section 502(a); and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to your claim for benefits.

The decision of the vendor on this claim is final and binding.

Review Procedure for Medical Claims Provided Through Medical Mutual

You or your authorized representative may appeal the decision by Medical Mutual to deny any claim for medical Benefits in whole or in part. An "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

You may file a written notice of appeal to Medical Mutual at any time within 180 days after the mailing of the “Notice of Adverse Benefit Determination.” The written notice only needs to state your name, address, identification number and the fact that you are appealing from the decision of Medical Mutual, giving the date of the notice. The appeal should be addressed as follows:

Member Appeals Unit
Medical Mutual Services
P.O. Box 94580
Cleveland, Ohio 44101-4580
MZ: 01-4B-4809

During the appeals process, upon request, you will also be afforded access to all relevant information related to your claim for Benefits and its denial, and you may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, Medical Mutual shall consult an appropriate health care professional and will disclose the identity of such individual to you upon request.

Medical Mutual will consider your appeal of a claim for payment of services which you already obtained, called "post-service claims," within 30 days from receipt of your request. You will be notified of the decision of Medical Mutual as soon as possible after it is made.

In the event that the denial of the claim is upheld, you will receive a written notice which includes the following information:

- The specific reason for the denial;
- Reference to the sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- If the Claim was denied based on medical necessity, experimental treatment, or a similar Plan exclusion or limit, notice of your right to a written explanation of any such exclusion which affects your claim, if applicable;
- A notice of your right to file a voluntary appeal to the Board of Trustees as outlined below;
- A notice of your right to file a lawsuit under ERISA Section 502(a); and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to your claim for benefits.

Review Procedure for Dental, Vision, Prescription, Death, and Loss of Time Weekly Benefit

You or your authorized representative may appeal the decision by Optum Rx or the Fund office to deny any claim for dental, death, accidental death, accidental dismemberment, or loss of time weekly Benefits in whole or part. Additionally, any point of service purchase of prescription Benefits which is not covered at the pharmacy can be appealed through this review procedure. An "authorized representative" must be designated in writing to act on your behalf, and the extent of the person's authority must be clearly indicated in the authorization.

You may file a written notice of appeal to the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number and the fact that you are appealing from the decision of Optum Rx or the Fund office, giving the date of the Notice. The appeal should be addressed to the following:

Board of Trustees
Ohio Conference of Teamsters & Industry Health and Welfare Fund
435 South Hawley Street
Toledo, Ohio 43609

During the appeals process, you will also be afforded access to all relevant information related to your claim for Benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Board of Trustees shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Board of Trustees will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim," at its next regularly scheduled quarterly meeting. In the event that your appeal is received less than (30) days prior to the scheduled meeting date, it will be reviewed at the second quarterly meeting following the receipt of the appeal. You will be notified of the decision of the Board of Trustees as soon as possible after the meeting, but in no case later than five (5) days after the decision is made.

In the event that the denial is upheld, you will receive a written notice which includes the following information:

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file a suit under ERISA Section 502(a).

The decision of the Board of Trustees is final and binding.

Exhaustion, Forum, and Time Limitation

You cannot bring a suit against the Plan based upon an adverse Benefit determination until you have pursued an appeal. You must follow the appeal procedures as described above completely.

This exhaustion of appeals requirement applies regardless of the claim type; in other words, it applies to any attempt to receive Benefits under the Plan, to enforce your rights under the terms of the Plan, and to clarify your right to a future Benefit under the Plan.

Any dispute related to Plan that remains after all required appeals have been exhausted shall be brought and litigated in the Northern District of Ohio. The terms of the Plan require that any such litigation commence within three years of the issuance of upholding of the denial on appeal as described above.

Voluntary Appeals to the Board of Trustees

Once you have filed your appeal through Medical Mutual or the Fund office as detailed above, you have the right to file a lawsuit in federal court. However, you can also file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within 60 days of the mailing of the Notice of Final Decision on your appeal.

The Appeal should be addressed to the following:

Board of Trustees
Ohio Conference of Teamsters & Industry Health and Welfare Fund
435 South Hawley Street
Toledo, Ohio 43609

The Board of Trustees will review the appeal at their next scheduled quarterly meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting, you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive notice of the decision of the Board of Trustees as soon as possible after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

1. The Plan will not assert a failure to exhaust administrative remedies;

2. The Plan agrees that any Statute of Limitations applicable to pursing the claim in court will be tolled during the period of the voluntary appeal process;

3. The Plan requires that the voluntary level of appeal is available only after the claimant has pursued the required appeal(s);

4. You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a Benefit dispute under the voluntary appeal process, including:

    - A statement that using this procedure will have no effect on your right to receive other Benefits under this Plan.
    - A statement that you have the right to have a personal representative with regard to your claim.
    - A notice of any circumstances which may impair the impartiality of the Board of Trustees.

5. The Plan will not impose any fees or costs on you as part of this voluntary appeal process.

BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE TRUSTEES DECIDE IN THEIR DISCRETION THAT THE APPLICANT IS ENTITLED TO THEM

BENEFICIARY PROVISIONS

Designation of Beneficiary

In order to designate a Beneficiary, you must complete, sign and return to the Fund office a "Designation of Beneficiary" form. You may change the designated Beneficiary at any time by completing, signing and returning to the Fund office a "Change of Beneficiary" form. The Fund office must be in receipt of these forms before any intended Beneficiary will be eligible for Death and Accidental Death Benefits. If you die before the "Designation of Beneficiary" or "Change of Beneficiary" forms are received, they will not be considered effective.

Payment of Benefits

Benefits become payable to the designated Beneficiary if you die, and if the claims procedure as outlined is followed, except when:

1. No Beneficiary designation has been received; or
2. The designated Beneficiary dies before you; or
3. The designated Beneficiary is your divorced spouse; your divorce decree does not specify your divorced spouse as Beneficiary; and no "Change of Beneficiary" form was filed.

If any of these three situations exist, Benefits become payable in the following order:

1. To your surviving spouse;
2. To each of your natural or legally adopted surviving children in equal portions;
3. To your parents;
4. To brothers and sisters in equal shares; or
5. To the executor or administrator of your estate.

GENERAL PROVISIONS

Payments of Benefits Limited to Plan

All Benefits under the Plan shall be payable through employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Plan can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no Benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for Benefits against the Union, any Employer or the Trustees. The Trustees, the Employers and the Union shall not be held liable for any Benefits except as provided in the Agreement(s) between the Employers and Union.

Validity of Plan and Plan Provisions

This Welfare Plan is established in the State of Ohio and all questions pertaining to the validity and construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Ohio, except as preempted by Federal law. Where all or part of a Plan provision is declared invalid, any remaining balance of such provision will remain valid.

Right to Recovery

If Benefits have been overpaid by the Ohio Conference of Teamsters and Industry Health and Welfare Fund, or paid in error, the Trustees have the right to recover those payments from among one or more of the following as determined by the Trustees:

1. Any persons to or for whom such Benefits were paid,

2. Any insurance companies, or

3. Any other organization.

These excess payments can be recovered either directly or by a payment to the Plan or by withholding future Benefit payments.

Right to Receive and Release Information

For the purpose of determining claim liability and administering the provisions of this Plan, the Trustees may, without the consent of or notice to the Employees, release or obtain from any insurance company, other organization or person, information with respect to any eligible Employee or Dependent.

Any eligible Employee or Dependent claiming Benefits under this Plan will be required to furnish information to the Trustees for the purpose of determining claim liability and administering these provisions of this Plan.

Right of Examination

The Trustees or their representatives have the right to have a Physician examine any person claiming Benefits for injury or sickness. The Physician will be chosen by the Fund's representative and the frequency of examination will be as often as reasonably necessary to substantiate a claim for Benefits.

Plan Termination

The Board of Trustees of the Ohio Conference of Teamsters and Industry Health and Welfare Fund may terminate the Plan at any time.

Plan Modification and Amendment

The Board of Trustees of the Ohio Conference of Teamsters and Industry Health and Welfare Fund may modify or amend the Plan from time to time at its sole discretion, and such modification or amendment will be final and binding on all individuals claiming Benefits under this Plan.

Notice of Change in Benefit Schedules

If a change in Benefits is made, the change will generally become effective for deaths, accidents and illnesses which occur or begin on or after the effective date of the change and for treatments or services which are received on or after the effective date of the change, unless the Board of Trustees expressly provides otherwise.

SUBROGATION CLAUSE AND REIMBURSEMENT

Subrogation Process. All accident-related claims are flagged and put on hold until the details of the accident are reported to the Plan. Upon receipt of an accident-related claim, the Plan will send a questionnaire to the member. Unless and until that questionnaire is returned to the Plan, no claims related to the accident will be paid by the Plan. If the questionnaire is not returned, the related claims will be denied. If the Plan determines that subrogation is necessary, the member will be provided a subrogation contract, as below. If that contract is not signed and returned, all claims related to the accident will be denied.

Subrogation. In the event of any payment under the Plan, the Plan shall, to the full extent of such payment, be subrogated to all of a covered person's rights of recovery arising out of the acts or omissions of any person or entity, or arising under any no-fault coverage (for the purposes of this provision, collectively referred to as "Other Coverage").

The Plan is subrogated to all rights of recovery of a covered person, regardless of whether the covered person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan's subrogation interest shall take priority over any and all rights of recovery held by a covered person against such person, entity, or Other Coverage arising out of the event which triggered the Plan's payment of Medical Benefits. The Plan's subrogation interest shall apply regardless of whether the covered person has been or will be made whole, and regardless of whether the covered person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule shall not apply.

In the event the Plan has a subrogated interest or right of recovery, no covered person shall release any party, person, corporation, entity, insurance company, insurance policies, or funds that may be liable or obligated to the covered person for the acts or omissions of any person or entity without the written approval of the Plan.

In the event a covered person pursues a claim against any person, entity, or Other Coverage, the covered person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a covered person does not pursue a claim against any person, entity,

or Other Coverage, the Plan shall have the right to pursue, sue, compromise, or settle any such claims in the covered person's name and to execute any and all documents necessary to pursue said claim in the covered person's name.

Reimbursement. Each covered person hereby agrees to reimburse the Plan for any medical Benefits paid by the Plan, from any money recovered from any person, entity, or other coverage as the result of judgment, settlement, or otherwise, regardless of how the money is classified. **The Plan has the right to be reimbursed in an amount equal to the amount of medical Benefits paid hereunder, regardless of whether the covered person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan shall be reimbursed on a first priority basis, regardless of whether or not the covered person has been or will be made whole, and regardless of whether the covered person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule shall not apply.**

In the event a covered person settles, recovers from, or is reimbursed by any person, entity, or Other Coverage, the covered person shall hold any such money in trust for the benefit of the Plan. If a covered person fails to reimburse the Plan in accordance with this provision, the covered person shall be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the covered person; and the Plan may maintain an equitable claim on such funds. Each covered person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights under this Plan.

The Plan will not pay or be responsible for, without the written consent of the Plan Administrator, any fees or costs associated with a covered person pursuing a claim against a third party or any other coverage. The Plan's subrogation interest and the Plan's reimbursement interest shall not be subject to offset for any fees or costs associated with a covered person pursuing a claim against a third party or any Other Coverage.

For purposes of this provision, the term "covered person" includes anyone acting for, or on behalf of, a covered person when the covered person is referred to as taking an action.

Incapacitation

If you should become incapacitated and be unable to prepare, complete or execute the forms and documents prescribed by the Trustees or the Fund office for filing of claims and receipt of Benefits, the forms and documents may be signed on your behalf by other persons, as follows:

- A guardian appointed for you by a court of competent jurisdiction; or
- If no guardian has been appointed, then the persons in the following order of priority after being found acceptable by the Trustees:
  - Spouse,
  - A child,
  - A parent,
  - A brother or sister, or
  - Your state.

Workers' Compensation

The Ohio Conference of Teamsters and Industry Health and Welfare Fund will not cover any disability due to illness or injury arising out of or the course of any employment for wage or profit, which is covered by a Workers' Compensation Act or similar legislation.

Construction by Trustees

Under the Plan of Benefits and the Trust Agreement creating the Plan, the Trustees or persons acting for them, such as a Trustee Review Committee, have the sole and exclusive authority and discretion to make final determinations regarding:

- Any application for Benefits under the Plan, and
- The interpretation of the Plan of Benefits, the Trust Agreement, the Plan document, or any other rules, regulations, procedures or administrative rules adopted by the Trustees.

Any questions or interpretations about the Plan or Trust Agreement, or disputes about eligibility for, and amount of Benefits, shall be resolved by the Board of Trustees in their sole and absolute discretion. Decisions of the Trustees, or where appropriate, decisions of those acting for the Trustees in such matters, are final, binding and conclusive on all persons dealing with the Plan or claiming a Benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the further intention of the parties to the Trust that such decision to be upheld unless it is determined to be arbitrary and capricious.

Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the claimant's right to legal action, be final and binding on all parties.

It is the intent of the Trustees to continue this Plan of Benefits for all eligible Employees. However the Trustees reserve the right to modify or terminate the program if necessary. The Benefit Plan currently provided for retirees and Total and Permanently Disabled Employees may also be modified or terminated by the Trustees if necessary.

DEFINITIONS

The following definitions apply in the administration of your Benefit program:

After Hours Care is that received in a Physician's office at other than regularly scheduled hours, including when the office is usually closed such as Sundays or holidays.

Allowed Amount means the maximum amount payable for covered services. For PPO Network and Contracting Providers, the Allowed Amount is the lesser of the Negotiated Amounted or the Covered Charge. For Non-Contracting Providers, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the Provider's Billed Charges.

Balance Billing means Charges you are responsible for that exceed the Allowed Amount.

Beneficiary means a person who receives the proceeds of a life insurance policy upon the death of the insured.

Benefit means a monetary amount either paid or provided for under the Plan by the Fund. Benefit is a general term referring to any service (such as an office visit, laboratory test, surgical procedure, etc.) or supply (such as prescription drugs, durable medical equipment, etc.) covered by the Plan in the normal course of a patient's healthcare. A Benefit can take the form of a health Benefit which pays, for example, medical expenses. It can also take the form of a welfare Benefit, which pays an amount to the Employee or his Beneficiary, such as a Death Benefit.

Billed Charges are the amount of the claim submitted by the Provider for services and supplies provided to the Covered Person.

Charge means the provider's list of Charges for services or supplies before any adjustments for discounts, allowances, incentives or settlements.

Coinsurance means your share of the costs of a health care service. It is usually figured as a percentage of the total Charge for the service.

Contracting Providers are those who have an agreement with Medical Mutual or another network used by the Plan, or are otherwise designated Contracting Providers.

Covered Charges means Charges for Covered Services that have been billed under your Plan, except charges for Covered Services provided by a Non-Contracting Provider may be limited to the Non-Contracting Amount.

Covered Person is the member and his or her spouse and dependents.

Covered Services are services or supplies as described herein for which the Plan will provide Benefits.

Deductible means the amount of covered expenses that an individual must satisfy before being eligible for the Major Medical Benefit.

Employee means a person covered under this Plan for whom contributions are being made, either by a participating Employer or by the individual member himself.

Employer means each individual company or legal entity making contributions to the Fund for persons who are employed by such company or legal entity in accordance with a collective bargaining agreement with a local union to which they are a party.

Explanation of Benefits (EOB) Statement is a statement outlining Charges, Deductibles, exclusions and payments by the provider of the Benefits.

Hospital means any institution which is an approved and accredited Hospital recognized as such by the American Hospital Association and which is primarily engaged in providing diagnostic and therapeutic facilities for the medical care of injured and sick persons on a basis other than as a rest home, a nursing home, a convalescent home, a place for the aged, a place for drug addicts or a place for alcoholics; or any institution which maintains permanent and full-time facilities for bed care of five (5) or more resident patients; has a doctor in regular attendance; continuously provides twenty-four (24) hour a day nursing service by registered nurses; is primarily engaged in providing diagnostic and therapeutic facilities for the medical and surgical care of injured and sick persons on a basis other than as a rest home, a nursing home, a convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics; provided such institution is operating lawfully in the jurisdiction where it is located.

Inpatient means a Covered Person who receives care as a registered bed patient in a Hospital or Other Facility Provider where a room and board charge is made.

Lesser Amount, for contracting and participating providers, is the lesser of the Negotiated Amount or the Covered Charges. For Non-Contracting Providers, the Lesser Amount means the lesser of the Billed Charges or the Covered Charges.

Negotiated Amount - the amount the provider has agreed with Medical Mutual to accept as payment in full for covered services. The Negotiated Amount may include performance withholds and/or payments to Providers for quality or wellness incentives that may be earned and paid at a later date. Your copayment, Deductible, or Coinsurance may include a portion that is attributable to a quality incentive payment or bonus and will not be adjusted or changed if such payments are not made.

The Negotiated Amount for Institutional Providers does not include adjustments and/or settlement due to most favored nations rate violations, prompt payment discounts, guaranteed discount corridor provisions, maximum Charge increase limitation violations or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim.

The Negotiated Amount for prescription drugs does not include any share of formulary reimbursement savings, volume based credits or refunds or discount guarantees.

The Negotiated Amount for contracting institutional providers may exceed the Covered Charges.

The Negotiated Amount for participating Physicians and other professional providers does not include any performance withhold adjustments.

In certain circumstances, Medical Mutual may have an agreement or arrangement with a vendor who purchases the services, supplies or products from the provider instead of Medical Mutual contracting directly with the provider itself. In these circumstances, the Negotiated Amount will be based upon the agreement or arrangement Medical Mutual has with the vendor and not upon

the vendor's actual negotiated price with the provider, subject to the further conditions and limitations set forth herein.

Network is the status of a provider designated by us as Network.

Non-Contracting Provider is the status of a Hospital or facility other provider that does not a contract with Medical Mutual or one of its networks.

Non-Contracting Amount is the maximum amount allowed for Covered Services provided to Covered Persons by a Non-Contracting Provider based on various factors, including, but not limited to, market rates for that service, Negotiated Amounts for that service, and the Medicare reimbursement rate for that service. If you receive services from a Non-Contracting Provider, and you are balanced billed, you may be responsible for the full amount up to the Billed Charges, even if you have otherwise met your Out-of-Pocket Limit.

Non-Network is the status of a provider which does not meet the definition of a Network provider.

Non-Network Coinsurance is the percentage of the Allowed Amount for services rendered by a Non-PPO Network provider for which you are responsible after you have met your Deductible.

Non-Network Provider means Non-PPO Network Hospitals, and any affiliated other facility providers, Physicians, or other professional providers as designated at Non-Contracting Providers.

Non-Participating is the status of a Physician or Other Professional Provider that does not have an agreement with Medical Mutual about payment for Covered Services.

Other Facility Provider means institutions that are licensed, where required, and where Covered Services are provided. The following types of institutions are considered Other Facility Providers:

- Alcoholism Treatment Facility
- Ambulatory Surgical Facility
- Day/Night Psychiatry Facility
- Psychiatric Hospital
- Dialysis Facility
- Drug Abuse Treatment Facility
- Home Health Care Agency
- Hospice Facility
- Skilled Nursing Facility

Other Professional Provider includes only the following persons or entities, which are licensed as required:

- Advanced nurse practitioner (A.N.P.)
- Ambulance service
- Certified dietitian
- Certified nurse practitioner
- Clinical nurse specialist

- Dentist
- Doctor of Chiropractic Medicine
- Durable medical equipment or prosthetic appliance vendor
- Laboratory
- Licensed independent social worker (L.I.S.W.)
- Licensed practical nurse (L.P.N.)
- Licensed professional clinical counselor
- Licensed professional counselor
- Licensed vocational nurse (L.V.N.)
- Mechanotherapist (if licensed prior to Novemer 3, 1975)
- Nurse-midwife
- Occupational therapist
- Osteopath
- Pharmacy
- Physical therapist
- Physician assistant
- Podiatrist
- Psychologist
- Registered nurse (R.N.)
- Registered nurse anesthetist
- Urgent care provider

Physician means a doctor or surgeon licensed to practice medicine. The term Physician includes Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Dentistry and Chiropractors.

Plan Document means the legal document setting forth detailed rules for eligibility and coverage. This is the Plan Document and Summary Plan Description.

Provider means a Hospital, Other Facility Provider, Physician, or Other Professional Provider.

Residential Treatment Facility means a facility that provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders. The facility provides room and board as well as providing an individual treatment plan for the chemical, psychological and social needs of each of its residents.

The facility must meet all regional, state and federal licensing requirements. The residential care treatment program must be supervised by a professional staff of qualified Physician(s), licensed nurses, counselors and social workers.

Summary Plan Description ("SPD") – Summary of the Plan's provisions.

Total and Permanent Disability means the inability of an Employee to perform any work for gainful employment and because of this inability qualifies for a social security disability award.

LEGAL NOTICES

Grandfathered Status Notice

This group health Plan believes this 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, the elimination of lifetime limits on Benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administrative Manager at (419) 254-3310 or (800) 523-8467. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Medicaid and the Children's Health Insurance Program (CHIP) Offer of Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your Employer, but are unable to afford the premiums, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage, but need assistance in paying their health premiums.

To see if your State has a premium assistance program, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Newborn's Act Disclosure

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 a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, this Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides Benefits for mastectomy-related services,

including all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to achieve symmetrical appearance; prostheses; and treatment of physical complications resulting from a mastectomy, including lymphedema. Call the Administrative Manager at (419) 254-3310 or (800) 523- 8467 for more information.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy

This Notice of Privacy Practices ("Notice") applies to Protected Health Information associated with the Plan. This Notice describes how the Plan may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice. If we make material changes to our privacy practices, copies of revised notices will be mailed to all participants then covered by the Plan. Copies of our current Notice may be obtained by contacting the Administrative Manager, Ohio Conference of Teamsters & Industry Health and Welfare Fund, 435 South Hawley Street, Toledo, Ohio 43609, (800) 523-8467.

The Plan treats your medical information as confidential. However, the Plan must use and disclose medical information to others for treatment, payment, and health care operations. Medical information may be disclosed for (i) payment by, for example, sending your information to insurance companies to help the Plan's purchase of insurance, or to others if there may be duplicate coverage requiring Coordination of Benefits; and (ii) health care operations by, for example, disclosing information to utilization review groups, and contacting you and/or your medical providers about treatment alternatives and health-related Benefits. Your medical information is sometimes disclosed to the Plan's Board of Trustees for Plan administration—for example, to act on claim appeals. The Plan uses information for underwriting purposes but is prohibited from using any genetic information for such purposes.

The Plan is generally required to disclose health information to you, and when required by the Secretary of Health and Human Services to determine Plan compliance. The Plan is also permitted and may be required to disclose information to public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse, and other public health issues; to health oversight agencies, such as governmental auditors, a State Department of Health, and other agencies when required; to avert a serious threat to health or safety; to any individual when ordered by a court or other legal process to do so; to law enforcement officials when necessary for law enforcement purposes and permitted or required by law; to a coroner or medical examiner when necessary to enable them to perform their duties; to organ procurement organizations, to enable them to make suitability determinations; in cases of emergency; for workers' compensation; to appropriate military authorities, if you are a member of the armed forces; to federal officials for lawful intelligence, counter-intelligence and other national security purposes; to researchers if their research has been approved by an institutional review board or other board as may be permitted by HIPAA and they take certain steps to protect your privacy; and incident to a permitted or required use or disclosure, for which the Plan has complied with HIPAA's requirements.

The Plan will make other uses and disclosures of your medical information, including those not otherwise permitted or required by law only with your written authorization. These include uses or disclosures of psychotherapy notes, uses or disclosures for marketing purposes, or any disclosure constituting a sale of such information. You have the right to revoke any authorization you provide us.

Your Rights

For your private health information, you have certain rights:

- To request restrictions on certain uses and disclosures (for example, if the health care provider has been totally paid by your Out-of-Pocket payments), but the Plan is required to agree to such a restriction only in limited circumstances;

- To request communications by alternative means or at alternative locations stated in writing;

- To generally inspect and receive a copy such information (for a Reasonable fee);

- To request amendment of information if you furnish your reason in writing;

- To receive an accounting of certain uses and disclosures other than those to carry out treatment, payment or health care operations and certain other exceptions, and to receive an accounting of certain uses and disclosures made through electronic health records to carry out treatment, payment, or health care operations; and

- To receive a paper copy of this Privacy Policy upon request.

You may exercise the above rights by writing to the Privacy Officer at the address shown below.

Our Obligations

This Plan must:

- Maintain the privacy of protected health information according to law and our policies and procedures;

- Furnish you with notice of the Plan's Privacy Policy and privacy practices with respect to your medical information, and act in accordance with the Plan's Policy, practices, and this notice;

- Notify you of any breach of unsecured protected health information; and

- Notify you in writing of a change in the Plan's Privacy Policy, privacy practices, or this notice, which change may be effective for protected health information received before the change.

You should contact the Plan's Privacy Officer, at the below address, for further information or to express any concerns. If the matter is not resolved or you believe your privacy rights have been violated, you should file a written complaint with the Privacy Officer, Ohio Conference of Teamsters & Industry Health and Welfare Plan, 435 South Hawley Street, Toledo, Ohio 43609. You will not be retaliated against for any complaint. You may also file a complaint with the Secretary of Health and Human Services.

The Plan is required by law to notify affected individuals following a breach of unsecured Protected Health Information.

The Family & Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires your Employer to provide you with up to 12 weeks of unpaid leave during any 12 month period for specified family and medical reasons, if you are eligible. During this period, your Employer must provide health coverage for you on the same terms and conditions that you would receive if you continued to work.

To be eligible for leave under FMLA, you must work for the same contributing Employer for at least 12 months and for at least 1,250 hours during the 12 month period before the leave begins. Generally, your Employer is obligated to provide Family and Medical leave only if your Employer employs 50 or more employees each working day during each of 20 or more work weeks during the current or preceding calendar year.

During the FMLA leave, your Employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you receive continued coverage.

A covered Employer must grant an eligible participant up to a total of 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- For the birth or placement of a child for adoption or foster care;
- To care for an immediate family member (spouse, child or parent) with a serious health condition; or
- To take medical leave when the participant is unable to work because of a serious health condition.

Upon return from FMLA leave, a participant must be restored to his or her original job or to an equivalent job. In addition, a participant's use of FMLA leave cannot result in the loss of any employment Benefit that the employee earned or was entitled to before using FMLA leave.

If you return to work within 12 weeks, you will not lose health care coverage. If you do not return within 12 weeks, you may then qualify to continue coverage under COBRA. You may self-pay for COBRA coverage for up to 18 additional months.

If you take a leave under the FMLA and you fail to return to your Employer for any reason after such absence, under the Act your Employer has the right to be reimbursed from the Fund for all contributions made on your behalf during such leave of absence. Thus, to insure your continuing coverage under this Plan and to prevent possible repayment of all contributions to your Employer, you should return to work at the end of your leave of absence under the FMLA.

Please contact the Fund office if you have any questions regarding your options under the FMLA.

Dental and Vision Opt-Out

In response to technical rules under the Affordable Care Act, Employees have the ability to opt out solely of the Dental and Vision Benefit portions of the Plan. Please understand: there is no financial or other benefit to you by opting out. Instead, you and all of your eligible dependents will lose dental and vision benefits and get nothing in return if you choose to opt out. The ability for participants to opt out of Dental and Vision benefits (though there is no financial benefit to do so) is solely to comply with technical rules regarding classification of different benefits under the Affordable Care Act's provisions.

Should you wish to opt out of the Plan's Vision and Dental Benefits for you and all of your eligible dependents, the appropriate form is available from the Fund Office.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT SECURITY ACT OF 1974 (ERISA)

As a participant in the Ohio Conference of Teamsters & Industry Health and Welfare 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 and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue 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 your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by the Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for 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 health benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, the court may require the Plan Administrator to provide materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied, in whole or in part, you may file a suit in a state or federal court, after exhausting the claim appeals process described in this Summary Plan Description. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If this should happen that the plan fiduciaries misuse the plans 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 Pension and Welfare Benefits Administration, U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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, or visiting the U.S. Department of Labor web site at http://www.dol.gov/ebsa.

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