Ohio Conference of Teamsters
& Industry Health & Welfare Fund

YOUR HEALTH BENEFITS

Restated as of December 2017

Retiree Program

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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CERTIFIED PUBLIC ACCOUNTANT
Clark Schaefer Hackett

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"). This SPD replaces any and all booklets previously issued.

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 provide network and claim administration services. Your 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 Network providers at identified locations only.

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 Network Provider Directory. If treatment is sought in a facility not listed in the Network Provider Directory, while the Plan will pay 80% of the Allowed Amount, you may be subject to a balance bill. FOR MAXIMUM BENEFITS ONE MUST SEEK TREATMENT FROM PHYSICIANS PRACTICING MEDICINE AT THE NETWORK FACILITIES.

Services obtained from a Physician or other professional provider who is not part of the 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). 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.

This does not mean you cannot see you current Physician or specialist if he is not listed in the directory. You have the freedom to seek care outside the network and still receive benefits from this Plan. However, payment for services obtained from a provider who does not contract with Medical Mutual will be based on the Allowed Amount as established by Medical Mutual.

Hospital Care

All contracting Hospitals have agreed to provide specific services at a negotiated rate, so you will receive the maximum benefit about by having your Physician select a Network hospital.

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 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.

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 – Retiree Program. 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. The specific Benefits in this booklet are revised periodically by the Trustees, with notice of major changes being distributed to participating Employees.

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 Network.

The prescription drug Benefit coverage is insured and administered by the Fund.

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**.	**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

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	**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

Eligibility for Retiree Program

In order for you to be eligible for the Retiree Plan, you must retire from active employment with a participating Employer; have previously been covered by one of the Plans provided by the Ohio Conference of Teamsters & Industry Health and Welfare Fund that provides for retiree coverage; and meet the following requirements:

1. Have completed five (5) full years of employment in a Benefit Plan (that 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 (that provides retiree coverage) as of your retirement date;

2. Be at least age 50;

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

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

5. Have your application approved by the Fund office; and

6. Your last Employer immediately before retirement must be a participating Employer in the Plan, and you must be a participant in the Plan at the time of your 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 the active Plan until you are eligible for the Retiree Plan 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. Your eligibility for any group health insurance coverage;

5. Your eligibility for Medicare;

6. Cessation of contributions to fund this Plan by one or a number of Employers;

7. Your Employer's termination of participation in the Fund through collective bargaining;

8. The Plan's termination; or

9. Your failure to 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's eligibility for group coverage under another plan;

5. The spouse's eligibility for Medicare;

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

7. The failure to 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 attainment of age 65, coverage for the spouse will continue for the balance of a five-year period beginning on the date the Employee retired.

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

Coverage is effective the first of the month after receipt of the required contribution. It cannot be retroactive to the date of termination. Benefits are payable only for the Retired Employee and spouse.

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.

Special Enrollments and Waiver of Coverage

If you or your Dependent are eligible for other group health coverage, you may waive coverage under this Retiree Program. If you later lose that other coverage due to death, divorce, termination of employment, or reduction in hours of employment, or termination of employer contributions towards your other coverage whether or not you also lose coverage as a result, you may enroll in this Plan within 30 days of that loss.

Extended Benefits

If you or your Spouse are in the Hospital when coverage terminates, or within three months of termination due to an illness or injury that existed on the day coverage terminated, then Hospital Benefits described in the Schedule of Benefits will be extended for up to three months from your coverage termination date. To qualify for this extension, you or your Spouse must be totally disabled from the date coverage terminated until you are hospitalized or surgery is performed.

Benefits are payable:

- Limited to Hospital charges for each day you or your Spouse stay in the hospital, and
- At the daily rate in effect on the day coverage is terminated.

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

It is the intent of the Trustees to continue this Plan of Benefits for all eligible participants. However, the Trustees reserve the right to modify or terminate the program if necessary.

REQUIRED CONTRIBUTIONS

You will be required to pay a monthly contribution payment to provide coverage for you and your spouse, due on or prior to the first day of each month for which you want coverage.

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. This Plan does not coordinate benefits, as participants lose coverage under this Plan upon eligibility for any other group health plan or Medicare.

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.

When you leave active employment, if you do not choose continuation coverage, your group health plan coverage under the Ohio Conference of Teamsters & Industry Health and Welfare Plan will generally end. However, if your active coverage includes access to this Retiree Program, you may elect coverage for you and your Spouse as a Retiree. **In order to access the Retiree Program, You must first waive coverage under COBRA.**

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.

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 and spouses 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.

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), *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 through COBRA or the Retiree Program outlined in this booklet, your group health insurance coverage will end. At the time of your retirement, you will be notified of any rights you may have, if you are eligible, and the choices available to you. If you reject continuation coverage, your Spouse will be given the opportunity to elect coverage independently from you.

Specific cost information will be provided to you when you become eligible for continuation coverage. You 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 spouse. 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) or divorce or legal separation, COBRA continuation coverage lasts for up to a total of **36** months.

If an Employee 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 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 if the former Employee dies, enrolls in Medicare (Part A, Part B or both) or gets divorced or legally separated. 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.

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

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.

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.

OHIO CONFERENCE OF TEAMSTERS & INDUSTRY HEALTH & WELFARE FUND

RETIREE PROGRAM SCHEDULE OF BENEFITS

BENEFITS	
Precertification	Required – provider completes at Network Hospitals Participant must complete at Non-Contracting and out-of-state Hospitals.
Deductible	$100/individual Does not apply to hospital benefits
Coinsurance Limit/ Out-of-Pocket Maximum	None
Annual Maximum	No annual maximum
COMPREHENSIVE MAJOR MEDICAL SERVICES	
Room and Board	100%*
Ancillary Services	80%
Inpatient X-ray & Lab	80%
Outpatient X-ray & Lab	80%
Outpatient Surgery	80%
Medically Necessary Physical, Occupational & Speech Therapies (Institutional or Professional) (40-visit limit, per therapy type, per person, per year)	80%
Chemotherapy	80%
Emergency Room – medical emergencies (no hour limit) (use of "prudent layperson")	80%
Emergency Room – (All other causes)	80%
Urgent Care	80%
Radium Therapy	80%
Outpatient Cardiac Rehab	80%
Outpatient Respiratory Therapy	80%
Outpatient Dialysis	80%
In-Hospital Physician Service	80%
Office Visits	80%
Surgical Expenses	80%
Ambulatory or Outpatient Surgery (Professional)	80%
Inpatient Anesthesia	80%
Outpatient Anesthesia	80%
Maternity	80% (100% for delivery and inpatient services)
Temporomandibular Joint Disorder (TMJ) $500 Annual Maximum	50%
Ambulance	1st $500 paid at 100%. After Deductible, balance paid at 80%.
Routine Mammograms	80%; Limited to one per calendar year
Pap Smear	80%; Limited to one routine per calendar year
Colonoscopy	80%

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

Prescription Drug Benefits.....80% of the retail cost

*If you do not use a hospital that participates in the Medical Mutual network, you must pay a penalty of 20%, up to $200, per visit.

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.

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.

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.

COMPREHENSIVE
MAJOR MEDICAL BENEFIT PLAN

INTRODUCTION

The Ohio Conference of Teamsters & Industry Health and Welfare Fund Retiree Program pays benefits to you and your eligible Dependents based on the Allowed Amount for the services you receive, determined by Medical Mutual, subject to Deductibles, Coinsurance, and other limits as described herein.

The Comprehensive Major Medical Benefit Plan utilizes a 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.

While your health Benefit Plan gives you the option to choose your own personal Physician, specialist and Hospital facility, if you choose from the provider Network directory, you will not be subject to a balance bill from that provider.

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 may subject you to a balance bill.

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 Contracting Amount, with any additional charges due to the provider billed to you in addition to the Coinsurance.

Deductible

Each calendar year (January 1 through December 31), you must pay the Deductible amount for any services not covered at 100% before the Plan pays any Benefit. The Deductible per individual is $100.00 each calendar year.

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 Comprehensive Major Medical Plan will pay 80% of the Allowed Amount of covered expenses for injuries or sickness that are in excess of your Deductible.

EXAMPLE:

You are injured in an automobile accident. Hospital and other medical expenses billed to you total $5,000. After hospital charges of $4,000 are paid (at 100%), $1,000 remains. Major Medical will cover the remaining as follows:

Total Medical Charges:	$5,000
Minus Hospital charges:	- 4,000
Eligible Major Medical charges:	$1,000
Minus the deductible:	- 100
	$900
Minus 80% coinsurance:	- 720
Total payable for Major Medical:	**$180**

Annual Maximum

Beginning March 1, 2014, the Plan has no annual maximum.

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 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, if you incur Charges for services provided from Non-Contracting Physicians, **you may be billed by a Non-Contracting Physician for the amount in excess of the Allowed Amount; and you may be responsible for paying the difference between the Allowed Amount and the provider's Charge**.

Hospital Program
If you do not utilize a Medical Mutual participating Hospital, you will be responsible for a 20% penalty up to $200 per visit.

Covered Benefits
The following medical Benefits will be covered under the 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.

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 is paid after the annual Deductible has been satisfied, at 80% of the Allowed Amount. 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, 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, as long as:

1. They are not covered elsewhere in the Plan;

2. They are for you or your Dependent's non-occupational injury or sickness; and

3. They are ordered by a Physician.

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 charges in excess of your Deductible.

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 100% of the Lesser Amount, after the Deductible. The Plan will pay up to $500.00 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, 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 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 Comprehensive Major Medical Plan will receive coverage for inpatient mental/nervous disorders, alcoholism, and drug abuse payable at 100% of the Allowed Amount.

Outpatient coverage for mental/nervous disorders, alcoholism, and drug abuse treatment for you and your Dependents will be payable at 80% of the Allowed Amount.

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, you will be charged a $200 penalty; and if 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 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

Routine physicals and well-child screenings are not covered services.

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. Routine PAP smears and Mammograms are covered after the Deductible at 80% of the Allowed Amount, but no more frequently than once per calendar year.

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

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 80% of the Allowed Amount.

Coverage is provided for surgery, as well as 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:

1. Any Charges for dental work or treatment.

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

3. 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.

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

5. Any services for which no Charges are made.

6. 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, 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 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 retail cost. The Plan's Deductible does apply.

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.

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

The pharmacist will fill the prescription and Charge you the full retail price. The pharmacist will generally ask you to sign the form to indicate that you received the prescription. This point of sale purchase of a prescription is not a claim for Benefits. Follow the claim reimbursement procedure described herein to obtain reimbursement of prescription expenses.

You can obtain a reimbursement form from the Fund office. You must 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.

If you are not eligible for Benefits at the time you fill the prescription 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.

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 Prescription Benefit

You or your authorized representative may appeal the decision by the Fund to deny any claim for 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 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

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 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-Network provider for which you are responsible after you have met your Deductible.

Non-Network Provider means Non-Network Hospitals, and any affiliated other facility providers, Physicians, or other 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.

Out-of-Pocket Limit means the maximum amount of covered expenses for which the participant is responsible. This is the participant's 20% Coinsurance and is not to exceed $1,000 per individual or $3,000 per family. This does not include your Deductible.

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 any more States have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, 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.

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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