SOUTHWEST OHIO REGIONAL COUNCIL OF CARPENTERS HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE JUNE 1, 2007

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June 1, 2007

Dear Participant:

Your Welfare *Plan* includes Comprehensive Medical Expense Benefits, Prescription Drug Benefits, a Medical Reimbursement Account, Weekly Disability Benefits (Employees Only), and Death Benefits. These benefits are described in this booklet. For your convenience, terms defined for you at pages 72 - 80 are italicized throughout this booklet.

For Comprehensive Medical Expense Benefits, you have a choice of using Participating Providers participating in a provider network designated by the *Plan* ("PAR Providers"), or providers outside that network ("NON-PAR Providers"). You generally have less out-of-pocket expense when you select PAR Providers. However, the selection of providers is up to you.

When using the Medical Benefits, you must show your *Plan* identification card every time you request health care services. If you do not show your card, the Providers have no way of knowing that you are covered by the *Plan* and you may receive a bill for health care services. **If you do not have a card or need a replacement card, please contact the *Third Party Administrator* at the telephone number on page v of this Summary *Plan* Description.**

If you desire to be reimbursed for Covered health services provided by NON-PAR Providers, you must give the Provider or *Plan Manager* all the information required to process the claim. If you do not provide the required information, you may not be reimbursed.

The *Plan* Sponsor may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, cover services which would otherwise not be covered under the *Plan*. The fact that the *Plan* Sponsor does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

The *Plan* Sponsor may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the *Plan*, including claims processing and utilization management services. The identity of these service providers and the nature of the services provided may be changed from time to time in the *Plan* Sponsor's sole discretion without prior notice to or approval by *Plan* participants. You must cooperate with those persons or entities in the performance of their responsibilities.

Please be aware that only the Board of Trustees has the authority to interpret and answer questions regarding eligibility for fund participation or coverages. No *Union* or *Employer* representative, Trustee, business agent or other individual has the authority to answer questions and/or interpret the provisions or the types of benefits, amount, duration or nature provided by the *Plan* unless such individual has been given written authority by the Board of Trustees and is acting on their behalf.

Fraternally,

Your Board of Trustees

CUSTOMER SERVICE AND CLAIMS SUBMITTAL

Third Party Administrator* or *TPA

For information regarding: Eligibility, Self-Payments, Death Benefits, Weekly Disability Benefits, or Dollar Bank Reimbursements:

Compensation Programs of Ohio, Inc. (CPI)
33 Fitch Boulevard
Austintown, Ohio 44515 Call: 1 (800) 435-2388

Prior Authorizations

Medical Benefits:

To Receive Prior Authorization for Health Services Call: 1 (888) 357-6767
Active participants – Group No. 685225

Mental Health/Substance Abuse Services

To receive Prior Authorization for Covered Mental Health or Substance Abuse Services, Call: 1 (877) 275-9868.

***Plan Manager* for Medical Benefits**
Humana

For any information or questions regarding the Medical Benefits: Call: 1 (888) 357-6767

Nurse Advice Line Call: 1 (800) 622-9529
Benefit Networks

To determine if your provider is a network provider, contact:

1 (888) 357-6767, or visit Humana's website at www.humana.com
Printed directories are also available upon request

Pharmacy Benefit Manager (PBM)

For any information or questions regarding the Prescription Drug Benefits:

Express Scripts
711 Ridgedale Avenue
East Hanover, New Jersey 07936 Call: 1 (800) 462-6035

For any information or questions regarding the mail order program, contact CFI at: Call: 1 (800) 628-0717

Medical Claims Submission Address

Medical Claims:
Group No. 685225
Humana Claims Office
P.O. Box 14610
Lexington, Kentucky 40512-4601

Mental Health Claims:
Group No. 685225
CorpHealth
1300 Summit Ave., Suite 811
Fort Worth, Texas 76102-4420

Prescription Drug Claims Submission Address

Express Scripts
711 Ridgedale Avenue
East Hanover, New Jersey 07936
Attn: Administrative Unit
1-800-467-2006
www.express-scripts.com

Medical Claim Appeals Submission Address:

Humana G&A
P.O. Box 14546
Lexington, Kentucky 40512-4546

All Other Claim Appeals:

Board of Trustees
Southwest Ohio Regional Council of Carpenters
Health and Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

SCHEDULE OF BENEFITS

WEEKLY DISABILITY BENEFITS
For Temporary, Non-Occupational Related Disabilities
(For *Eligible Employee*s Only)
See pages 21 - 22

Benefit Amount	$200/week
Maximum Period of Payment	13 weeks
Waiting Periods:	
For Disability Due to Disease or Illness	7 Days
For Disability Due to Accident or Injury	None

Return to Work:
Two full weeks of continuous *covered employment* are required between periods for which weekly disability is payable; one day is required if the disability is unrelated to the prior accident or sickness.

MEDICAL EXPENSE REIMBURSEMENT
(*Eligible Employees* Only)
See pages 23 – 25

When you have Dollar Bank Credits **in excess of three months' eligibility**, those Credits may be used for deductibles, *copayments* and other medical expense shown in Internal Revenue Code section 213. When you receive reimbursement, your Dollar Bank is reduced by the amount of the Credits. The deadline for filing for reimbursement for Medical Reimbursement claims is December 31 following the end of the *Plan* Year in which you incurred the claim expense(s).

DEATH BENEFITS
(For *Eligible Employee*s and *Eligible Retiree*s)
See pages 19 – 20

To be eligible for the Death Benefits, you must be eligible in the *Plan* at the time of your death. These benefits are NOT for *dependent*s. The amount of Death Benefits for you will be in accord with your classification in this Schedule:

Class 1	$7,500	All Active Employees.
Class 2	$1,000	Core benefit for Retiree Employees who retired on or after 1/1/1999 (no Accidental Death and Dismemberment benefit).
Class 3	$5,000	Retired Employees who retired on or after 1/1/1999, and elect the buy-up benefit (core benefit of $1,000 plus $4,000); the retiree must pay for the additional benefit at a rate established by the Trustees.
Class 4	$5,000	Early Retirees (pre-age 65) from the Cincinnati *Plan*, who retired prior to 1/1/1999 and were paying $320 in the monthly self-pay as of December, 1998 (includes Accidental Death benefit).
Class 5	$1,000	Retirees who are at least 65 who retired from the Cincinnati *Plan* prior to 1/1/1999 (no Accidental Death and Dismemberment benefit). OR Early retiree (pre-Age 65) who retired from the Cincinnati *Plan* prior to 1/1/1999 and who were paying $255 or $280 in the monthly self-pay as of December, 1998 (no Accidental Death and Dismemberment benefit). OR

		Retirees who retired prior to 1/1/98 and who were eligible in the Cincinnati *Plan* at the time of retirement and not eligible in this Fund on 1/1/1988 (no Accidental Death and Dismemberment benefit).
Class 6	$7,500	Early Retirees (pre-Age 65) from the Dayton *Plan* who retired prior to 1/1/1999 (includes Accidental Death benefit).
Class 7	$5,000	Retirees who are at least age 65 who retired from the Dayton *Plan* prior to 1/1/1999 and were paying $22.50 per month for this benefit as of December, 1998.

PRESCRIPTION DRUG BENEFITS
(*Eligible Employee*s, *Eligible Retiree*s, and *Eligible Dependents*)
See pages 43 - 45

The Prescription Drug Benefit allows for a 31-day supply at a Preferred Pharmacy for the following *copayments*:

The Retail *copayments* are:
- $ 20.00 per prescription for a Generic Drug
- $ 40.00 per prescription for a Brand Name Drug.

You also have access to CFI, Express Scripts' Exclusive Mail-Order Pharmacy Service. This program allows you to obtain a 90-day supply of your prescription medication delivered directly to your home. The CFI Mail Order Program is designed to allow members to receive large quantities of maintenance medications (e.g. heart medication, blood pressure medication, diabetic medication, etc.) directly through the mail.

The CFI co-payments are:
- $ 40.00 per prescription for a 90 day supply of Generic Medication
- $ 80.00 per prescription for a 90 day supply of Brand Name Medication.

COMPREHENSIVE MEDICAL EXPENSE BENEFITS
(*Eligible Employee*s, *Eligible Retiree*s, and *Eligible Dependents*)
See pages 26 – 42

Subject to the Precertification (pages ix, x, xi), Preferred Provider and Facility *Plan* Option (both of which are PAR providers) (page xi-xii), identification of *covered expenses* and other *Plan* terms and limitations, the Deductible and Coinsurance Information for Comprehensive Medical Expense Benefits is:

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION		
BENEFIT	**PAR PROVIDER**	**NON-PAR PROVIDER**
Lifetime Maximum	$2,000,000 per *covered person*.	$1,000,000 per *covered person*.
If *you* use a combination of PAR and Non-PAR providers, Non-PAR benefits will reduce the PAR lifetime maximum; however, PAR benefits will not reduce the Non-PAR lifetime maximum. The total lifetime maximum will not exceed the PAR Provider allowance.		
Deductible: Individual Family	 $400 $800 aggregate	 $ 800 $1,600 aggregate
Coinsurance	80% (*you* pay 20%)	70% (*you* pay 30%)

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION		
BENEFIT	**PAR PROVIDER**	**NON-PAR PROVIDER**
Out-of-Pocket Limit (excludes deductibles and copayments): Individual Family	 $3,600 $7,200	 $ 7,200 $14,400
When the amount of combined *covered expenses* paid by *you* and/or all *your* covered *dependents* satisfy the separate PAR and Non-PAR provider deductible and out-of-pocket limits as shown on the Schedule of Benefits, the *Plan* will pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums and the lifetime maximum of the *Plan*.		

Precertification

Medical Management is a Utilization/*Case Management* Program provided by the *Plan Manager*.

The Medical Management team will provide *precertification* as required by *your Plan*. Medical Management recommends calling as soon as possible to receive proper *precertification*. Refer to *your* ID card for the phone number to call for *precertification*.

CorpHealth provides *precertification* of all *mental disorder*, chemical dependence and alcoholism services. CorpHealth recommends calling as soon as possible to receive proper *precertification.* The CorpHealth toll-free number is 1-877-275-9868.

The following benefits require *precertification*:

	Requires Pre-Cert Participating Provider (yes/no)	**Requires Pre-Cert Non Participating Provider (yes/no)**	**Penalty Taken When Pre Cert not Completed**
INPATIENT HOSPITAL AND INPATIENT REHABILITATION	No	Yes	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
INPATIENT MENTAL DISORDER ALCOHOLISM AND CHEMICAL DEPENDENCY	Yes	Yes	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
OUTPATIENT MENTAL DISORDER, ALCOHOLISM, AND CHEMICAL DEPENDENCY	No	Yes	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
OUTPATIENT SURGERY	No	No	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
SKILLED NURSING FACILITY	No	Yes	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
HOSPICE CARE	No	Yes	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
HOME HEALTH CARE	No	No	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar

	Requires Pre-Cert Participating Provider (yes/no)	Requires Pre-Cert Non Participating Provider (yes/no)	Penalty Taken When Pre Cert not Completed
NON-EMERGENCY AMBULANCE TRANSPORTATION	No	No	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
ACCIDENT RELATED DENTAL SERVICES	No	No	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
DURABLE MEDICAL EQUIPMENT, PROSTHETICS ORTHOTIC APPLIANCES, MEDICAL SUPPLIES OVER $750	Yes	Yes	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
IMPLANTS AND RELATED HEALTH SERVICES	Yes	Yes	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar
GROWTH HORMONE THERAPY	Yes	Yes	Additional 10% coinsurance - Benefit will be 70% Par and 60% NonPar

Covered and Non-Covered Expenses

Benefits are payable only if *services* are considered to be a *covered expense* and are subject to the specific conditions, limitations and applicable maximums of the Plan. The benefit payable for *covered expenses* will not exceed the *maximum allowable fee(s)*.

A *covered expense* is deemed to be incurred on the date a covered *service* is received.

If *you* incur non-covered expenses, whether from a PAR provider or a Non-PAR provider, *you* are responsible for making the full payment to the health care provider. The fact that a *qualified practitioner* has performed or prescribed a medically appropriate procedure, treatment, or supply, or the fact that it may be the only available treatment for a *bodily injury* or *sickness*, does not mean that the procedure, treatment or supply is covered under the Plan.

Please refer to the "Schedule of Benefits" and the "Limitations and Exclusions" sections of this Summary Plan Description for more information about *covered expenses* and non-covered expenses.

Preferred Provider and Facility *Plan* Option

Agreements have been made with certain providers and facilities of health care called Preferred Providers (PAR providers) and Preferred Facilities (PAR facilities). *You* may select any provider to provide *your* medical care.

In most cases, if *you* receive *services* from a PAR provider, the Plan will pay a higher percentage of benefits and *you* will incur lower out-of-pocket costs. *You* are responsible for any applicable deductible, coinsurance and/or *copayment*.

If *you* receive *services* from a Non-PAR provider, the Plan will pay benefits at a lower percentage and *you* will pay a larger share of the costs. Since Non-PAR providers do not have contractual arrangements with the *Plan Manager* to accept discounted or negotiated fees, they

may bill *you* for charges in excess of the *maximum allowable fee*. *You* are responsible for charges in excess of the *maximum allowable fee* in addition to any applicable deductible, coinsurance and/or *copayment*. Any amount *you* pay to the provider in excess of *your* coinsurance or *copayment* will not apply to *your* out-of-pocket limit or deductible.

Not all *qualified practitioners* including, but not limited to, pathologists, anesthesiologists, radiologists, assistant surgeons and emergency room physicians, who provide *services* at PAR *hospitals* are PAR *qualified practitioners.* If *services* are provided to *you* by such Non-PAR *qualified practitioners* at a PAR *hospital,* the Plan will pay for those *services* at the PAR provider benefit percentage subject to the *maximum allowable fee*. Non-PAR *qualified practitioners* may require payment from *you* for any amount not paid by the Plan. If possible, *you* may want to verify whether *services* are available from a PAR *qualified practitioner.*

The Fund Manager will automatically provide, without charge, information to *you* about how *you* can access a directory of PAR Providers, appropriate to *your* service area. The PAR provider directory will be available either in hard copy as a separate document, or in electronic format. Because health care providers enter and exit networks unpredictably, the *Plan Manager* or *Third Party Administrator* can be contacted for network provider verification. An online directory of PAR providers is available to *you* and accessible via the *Plan Manager's* website at www.humana.com.

If *you* choose to receive *your* medical care from a Preferred Provider, *services* are payable as shown on the Schedule of Benefits. Office exams are subject to a $30 *copayment* per visit as shown on the Schedule of Benefits. The *copayment* does not apply to the coinsurance or out-of-pocket limits shown on the Schedule of Benefits.

If *you* choose to receive *your* medical care from a Preferred Facility, *covered expenses* are payable as shown on the Schedule of Benefits.

Any applicable *copayment* or penalty does not apply to the deductible or out-of-pocket limits shown on the Schedule of Benefits.

This schedule provides a brief overview of *Plan* benefits and is not a complete description. Refer to the text for a detailed description of *your Plan* benefits.

One *copayment* will be taken per visit per *qualified practitioner*.

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION		
BENEFIT	**PAR PROVIDER**	**NON-PAR PROVIDER**
Lifetime Maximum	$2,000,000 per *covered person*.	$1,000,000 per *covered person*.
Deductible: Individual Family	 $400 $800 aggregate	 $ 800 $1,600 aggregate
Coinsurance	80% (*you* pay 20%)	70% (*you* pay 30%)
Out-of-Pocket Limit: Individual Family	 $3,600 $7,200	 $ 7,200 $14,400
When the amount of combined *covered expenses* paid by *you* and/or all *your* covered *dependents* satisfy the separate PAR and Non-PAR provider deductible and out-of-pocket limits as shown on the Schedule of Benefits, the *Plan* will pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums and the lifetime maximum of the *Plan*.		

MEDICAL COVERED EXPENSES		
BENEFIT	**PAR PROVIDER**	**NON-PAR PROVIDER**
Inpatient *Hospital*	Subject to deductible and coinsurance.	Subject to deductible and coinsurance. *Precertification* is required. If *precertification* is not received, benefits are subject to the penalty described on the Schedule of Benefits.
***Emergency* Room Care**		
True *Emergency* Services	Subject to a $100 *copayment,* then payable at 100%. Subject to 80% coinsurance if *you* are admitted.	Subject to a $100 *copayment,* then payable at 100%. Subject to 80% coinsurance if *you* are admitted.
Emergency Room Physician	Subject to a $100 *copayment,* then payable at 100%.	Subject to deductible and coinsurance.
Non-*Emergency* Services including *Emergency* Room Physician	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined.	
Outpatient *Hospital*	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Free Standing Surgical Facility	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Urgent Care Facility	Subject to a $60 *copayment*, then payable at 100%.	Subject to a $60 *copayment*, then payable at 100%.
Qualified Practitioner (Office Visits)	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
Other services performed in an office setting.	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined.	
Qualified Practitioner (Other than Office Visits)	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Independent Lab	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined.	
Assisting the Surgeon	20% of the primary surgeon's fee, subject to deductible and coinsurance.	20% of the primary surgeon's fee, subject to deductible and coinsurance.
Physician Assistant	20% of the primary surgeon's fee, subject to deductible and coinsurance.	20% of the primary surgeon's fee, subject to deductible and coinsurance.
Second Surgical Opinions	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined.	
Routine *Child* Care		
Exam	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
Lab and X-ray (includes outpatient *hospital* services)	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
Immunizations	Payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined. Non-PAR *covered expenses* aggregate to a maximum of $150 per *calendar year*	

MEDICAL COVERED EXPENSES		
BENEFIT	**PAR PROVIDER**	**NON-PAR PROVIDER**
Routine Adult Care		
Exam	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
Lab and X-ray	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
Immunizations	Payable at 100%.	Subject to deductible and coinsurance.
Prostate Antigen Testing	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
Routine Pap Smear	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
Routine Mammogram	Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined. Non-PAR *covered expenses* aggregate to a maximum of $150 per *calendar year.*	
Ambulance Service	Subject to deductible and coinsurance.	Subject to PAR deductible and 80% coinsurance.
Pregnancy Benefits	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Newborn Benefits		
Well-Newborn	Subject to coinsurance.	Subject to coinsurance.
Sick-Newborn	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
Birthing Centers	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Skilled Nursing Facility	Subject to deductible and coinsurance.	Subject to deductible and coinsurance. *Precertification* is required. If *precertification* is not received, benefits are subject to the penalty described on the Schedule of Benefits.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 180 days per *calendar year*.	
Home Health Care	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 60 visits per *calendar year*.	
Hospice Care Benefits		
Inpatient and Outpatient	Subject to deductible and coinsurance.	Subject to deductible and 80% coinsurance.
Home	Subject to deductible and 100% coinsurance.	Subject to deductible and 100% coinsurance.
Bereavement	Subject to deductible and coinsurance.	Not Covered. *Precertification* is required. If *precertification* is not received, benefits are subject to the penalty described on the Schedule of Benefits.
Mental Disorder, Chemical Dependence and Alcoholism	Payable as shown at p. 37.	Payable as shown at p. 37.

MEDICAL COVERED EXPENSES		
BENEFIT	**PAR PROVIDER**	**NON-PAR PROVIDER**
Allergy Benefits		
Allergy Testing	Subject to a $30 *copayment*, then payable at 80%.	Subject to deductible and coinsurance.
Vials	Payable at 100%.	Subject to deductible and coinsurance.
Allergy Injections	Payable at 100%.	Subject to deductible and coinsurance.
Routine Vision Benefits		
Exam	Subject to a $30 *copayment*, then payable at 100%.	Not Covered.
Refraction	Subject to a $30 *copayment*, then payable at 100%.	Not Covered.
Tonometry	Subject to a $30 *copayment*, then payable at 100%.	Not Covered.
	One *copayment* applies per visit for all services combined. PAR and Non-PAR *covered expenses* aggregate to a maximum of 1 visit per *calendar year.*	
Routine Hearing Benefits		
Exam	Subject to a $30 *copayment*, then payable at 100%.	Not Covered.
Testing	Subject to a $30 *copayment*, then payable at 100%.	Not Covered.
	One *copayment* applies per visit for all services combined. PAR and Non-PAR *covered expenses* aggregate to a maximum of 1 visit per *calendar year.*	
Chiropractic Care		
Exam	Subject to a $30 *copayment* then payable at 100%.	Subject to deductible and coinsurance.
Lab, X-ray, Therapy, and Manipulations	Subject to a $30 *copayment* then payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined. PAR and Non-PAR *covered expenses* aggregate to a maximum of 24 visits per *calendar year.*	

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION		
BENEFIT	**PAR PROVIDER**	**NON-PAR PROVIDER**
Therapy Services		
Speech Therapy		
Outpatient *Hospital*	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Office/Clinic Setting	Subject to a $30 *copayment* then payable at 100%.	Subject to deductible and coinsurance.
Physical Therapy		
Outpatient *Hospital*	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Office/Clinic Setting	Subject to a $30 *copayment* then payable at 100%.	Subject to deductible and coinsurance.
Occupational Therapy		
Outpatient *Hospital*	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Office/Clinic Setting	Subject to a $30 *copayment* then payable at 100%.	Subject to deductible and coinsurance.
Respiratory Therapy		
Outpatient *Hospital*	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Office/Clinic Setting	Subject to a $30 *copayment* then payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined. PAR and Non-PAR *covered expenses* aggregate to a maximum of 30 visits per *calendar* year for outpatient/clinic office visits for speech, occupational and physical therapies.	
Chemotherapy and Radiation Therapy	Subject to a $30 *copayment* then payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined.	
Growth Hormone Therapy	Subject to deductible and coinsurance. *Precertification* is required. If *precertification* is not received, benefits are subject to the penalty described on the Schedule of Benefits.	Not Covered.
Cardiac Rehabilitation		
Outpatient *Hospital*	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Office/Clinic Setting	Subject to a $30 *copayment* then payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined.	
Inpatient Rehabilitation Services	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of 45 days per *calendar year*.	

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION		
BENEFIT	**PAR PROVIDER**	**NON-PAR PROVIDER**
Sterilization Services		
Outpatient *Hospital*	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Office/Clinic Setting	Subject to a $30 *copayment* then payable at 100%.	Subject to deductible and coinsurance.
	One *copayment* applies per visit for all services combined.	
Infertility Services	Payable the same as any other *sickness*.	Payable the same as any other *sickness*.
	PAR and Non-PAR *covered expenses* aggregate to a maximum of $2,000 per *calendar year.*	
Implants and Related Health	Subject to deductible and coinsurance. *Precertification* is required. If *precertification* is not received, benefits are subject to the penalty described on the Schedule of Benefits.	Not Covered.
Morbid Obesity (This benefit sunsets on May 31 of each year, and must be affirmatively renewed by the Trustees for the following year.)	Subject to deductible and then payable at 70% coinsurance of *covered expenses*.	Subject to deductible and then payable at 70% coinsurance of *covered expenses*.
	Precertification is required. If *precertification* is not received, benefits will not be payable. PAR and Non-PAR *covered expenses* aggregate to a maximum of $20,000 per lifetime, including follow-up treatment and any medical complications.	
Other Covered Expenses	Subject to deductible and coinsurance, including all medical complications arising from morbid obesity surgery.	Subject to deductible and coinsurance.
MEDICAL COVERED EXPENSES		
BENEFIT	**HUMANA NATIONAL TRANSPLANT NETWORK FACILITY (PAYABLE AT THE PAR BENEFIT LEVEL)**	**OTHER THAN A HUMANA NATIONAL TRANSPLANT NETWORK FACILITY (PAYABLE AT THE NON-PAR BENEFIT LEVEL)**
Organ Transplants	Same as any other Sickness.	Not covered.
Transportation	Subject to deductible and coinsurance	Not covered.
Lodging	Subject to deductible and coinsurance up to a *maximum benefit* of $100 per day.	Not covered.
Covered expenses for organ transplants do not aggregate toward the out-of-pocket limits described in the Schedule of Benefits and are limited to a lifetime maximum of $1,000,000 and will reduce the overall lifetime maximum of the Plan.		

IMPORTANT NOTE FOR *MEDICARE*-ELIGIBLE PERSONS

All persons **must** obtain both *Medicare* Part A and *Medicare* Part B coverage. You should enroll in both parts of Medicare as soon as you are eligible based on age, disability or end-stage renal disease. *Medicare* Part A covers *hospital* services. It is premium-free for most people eligible for *Medicare*. You will have a deductible for inpatient *hospital* care for every benefit period. There are also *copayments* for some of the Part A services. *Medicare* Part A helps pay the cost of Inpatient *Hospital* care, Skilled Nursing care, Home Health care, and Hospice care. *Hospital*, skilled nursing facility, and home health services are covered for limited benefit periods.

Medicare Part B covers physician services, outpatient *hospital* care, and laboratory services. A monthly premium is normally deducted from your social security check. In addition, you pay an annual deductible and a percentage of the amount *Medicare* approves for your medical bills.

Remember, unless you have current employment status, the *Plan* will process claims as if you were enrolled in Parts A and B on a timely basis. Further, if you don't enroll in Part B when first eligible and you don't qualify for an exemption or a special enrollment period, you must pay a 10% premium penalty for each year you wait to enroll.

ADDITIONAL INFORMATION ABOUT THE PLAN

Name of *Plan*:

Southwest Ohio Regional Council of Carpenters Health and Welfare *Plan*

Name, Address and Telephone Number of *Plan* Administrator, *Plan* Sponsor and Named Fiduciary:

Board of Trustees
Southwest Ohio Regional Council of Carpenters
Health and Welfare Fund
c/o Compensation Programs of Ohio
33 Fitch Boulevard
Austintown, Ohio 44515
1 (800) 435-2388

The *Plan* Sponsor retains all fiduciary responsibilities with respect to the *Plan* except to the extent the *Plan* Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the *Plan*.

Employer Identification Number (EIN): #31-6031946.

IRS *Plan* Number: 501.

Effective Date of *Plan*:

The effective date of this Summary *Plan* Description is June 1, 2007.

Type of *Plan*: Health and Welfare *Plan*

Name, Business Address, and Business Telephone Number of *Third Party Administrator* (*TPA*):

Compensation Programs of Ohio
33 Fitch Boulevard
Austintown, Ohio 44515
1 (800) 435-2388

***Plan Manager*:**

The company which provides certain administrative services for the *Plan*, including the processing of medical claims.

Humana Insurance Company
500 West Maine Street
Louisville, Kentucky 40202

Type of Administration of the *Plan*:

The *Plan* Sponsor is the Board of Trustees. The *Plan* Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a preferred Provider network; claims processing services, including coordination of benefits; utilization management and complaint resolution assistance. This external administrator is referred to as the *Plan Manager*. The *Plan* Sponsor also uses a *Third Party Administrator* for, among other services, collection of *employer* contributions, eligibility determinations, and processing of benefit claims (other than comprehensive medical claims and prescription drug claims). The *Plan* Sponsor also has contracted with Express Scripts to administer the prescription drug benefits for the *Plan*. The named fiduciary of *Plan* is the Board of Trustees of the Southwest Ohio Regional Council of Carpenters Health and Welfare Fund, the *Plan* Sponsor and *Plan* Administrator.

Person Designated as Agent for Service of Legal Process:

Plan Administrator
c/o Compensation Programs of Ohio
33 Fitch Boulevard
Austintown, Ohio 44515
1 (800) 435-2388

***Plan* Sponsor**:

Union Trustees	Employer Trustees
Mr. Robert Peto Executive Secretary/Treasurer Ohio & Vicinity Regional Council of Carpenters 3615 Chester Avenue Cleveland, Ohio 44114-4694	Mr. Randall L. Fox, Executive Director Associated General Contractors 115 Linwood Street Dayton, Ohio 45405
Mr. Frank Reynolds Ohio & Vicinity Regional Council of Carpenters 204 North Garver Road Monroe, Ohio 45050	Mr. Steve Schramm O.K. Interiors 537 Ashburn Road Cincinnati, Ohio 45240-3701
Mr. Herb Adams Ohio & Vicinity Regional Council of Carpenters 204 North Garver Road Monroe, Ohio 45050	Mr. Mark Combs, Jr. Combs Interior Specialists 471 Funderburg Road Fairborn, Ohio 45324
Mr. Michael Moore Ohio & Vicinity Regional Council of Carpenters 204 North Garver Road Monroe, Ohio 45050	Mr. Mark Trimbach Universal Contracting Corporation 515 Fishwick Drive Cincinnati, Ohio 45246
Mr. Mark Galea, Alternate Ohio & Vicinity Regional Council of Carpenters 204 North Garver Road Monroe, Ohio 45050	

Source of Contributions under the *Plan*:

The *Plan* is funded through contributions to a trust and is maintained pursuant to *Collective Bargaining Agreements* by and between Southwest Ohio Regional Council of Carpenters and all *employers* signatory to these agreements. Copies of the agreements may be inspected or obtained by a participant upon written request to the *Third Party Administrator*.

Funding:

The *Plan* receives contributions from *employers* who have entered into *Collective Bargaining Agreements* with the Southwest Ohio Regional Council of Carpenters. Self-payments are also received from eligible participants and *dependent*s who continue their coverage under the self-payment and continuation of coverage rules of the *Plan*.

Date of the End of the Year for Purposes of Maintaining *Plan*'s Fiscal Records:

The *Plan* year shall be a twelve month period ending December 31.

Insurance Status

Benefits of the *Plan* are self-funded. The *Plan* Sponsor does, however, purchase stop loss coverage to protect against catastrophic losses of individuals covered by the Comprehensive Medical Expense Benefits portion of the *Plan*. The stop loss carrier is Humana Insurance Company.

RULES FOR ELIGIBILITY

Obtaining Eligibility Credits

You will receive "Dollar Bank Credits" for the contributions your *employer* makes for you. These Credits are used to establish and maintain your eligibility. You receive Credits in the third month (eligibility month) after the month in which you work the hours (contribution month). This allows time for recordkeeping.

Initial Eligibility

You become eligible for benefits on the first day of the third month after you accumulate $570 of credits (and such other amount as the Trustees decide from time to time) in 3 or fewer consecutive months. An enrollment form must be completed timely.

Employees who are not members of the bargaining unit may become eligible under Rules established by the *Plan* Sponsor. Self-employed persons cannot become eligible for benefits.

Employee Delayed Effective Date

If the *employee* is not in *active status* on the effective date of coverage, coverage will be effective the day the *employee* returns to *active status*.

Dependent Eligibility

Each *dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage; or

2. The date of the *employee's* marriage for any *dependent* acquired on that date; or

3. The date of birth of the *employee's* natural-born child; or

4. The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or

5. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a *qualified medical child support order*.

The covered *employee* may cover *dependents* only if the *employee* is also covered.

If an *Eligible Employee's* spouse working under the Collective Bargaining Agreement also attains coverage as an *Eligible Employee* under the *Plan*, Coordination of Benefits will be applied as if the spouse was covered by two separate group plans.

Special Enrollment—Change of Family Status

Once an election for coverage is made, it cannot be changed unless you have a change of family status.

- **Loss of Other Coverage**. A special enrollment right applies if you (or your *Dependent*) were eligible to enroll in the group insurance programs, but chose not to enroll because you (or your *Dependent*) had other health insurance coverage. If you (or your *Dependent*) lose the other health insurance coverage, you will be offered the opportunity to enroll (and/or to enroll your *Dependent*), provided you (or your *Dependent*) would otherwise be eligible for coverage and either:

  - The other coverage was under COBRA and is lost due to the exhaustion of COBRA continuation coverage;

  - The other coverage was not under COBRA and is lost due to a loss of eligibility for coverage (including a loss resulting from a legal separation, divorce, loss of *dependent* status, death, termination of employment, reduction in number of hours of employment, meeting or exceeding a lifetime limit on all benefits, or a *Plan* no longer offers benefits to similarly situated individuals); or

  - The *employer* contributions towards the other coverage are terminated.

  This special enrollment right will not apply if the other coverage is lost because you or your *Dependent* failed to pay applicable premiums.

- **New *Dependent***. A special enrollment right will apply if you acquire a *Dependent* by marriage, birth, adoption, or placement for adoption.

Dollar Bank Credits

Where you have more Dollar Credits than are necessary to establish or maintain eligibility, the excess Dollar Credits are placed in your Dollar Bank on your behalf. Then, when you do not have enough Credits from *employer* contributions to maintain eligibility, any Credits in your Dollar Bank can be used. However, these credits don't vest. The Trustees may reduce or otherwise adjust the number of Credits in *Covered Person's* Dollar Banks from time to time based on medical inflation and other factors so that the *Plan* can remain financially healthy. You will lose any credit in the Dollar Bank upon the earlier of the following:

- When you cease to be available for covered work; or

- You do not have enough Credits to maintain your eligibility and you fail to make the timely self-payments needed to maintain that eligibility; or

- The Trustees' cancellation of Dollar Credits.

Continuing Your Eligibility

After you have become eligible, Dollar Bank Credits will be used to continue that eligibility. You will remain eligible if you receive $570 Dollar Bank Credits (and such other amount as the Trustees decide from time to time) for each month:

Contribution Month for Work Done In	Dollar Bank Credits	Eligibility Month
January	$570	April
February	$570	May
March	$570	June
April	$570	July
May	$570	August
June	$570	September
July	$570	October
August	$570	November
September	$570	December
October	$570	January
November	$570	February
December	$570	March

If you do not have enough Dollar Credits in a Contribution Month, you will lose coverage unless you:

- Have enough Credits available for withdrawal from your Dollar Bank; or
- Make timely self-payments to obtain the needed Credits for the Contribution Month.

You can combine self-payments with your Dollar Bank Credits to maintain eligibility.

Self-Payments

Partial self-payments can be made when you do not have enough Credits in your Bank to maintain your eligibility. The amount is determined by subtracting your Credits from the amount of Credits you need in the Eligibility Month to maintain your eligibility. If you remain available for work and continue any self-payments each month needed to maintain your eligibility, the self-payment amount will be reduced by 20 percent. In addition to the 20% discount granted to active members when having to self pay such person's premium, apprentices will be afforded an additional discount according to the following table:

Year 1	50% discount
Year 2	40% discount
Year 3	30% discount
Year 4	20% discount

Anytime after the 4th year there are no additional discounts; but the *Plan* will not impose any limit on the number of months you can make partial self-payments.

Full self-payments may be made when you have no Dollar Bank Credits to maintain your eligibility. For the first month of full self-payments and the next five months of full self-payments,

the self-payment amount will continue to be reduced by 20 percent so long as you continue your self-payments each month and remain available for work.

After six months of self-payments:

- Any Dollar Bank Credits you earn will be applied towards reestablishment of Initial Eligibility only; and

- Any further payments must be the applicable premium for COBRA continuation coverage.

After six (6) consecutive months of full self-payment, any self-payments will count toward the maximum period of any COBRA coverage.

Self-payments must be made by the deadline set by the Trustees. If payments are not received by the deadline, no further self-payments are permitted.

If You Cannot Work Because You Are Temporarily Disabled

If you are temporarily disabled and cannot work, you are given credit for hours worked for up to $142.50 Dollar Bank Credits per week beginning June 1, 2007 (maximum $570 Credits per Contribution Month beginning June 1, 2007) to help maintain eligibility for benefits. This credit is given if you:

- Are receiving Loss of Time Benefits from this Fund, or entitled to benefits under any Workers' Compensation or *occupational disease* law; and

- Are seen by a physician on a regular basis who so states you are disabled; and

- Make written application to the Fund Office within 4 months after the disability starts.

Eligibility credit is given the first day for an injury and beginning the eighth day for an illness. You receive credit until you are no longer receiving Weekly Disability Benefits or until you have received 26 weeks' credit, whichever comes first. The *Plan* may require that you be examined by the *Plan*'s physicians from time to time.

Reciprocity Credits

From time to time and upon request, the *Plan* enters into reciprocity agreements with other health and welfare funds, which allow for contributions to be sent back to this Fund. If you choose to work temporarily outside the jurisdiction of the Fund for an *employer* who is not required to make contributions to this Fund for such work, it is your obligation to contact the Fund Office immediately to find out if there is a reciprocity agreement with the fund in whose jurisdiction you will be working. You must complete reciprocity forms promptly as reciprocity payments will not be made retroactively. Reciprocity payments will be credited only after the Fund Office receives them. Until payments have been forwarded to this Fund, you will need to make timely self-payments to continue your eligibility.

Delinquent Employer Contributions

If you work for a signatory Employer who becomes delinquent in making contributions to the *Plan*, you may be entitled to certain credit toward eligibility for your work in *covered employment*. The *employer* must not be new but, rather, must have a contribution history with the *Plan*. Further, such *Employer* must not have been delinquent when you became employed with such *Employer*, and you must have cleared employment with the Ohio and Vicinity Regional Council of Carpenters. You must furnish the Fund Office with proof of hours worked. If these requirements are met, the *Plan* will advance Dollar Bank Credits for up to a maximum of two consecutive Eligibility Months while you are with any one delinquent *Employer*. Dollar Bank Credits will not be advanced for *Employer* contributions to be collected by and/or reciprocated from other employee welfare benefit *Plan*s.

Participation by Bargaining Unit Alumni

The general rule is that only carpenters and millwrights may participate in the *Plan*. They must be bargaining unit members working under collective bargaining or other written agreements between the Ohio & Vicinity Regional Council of Carpenters and *Employers* participating in the *Plan*.

An exception to the general rule limiting participation to bargaining unit employees is for employees who have been transferred or promoted out the bargaining unit (alumni). Where the *Employer* enters into a special participation agreement that is approved by the *Plan*'s Trustees, agreeing to coverage of all of its alumni, it is possible for alumni to remain covered under the *Plan*. Contributions of 160 hours times the current contribution rate are required monthly for each alumnus.

A number of other requirements must be met before an alumnus will be permitted to have coverage under the Welfare *Plan*. These are set forth in a Promulgation of Rules, entitled "Eligibility for Participation by Non-bargaining Unit Employees (Alumni Rule)." Please contact the Fund Office for a copy of these Rules.

NOTE: Only common-law employees may participate in the *Plan*. Self-employed persons cannot participate in the *Plan* under applicable law. That means that partners and sole proprietors cannot participate in the *Plan*.

Family and Medical Leave Act Credits

There is a Federal law that requires some *employers* to continue making contributions to the Welfare Fund for certain employees who take leave for certain family or medical purposes. Because this is a requirement placed on the *Employer*, it is the *Employer's* obligation to provide you with information on the law's details. If you have any questions about this law please request information from your *employer*.

If You Are Called to Active Military Duty

To protect your rights, you must notify the Fund Office before you leave the *Plan*'s jurisdiction for military service.

If your military service is for 30 or fewer days, you and your family can continue coverage under the *Plan* at the same cost as before your short service. For example, if you are in the middle of

a benefit period, your coverage is not affected. Likewise, if a self-payment is owed to continue coverage, that self-payment would still be owed.

If your reduced hours from active duty of more than 30 days will result in your becoming ineligible under the *Plan*, you can continue your coverage under the *Plan* for you and your *dependent*s by making payments in the amount required for COBRA continuation coverage. Continuation coverage is available for up to 24 months.

If you are on active duty for more than 30 days, you and your *dependent*s generally should be covered by military health care. For more information on these programs contact your military unit. If you determine military coverage is satisfactory, your status in this *Plan* (including any Dollar Bank) will be "frozen."

You and your family may have the right to enroll in other group health plan coverage if it is available to you (for example, if your *spouse*'s *employer* sponsors a group health plan special enrollment rights may be available under the Health Insurance Portability and Accountability Act). If you use other coverage or otherwise notify the Fund Office of your desire to preserve your Dollar Bank, your status in this *Plan* (including any hour bank) will be "frozen."

If you choose to let your coverage in this *Plan* lapse while you are on active duty, but return to work for a participating *employer* directly after your discharge, as described below, your health coverage will be reinstated to the same status as before you began your military service. Any Dollar Bank you had before your military service will be re-activated. Further, no preexisting condition provision will apply.

Deadline for Applying for Work with a Participating Employer

If the period of service in the uniformed services:	**Applicable deadline:**
Lasted less than 31 days	By the beginning of the next regular scheduled work period on a day following completion of the uniformed service, and at least eight hours after the period needed for the participant to return home from the place of that uniformed service
Consisted solely of a physical or medical examination to verify fitness	By the beginning of the next regular work period
Lasted more than 30 days but less than 181 days	Within 14 days after completion of service in the uniformed services
Lasted for 180 days or more	Within 90 days after completion of the period of service in the uniformed services
Ends while the participant is hospitalized or convalescing from an injury or illness incurred in the uniformed service	After the participant has recovered, but not more than two years after the injury or illness.

You must then notify the Fund Office in writing no later than 120 days after this deadline for applying for work with a contributing *employer*. The Fund Office has the right to request you to provide written documentation regarding your service in the uniformed services.

For purposes of federal law, your military service may be with the Armed Forces of the United States, the Army National Guard or the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the Commissioned Corps of the Public Health Service and any other category designated by the President in time of war or *emergency*. "Service" means the performance of duty on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard Duty, and a period for which you are absent from employment for a physical examination to determine your ability to perform service in the uniformed services.

Termination of Coverage

Coverage for you and your *dependent*s will terminate on the earliest of the following dates:

- The last day of the Eligibility Month if you have insufficient Dollar Bank Credits, and fail to make timely self-payments; or
- When you begin active duty in the military, as explained above; or
- The last day of the Eligibility Month in which you die (although your *Dependent*s may use any Dollar Bank Credits you have); or
- The date you become employed by a non-participating *Employer* in this geographic jurisdiction in the Union's covered trade or craft (including supervision); or
- The Effective Date of your Withdrawal from the *Plan*; or
- The date specified by the *Plan* that a *Covered Person*'s coverage will terminate because the *Covered Person* permitted the use of his or her identification card by any unauthorized Person or used another Person's card; or
- The date the *Plan* terminates.

Dependent coverage may also terminate for your *dependent* if that class of coverage is terminated or on the date that your *dependent*:

- Ceases to meet the *Plan*'s definition of *Dependent*; or
- Becomes an *Eligible Employee* under the *Plan*; or
- Begins active military service.

Continuing Your Coverage Under the *Plan*

Even if you are not actively working for an *Employer* participating in this *Plan*, it may be possible for you to continue your *Plan* eligibility. For example, can you maintain eligibility based on:

- A balance in your Dollar Bank? See pages 5 - 7.
- By making self-payments to continue your eligibility? See pages 6 - 7.

- An election of COBRA continuation coverage? See pages 12 – 14.

- Disability credits towards maintenance of eligibility because you have been unable to work? See page 7.

- Family and Medical Leave Act credits? See page 8.

- Enrollment in one of the *Plan*'s programs for retirees, widows or disabled persons? See pages 14 – 18.

Consult this booklet promptly so that you don't miss any deadlines.

Important Notice for Employees and Spouses Age 65 and Over

Federal law may affect *your* coverage under this Plan. The *Medicare* as Secondary Payer rules were enacted by an amendment to the Social Security Act. Also, additional rules which specifically affect how a large group health plan provides coverage to employees (or their *spouses*) over age 65 were added to the Social Security Act and to the Internal Revenue Code.

Persons who have "current employment status" with an employer are generally employees who are actively working and also persons who are NOT actively working as follows:

- Individuals receiving disability benefits from an employer for up to 6 months, or

- Individuals who retain employment right and have not been terminated by the employer and for whom the employer continues to provide coverage under this Plan. (For example, employees who are on an approved leave of absence.)

If you are a person having "current employment status" who is age 65 and over (or the *dependent spouse* age 65 and over of an *employee* of any age), *your* coverage under this Plan will be provided on the same terms and conditions as are applicable to *employees* (or *dependent spouses*) who are under the age of 65. *Your* rights under this Plan do not change because you (or your *dependent spouse*) are eligible for *Medicare* coverage on the basis of age, as long as you have "current employment status" with a participating employer in this Plan and are not a retiree with insufficient hours to qualify as an *eligible employee* under the active program.

If you (or your *dependent spouse*) obtain *Medicare* coverage on the basis of age, and not due to disability or end-stage renal disease, this Plan will consider its coverage to be primary to *Medicare when* you *have* "current employment status."

If you or your *spouse* is eligible to obtain Medicare coverage and you do not have current employment status, the Plan will process your claims as if Medicare had paid on a primary basis. **Accordingly, it is important for you to enroll in Medicare Parts A and B as soon as you are eligible.**

If *you* have any questions about how coverage under this Plan relates to *Medicare* coverage, please contact the Third Party Administrator.

Continuation of Comprehensive Medical Expense Benefits and Prescription Drug Benefits Coverage Under Federal Law

A *Covered Person* should contact the *Third Party Administrator* to determine if they are eligible to continue the Comprehensive Medical Expense Benefits and Prescription Drug Benefits Coverage under federal law.

A *Covered Person* whose Comprehensive Medical Expense Benefits and Prescription Drug Benefits Coverage would otherwise end under the *Plan* may be entitled to elect continuation coverage in accordance with federal law and as outlined below. For the purpose of continuation coverage under COBRA, a newborn child or a child placed for adoption with the *Covered Person* during the period of continuation coverage shall be considered on the same basis as a *Covered Person*.

Qualifying Events for Continuation Coverage

If the *Covered Person*'s Comprehensive Medical Expense Benefit and Prescription Drug Benefits Coverage terminates due to a Qualifying Event, they are entitled to continue coverage. Qualifying Events are defined as follows:

A. The *Eligible Employee*'s termination from employment, or reduction of hours, for any reason other than gross misconduct; or

B. Death of the Covered Person; or

C. Divorce or legal separation of the *Covered Person*; or

D. Loss of eligibility by an Enrolled *Dependent* who is a child; or

E. Entitlement of the Covered Person to *Medicare* benefits.

The *Covered Person* may elect the same medical and drug coverage that they had at the time of the qualifying event.

Notification Requirements and Election Period for Continuation Coverage

The *Covered Person* must notify the *Third Party Administrator* within 60 days of such person's divorce, legal separation, or loss of eligibility as an Enrolled *Dependent*. A *Covered Person* who is continuing coverage under Federal Law must notify the *Third Party Administrator* within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the *Covered Person*'s Qualifying Event occurs; or 60 days after the *Covered Person* receives "Notice of Continuation Rights" from the *Third Party Administrator*.

A *Covered Person* whose Coverage was terminated due to a Qualifying Event must pay the initial premium due to the *Third Party Administrator* on or before the 45th day after electing continuation.

Terminating Events for Continuation Coverage

Continuation under the *Plan* will end on the earliest of the following dates:

A. Eighteen (18) months from the date continuation began for a *Covered Person* whose coverage ended because employment was terminated or hours were reduced, in accordance with Qualifying Event described in Section A above. A *Covered Person* who is disabled at the time of the Qualifying Event, or within the first 60 days of continuation coverage, may extend continuation coverage to a maximum of 29 months as described below.

B. A Covered Person who is disabled at the date of Qualifying Event, or within the first 60 days of continuation coverage, must provide notice of such disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend coverage beyond 18 months. If such notice is provided, the *Covered Person's* coverage may be extended up to a maximum of 29 months from the date of a Qualifying Event or until the first month that begins more than 30 days after the date of any final determination that the qualified *beneficiary* is no longer disabled. Each *Covered Person* must provide notice of any final determination.

C. Thirty-six (36) months from the date continuation began for an Enrolled *Dependent* whose coverage ended because of the death of the *Covered Person*, divorce or legal separation of the *Covered Person*, loss of eligibility by an Enrolled *Dependent* who is a child, or entitlement of the *Covered Person* to *Medicare* benefits, in accordance with Qualifying Events B, C, D, or E described above.

D. The date coverage terminates under the *Plan* for failure to make timely payment of the premium.

E. The date coverage is obtained under any other group health plan (unless you already had the other group coverage before you elected continuation coverage under this *Plan*). If such coverage contains a limitation or exclusion with respect to any pre-existing condition of the *Covered Person*, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services, which are subject to the pre-existing condition limitation or exclusion.

F. The date the *Covered Person* becomes entitled to *Medicare*.

G. The date the entire *Plan* is terminated.

H. The date coverage would otherwise terminate under the *Plan*.

If a *Covered Person* is entitled to 18 months of continuation and a second qualifying event occurs during that time, the *Covered Person*'s coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were

reduced, in accordance with Qualifying Event A described above. Terminating events B through G described above shall apply during the extended continuation period.

Continuation Coverage for Enrolled *Dependent*s of a *Covered Person* whose continuation Coverage terminates because such person becomes entitled to *Medicare* may be extended for an additional period of time. Such *Covered Person*s should contact the *Third Party Administrator* for information regarding the continuation period.

Should you have any questions about continuation coverage, please contact the *Third Party Administrator's Eligibility Administrator*.

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 new 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.

Withdrawals – Effect on Coverage

Employees who remain with an *Employer* or Union who withdraws from *Plan* participation and employees who cease to be available for *Covered Employment* are treated as having withdrawn from *Plan* participation; coverage will not extend beyond the Effective Date of Withdrawal.

Certificate of Creditable Coverage Available After You Lose Coverage Under This Welfare *Plan*

When you become covered under a new medical plan or another welfare plan or insurance policy that contains a pre-existing conditions provision, the exclusion period is reduced by your "*creditable coverage*." If you request (or authorize others to request) certification from this *Plan* within 24 months of the date your coverage terminated, the *Plan* will provide you with a certificate documenting the period of time you were covered by this *Plan*. If there is no more than a 63-day break in coverage, the time you were covered by this *Plan* may reduce the preexisting conditions period under the new *Plan*.

Eligibility for Early and Normal Retirees and Dependents

An Early or Normal Retiree is able to continue such person's eligibility through self-payments if:

- They are eligible to receive benefits from a multiemployer Pension Plan whose Union Sponsor is an affiliate of the United Brotherhood of Carpenters and Joiners of America;

- They have had at least 12 months' eligible participation in this Welfare *Plan* out of the 18 months immediately before retirement; and

- They have been eligible in this Welfare *Plan* for at least 5 years as an active employee; and

- They are at least 55 years of age (or at least 50 years of age and actually receiving retiree benefits from a multiemployer Pension Plan whose Union Sponsor is an affiliate of the United Brotherhood of Carpenters and Joiners of America); and

- They notify the Fund Office in writing, before the effective date of retirement, that they want to maintain eligibility under the retiree coverage classes; and

- They are retired from active employment in the trade; and

- They are eligible in this Welfare Fund the month immediately before the effective date of such person's retirement.

The retiree will be notified by the Fund office of the self-payment amount due. Self-payments must be made from the date coverage was lost. They must be made before the first of the month for which the coverage applies. If a self-payment is not made on time, coverage is lost and it cannot be reinstated. Any remaining Dollar Bank Credits may be applied towards self-payments at the applicable retiree rate for self-payments. Enrolled retirees may also apply any Dollar Bank Credits towards Medical Expense Reimbursements. Retiree self-payment rates may vary by retiree category, including years of service and whether the retiree remains a member of the common working unit (including keeping active Union membership).

*Eligible Retiree*s can elect COBRA continuation coverage or retiree coverage under this *Plan*, but not both. A retiree electing COBRA continuation coverage under this *Plan* cannot thereafter elect the Retiree Program when his continuation coverage expires.

The Comprehensive Medical Expense Benefits and Prescription Drug Benefits Coverage available to *Eligible Retirees* is the same as that available to *Eligible Employees* until the Retired Employee becomes eligible for *Medicare*. Coverage for *Medicare*-eligible Retired Employees is coordinated with *Medicare*.

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 such person's 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.

Should you fail to continue your coverage and make timely self-payments, your coverage is forever waived. You cannot re-enroll. After you have ceased to be an Active Employee late enrollment will be permitted in the Retiree programs only, as follows:

- You notified the Fund Office before the effective date of retirement that you were waiving coverage under the Retiree program because you had other coverage (for example, through a *spouse*), and you later lost other coverage (other than because of a failure to make self-payments); or

- Other "Special Enrollment" rules (at pages 4 to 5) apply.

You must request enrollment within 60 days of any of the above changes in family coverage.

Retirees Returning to Work

If you are retired, any further coverage under this *Plan* must be under the *Plan*'s programs for Early, Normal or Disabled Retirees. You will remain in these programs even if you return to active employment. Self-payments must be made at retiree rates. Any *employer* contributions made on your behalf will be offset against your retiree self-payments.

When you become eligible for *Medicare* because of attained age, the *Plan* generally will continue to offset *employer* contributions against retiree self-payments. However, should you receive sufficient *employer* contributions to establish initial eligibility as an active employee, you will be treated as an active employee. The *Plan* will become primary payor for your claims, and *Medicare* will be the secondary payor. When *employer* contributions and dollar bank credits become inadequate for maintenance of your eligibility, you should be re-enrolled automatically in the retiree program and *Medicare* again will become your primary payor.

Disabled Retirees

If you are Totally and Permanently Disabled, you are able to continue eligibility under the retiree program through timely self-payments if:

- You notify the Fund Office, in writing, before the effective date of retirement or loss of coverage that you want to maintain your eligibility under the retiree coverage classes; and

- You must be eligible in this Welfare Fund the month before the effective date of your retirement; and

- Your disability prevents you from working at any job for which you would receive compensation; and

- You are eligible to receive a benefit from a multiemployer Pension *Plan* whose Union Sponsor is an affiliate of the United Brotherhood of Carpenters and Joiners of America. However:

    - If an individual is Totally and Permanently Disabled but has not been approved by a multiemployer Pension Plan whose Union Sponsor is an affiliate of the United Brotherhood of Carpenters and Joiners of America, they can continue eligibility under the retiree coverage class with approval of the Trustees. The individual must notify the Fund Office, in writing, before they lose coverage as an active employee that they want to maintain their eligibility under the retiree coverage classes and provide proof of the disability.

    - The individual must provide proof satisfactory to the Board of Trustees that such individual made timely application for a Social Security disability benefit and is actively pursuing the disability benefit. The individual must also provide a physician's statement satisfactory to the Board of Trustees of Total and Permanently Disability; and

- You must have been eligible in this Welfare Fund for at least six years out of the preceding ten years prior to the date of the disability, excluding months of COBRA continuation coverage but including months of self-payment continuation coverage; and

- You must have been eligible in this Welfare Fund for at least twelve months out of the eighteen months immediately before retirement, excluding months of COBRA continuation coverage, but including months of self-payment continuation coverage.

At the expiration of coverage under this section, you may enroll in Early or Normal Retirement benefits (see above) if you are eligible. However, you must do so on a timely basis and there must not have been a break in your eligibility or required self-payments.

The Employee must notify the Fund office that he wants to maintain his eligibility through self-payments. Any remaining Dollar Bank Credits may be applied towards self-payments at the applicable retiree rate for self-payments. Payments must be made before the first day of each month for which the coverage applies. If the employee fails to make a timely self-payment, the employee loses eligibility and it cannot be reinstated. Self-payments must be made from the date coverage was lost, and count toward the required duration of any COBRA continuation coverage.

You should enroll in Medicare Parts A and B as soon as you become eligible. Coverages will be coordinated with coverage available from Medicare, regardless of whether you have actually enrolled in Medicare.

Coverage will terminate if your self-payments are late or your disability ends and you are able to return to active employment.

The coverage available to the disabled Retiree is set forth in the Schedule of Benefits.

Disabled Employee 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 the Employee becomes disabled. The Trustees may expand, reduce or cancel coverage for Disabled Employees, 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 Disabled Employee or any other person.

Coverage for Surviving Spouse of Deceased Eligible Retiree

A surviving *spouse* of a deceased *Eligible Retiree* can maintain the Comprehensive Medical Expense Benefits and Prescription Drug Benefits Coverage by making self-payments if:

- Such *spouse* was eligible under the *Plan* at the time of the *Covered Person's* death; and

- The deceased Covered Person was a participant in this Retiree Program at the time of such Person's death.

The surviving *spouse* must notify the Fund Office that the *spouse* desires to maintain eligibility through self-payments within three months of the last month in which the *spouse* was covered under the *Plan* as a *dependent* of the deceased *Covered Person*. The surviving *spouse* will be notified by the Fund Office of the amount due. Self-payments must be made from the date

coverage was lost, and must be made before the first of each month for which coverage applies. If the surviving *spouse* fails to make timely self-payments, the surviving *spouse* will automatically lose coverage and it cannot be reinstated. Any remaining Dollar Bank Credits may be applied towards self-payments at the applicable retiree rate for self-payments. The period of full self-payments shall count toward the required duration of any COBRA coverage. The coverage available to surviving *spouse*s is set forth in the Schedule of Benefits.

Surviving *spouse* and the *Covered Person's* other *dependent*s currently are able to continue eligibility by self-payments until the earlier of the following dates:

- The date they no longer meet the definition of a *Dependent*; or
- The date they become covered by another group *Plan*; or
- The date the surviving *spouse* remarries; or
- The date the surviving *spouse* dies.

Benefits for surviving *spouse*s of deceased eligible participants 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 the employee's death. The Trustees may expand, reduce or cancel coverage for such widows, 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 widow or any other person.

Options If No Further Coverage Is Available Under the *Plan*

If you are losing coverage options under the *Plan*, 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*) and/or;
- Enrolling in a health maintenance organization or HMO (health insuring corporation); and/or
- Purchasing a "HIPAA policy" if you are a "federally eligible individual"; and/or
- Enrolling in *Medicare* based on your age, a Total and Permanent Disability or end-stage renal disease; and/or
- Purchasing Supplementary *Medicare* Coverage.

You may lose valuable legal rights if you delay consideration.

Information Regarding Eligibility

Any questions regarding eligibility should be directed to the *Third Party Administrator*, Compensation Programs of Ohio, 33 Fitch Blvd., Austintown, Ohio 44515, (800) 435-2388.

DEATH BENEFITS
(For Eligible Employees and Eligible Retirees Only)

If you should die while covered under this *Plan*, the *Plan* will pay to the person you have named as *beneficiary* the amount of the Death Benefit specified in the Schedule of Benefits. A Statement of Claim Form, including proof of death, must be filed with the *Third Party Administrator* in order to receive the Death Benefit.

If there is no Designation of Beneficiary Form on file with the *Third Party Administrator* at the time of your death, or if the *beneficiary* you have named is no longer living, the Death Benefit will be paid:

- To your surviving *spouse*; if none, then
- To your surviving natural and/or adopted *children*; if none, then
- To your surviving parent(s); if none, then
- To your estate.

Death Benefits available to active employees will reduce at retirement to $1,000 as indicated in the Schedule of Benefits. Retiring employees will have a one-time opportunity to purchase additional Death Benefits in the amount of $4,000. The cost of this coverage must be self-paid by the Retired Employee. Please refer to the rules of self-payment on pages 6 - 7 for information and rules for self-payments.

Retiring employees must elect the additional $4,000 of Death Benefit coverage not later than 31 days from such person's official retirement date. Elections for the additional Death Benefits must be in writing and should be directed to the *Third Party Administrator*. If the additional coverage is not elected during the 31-day period, the additional Death Benefit option will expire and will not be available again to the Retiree.

Note: Employees who retired before the January 1, 1999 merger of the Cincinnati and Dayton Health and Welfare Funds will continue to be covered by the respective Life Insurance Benefit *Plan* that was in place at the time of retirement. Contact the *Third Party Administrator* if you require additional information regarding your retired Life Insurance Benefits.

Beneficiary Designations

In order to name a *beneficiary*, you must complete a Designation of Beneficiary Form and return it to the *Third Party Administrator.* You may change your *Beneficiary* at any time, and as often as you desire, by completing a Change of Beneficiary Form. Change of Beneficiary Forms may be obtained from the *TPA* or any Local Union office. Any designation or change of *beneficiary* will become effective when the completed form is received by the *TPA*; however, no change will be effective if the form is received after the date of death.

Where the *Plan* has accepted in writing a qualified domestic relations order (QDRO) providing for a *beneficiary* different from the *beneficiary* shown in an initial or changed Designation of Beneficiary form, the QDRO will be followed and the instructions in the Designation of Beneficiary form will be deemed void.

Exclusions

Death Benefits are payable for death by any cause other than

- Any loss resulting from the *Covered Person's* participating in a riot or in the commission of a felony; or

- Any loss which results from an act of declared or undeclared war or armed aggression or terrorist activity. (However, the *Plan* will cover loss which is incurred while the *Covered Person* is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country, and for which any government body or its agencies are liable.)

WEEKLY DISABILITY BENEFITS
(*Eligible Employee*s Only)

Weekly Disability Benefits are weekly payments which you will receive from the *Plan* if you are unable to work because you are Disabled due to a Non-*Occupational Injury* or *Illness*. The amount and duration of benefits payable is outlined in the Schedule of Benefits.

To be eligible for these benefits, you must be Disabled and under the continuous care of a Physician. Weekly Disability Benefits will be paid to you as of the first day of a Disability due to an Accident or Injury, or the eighth day of a Disability due to illness or sickness. To receive these benefits you must provide documentation confirming your Disability and treatment from your Physician. No Disabilities, including those resulting from accidents, will be considered as beginning more than three days before you first receive treatment by a Physician.

Benefits will continue to be paid during the time you are certified by a Physician as Disabled, up to the maximum number of weeks allowed for any one continuous period of Disability. Unless successive periods of Disability are separated by at least 14 days of continuous employment, they will be considered one continuous period for purposes of determining the maximum weeks during which the benefit is payable. However, if you have a second period of Disability which is less than two weeks after a prior period of Disability, but the Disability *is not related to the prior* accident/injury or sickness/illness, and if you have completed at least one day of active work between the two periods, then the second period will be a new period for purposes of determining the maximum number of weeks during which the benefit is payable.

Benefit Payments

You do not have to wait until you return to work to file for your Weekly Disability Benefits. You need only complete a claim form and have your Physician indicate the diagnosis, dates of Disability, and the date the Physician was first consulted for the Disability. Employment status must be confirmed. Following receipt of this information by the *Third Party Administrator*, you will receive a Weekly Disability Benefit payment for a period of time determined by the *TPA*. The payment will be in accordance with your Disability and the information submitted by your Physician on the claim form.

The *Plan* will request proof of Continued Disability. If you are still Disabled, and desire to continue receiving Weekly Disability Benefits, you must complete the form. This will include a statement from your Physician confirming that you are still Disabled and receiving treatment for the Disability. Additional benefits will then be determined by the *TPA*. If you are entitled to additional Weekly Disability Benefits you will receive another benefit payment. You will be required to continue submitting proof of disability for review by the *TPA* in order to continue receiving benefits under the Weekly Disability Benefits Plan. This process is repeated until you are able to return to work or have received the *maximum benefits* payable for that period of disability.

Exclusions and Limitations for the Weekly Disability Benefits *Plan*

Weekly Disability Benefits are not payable for any Disability resulting from:

- Any period of Disability during which you are not under the regular care of a Physician; or

- Any Disability due to illness or sickness covered by a Workers' Compensation Act or similar legislation, or due to accident or injury arising out of or in the course of *any* employment for wage or profit; or

- Any period during which your continued eligibility is based only on Dollar Bank Credits or self-payments (unless you are available for work and otherwise eligible); or

- Any day for which you work for compensation or profit or for which you continue to receive compensation through an *Employer*, including unemployment benefits.

MEDICAL EXPENSE REIMBURSEMENT
(For *Eligible Employee*s Only)

When you have Dollar Bank Credits in excess of three months' eligibility, those Credits may be used to reimburse you for certain medical expenses. The *Plan* can reimburse you directly, or, if you prefer, benefits may be assigned directly to providers. When the *Plan* makes payment, your Dollar Bank is reduced by the amount of the Credits. The deadline for filing reimbursement for Medical Reimbursement claims is the December 31 following the end of the *Plan* Year in which you incurred the claim expense(s).

Expenses Eligible for Reimbursement

Unless listed in the exclusions and limitations below, the following unpaid medical expenses are eligible for reimbursement:

- *Hospital*, physician, surgeon, dentist, optometrist or other health care provider bills;
- Deductibles and *Copayments*;
- Services of a registered nurse;
- Ambulance service;
- Dental expenses;
- Prescription drugs and medicines;
- Diagnostic or laboratory fees;
- Corrective eyeglasses; and
- Other medical expenses identified in Internal Revenue Code Section 213, unless also listed as an Exclusion below.

Exclusions and Limitations

The following expenses are not eligible for reimbursement:

- Medical services in a U.S. Government *Hospital*;
- Medical services provided at no cost through any public program;
- Medical expenses for which reimbursement is available under any other Medical/Prescription Drug Benefits portion of this *Plan* or any other program which provides coverage for such medical expenses; or
- Any medical expenses related to *cosmetic surgery*.
- Expenses for which the Employee claimed or will claim a medical expense deduction on the Employee's tax returns;

- Expenses incurred before the Employee became Initially Eligible for medical benefits under this *Plan*;

- Expenses incurred after termination of employment or eligibility;

- Expenses for general health (even if following doctor's advice) such as –

    - Health Club dues;

    - Household help (even if recommended by a doctor);

    - Social activities such as dancing or swimming lessons;

    - Trips for general health improvement; or

    - Weight loss programs.

Reimbursement of Over-the-Counter Drugs

Certain over-the-counter drugs can be reimbursed from any balance available in your Dollar Bank in excess of three months' eligibility. Over-the-counter medications are excluded, however, from your Comprehensive Medical Benefits and Prescription Drug Programs.

When Reimbursement is Available

Reimbursement is available only for a *reasonable quantity* of products used for *medical care*. Reimbursement is *disallowed* for expenses:

- for *general health* (for example, vitamins or herbal supplements);

- of a *cosmetic* nature (for example, teeth whitening products);

- for *toiletries* (for example, deodorant); or

- incurred before you became eligible.

When a product is *dual purpose* (that is, it could have both a medical purpose and purpose which would be disallowed (for example, cosmetic)), you must obtain a medical practitioner's signed note.

A list of *allowed*, *disallowed*, and *dual-purpose* products is set forth below.

How to Obtain Reimbursement

1. Complete a Medical Reimbursement Account Form.

    AND

2. Attach a *receipt* which shows *all* of the following:

    a. Your name, and

b. Name of store where purchased, and

c. Full name of product, and

d. Purchase price, and

e. Date purchased.

You must circle or underline each eligible expense. You cannot hand-write the name of the item on the receipt. However, if an item is abbreviated, you must write the full name of the eligible expense on the receipt. For example, “Neo ms oint” would be written as “Neosporin Maximum Strength.”

AND

3. If the item is *dual purpose*, you must also submit a note signed by a medical practitioner stating: “I am recommending [name of product] for [your name or your dependent] to treat a specific medical condition which is not cosmetic.”

AND

4. Submit the Reimbursement Form and receipt to the Fund Office (with a medical practitioner’s statement for dual-purpose products).

COMPREHENSIVE MEDICAL BENEFITS
(Eligible Employees, Eligible Retirees and Eligible Dependents)

Utilization/Case Management

Utilization management and *case management* are designed to assist *covered persons* in making informed medical care decisions resulting in the delivery of appropriate levels of *Plan* benefits for each proposed course of treatment. These decisions are based on the medical information provided by the patient and the patient's physician. The patient and his or her physician determine the course of treatment. The assistance provided through these services does not constitute the practice of medicine. Payment of *Plan* benefits is not determined through these processes.

Precertification

Utilization review includes *precertification* and *concurrent review*.

This provision will not provide benefits to cover a *confinement* or *service* which is not *medically necessary* or otherwise would not be covered under the *Plan*. *Precertification* is not a guarantee of coverage.

If *you* or *your* covered *dependent* are to receive a *service* which requires *precertification*, *you* or *your qualified practitioner* must contact the *Plan Manager* or CorpHealth by telephone or in writing. Refer to the Schedule of Benefits for time requirements.

After *you* or *your qualified practitioner* have provided the *Plan Manager* or CorpHealth with *your* diagnosis and treatment *Plan*, the *Plan Manager* or CorpHealth will:

1. Advise *you* in writing if the proposed treatment *Plan* is *medically necessary*;

2. Advise *you* in writing the number of days the *confinement* is initially *precertified*; and

3. Conduct *concurrent review* as necessary.

If *your qualified practitioner* extends *your confinement* beyond the number of days initially *precertified*, the extension must be *precertified* through *concurrent review*.

If it is determined at any time *your* proposed treatment *Plan*, either partially or totally, is not a *covered expense* under the terms and provisions of the *Plan*, benefits for *services* may be reduced or *services* may not be covered.

Penalty For Not Obtaining Precertification

If *you* do not obtain *precertification* for *services* being rendered, *your* benefits for both *qualified practitioner* and *hospital* or *qualified treatment facility* may be reduced. Refer to the Schedule of Benefits for the applicable penalty.

Second Surgical Opinion

A second surgical opinion may be required, as provided in the *Plan*, before the *confinement* will be *precertified*. Benefits for the second surgical opinion, including any *medically necessary* x-ray and laboratory tests performed by the second *qualified practitioner*, are payable as shown in the schedule of benefits.

If the two opinions disagree, *you* may obtain a third opinion. Benefits for the third opinion are payable the same as for the second opinion.

The *qualified practitioners* providing the surgical opinions MUST NOT be in the same group practice or clinic. The *qualified practitioner* providing the second or third surgical opinion may confirm the need for *surgery* or present other treatment options. The decision whether or not to have the *surgery* is always *yours*.

Disease Management

Certain Disease Management Programs may be available to *you* and any eligible *dependents* covered by this *Plan*. These Disease Management Programs will be provided at no cost to *you* or *your qualified practitioner*. Please contact the Third Party Administrator to determine the availability of programs.

Predetermination of Medical Benefits

You or *your qualified practitioner* may submit a written request for a *predetermination of benefits*. The written request should contain the treatment Plan, specific diagnostic and procedure *codes*, as well as the expected charges. The *Plan Manager* will provide a written response advising if the *services* are a *covered* or non-*covered expense* under the *Plan*, what the applicable *Plan* benefits are and if the expected charges are within the *maximum allowable fee*. The *predetermination of benefits* is not a guarantee of benefits. *Services* will be subject to all terms and provisions of the *Plan* applicable at the time treatment is provided.

If treatment is to commence more than 90 days after the date treatment is authorized, the *Plan Manager* will require *you* to submit another treatment plan.

MEDICAL DEDUCTIBLE AND COINSURANCE INFORMATION

Covered expenses are payable, after satisfaction of the deductible, to a *maximum allowable fee* at the coinsurance percentages and up to the *maximum benefits* shown on the Schedule of Benefits.

Deductible

The deductible applies to each *covered person* each *calendar year*. Only charges which qualify as a *covered expense* may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits. Any *covered expense* incurred during the last three months of the *calendar year* that is used to satisfy all or part of the deductible for that year, will be used to satisfy all or part of the deductible for the following *calendar year*.

Maximum Family Deductible

The total deductible applied to all *covered persons* in one family in a *calendar year* is subject to the maximum shown on the Schedule of Benefits.

Coinsurance

The term coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and the self-insured *Plan*.

Covered expenses are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each *calendar year*.

Out-of-Pocket Limit

When the amount of combined *covered expenses* paid by *you* and/or all *your* covered *dependents* satisfy the separate PAR and Non-PAR provider deductible and out-of-pocket limits as shown on the Schedule of Benefits, the *Plan* will pay 100% of *covered expenses* for the remainder of the *calendar year*, unless specifically indicated, subject to any *calendar year* maximums and the lifetime maximum of the *Plan*.

If *you* and *your* covered *dependents* use a combination of PAR and Non-PAR providers, the out-of-pocket amounts will track separately, however the combined out-of-pocket will not exceed the Non-PAR provider out-of-pocket limit. Office visit *copayments* are not applied to the out-of-pocket limit.

Covered expenses are subject to any *calendar year* maximums or the lifetime maximum of the *Plan*.

Lifetime Maximum

Lifetime maximum means the maximum amount of benefits available while *you* are covered under the *Plan*. Under no circumstances does lifetime mean during the lifetime of the *covered person*.

MEDICAL COVERED EXPENSES

Inpatient *Hospital*

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a:

- *Hospital* for daily semi-private, ward, intensive care or coronary care room and board charges for each day of *confinement*. The maximum amount payable is shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the *maximum allowable fee* charged for a semi-private room in the *hospital* while a registered bed patient;

- *Hospital* for services furnished for your treatment during *confinement*.

Outpatient *Hospital*

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a *hospital* for *services* and equipment that are supplied by and used in the outpatient department.

Free-Standing Surgical Facility

Charges made by a *free-standing surgical facility*, for surgical procedures performed and for *services* rendered in the facility are payable as shown on the Schedule of Benefits.

Urgent Care Facility

Facility charges made by an urgent care center are payable as shown on the Schedule of Benefits. Outpatient *surgery*, diagnostic x-ray, laboratory tests and any additional *services* other than the facility charge are not payable under this benefit. Please refer to the other provisions of this *Plan* for available coverage.

Qualified Practitioner

Covered expenses are payable as shown on the Schedule of Benefits and include charges made by a *qualified practitioner* when incurred for:

- Office, home, *emergency* room physician or inpatient *hospital* visits;

- Diagnostic x-ray or laboratory tests;

- Professional services of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium and radioactive isotope therapy;

- Other covered medical services received from or at the direction of a qualified practitioner;

- Administration of anesthesia;

- A surgical procedure, including pre-operative and post-operative care.

  If multiple surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the *maximum allowable fee* for the primary procedure and 50% of the *maximum allowable fee* for subsequent procedures when performed independently.

  No benefits will be payable for incidental procedures.

- Assisting the surgeon;

- Physician assistant;

- Charges made by a *qualified practitioner* for *services* in performing certain oral surgical operations due to *bodily injury* or *sickness* are covered as follows:

  - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;

  - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

  - Reduction of fractures and dislocations of the jaw;

  - External incision and drainage of cellulitis;

  - Incision of accessory sinuses, salivary glands or ducts;

  - Frenectomy (the cutting of the tissue in the midline of the tongue); and

Routine Care

The following expenses are payable for *you* or *your* covered *dependent*, up to the amount shown on the Schedule of Benefits, subject to all terms and provisions of the *Plan*, except the exclusion for *services* which are not *medically necessary*, if *you* are not confined in a *hospital* or *qualified treatment facility* and if such expenses are not incurred for diagnosis of a specific *bodily injury* or *sickness.*

Benefits include:

- Routine exams and annual checkups;

- Immunizations;

- Pap smears;

- Mammograms:
  - 1 baseline mammogram between the ages of 35-39;
  - Mammogram every two years or more frequently based upon a physician's recommendation ages 40-49;
  - Mammogram every year age 50 and up;
- Routine x-ray and laboratory tests;
- Prostate antigen testing;
- Routine vision (limited to 1 per *calendar year*);
- Routine Hearing (limited to 1 per *calendar year*).

No benefits are payable under this benefit for:

- Any dental examinations;
- Medical examination for *bodily injury* or sickness;
- Medical examination caused by or resulting from pregnancy.

Ambulance Service

Local professional ambulance service to the nearest *hospital* equipped to provide the necessary treatment is covered as shown on the Schedule of Benefits. Non-*emergency* ambulance transport is only allowed when provided as part of an authorized monitored care *Plan*. Ambulance service must not be provided primarily for the convenience of the patient or the *qualified practitioner*.

Pregnancy Benefits

Pregnancy is a *covered expense* for any *covered person* payable as shown on the Schedule of Benefits.

Complications of pregnancy are payable as any other covered *sickness* at the point the complication sets in for any *covered person*.

Pregnancy benefits are subject to all terms and provisions of the *Plan*.

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 may not, under Federal

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

Newborn Benefits

Benefits for newborns are subject to the Eligibility and Effective Date of Coverage section of this booklet, as well as all terms and provisions of the *Plan*.

Well-Newborn

Covered expenses incurred during a well-newborn child's initial inpatient *hospital confinement* include *hospital* expenses for nursery room and board and miscellaneous *services*; *qualified practitioner's* expenses for circumcision; and *qualified practitioner's* expenses for routine examination before release from the *hospital*.

Sick-Newborn

Covered expenses for a sick-newborn are *expenses incurred* for the treatment of a *bodily injury* or *sickness*.

Birthing Centers

A birthing center is a free standing facility, licensed by the state, which provides prenatal care, delivery and immediate postpartum care, and care of the newborn child.

Expense incurred within 48 hours after *confinement* in a birthing center for *services* and supplies furnished for prenatal care and delivery of child(ren) are payable as shown on the Schedule of Benefits.

Skilled Nursing Facility

Covered expenses for a skilled nursing facility *confinement* are payable when the *confinement*:

- Begins while you or an eligible *dependent* are covered under this *Plan*;
- Begins after discharge from a *hospital confinement* or a prior covered skilled nursing facility *confinement*;
- Is necessary for care or treatment of the same *bodily injur*y or sickness which caused the prior *confinement*; and
- Occurs while you or an eligible *dependent* are under the regular care of the physician who *precertified* the required skilled nursing facility *confinement*.

Skilled nursing facility means only an institution licensed as a skilled nursing facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

- Permanent and full-time bed care facilities for resident patients;
- A physician's *services* available at all times;

- 24-hour-a-day skilled nursing *services* under the full-time supervision of a physician or registered nurse (R.N.);

- A daily record for each patient;

- Continuous skilled nursing care for sick or injured persons during their convalescence from sickness or *bodily injury*; and

- A utilization review *Plan*.

A skilled nursing facility is not except by incident, a rest home, a home for care of the aged, or engaged in the care and treatment of *mental disorders*, chemical dependence or alcoholism.

Benefits Payable

Expense incurred for daily room and board and general nursing *services* for each day of *confinement* in a skilled nursing facility is payable as shown on the Schedule of Benefits. The daily rate will not exceed the maximum daily rate established for licensed skilled nursing care facilities by the Department of Health and Social Services.

Home Health Care

Expense incurred for home health care as described below is payable as shown on the Schedule of Benefits.

Each visit by a home health care provider for evaluating the need for, developing a plan, or providing *services* under a home health care plan will be considered one home health care visit. Up to 4 consecutive hours of service in a 24-hour period is considered one home health care visit. A visit by a home health care provider of 4 hours or more is considered one visit for every 4 hours or part thereof.

Home health care provider means an agency licensed by the proper authority as a home health agency or *Medicare* approved as a home health agency.

Home health care will not be reimbursed unless the *Plan* determines:

- Hospitalization or *confinement* in a skilled nursing facility would otherwise be required if home care were not provided;

- Necessary care and treatment are not available from a *family member* or other persons residing with *you*; and

- The home health care services will be provided or coordinated by a state-licensed or *Medicare*-certified home health agency or certified rehabilitation agency.

The home health care plan must be reviewed and approved by the *qualified practitioner* under whose care *you* are currently receiving treatment for the *bodily injury* or *sickness* which requires the home health care.

The home health care plan consists of:

- Care by or under the supervision of a registered nurse (R.N.);
- Physical, speech, occupational and respiratory therapy and home health aide *services*; and
- Medical supplies and *durable medical equipment*, laboratory *services* and nutritional counseling, if such *services* and supplies would have been covered if *you* were *hospital* confined.

Limitations on Home Health Care Benefit

Home health care benefits do not include:

- Charges for mileage or travel time to and from the *Covered Person's* home;
- Wage or shift differentials for home health care providers; or
- Charges for supervision of home health care providers.

Hospice Care

Hospice *services* must be furnished in a hospice facility or in *your* home. A *qualified practitioner* must certify *you* are terminally ill with a life expectancy of six months or less.

For hospice *services* only, *your* immediate family is considered to be *your* parent, s*pouse*, and *your children* or step-*children*.

Covered expenses are payable as shown on the Schedule of Benefits for the following hospice *services*:

- Room and board and other *services* and supplies;
- Part-time nursing care by or supervised by a R.N. for up to 8 hours per day;
- Counseling *services* by a *qualified practitioner* for the hospice patient and the immediate family;
- Medical social services provided to you or your immediate family under the direction of a *qualified practitioner* which include the following:
    - Assessment of social, emotional and medical needs, and the home and family situation,
    - Identification of the community resources available, and
    - Assistance in obtaining those resources;

- Nutritional counseling;
- Physical or occupational therapy;
- Part-time home health aide service for up to 8 hours in any one day;
- Medical supplies, drugs and medicines prescribed by a *qualified practitioner*; and
- Bereavement counseling *services* by a *qualified practitioner* for your immediate family.

Limitations on Hospice Care Benefits

Hospice care benefits do NOT include: (1) private duty nursing *services* when confined in a hospice facility; (2) a *confinement* not required for pain control or other acute chronic symptom management; (3) funeral arrangements; (4) financial or legal counseling, including estate planning or drafting of a will; (5) homemaker or caretaker *services*, including a sitter or companion *services*; (6) housecleaning and household maintenance; (7) *services* of a social worker other than a licensed clinical social worker; (8) *services* by volunteers or persons who do not regularly charge for their *services*; or (9) *services* by a licensed pastoral counselor to a member of his or her congregation when *services* are in the course of the duties to which he or she is called as a pastor or minister.

Hospice care program means a written plan of hospice care, established and reviewed by the *qualified practitioner* attending the patient and the hospice care agency, for providing palliative and supportive care to hospice patients. It offers supportive care to the families of hospice patients, an assessment of the hospice patient's medical and social needs, and a description of the care to meet those needs.

Hospice facility means a licensed facility or part of a facility which principally provides hospice care, keeps medical records of each patient, has an ongoing quality assurance program and has a physician on call at all times.

A hospice facility provides 24-hour-a-day nursing *services* under the direction of a R.N. and has a full-time administrator.

Hospice care agency means an agency which has the primary purpose of providing hospice *services* to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meets all of these requirements: (1) has obtained any required certificate of need; (2) provides 24-hours a day, 7 day-a-week service supervised by a *qualified practitioner*; (3) has a full-time coordinator; (4) keeps written records of *services* provided to each patient; (5) has a nurse coordinator who is a R.N., who has four years of full-time clinical experience, of which at least two involved caring for terminally ill patients; and, (6) has a licensed social service coordinator.

A hospice care agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its *services* for their patients, and use volunteers trained in care of and *services* for non-medical needs.

***Mental Disorder*, Chemical Dependence or Alcoholism Benefit**

Expense incurred by *you* during a plan of treatment for *mental disorder*, chemical dependence or alcoholism is payable for:

- Charges made by a *qualified practitioner*;
- Charges made by a *hospital*;
- Charges made by a *qualified treatment facility*;
- Charges for x-ray and laboratory expenses;
- *Services* related to the treatment or diagnosis of sexual dysfunction/impotence.

Inpatient Benefits

Covered expenses while confined as a registered bed patient in a *hospital* or *qualified treatment facility* are payable as shown below:

PAR PROVIDER	NON-PAR PROVIDER
Subject to deductible and payable at 80%.	Subject to deductible and payable at 70%.
PAR and Non-PAR inpatient treatment of a *mental disorder*, chemical dependence or alcoholism aggregates to a *maximum benefit* of 30 days per *calendar year*. When prior approval is received, 2 (two) sessions of transitional care may be substituted for 1 (one) inpatient day. Non-PAR inpatient and outpatient substance abuse programs aggregates to a *maximum benefit* of $550 per *calendar year*. PAR and Non-PAR substance abuse rehabilitation programs aggregates to a *maximum benefit* of 2 (two) per lifetime.	

Covered expenses for inpatient treatment aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

Transitional treatment arrangements mean *covered expenses* for the treatment of *mental disorders*, chemical dependence or alcoholism that are provided to *you* in a less restrictive manner than are inpatient *hospital services*, but in a more intensive manner than are outpatient *services* (includes but is not limited to day hospitalization).

Outpatient and Office / Clinic Setting Benefits

Covered expenses for outpatient treatment received while not confined in a *hospital* or *qualified treatment facility* are payable as shown below:

PAR PROVIDER	NON-PAR PROVIDER
Subject to a $30 *copayment*, then payable at 100%.	Subject to deductible and payable at 70%.
PAR and Non-PAR outpatient treatment of a *mental disorder*, chemical dependence or alcoholism aggregate to a *maximum benefit* of 30 visits per *calendar year*.	

Covered expenses for outpatient treatment aggregate toward the coinsurance and out-of-pocket limits described on the Schedule of Benefits.

Limitations on *Mental Disorder*, Chemical Dependence or Alcoholism Benefit

No benefits are payable under this provision for marriage counseling, treatment of nicotine habit or addiction, or for treatment of being obese or overweight.

No benefits are payable under this provision for services performed at a Residential Treatment Facility.

Treatment must be provided for the cause for which benefits are payable under this provision of the *Plan*.

Other Covered Expenses

The following are other *covered expenses* payable as shown on the Schedule of Benefits:

- Blood and blood plasma are payable as long as it is NOT replaced by donation, and administration of blood and blood products including blood extracts or derivatives;

- Oxygen and rental of equipment for its administration;

- Initial prosthetic devices or supplies, including but not limited to, limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore minimal basic function. Replacement is a *covered expense* if due to pathological changes. *Covered expense* includes repair of the prosthetic device if not covered by the manufacturer;

- Casts, trusses, crutches, splints except for dental splints, and braces except for orthodontic braces;

- Supplies, up to a 30-day supply, when prescribed by *your* attending physician;

- Initial contact lenses or eyeglasses following cataract *surgery*;

- The rental, up to but not to exceed the purchase price, of a wheelchair, *hospital* bed, ventilator, *hospital* type equipment or other *durable medical equipmen*t (DME). The *Plan*, at its option, may authorize the purchase of *DME* in lieu of its rental, if the rental price is projected to exceed the purchase price. Repair, maintenance or duplicate *DME* rental is not considered a *covered expense*. *Precertification* is required. If *precertification* is not received, benefits are subject to the penalty described on the Schedule of Benefits;

- Chiropractic care for treatment of a *bodily injury* or *sickness*. *Maintenance care* is not covered;

- Services for the treatment of a *dental injury* to a *sound natural tooth*, including but not limited to extraction and initial replacement. *Services* must begin within 6 months and be completed within 6 months after the date of the *dental injury*. Benefits will be paid only for *expense incurred* for the least expensive service that will, in the *Plan Manager's* opinion, produce a professionally adequate result;

- Installation and use of an insulin infusion pump, diabetic self-management education programs and other equipment or supplies in the treatment of diabetes;

- Reconstructive *surgery due* to *bodily injury*, infection or other disease of the involved part or congenital disease or anomaly of a covered *dependent* child which resulted in a functional defect;

- Reconstructive *services* following a covered mastectomy, including but not limited to:

  - reconstruction of the breast on which the mastectomy was performed;
  - reconstruction of the other breast to achieve symmetry;
  - prosthesis; and
  - treatment of physical complications of all stages of the mastectomy, including lymphedemas;

- Speech, occupational, physical and respiratory therapy;

- Vision therapy;

- Chemotherapy and radiation therapy;

- Cardiac rehabilitation, limited to phases I and II;

- All fertility testing or *services* performed to achieve pregnancy or ovulation by artificial means, except artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;

- Growth Hormone Therapy for the treatment of *children* or adolescents appropriately diagnosed with growth hormone deficiency, Turner's Syndrome, growth delay due to cranial radiation or chronic renal disease;

- Coverage for implant devices and related implantation health services including cochlear implants, penile implants and implants for the delivery of prescription medication when provided in accordance with the *Plan* Manager's guidelines and authorized in advanced;

- *Services* for *morbid obesity*, including gastric surgery, any pre-surgical consultation or treatment, follow-up or medical complications arising from the procedure, up to the maximum shown in the schedule of benefits. *Precertification* is required prior to the surgery. If *precertification* is not received, benefits will not be payable. The *covered person* must be qualified as *morbid obesity* and meet the following requirements:

    - has failed to lose weight significantly or has regained weight despite compliance with a multidisciplinary non-surgical program (including a low or very low calorie diet, supervised exercise, behavior modification and support) for at least six (6) months prior to the requested surgery, which program is under the direction of the physician who refers the patient for surgery; and

    - has no specifically correctable cause for obesity (e.g. an endocrine disorder and has full growth); and

    - is being treated in a surgical program with experience in obesity surgery, including, not only surgeons experienced with Rouxen-Y gastric bypass, or vertical-banded gastroplasty, but also a multidisciplinary approach including all of the following (1) preoperative medical consultation and approval; (2) preoperative psychiatric consultation and approval; (3) nutritional counseling; (4) exercise counseling; (5) psychological counseling; and (6) support group meetings.

The following services are considered other *covered expense*s and are payable as shown on the Schedule of Benefits, subject to all terms and provisions of the *Plan*, except the exclusion for services which are not *medically necessary*:

- Elective sterilizations;

- Diagnosis and/or treatment of sexual dysfunction/impotence.

Organ Transplant Benefit – Lifetime Maximum: $1,000,000

The *Plan* will pay benefits for the expense of a transplant as defined below when incurred by a *covered person* and approved in advance by the *Plan Manager*, subject to those terms, conditions and limitations described below and contained in the *Plan*. Please contact the *Plan Manager* when in need of these services. **Humana's Centers of Excellence must be used for transplant services.**

Covered Organ Transplant

Only the *services*, care, and treatment received for or in connection with the pre-approved transplant of the organs identified hereafter, which are determined by the *Plan Manager* to be *medically necessary services* and which are not *experimental, investigational or for research purposes*. The transplant includes pre-transplant, transplant inclusive of any chemotherapy and associated *services*, post-discharge *services*, and treatment of complications after transplantation of the following organs or procedures only:

- Heart;
- Lung(s);
- Heart-lung;
- Liver;
- Kidney;
- Bone Marrow;
- Intestine;
- Simultaneous pancreas/kidney;
- Pancreas following kidney;
- Any organ not listed above required by state or federal law.

The term bone marrow identified in the foregoing transplant definition refers to the transplant of human blood precursor cells which are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant or from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation and the chemotherapy components. Storage of cord blood and stem cells will not be covered unless as an integral part of a transplant of bone marrow approved by the *Plan Manager*.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, and kidney transplants are considered part of regular *Plan* benefits and are subject to other applicable provisions of the *Plan*.

For a transplant to be considered fully approved, prior written approval from the *Plan Manager* is required in advance of the transplant. Y*ou* or *your qualified practitioner* must notify the *Plan Manager* in advance of *your* need for an initial evaluation for the transplant in order for the *Plan Manager* to determine if the transplant will be covered. For approval of the transplant itself, the *Plan Manager* must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Limitations and Exclusions

No benefit is payable for or in connection with a transplant if:

- It is *experimental, investigational or for research purposes* as defined elsewhere in the *Plan*.

- The *Plan Manager* is not contacted for authorization prior to referral for evaluation of the transplant, unless such authorization is waived by the *Plan Manager*.

- The *Plan Manager* does not approve coverage for the transplant, based on its established criteria.

- Expenses are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received.

- The expense relates to the transplantation of any non-human organ or tissue, unless otherwise stated in the *Plan*.

- The expense relates to the donation or acquisition of an organ for a recipient who is not covered by the *Plan*.

- A denied transplant is performed; this includes the pre-transplant evaluation, the transplant procedure, follow up care, immunosuppressive drugs, and complications of such transplant.

- The *covered person* for whom a transplant is requested has not met pre-transplant criteria as established by the *Plan Manager*.

- All direct, non-medical expenses for the *covered person* receiving the transplant and his/her *family member(s)*.

Once the transplant is approved, the *Plan Manager* will advise the *covered person's qualified practitioner*. Benefits are payable only if the pre-transplant *services*, the transplant and post-discharge *services* are approved by the *Plan Manager*.

Covered Services

For approved transplants, and all related complications, the *Plan Manager* will cover only the following expenses:

- *Hospital* benefits shown in the Schedule of Benefits under the *Hospital* Benefit section of this *Plan* will be paid at: (a) 80% of *covered expenses* after the deductible if received at a PAR *hospital* designated by the *Plan Manager* as an approved transplant facility; and (b) not covered if received at a Non-PAR *hospital*.

- *Qualified practitioner* benefits shown in the Schedule of Benefits under the *Qualified Practitioner* section of this *Plan* will be paid at (a) 80% of *covered expenses* after the deductible if received from a PAR *qualified practitioner* designated by the *Plan Manager* as an approved transplant provider; and (b) not covered if received from a Non-PAR *qualified practitioner*.

- Organ acquisition and donor costs. Except for bone marrow transplants, donor costs are not payable under the *Plan* if they are payable in whole or in part by any other group *Plan*, insurance company, organization or person other than the donor's family or estate. Coverage for bone marrow transplants procedures will include costs associated with the donor-patient to the same extent and limitations associated with the *covered person*, except the reasonable costs of searching for the donor may be limited to the immediate *family members* and the National Bone Marrow Donor Program.

Please contact the Transplant Management Department at our toll-free number (866) 421-5663 when in need of these *services*.

PRESCRIPTION DRUG BENEFITS
(For Eligible Employees, Eligible Retirees and Eligible Dependents)

Covered Benefits

The *Plan* will cover up to a consecutive 31-day supply (90 days for mail order) prescribed by your Physician or Dentist of:

- A drug approved by the Food and Drug Administration (FDA) and which is required to be labeled: "Caution: Federal Law prohibits dispensing without prescription;" and
- Injectable insulin.

Information to Share with Your Physician

When you go to your Physician or Dentist, you should take your *Plan* identification card. Your Physician may desire to keep a copy of it in your file.

Copayments

A *copayment* must be paid by you to the Preferred Pharmacy for each prescription or refill. This *copayment* is less for generic equivalents.

Copayments and other costs are shown in the Benefit Schedule for the Prescription Drug Benefits.

Using Preferred Pharmacies

Preferred Pharmacies are local and national pharmacies that "participate" in the drug card program selected by the *Plan*. You may check with the Pharmacy Benefit Manager shown at page vi for information about the pharmacies that are "participating."

To have your prescription filled, simply present your drug identification card and pay the *copayment*.

Using Non-Preferred Pharmacies

If you have the prescription filled at a non-preferred pharmacy, you will be required to pay the entire cost at the time of your purchase. Be sure to take a Prescription Drug Claim Form with you and have the pharmacist complete the Form. You must include the original receipts with the Form. The Form and receipts should be submitted to the Pharmacy Benefit Manager at the address provided on page vi. Upon receipt of this information, the Pharmacy Benefit Manager will determine the amount of benefits due under the Prescription Drug Benefit *Plan* and will then send you a benefit payment.

Mail Order

You may also obtain prescriptions for maintenance drug therapies through the Prescription Drug Benefit Plan mail order program. The *Plan*'s mail order program is a cost-effective way for you to obtain maintenance drugs. You are encouraged to use this program for medications that are prescribed for more than 90 days.

Exclusions and Limitations

Medications that are not covered under the program include the following:

- Appetite suppressants, even if *medically necessary* for attention deficit disorder, narcolepsy or other condition;
- Compounded prescription medications with ingredients not requiring a Physician's authorization by state or federal law;
- Infertility medications;
- *Investigational* or *experimental* medications;
- Medications for cosmetic purposes only (for example, Retin-A for aging or Rogaine for hair loss; however, Retin-A is available for acne up to age 26);
- Medications for smoking cessation;
- Medications used for *experimental* indications and/or dosage regimens determined to be *experimental* (e.g. Progesterone suppositories or suspension or Nystatin oral power);
- Medications with no approved FDA indications (e.g. yohimbine);
- Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription medication that is available as an OTC medication;
- Prescription refills dispensed after one year from original date of dispensing;
- Replacement prescriptions resulting from loss, theft or breakage;
- Devices or equipment of any type;
- Vitamins (unless injectable or not available over-the-counter);
- For any drugs provided while you or a *dependent* are *confined* or an outpatient at a *Hospital* or other facility if benefits are payable for such drugs under any other part of this *Plan*;
- For any drug refill it is more than the number of refills specified. (The *Plan* or its designee, before recognizing charges for claim payment, may require a new prescription or evidence as to need, if the number of refills has not been specified or if the frequency

or number of prescriptions or refills appears excessive under accepted medical practice standards); or

- Medications for sexual dysfunction.

See also "Exclusions and Limitations."

Your Drug Identification Card and Card Replacement

When you become eligible for the Prescription Drug Benefits, you will receive an identification card. The identification card should be used when purchasing drugs through a Preferred Pharmacy.

You may request a new identification card by contacting the *Third Party Administrator* Replacement identification card may be requested for any of the following reasons:

- You are adding or dropping a *Dependent* from your coverage;
- There is a change in personal information, such as a name change due to marriage;
- Some of the information is wrong, such as a misspelled name or an incorrect identification number; or
- There is a change in the *Plan*'s benefits, such as the amount of co-payments.

LIMITATIONS AND EXCLUSIONS

The *Plan* does not provide benefits for:

- Services:
  - Not furnished by a *qualified practitioner* or *qualified treatment facility*;
  - Not authorized or prescribed by a *qualified practitioner*;
  - Not covered by this *Plan* whether or not prescribed by a *qualified practitioner*;
  - Which are not provided;
  - For which no charge is made, or for which you would not be required to pay if you were not covered under this *Plan* unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or
  - Furnished by or payable under any Plan or law through any government or any political subdivision (this does not include *Medicare* or Medicaid);
  - Furnished for a military service connected *sickness* or *bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
  - Performed in association with a *service* that is not covered under this *Plan*;
  - Performed as a result of a complication arising from a *service* that is not covered under this *Plan*;
- Routine eye exams, *services* to correct eye refractive disorders, eyeglass frames and lenses or contact lenses, the fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this *Plan*;
- Hearing aids, the fitting or repair of hearing aids;
- Physical exams and related *services* for occupation, employment, school, travel, purchase of insurance or premarital tests or examinations (however, the *Plan* will cover vaccines and immunizations related to work-related conditions);
- Elective abortions, unless the pregnancy is a life-threatening physical condition of the covered female person;
- *Services* related to gender change;
- *Services* for a reversal of sterilization;

- Any *bodily injury* or *sickness* arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:

  - Benefits are provided or payable under any Workers' Compensation or *Occupational Disease* Act or Law, or

  - Coverage was available under any Workers' Compensation or *Occupational Disease* Act or Law regardless of whether such coverage was actually purchased;

- *Services* for *cosmetic surgery*;

- Dental *services* or appliances for the treatment of the teeth, gums, jaws or alveolar processes, excision of partially or completely unerupted impacted teeth including but not limited to, osteotomies, routine dental extractions, implants and related procedures, and orthodontic procedures, unless specifically provided under this *Plan*;

- Any loss caused by or contributed to:

  - War or any act of war, whether declared or not, or

  - Any act of armed conflict, or any conflict involving armed forces of any authority;

- The treatment of *mental disorders*, chemical dependence or alcoholism, unless specifically provided under this *Plan*;

- Any drug, medicine or device which does not have the United States Food and Drug Administration formal market approval through a New Drug Application, Premarket Approval, 510K, or PLA;

- Any *service* which is *experimental, investigational or for research purposes*;

- *Custodial care* and *maintenance care*;

- *Services* provided by a person who ordinarily resides in *your* home or who is a *family member*;

- Charges in excess of the *maximum allowable fee* for the *service*;

- Any *expense incurred* prior to *your* effective date under the *Plan* or after the date *your* coverage under the *Plan* terminates, except as specifically described in this *Plan*;

- Any expense due to commission or attempt to commit a civil or criminal battery or felony;

- *Services* not *medically necessary* for diagnosis and treatment of a *bodily injury* or *sickness*;

- Private duty nursing;

- *Expenses incurred* for which *you* are entitled to receive benefits under *your* previous dental or medical *Plan*;

- Artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;

- Therapy and testing for treatment of allergies, including but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by:

  - The American Academy of Allergy and Immunology, or

  - The Department of Health and Human Services or any of its offices or agencies;

- Professional pathology or radiology charges, including but not limited to, blood counts, multi-channel testing, and other clinical chemistry tests, when:

  - The *services* do not require a professional interpretation, or

  - The *qualified practitioner* did not provide a specific professional interpretation of the test results of the *covered person*;

- *Services* for the treatment of obesity, including but not limited to surgical procedures, except as specifically described in this *Plan*;

- Services performed at a Residential Treatment Facility;

- Surgical or non-surgical treatment including but not limited to, appliances and therapy, for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull;

- *Sickness* or *bodily injury* for which medical payments/personal injury protection (PIP) coverage exists under any automobile, homeowner, marine, aviation, premise, or any other similar coverage, whether such coverage is in effect on a primary, secondary, or excess basis. This exclusion applies up to the available limit under the other coverage regardless of whether a claim is filed with the medical payments/PIP carrier. Whether medical payment or expense coverage is payable under another coverage is to be determined as if the coverages under this *Plan* did not exist;

- Any *covered expenses* to the extent of any amount received from others for losses which necessitate such benefits. "Amounts received from others" specifically includes, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments;

- Services and supplies for smoking cessation programs and the treatment of nicotine addiction;

- Birth control pills, devices, injections, or implant systems (except as might be covered under your prescription drug card);

- Diagnosis and/or treatment of sexual dysfunction.

Certain medical services may, however, be eligible for reimbursement from your Dollar Bank.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

Benefits described in this *Plan* are coordinated with benefits provided by other *Plans* under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of medical coverage.

For this purpose, a *Plan* is one which covers medical or dental expenses and provides benefits or *services* by group, franchise or blanket insurance coverage. This includes group-type contracts not available to the general public, obtained and maintained only because of the *Covered Person's* membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. *Plan* also includes any coverage provided through the following:

1. *Employer*, trustee, union, employee benefit, or other association; or

2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution. Allowable expense means any eligible expense, a portion of which is covered under one of the plans covering the person for whom claim is made. Each plan will determine what is an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be deemed to be both an allowable expense and a benefit paid.

Effect on Benefits

One of the plans involved will pay benefits first. This is called the primary *Plan*. All other plans are called secondary plans.

When this *Plan* is secondary to a *Medicare Plan*, the sum of the benefit payable will not exceed 100% of the total allowable expenses incurred under the *Plan* and any other plans included under this provision.

When this *Plan* is secondary to a medical *Plan*, the sum of the benefit payable by this *Plan* when added to the primary *Plan's* benefits will not exceed this *Plan's* normal liability.

If an *Eligible Employee*'s *spouse* working under the *Collective Bargaining Agreement* also attains coverage as an *Eligible Employee* under the *Plan*, the coordination will be applied as if the *spouse* was covered by two separate group plans.

Order of Benefit Determination

In order to pay claims, it must be determined which *Plan* is primary and which Plan(s) are secondary. A plan will pay benefits first if it meets one of the following conditions:

1. The plan has no coordination of benefits provision;

2. The plan covers the person as an *employee*;

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the plan which has covered the person for the longer period of time will be determined the primary plan ;

If a plan other than this *Plan* does not include provision 3, then the gender rule will be followed to determine which plan is primary.

4. In the case of *dependent children* covered under the plans of divorced or separated parents, the following rules apply:

   a. The plan of a parent who has custody will pay the benefits first;

   b. The plan of a step-parent who has custody will pay benefits next;

   c. The plan of a parent who does not have custody will pay benefits next;

   d. The plan of a step-parent who does not have custody will pay benefits next.

There may be a court decree which gives one parent financial responsibility for the medical or dental expenses of the *dependent children*. If there is a court decree, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

5. If a person is laid off or is retired or is a *dependent* of such person, that plan covers after the plan covering such person as an active *employee* or *dependent* of such *employee*. If the other plan does not have this rule, and if, as a result, the plan do not agree on the order of benefits, this rule will be ignored.

If the above rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

Coordination of Benefits with *Medicare*

In all cases, Coordination of Benefits with *Medicare* will conform to Federal Statutes and Regulations. In the case of *Medicare* each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage (i.e. Part A *hospital* insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. *Your* benefits under the *Plan* will be coordinated to the extent benefits would otherwise have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

Right of Recovery

The *Plan* reserves the right to recover benefit payments made for an allowable expense under the *Plan* in the amount which exceeds the maximum amount the *Plan* is required to pay under these provisions. This right of recovery applies to the *Plan* against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other *Plan*.

The *Plan* alone will determine against whom this right of recovery will be exercised.

Note:

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

REIMBURSEMENT/SUBROGATION

The *beneficiary* agrees that by accepting and in return for the payment of *covered expenses* by the *Plan* in accordance with the terms of this *Plan*:

- The *Plan* shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the bodily injuries or losses which necessitated such *covered expense*s. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

- The *Plan's* right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.

- The right to recover amounts from others for the injuries or losses which necessitate *covered expense*s is jointly owned by the *Plan* and the *beneficiary*. The *Plan* is subrogated to the *beneficiary*'s rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the *Plan* as prescribed above; the *Plan* has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the *Plan* is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.

- The *beneficiary* will cooperate with the *Plan* in any effort to recover from others for the bodily injuries and losses which necessitate *covered expense* payments by the *Plan*. The *beneficiary* will notify the *Plan* immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the *Plan*. Neither the *Plan* nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

Right to Collect Needed Information

You must cooperate with the *Plan Manager* and *TPA* and when asked, assist the *Plan Manager* and *TPA* by:

- Authorizing the release of medical information including the names of all providers from whom you received medical attention;

- Obtaining medical information and/or records from any provider as requested by the *Plan* Manager and *TPA*;

- Providing information regarding the circumstances of your sickness or *bodily injury*;

- Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or sickness for which another party may be liable to pay compensation or benefits; and

- Providing information the *Plan Manager* and *TPA* requests to administer the *Plan*.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to a *bodily injury* or *sickness* for which the information is sought, until the necessary information is satisfactorily provided.

Duty to Cooperate in Good Faith

You are obliged to cooperate with the *Plan Manager* and *TPA* in order to protect the *Plan*'s recovery rights. Cooperation includes promptly notifying the *Plan Manager* and *TPA* that *you* may have a claim, providing the *Plan Manager* and *TPA* relevant information, and signing and delivering such documents as the *Plan Manager* reasonably requests to secure the *Plan*'s recovery rights. *You* agree to obtain the *Plan*'s consent before releasing any party from liability for payment of medical expenses. *You* agree to provide the *Plan Manager* with a copy of any summons, complaint or any other process serviced in any lawsuit in which *you* seek to recover compensation for *your bodily injury* or *sickness* and its treatment.

You will do whatever is necessary to enable the *Plan Manager* and *TPA* to enforce the *Plan's* recovery rights and will do nothing after loss to prejudice the *Plan's* recovery rights.

You agree that *you* will not attempt to avoid the *Plan's* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide the *Plan Manager and TPA* such notice or cooperation, or any action by the *covered person* resulting in prejudice to the *Plan's* rights will be a material breach of this *Plan* and will result in the *covered person* being personally responsible to make repayment. In such an event, the *Plan* may deduct from any pending or subsequent claim made under this *Plan* any amounts the *covered person* owes the *Plan* until such time as cooperation is provided and the prejudice ceases.

Right of Reimbursement

If benefits are paid under the *Plan* and *you* recover from any legally responsible person, their insurer, or any Uninsured Motorist, Underinsured Motorist, Medical Payment/Expense, No-fault, or other similar coverage, the *Plan* has the right to recover from *you* an amount equal to the amount the *Plan* paid.

You shall notify the *Plan*, in writing, within 31 days of any settlement, compromise or judgment. Any *covered person* who waives, abrogates, or impairs the *Plan's* Right of Reimbursement or fails to comply with these obligations, relieves the *Plan* from any obligation to pay past or future benefits or expenses until all outstanding lien(s) are resolved.

WORKERS' COMPENSATION

Workers' Compensation Not Affected

The *Plan* is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or *Occupational Disease* Act or Law.

Workers' Compensation Advance

If benefits are paid by the *Plan* and the *Plan* determines *you* received Workers' Compensation for the same incident, the *Plan* has the right to recover as described under the Reimbursement/Subrogation provision. The *Plan* will exercise its right to recover against *you* even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier;
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the *Plan*, *you* will notify the *Plan Manager* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse the *Plan* as described above.

PRIVACY OF PROTECTED HEALTH INFORMATION

The *Plan* is required by law to maintain the privacy of *your protected health information* in all forms including written, oral and electronically maintained, stored and transmitted information and to provide individuals with notice of the *Plan's* legal duties and privacy practices with respect to *protected health information*.

The *Plan* has policies and procedures specifically designed to protect *your* health information when it is in electronic format. This includes administrative, physical and technical safeguards to ensure that *your* health information cannot be inappropriately accessed while it is stored and transmitted to the *Plan Manager* and others that support the *Plan*.

In order for the *Plan* to operate, it may be necessary from time to time for health care professionals, the *Plan Administrator*, individuals who perform *Plan*-related functions under the auspices of the *Plan Administrator*, the *Plan Manager* and other service providers that have been engaged to assist the *Plan* in discharging its obligations with respect to delivery of benefits, to have access to what is referred to as *protected health information*.

A *covered person* will be deemed to have consented to use of *protected health information* about him or her by virtue of enrollment in the *Plan*. Any individual who may not have intended to provide this consent and who does not so consent must contact the *Plan Administrator* prior to filing any claim for *Plan* benefits, as coverage under the *Plan* is contingent upon consent.

Individually identifiable health information will only be used or disclosed for purposes of *Plan* operation or benefits delivery. In that regard, only the minimum necessary disclosure will be allowed. The *Plan Administrator*, *Plan Manager*, *TPA* and other entities given access to *protected health information*, as permitted by applicable law, will safeguard *protected health information* to ensure that the information is not improperly disclosed.

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than *Plan* operation or benefits delivery. Disclosure for *Plan* purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to an *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

The *Plan Manager* will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. However, *Plan* records that include *protected health information* are the property of the *Plan*. Information received by the *Plan Manager* is information received on behalf of the *Plan*.

The *Plan Manager* will afford access to *protected health information* as reasonably directed in writing by the *Plan* Administrator, which shall only be made with due regard for confidentiality. In that regard, the *Plan Manager* has been directed that disclosure of *protected health information* may be made to a designated representative of the *Plan Administrator*.

Individuals who have access to *protected health information* in connection with their performance of *Plan*-related functions under the auspices of the *Plan Administrator* will be trained in these privacy policies and relevant procedures prior to being granted any access to

protected health information. The *Plan Manager* and other *Plan* service providers will be required to safeguard *protected health information* against improper disclosure through contractual arrangements.

In addition, *you* should know that the *Plan* Sponsor may legally have access, on an as-needed basis, to limited health information for the purpose of determining *Plan* costs, contributions, *Plan* design, and whether *Plan* modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to *protected health information* to police federal legal requirements about privacy.

Covered persons may have access to *protected health information* about them that is in the possession of the *Plan*, and they may make changes to correct errors. *Covered persons* are also entitled to an accounting of all disclosures that may be made by any person who acquires access to *protected health information* concerning them and uses it other than for *Plan* operation or benefits delivery. In this regard, please contact the *Third Party Administrator*.

Covered persons are urged to contact the originating health care professional with respect to medical information that may have been acquired from them, as those items of information are relevant to medical care and treatment. And finally, *covered persons* may consent to disclosure of *protected health information*, as they please.

CLAIMS PROCEDURES

Submitting a Claim

Medical Benefits

This section describes what a *covered person* (or his or her authorized representative) must do to file a claim for Medical *Plan* benefits.

- A claim must be filed with the *Plan Manager* in writing and delivered to the *Plan Manager*, by mail, postage prepaid.

- Claims must be submitted to the *Plan Manager* at the address indicated in the documents describing the *Plan* or *claimant's* identification card. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

- Also, claims submissions must be in a format acceptable to the *Plan Manager* and compliant with any applicable legal requirements. Claims that are not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by the *Plan*.

- Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than 15 months after the date of loss, except if *you* were legally incapacitated. *Plan* benefits are only available for claims that are incurred by a *covered person* during the period that he or she is covered under the *Plan*.

- Claims submissions must be complete. They must contain, at a minimum:

    a. The name of the *covered person* who incurred the *covered expense*;
    b. The name and address of the health care provider;
    c. The diagnosis of the condition;
    d. The procedure or nature of the treatment;
    e. The date of and place where the procedure or treatment has been or will be provided;
    f. The amount billed and the amount of the *covered expense* not paid through coverage other than *Plan* coverage, as appropriate;
    g. Evidence that substantiates the nature, amount, and timeliness of each *covered expense* in a format that is acceptable according to industry standards and in compliance with applicable law.

A general request for an interpretation of *Plan* provisions will not be considered to be a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the *Plan*, should be directed to the *Third Party Administrator*.

Medical claims, medical correspondence should be mailed to:

Humana Claims Office
P.O. Box 14610
Lexington, Kentucky 40512-4610

Miscellaneous Medical Charges

If *you* accumulate bills for medical items *you* purchase or rent yourself, send them to the *Plan Manager* at least once every three months during the year (quarterly). The receipts must include the patient name, name of item, date item purchased or rented and name of the provider of *service*.

Procedural Defects

If a *pre-service claim* submission is not made in accordance with the *Plan*'s procedural requirements, the *Plan Manager* will notify the *claimant* of the procedural deficiency and how it may be cured no later than within five (5) days (or within 24 hours, in the case of an *urgent care claim*) following the failure. A *post-service claim* that is not submitted in accordance with these claims procedures will be returned to the submitter.

Assignments and Representatives

A *covered person* may assign his or her right to receive *Plan* benefits to a health care provider only with the consent of the *Plan Manager*, in its sole discretion, except as may be required by applicable law. Assignments must be in writing. If a document is not sufficient to constitute an assignment, as determined by the *Plan Manager*, then the *Plan* will not consider an assignment to have been made. An assignment is not binding on the *Plan* until the *Plan Manager* receives and acknowledges in writing the original or copy of the assignment before payment of the benefit.

If benefits are assigned in accordance with the foregoing paragraph and a health care provider submits claims on behalf of a *covered person*, benefits will be paid to that health care provider.

In addition, a *covered person* may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The designation must be explicitly stated in writing and it must authorize disclosure of Protected Health Information with respect to the claim by the *Plan*, the *Plan Manager* and the authorized representative to one another. If a document is not sufficient to constitute a designation of an authorized representative, as determined by the *Plan Manager*, then the *Plan* will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to the *Plan Manager* in advance, or at the time an authorized representative commences a course of action on behalf of a *claimant*. At the same time, the authorized representative should also provide notice of commencement of the action on behalf of the *claimant* to the *claimant*, which the *Plan Manager* may verify with the *claimant* prior to recognizing the authorized representative status.

- In any event, a health care provider with knowledge of a *claimant's* medical condition acting in connection with an *urgent care claim* will be recognized by the *Plan* as the *claimant's* authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. An authorized representative may make decisions independent of the *covered person*, such as whether and how to appeal a claim denial.

Death Benefits

A claim must be filed with the *Third Party Administrator* in writing and delivered to the *TPA* by mail, postage prepaid.

Claims must be submitted within one year of death. Timely filing is the *beneficiary*'s responsibility. Late claims are not payable.

The claim must be accompanied by a certified copy of the *Covered Person's* death certificate.

Medical Reimbursement Claims

See pages 23 - 25.

Weekly Disability Benefits

A claim must be filed with the *Third Party Administrator* in writing and delivered to the *TPA* by mail, postage prepaid. Your physician must indicate the diagnosis date of disability, and the date the physician was first consulted for the disability.

Claims must be filed within 120 days of the onset of the disability. Late claims are not considered.

Prescription Drugs

Participating Pharmacy – Present your identification card at a participating pharmacy and make the copayment. (This point of sale purchase of a prescription is not a claim for benefits. If you do not receive your prescription at a Participating Pharmacy due to a denial of coverage, you need to contact the *TPA* to make a claim for benefit coverage).

Non-Participating Pharmacy – If you use a non-participating pharmacy, pay for the prescription and submit your obtained receipts (other than cash register) to the Pharmacy Benefit Manager. Claim forms must be submitted within one year of the purchase in order to be considered for reimbursement.

Claims Decisions

After submission of a claim by a *claimant*, the *Plan Manager* will notify the *claimant* within a reasonable time, as follows:

Pre-Service Claims

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the *Plan*.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the *Plan*. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 15-day period, the circumstances requiring the extension, and the date by which the *Plan* expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information.

Urgent Care Claims

The *Plan Manager* will determine whether a claim is an *urgent care claim*. This determination will be made on the basis of information furnished by or on behalf of a *claimant*. In making this determination, the *Plan Manager* will exercise its judgment, with deference to the judgment of a physician with knowledge of the *claimant's* condition. Accordingly, the *Plan Manager* may require a *claimant* to clarify the medical urgency and circumstances that support the *urgent care claim* for expedited decision-making.

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination as soon as possible, taking into account the medical exigencies particular to the *claimant's* situation, but not later than 72 hours after receipt of the *urgent care claim* by the *Plan*.

However, if a claim is submitted that does not provide sufficient information to determine whether, or to what extent, expenses are covered or payable under the *Plan*, notice will be provided by the *Plan Manager* as soon as possible, but not more than 24 hours after receipt of the *urgent care claim* by the *Plan*. The notice will describe the specific information necessary to complete the claim.

- The *claimant* will have a reasonable amount of time, taking into account his or her circumstances, to provide the necessary information but not less than 48 hours.

- The *Plan Manager* will notify the *claimant* of the *Plan*'s *urgent care claim* determination as soon as possible, but in no event more than 48 hours after the earlier of:

    a. The *Plan*'s receipt of the specified information; or

    b. The end of the period afforded the *claimant* to provide the specified additional information.

Concurrent Care Decisions

The *Plan Manager* will notify a *claimant* of a *concurrent care decision* that involves a reduction in or termination of benefits that have been pre-authorized. The *Plan Manager* will provide the notice sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination on review of the adverse determination before the benefit is reduced or terminated.

A request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided by the *Plan Manager* as soon as

possible, taking into account the medical exigencies. The *Plan Manager* will notify a *claimant* of the benefit determination, whether adverse or not within 24 hours after receipt of the claim by the *Plan*, provided that the claim is submitted to the *Plan* at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-Service Claims

The *Plan Manager* will notify the *claimant* of a favorable or adverse determination within a reasonable time, but not later than 30 days after receipt of the claim by the *Plan*.

However, this period may be extended by an additional 15 days, if the *Plan Manager* determines that the extension is necessary due to matters beyond the control of the *Plan*. The *Plan Manager* will notify the affected *claimant* of the extension before the end of the initial 30-day period, the circumstances requiring the extension, and the date by which the *Plan* expects to make a decision.

If the reason for the extension is because of the *claimant's* failure to submit information necessary to decide the claim, the notice of extension will describe the required information. The *claimant* will have at least 45 days from the date the notice is received to provide the specified information. The *Plan Manager* will make a decision no later than 15 days after the earlier of the date on which the information provided by the *claimant* is received by the *Plan* or the expiration of the time allowed for submission of the additional information.

Disability Claims

Weekly disability claims will be processed within 45 days of the *Third Party* Administrator's receipt of a claim. If additional time is required the 45-day period may be extended one time for up to 30 days provided that the *TPA* determines that such an extension is necessary due to matters beyond the *Plan*'s control and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension and the date by which the *Plan* expects to render a decision. If prior to the end of the first 30-day extension period, it is determined that, due to matters beyond the *Plan*'s control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, before the expiration of the first 30-day extension period of the circumstances requiring the extension and the date the *Plan* expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

Times for Decisions

The periods of time for claims decisions presented above begin when a claim is received by the *Plan*, in accordance with these claims procedures.

Payment of Claims

Many health care providers will request an assignment of benefits as a matter of convenience to both provider and patient. Also as a matter of convenience, the *Plan Manager* will, in its sole discretion, assume that an assignment of benefits has been made to certain Network Providers. In those instances, the *Plan Manager* will make direct payment to the *hospital*, clinic, or physician's office, unless the *Plan Manager* is advised in writing that *you* have already paid the

bill. If *you* have paid the bill, please indicate on the original statement, "paid by *employee,*" and send it directly to the *Plan Manager*. *You* will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

When an *employee's* child is subject to a medical child support order, the *Plan Manager* will make reimbursement of eligible expenses paid by *you*, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the medical child support order.

Payment of benefits under this *Plan* will be made in accordance with an assignment of rights for *you* and *your dependents* as required under state Medicaid law.

Benefits payable on behalf of *you* or *your* covered *dependent* after death will be paid, at the *Plan*'s option, to any *family member(s)* or *your* estate. The *Plan Manager* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the *Plan* from further liability.

Any payment made by the *Plan Manager* in good faith will fully discharge it to the extent of such payment.

Payments due under the *Plan* will be paid upon receipt of written proof of loss.

Initial Denial Notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX, or by e-mail, as appropriate, within the time frames noted above.

However, notices of adverse decisions involving *urgent care claims* may be provided to a *claimant* orally within the time frames noted above for expedited *urgent care claim* decisions. If oral notice is given, written notification will be provided to the *claimant* no later than 3 days after the oral notification.

A claims denial notice will state the specific reason or reasons for the adverse determination, the specific *Plan* provisions on which the determination is based, and a description of the *Plan*'s review procedures and associated timeline. The notice will also include a description of any additional material or information necessary for the *claimant* to perfect the claim and an explanation of why such material or information is necessary.

The notice will describe the *Plan*'s review procedures and the time limits applicable to such procedures, including a statement of the *claimant's* right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

The notice will also disclose any internal *Plan* rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on *medical necessity, experimental, investigational or for research purposes,* or similar exclusion or limit, the notice will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the

claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse decision of an *urgent care claim*, the notice will provide a description of the *Plan*'s expedited review procedures applicable to such claims.

Appeals of Adverse Determinations

A *claimant* must appeal an adverse determination within 180 days after receiving written notice of the denial (or partial denial). With the exception of *urgent care claims* and *concurrent care decisions*, the *Plan* uses a two level appeals process for all adverse determinations. For Comprehensive Medical claims, The *Plan Manager* will make the determination on the first level of appeal. If the *claimant* is dissatisfied with the decision on this first level of appeal, or if the *Plan Manager* fails to make a decision within the time frame indicated below, the *claimant* may appeal to the *Plan* Administrator. For Weekly Disability, Death Benefits, Health Reimbursement Claims, and Prescription Drug Benefits, a Clams Subcommittee will make the determination on the first level of appeal. *Urgent care claims* and *concurrent care decisions* are subject to a single level appeal process only, with the *Plan Manager* making the determination.

A first level appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

For Medical Claims:
Humana G&A
P.O. Box 14546
Lexington, Kentucky 40512-4546

For all other Claims:
Claims Subcommittee
SWORC Health Plan
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515

A second level appeal must be made by a *claimant* by means of written application, in person, or by mail (postage prepaid), addressed to:

For Medical Claims:
Trustee Claims Subcommittee
SWORC Health Plan
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515

For all other Claims:
Plan Administrator
SWORC Health Plan
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515

A voluntary third level of appeal to the full Board of Trustees (Plan Administrator) of the Plan is also available to you. This appeal also must be made by a claimant by means of written application in person, or by mail (postage prepaid), addressed to:

Plan Administrator
SWORC Health Plan
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515

The claimant must use the first and second levels of appeal before using this third level. This third level is voluntary; a claimant won't be deemed to have failed to exhaust administrative remedies if the claimant decides not to use this third level. The statute of limitations will be tolled during this third level, beginning with the date the claimant notifies the Plan Administrator of the claimant's intent to pursue the third level.

However, if favorable action has not been taken on the appeal within 180 days after the claimant notifies the Plan Administrator of its intent to pursue the third level of appeal, the appeal will be deemed to have been denied, and the statute of limitations will again begin running. In any event, the claimant's decision of whether to pursue the third level of appeal will not affect the claimant's other benefits under this Plan.

Appeals of denied claims will be conducted promptly, will not defer to the initial determination, and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

A *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with the adverse determination being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is *experimental, investigational, or for research purposes*, or not *medically necessary* or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time Periods for Decisions on Appeal - First Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent Care Claims	As soon as possible, but not later than 72 hours after the *Plan Manager* receives the appeal request. (If oral notification is given, written notification will follow in hard copy or electronic format within the next 3 days).
Pre-Service Claims	Within a reasonable period, but not later than 15 days after the *Plan Manager* receives the appeal request.
Post-Service Claims, Death Claims and Disability Claims	Within a reasonable period but no later than 30 days after the *Plan Manager* or *TPA* (as applicable) receives the appeal request.
Concurrent Care Decisions	Within the time periods specified above, depending upon the type of claim involved.

Time Periods for Decisions on Appeal - Second Level

Appeals of claims denials will be decided and notice of the decision provided as follows:

Pre-Service Claims	Within a reasonable period, but not later than 15 days after the *Plan Manager* receives the appeal request.
Post-Service Claims, Death Claims and Disability Claims	Within a reasonable period but no later than 30 days after the *Plan Manager* or *TPA* (as applicable) receives the appeal request.
Disability Claims	Within a reasonable period but no later than 15 days after the *TPA* receives the appeal request.

Appeal Denial Notices

Notice of a benefit determination on appeal will be provided to *claimants* by mail, postage prepaid, by FAX, or by e-mail, as appropriate, within the time frames noted above.

A notice that a claim appeal has been denied will convey the specific reason or reasons for the adverse determination and the specific *Plan* provisions on which the determination is based.

The notice will also disclose any internal *Plan* rule, protocol or similar criterion that was relied on to deny the claim. A copy of the rule, protocol or similar criterion relied upon will be provided to a *claimant* free of charge upon request.

If the adverse determination is based on a *medical necessity* or *experimental, investigational, or for research purposes* or similar exclusion or limit, the notice will provide either an ex*plan*ation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *claimant's* medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the event of a denial of an appealed claim, the *claimant* on appeal will be entitled to receive, upon request and without charge, reasonable access to and copies of any document, record or other information:

1. Relied on in making the determination.

2. Submitted, considered or generated in the course of making the benefit determination.

3. That demonstrates compliance with the administrative processes and safeguards required with respect to such determinations.

4. That constitutes a statement of policy or guidance with respect to the *Plan* concerning the denied treatment, without regard to whether the statement was relied on.

Right to Require Medical Exams
(Applies only to medical *Plan*s)

The *Plan* has the right to require that a medical exam be performed on any *claimant* for whom a claim is pending as often as may be reasonably required. If the *Plan* requires a medical exam, it will be performed at the *Plan*'s expense. The *Plan* also has a right to request an autopsy in the case of death, if state law so allows.

Exhaustion

Upon completion of the appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the *Plan*. If the *Plan Manager* or *Plan* Administrator fails to complete a claim determination or appeal within the time limits set forth above, the *claimant* may treat the claim or appeal as having been denied, and the *claimant* may proceed to the next level in the review process.

Legal Actions and Limitations

A civil action may not be brought with respect to *Plan* benefits until all remedies under the *Plan* have been exhausted.

ADMINISTRATION OF THE FUND

Payments of Benefits Limited to *Plan*

All benefits under this *Plan* shall be payable through employees or agents of the Trustees acting under their authority. Benefits as authorized under this *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.

Amendment or Termination of *Plan* or Benefits

The Trustees may change or terminate this *Plan*, or any part thereof, in their sole and exclusive discretion. Benefits will terminate when the *Plan*, or any applicable portion thereof, is terminated. No one has the authority to make any oral modification to the *Plan* or the Summary *Plan* Description.

Records

By accepting coverage under the *Plan*, each *Covered Person* (whether or not the *Covered Person* has signed the application) authorizes and directs any person or institution that has provided services to the *Covered Person*, to furnish the *Plan* Administrator or any of its agents or designees at any reasonable time, upon its request, any and all information and records or copies of records relating to the services provided to the *Covered Person*. *Plan* Administrator or its agents or designees shall have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the *Plan* or for appropriate medical review or quality assessment consistent with the terms of the *Plan*'s Privacy Policy. *Plan* Administrator is permitted to charge a *Covered Person* reasonable fees to cover costs for completing requested medical abstracts or forms.

Payment of Claims and Assignment of Benefits

Any benefits payable under this *Plan* are payable to the *Eligible Employee* or such person's designated *beneficiary*. However, unless the Covered Person requests otherwise, in writing, not later than the time proof of loss is filed, the *Plan* may pay any part or all of any benefits provided on account of *hospital*, nursing, medical, or surgical service directly to the person or entity which provided the service or treatment. The coverage and benefits under the *Plan* are not assignable without the consent of the Fund. Assigned benefits shall be paid to the assignee, regardless of the intervening death of the Covered Person. Otherwise, except as otherwise provided by law, benefits due under this *Plan* shall not be assignable nor subject to attachment, garnishment or other legal process for debts of Covered Persons.

Payment of Unassigned Benefits in Event of Death

If a Covered Person expires before the payment to him of any and all unassigned benefits, the *Plan* Manager or *TPA* may pay the amount of the unassigned but unpaid benefits as follows:

- If a probate administration is commenced in the Probate Court of the country in which the Covered Person was domiciled at the time of his death, the *Plan* Manager or *TPA* shall make prompt payment of the amount of the unassigned but unpaid benefit to the legal representative of the deceased, Covered Person appointed by the Probate Court, upon receipt of a Certificate of Official Character from said legal representative.

- If a probate administration is not commenced on behalf of the deceased Covered Person, the *Plan* Manager or *TPA*, in the absence of a designated *beneficiary* shall make prompt payment of the amount of the unassigned but unpaid benefit to the survivors in the following order of priority and upon evidence acceptable to the *Plan* Manager or *TPA* of their status and priority: (a) *spouse*, (b) *children*, pro rata; (c) parents; (d) brothers and sisters, pro rata; and (e) next of kin.

Misstatements

If any facts relevant to the existence or amount of coverage shall be misstated, the true facts will determine whether or not, and how much, coverage is in force.

Physical Examination

The Trustees, the *Plan Manager* and *Third Party Administrator* have the right to ask that you be examined by a Physician of their choice if there is a question about your eligibility or coverage. For death, the Trustees reserve the right to request an autopsy, if it is not forbidden by law.

Presentment of Claims on Behalf of Person Who is Incapacitated

If a Covered Person shall become incapacitated and be unable to prepare, complete, and/or execute the forms and documents prescribed by the Trustees and/or their *Plan* Manager or *TPA* for the filing of claims and/or receipt of benefits, the forms and documents may be signed for and on behalf of the Covered Person by other persons, as follows:

- If a guardian has been appointed by a court of competent jurisdiction for the Covered Person, by the guardian;

- If no guardian has been appointed, then by the persons in the following order of priority and upon evidence acceptable to the *Third Party Administrator* of status and priority: (1) *spouse*; (2) a child; (3) a parent; or (4) a brother or sister.

Claims for Medical Service Rendered Outside of the United States

Due to the increasing mobility of Covered Persons in the *Plan*, claims may be paid which arise from medical treatment received outside the United States, provided certain conditions are first met:

1. If there has been *Emergency* medical care, the Covered Person, upon returning to the United States, should submit the bills which have been paid for the *Emergency* treatment in order to be reimbursed according to the provisions and limitations within the *Plan*.

2. If there will be elective medical care, the Covered Person must first submit to the *Plan* Manager or utilization review group a request stating the intended medical procedures to be undergone. The Covered Person will receive a determination on whether or not it is in accordance with accepted medical procedures within the United States and whether it is encompassed within the framework of the *Plan*'s benefits. Until such a determination is received, the Covered Person cannot be assured that elective medical treatment will be covered under the *Plan*.

3. Payment will be made in accordance with the foreign exchange rate as of the date of the medical care. Foreign currency will be converted to United States values as of that date.

Recovery of Overpayment

If the *Third Party Administrator* or *Plan* Manager ascertains that *you* or any party on *your* behalf has received an erroneous overpayment of a benefit, they shall immediately notify such Person in writing, explaining the nature of the erroneous overpayment and requesting return of the amount of such overpayment. If the initial request for restitution is not successful, they shall renew the demand in writing upon *you* and/or the other party; and may take other reasonable actions to obtain reimbursement of the erroneous overpayment. The *Plan* has the right to recover against *you* if the *Plan* has paid *you* or any other party on *your* behalf.

If the taking of reasonable steps to obtain repayment of the overpayment has been unsuccessful, the Third Party Administrator or *Plan* Manager may treat the overpayment of benefits as an advance payment of benefits due to the Covered Person and offset the amount of such overpayment against any *Plan* benefits due or which may become due to the Covered Person until the full amount of the overpayment has been repaid to the *Plan*.

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.

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 Claims Review Committee, have the sole and exclusive authority to make final determinations regarding any application for benefits 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 or amount of benefits, shall be resolved by the Board of Trustees. 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 a decision is 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.

Legal Actions

All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. No action at law or in equity may be brought regarding claims for benefits or a fiduciary's breach of any duty under this *Plan*:

1. Earlier than 45 days after a claim has been filed; or
2. Later than two years after the date proof of loss is required; or
3. Until all *Plan* remedies have been exhausted.

DEFINITIONS

Active status means performing on a regular, full-time basis all customary occupational duties as determined by the *employer* at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if *you* were in an *active status* on *your* last regular working day prior to the vacation or holiday.

Beneficiary means *you* and *your* covered *dependent(s),* or legal representative of either, and anyone to whom the rights of *you* or *your* covered *dependent(s)* may pass.

Bodily injury means injury due directly to an accident and independent of all other causes.

Calendar year means a period of time beginning on January 1 and ending on December 31.

Case management means the process of assessing whether an alternative *Plan* of care would more effectively provide *medically necessary* health care *services* in an appropriate setting.

Claimant means a *covered person* (or authorized representative) who files a claim.

Code means the Internal Revenue Code.

Collective bargaining agreement is the agreement between your Union and Employer which governs the wages and conditions of your work.

Complications of pregnancy means:

- Conditions whose diagnoses are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia and missed abortion;
- A nonelective cesarean section surgical procedure;
- Terminated ectopic pregnancy; or
- Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy does not mean:

- False labor;
- Occasional spotting;
- Prescribed rest during the period of pregnancy;
- Conditions associated with the management of a difficult pregnancy but which do not constitute distinct *complications of pregnancy*; or

- An elective cesarean section.

Concurrent care decision means a decision by the *Plan* to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the *Plan* (other than by *Plan* amendment or termination) or a decision with respect to a request by a *claimant* to extend a course of treatment beyond the period of time or number of treatments that has been approved by the *Plan*.

Concurrent review means the process of assessing the continuing *medical necessity*, appropriateness, or utility of additional days of *hospital confinement*, outpatient care, and other health care *services*.

Confinement means being a resident patient in a *hospital* or a *qualified treatment facility* for at least 15 consecutive hours per day. Successive *confinements* are considered one *confinement* if:

- Due to the same *bodily injury* or *sickness*; and

- Separated by fewer than 30 consecutive days when *you* are not confined.

Copayment means the amount to be paid by *you* for each applicable medical *service*.

Cosmetic surgery means *surgery* performed to reshape structures of the body in order to change *your* appearance or improve self-esteem.

Covered employment is employment covered under the terms of a *collective bargaining agreement* between the Union and a participating Employer.

Covered expense means *services* incurred by *you* or *your* covered *dependents* due to *bodily injury* or *sickness* for which benefits may be available under the *Plan*. *Covered expenses* are subject to all provisions of the *Plan*, including the limitations and exclusions.

Covered person means the *employee or retiree* or any of such person's covered *dependents*.

Creditable coverage means the total time of prior continuous health *Plan* coverage periods used to reduce the length of any pre-existing condition limitation period applicable to *you* or *your dependents* under a successor *Plan* where prior continuous health coverage(s) existed with no more than a 63-consecutive day lapse in coverage.

Custodial care means *services* provided to assist in the activities of daily living which are not likely to improve *your* condition. Examples include, but are not limited to, assistance with dressing, bathing, toileting, transferring, eating, walking and taking medication. These *services* are considered *custodial care* regardless if a *qualified practitioner* or provider has prescribed, recommended or performed the *services*.

Dental injury is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. *Dental injury* does not include chewing injuries.

Dependent means a covered *employee's*:

- ***Spouse***. This means the person who is married to you in a legally recognized civil or religious ceremony. If you become divorced or legally separated, your spouse loses eligibility, and you are required to notify the *Third Party Administrator*.

  A common-law spouse shall be considered an eligible spouse by the Fund only if the state in which you live recognizes common-law marriage. The Fund will cover only claims incurred after the proper affidavit is furnished.

  Marriage is recognized only as a legal union between one man and one woman as husband and wife. The person must be of the opposite sex, and be a husband or wife.

- ***Children***. *Children* are covered from the date of birth, and are eligible dependents as long as they are unmarried and through the end of the year of the child's 19th birthday; or the end of the year of the child's 23rd birthday if such child is in regular full-time attendance at an accredited secondary school, college or university. The *dependent* child must be enrolled for sufficient course credits to maintain full-time status as defined by that school. A *dependent* child continues to be eligible for coverage for up to four months following the close of a school term only if enrolled as a full-time student for the following school term.

  The term "child" includes, in addition to your natural child, your stepchild, adopted child or child placed for adoption, foster child and any other child of whom you have care, custody and control under a court decree, provided the child is dependent on you for its principal support and maintenance. The term also includes a grandchild, as long as the employee's covered dependent, who is the parent of the grandchild, is not yet age 18.

  "Child" also includes a child for whom you are required to furnish medical coverage under a Qualified Medical Child Support Order or National Medical Support Order.

  If an unmarried dependent child is incapable of self-sustaining employment because of a physical handicap or mental retardation, and is dependent upon you for support and maintenance, coverage will be continued, provided the child's incapacity began before the age at which the child's coverage would have been terminated. You must submit proof of the child's incapacity to the Fund Office not later than 31 days after the date such child attains the age at which such person's coverage would otherwise terminate. Proof of continued incapacity shall be furnished to the fund Office from time to time upon request.

  You may be required as a condition of coverage—to furnish marriage certificates, divorce and other decrees, birth certificates, adoption decrees and judicial placement orders, student registrations and tax returns to support dependent status under the *Plan*.

Durable medical equipment (DME) means equipment that is *medically necessary* and able to withstand repeated use. It must also be primarily and customarily used to serve a medical purpose and not be generally useful to a person except for the treatment of a *bodily injury* or *sickness*.

Emergency means an acute, sudden onset of a *sickness* or *bodily injury* which is life threatening or will significantly worsen without immediate medical or surgical treatment.

Effective Eligibility Date – the date you become eligible for medical coverage.

Eligible Employee shall mean any employee or former employee of an Employer who is eligible for benefits consistent with the terms and provisions of *collective bargaining agreements* or other labor-management agreements and meeting the eligibility rules adopted by the Trustees from time to time.

Eligible Retiree shall mean a former employee of an Employer who is eligible for one or more lines of coverage based on the eligibility rules adopted by the Trustees from time to time.

Employer or ***Employers*** include those who:

- Have directly executed a collective bargaining agreement with the Union which requires contributions to the *Plan* and which is acceptable to the Trustees; or

- Have executed an Employer Participation Agreement with the *Plan* which requires contributions to the *Plan* and which is acceptable to the Trustees.

Expense incurred means the fee charged for *services* provided to *you*. The date a *service* is provided is the *expense incurred* date.

***Experimental, investigational or for research purposes*:**
A *service* is *experimental, investigational or for research purposes* if the *Plan Manager* determines;

- The *service* cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the *service* is furnished; or

- The *service* or *your* informed consent document utilized with the *service* was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or

- Reliable evidence shows that the *service* is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

- Reliable evidence shows that the prevailing opinion among experts regarding the *service* is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

  Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same *service*; or the

written informed consent used by the treating facility or by another facility studying substantially the same *service*.

Family member means *you* or *your* spouse, or *you* or *your* spouse's child, brother, sister, parent, grandchild or grandparent.

Free-standing surgical facility means a public or private establishment licensed to perform surgery and which has permanent facilities that are equipped and operated primarily for the purpose of performing *surgery*. It does not provide *services* or accommodations for patients to stay overnight.

Hospital means an institution which:

- Maintains permanent full-time facilities for bed care of resident patients;
- Has a physician and surgeon in regular attendance;
- Provides continuous 24 hour a day nursing *services*;
- Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
- Is legally operated in the jurisdiction where located; and
- Has surgical facilities on its premises or has a contractual agreement for surgical *services* with an institution having a valid license to provide such surgical *services*; or
- Is a lawfully operated *qualified treatment facility* certified by the First Church of Christ Scientist, Boston, Massachusetts.

Hospital does not include an institution which is principally a rest home, skilled nursing facility, convalescent home or home for the aged. *Hospital* does not include a place principally for the treatment of alcoholism, chemical dependence or *mental disorders*.

Maintenance care means any *service* or activity which seeks to prevent *bodily injury* or *sickness*, prolong life, promote health or prevent deterioration of a *covered person* who has reached the maximum level of improvement or whose condition is resolved or stable.

Maximum allowable fee for a *service* means the lesser of:

- The fee most often charged in the geographical area where the *service* was performed;
- The fee most often charged by the provider;
- The fee which is recognized as reasonable by a prudent person;
- The fee determined by comparing charges for similar *services* to a national data base adjusted to the geographical area where the *services* or procedures were performed; or

- The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown on the Schedule of Benefits. No further benefits are payable once the *maximum benefit* is reached.

Medically necessary or medical necessity means the extent of *services* required to diagnose or treat a *bodily injury* or *sickness* which is known to be safe and effective by the majority of *qualified practitioners* who are licensed to diagnose or treat that *bodily injury* or *sickness*. Such *services* must be:

- Performed in the least costly setting required by *your* condition;

- Not provided primarily for the convenience of the patient or the *qualified practitioner*;

- Appropriate for and consistent with *your* symptoms or diagnosis of the *sickness* or *bodily injury* under treatment;

- Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for *your* symptoms, diagnosis, *sickness* or *bodily injury*; and

- Substantiated by the records and documentation maintained by the provider of *service*.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Mental disorder means a mental, nervous, or emotional disease or disorder of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders, regardless of the cause or causes of the disease or disorder.

Morbid obesity means morbid or clinically severe obesity correlated with a Body Mass Index (BMI) of 40 kg/m2 or with being 100 pounds over ideal body weight or has a BMI of 35 kg/m2 with underlying medical conditions (e.g. obesity, hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction).

National Medical Support Notice or Order is a standardized medical child support order that is to be used by state child enforcement agencies to enforce medical child support obligations.

Occupational Disease is a disease or sickness arising out of, or in any way resulting from, any work for pay or profit.

Occupational Injury is an acci*dental injury* arising out of or in the course of any work for pay or profit, or in any way resulting from an injury which does.

Plan or Fund is the Southwest Ohio Regional Council of Carpenters Health and Welfare *Plan*.

Plan Administrator shall mean the Trustees. The *Plan* Administrator is also the *Plan* Sponsor. The *Plan Administrator* shall be the designated agent for service of process.

Plan Manager means Humana Insurance Company (HIC). The *Plan Manager* provides services to the *Plan* Administrator, as defined under the *Plan Manager* Agreement. The *Plan Manager* is not the *Plan* Administrator or the *Plan* Sponsor.

Plan year means a period of time beginning on January 1 and ending on December 31.

Post-service claim means any claim for a benefit under a group health *Plan* that is not a *pre-service claim*.

Preadmission testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a *hospital*. The tests must be for the same *bodily injury* or *sickness* causing the patient to be *hospital* confined. The tests must be accepted by the *hospital* in lieu of like tests made during *confinement*. *Preadmission testing* does not mean tests for a routine physical check-up.

Precertification means the process of assessing the *medical necessity*, appropriateness, or utility of proposed non-emergency *hospital* admissions, surgical procedures, outpatient care, and other health care *services*.

Predetermination of benefits means a review by the *Plan Manager* of a *qualified practitioner's* treatment plan, specific diagnostic and procedure codes and expected charges prior to the rendering of *services***.**

Pre-service claim means a claim with respect to which the terms of the *Plan* condition receipt of a *Plan* benefit, in whole or in part, on approval of the benefit by the *Plan Manager* in advance of obtaining medical care.

Protected health information means individually identifiable health information about a *covered person*, including: (a) patient records, which includes but is not limited to all health records, physician and provider notes and bills and claims with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

Qualified Medical Child Support Order (Order) is a court order requiring medical support which meets the *Plan*'s Rules and Regulations and federal law requirements to be a Qualified Medical Child Support Order. Please refer to the back of this booklet for a pre-approved sample.

Qualified practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a *bodily injury* or *sickness*, and who provides *services* within the scope of that license.

Qualified treatment facility means only a facility, institution or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

Rehabilitation Center means a facility which provides *services* of non-acute rehabilitation. All *services* are provided under the direction of a psychiatrist, a medical doctor with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide *services* of a custodial nature. The facility must be Medicare certified licensed by the State Department of Health as a "special *hospital*" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

Services mean procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Sickness means a disturbance in function or structure of *your* body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of *your* body.

Sound natural tooth means a tooth that:

- Is organic and formed by the natural development of the body (not manufactured);
- Has not been extensively restored;
- Has not become extensively decayed or involved in periodontal disease; and
- Is not more susceptible to injury than a whole natural tooth.

Surgery means excision or incision of the skin or mucosal tissues, or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

Third Party Administrator or ***TPA*** shall mean any person or entity the Trustees shall appoint to administer the day-to-day operations of the *Plan*, including collection of employer contributions and eligibility determinations.

Total disability *or* ***totally disabled*** means:

- During the first twelve months of disability *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from performing each and every material duty of *your* respective job or occupation;
- After the first twelve months, *total disability* or *totally disabled* means that *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from engaging in any job or occupation for wage or profit for which *you* or *your* employed covered spouse are reasonably qualified by education, training or experience;
- For a non-employed spouse or a child, *total disability* or *totally disabled* means the inability to perform the normal activities of a person of similar age and gender.

A *totally disabled* person also may not engage in any job or occupation for wage or profit.

Urgent care claim means a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- Generally, whether a claim is a claim involving urgent care will be determined by the *Plan* Manager. However, any claim that a physician with knowledge of a claimant's medical condition determines is a "claim involving urgent care" will be treated as a "claim involving urgent care."

Utilization review means the process of assessing the *medical necessity*, appropriateness, or utility of *hospital* admissions, surgical procedures, outpatient care, and other health care *services*. *Utilization review* includes *precertification* and *concurrent review*.

Union is Southwest Ohio Regional Council of Carpenters and any other Council or Local approved for participation in this *Plan*, as defined in the *Plan*'s Trust Agreement.

You and your means *you* as the *employee* and any of *your* covered *dependents*, unless otherwise indicated.

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

As a participant in the Southwest Ohio Regional Council of Carpenters Health and Welfare *Plan*, 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:

- Examine, without charge, at the *Plan* Administrator's office and at other specified locations, such as work sites and union halls, all *Plan* documents including: insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary *Plan* description.

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

- Receive a summary of the *Plan*'s Annual Report (Form 5500). The *Plan* Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

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

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health *Plan*, if you have 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, of 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.

In addition to creating rights for *Plan* participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit *Plan*. The persons 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 health benefit, or exercising your rights under ERISA.

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 suit in a state or federal court. In addition, if you disagree with the *Plan*'s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that *Plan* fiduciaries misuse the *Plan*'s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court.

- The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

- If you lose, the court may order you to pay these costs and fees, for example, if it finds the claim is frivolous.

If you have any questions about your *Plan*, you should contact the *Third Party Administrator*.

If you have any questions about this statement or about your rights under ERISA, 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 attain 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.

IN THE COURT OF _____
OF _____COUNTY, OHIO

_____ _____ _____ Plaintiff, -vs- _____ _____ _____ Defendant.	Case No. _____ Judge _____ **MEDICAL CHILD SUPPORT ORDER** Plaintiff's attorney: _____ _____ _____ _____ Phone: _____ Defendant's attorney: _____ _____ _____ _____ Phone: _____

* * *

The _____ (also known as "Participant"), may be a participant in one or more
(Plaintiff or Defendant)
group health Plans from time to time. Participant's last known mailing address is _____.

The Participant's Social Security Number is _____.

B. Participant's children ("Alternate Recipients") are:

Name	**D.O.B.**	**S.S.N.**
_____	_____	_____
_____	_____	_____
_____	_____	_____

The Alternate Recipients' last known address is _____.
Notices for the Alternate Recipients are to be sent to this address or to _____.

C. The Alternate Recipients' custodial parent or legal guardian, to whom reimbursement is to be made for covered expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian, is _____,
whose address is _____.

D. This Medical Child Support Order is directed to any group medical Plan ("Plan") available to Participant through his employment.

E. Other: _____

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

1. The Plan is hereby ordered to enroll the Alternate Recipients in Participant's Plan for all medical benefits (including any prescription drug, dental, or vision benefits) available to Dependent children under the Plan's terms.

2. This Order shall be effective from and after the date of execution hereof until each Alternate Recipient reaches the age of eighteen (18) or graduates from high school, whichever is later; provided, however, that the Plan shall not be required to provide any coverage inconsistent with the Plan's terms.

3. Such coverage shall terminate if any payment required by a Plan is not paid timely.

4. The Court shall retain jurisdiction to clarify this Order in the event a Plan Administrator raises questions regarding its interpretation or determines that this Order does not meet the requirements of a "Qualified Medical Child Support Order" under Section 609 of The Employee Retirement Income Security Act, as amended ("ERISA") 29 U.S.C. §1169, in its present form or as hereafter amended.

5. The Participant shall promptly forward a copy of this Medical Child Support Order to the Plan Administrator of any *Plan*s available to the Participant from time to time. The Plan Administrator shall follow procedures consistent with ERISA Section 609(a) for determining the qualified status of this Order.

_____
JUDGE

Date_____

cc: *Plan* Administrator

_____ *Plan*

_____
address

_____
Plaintiff

_____
Defendant

_____
Alternate Recipient's Representative