YOUNGSTOWN AREA ELECTRICAL WELFARE FUND

PLAN BOOKLET FOR ELIGIBLE MEMBERS AND THEIR DEPENDENTS

REVISED: SEPTEMBER 1, 2013

BOARD OF TRUSTEES

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This Plan is Administered by:

Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
(330) 270-0453
(800) 435-2388

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IMPORTANT NOTICE

Keep Your Information Current!

It is extremely important that you keep the Fund Office informed of any change in address or desired change in beneficiary. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility or benefits.

The importance of a current, correct address on file in the Fund Office cannot be overstated! It is the ONLY way the Trustees can keep in touch with you regarding plan changes and other developments affecting your interests under the Plan.

Also, you have the responsibility to inform the Fund Office within (30) days of a divorce, legal separation or a child losing dependent status under the Plan.

Fund Information and Updates

The Board of Trustees is the Fund's agent for serving of legal process.

The Fund is identified in U.S. Department of Labor and Internal Revenue Service files by employer identification number 34-0835041 and plan number 501. Records of the fund are kept on the basis of a fiscal year ending December 31. The Plan Year ends on December 31.

This booklet is the Plan in effect as of January 1, 2013. From time to time you will receive supplemental bulletins about changes to this Plan. It is your responsibility to review these bulletins.

Grandfathered Health Plan

The Fund believes it is a "grandfathered health plan" under the health care reform laws that were enacted in March, 2010 (these are the Patient Protection and Affordable Care Act, also known as the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverages that were already in effect when that law was enacted. Being a grandfathered health plan means that the Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing.

However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause the Fund to change from grandfathered health plan status can be directed to the Fund at (330) 270-0453 or 800-435-2388 (in other areas).

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

INTRODUCTION

We are pleased to present you with your new Summary Plan Description or SPD, containing the current pertinent provisions of the Youngstown Area Electrical Welfare Fund.

Your Plan is financed through employer contributions which are made into the Trust Fund, tax exempt to you. Employer contributions are based on an hourly rate and are determined by the provision of the collective bargaining agreements in effect between the local union and participating signatory employers. You may obtain a copy of the collective bargaining agreement by writing to the Plan Administrator, or you may examine the document at the Fund Office.

The Plan is administered by the Board of Trustees consisting of three (3) Trustees from Labor and three (3) Trustees from Management. Under ERISA, the Plan Administrator is the Board of Trustees and this Board has the authority to control and manage the operations and administration of the Plan and is the Agent for Service of Legal Process.

The Board of Trustees, as the Administrator of your Plan, has authorized the payment of the benefits of the Plan through Compensation Programs of Ohio, Inc., located at 33 Fitch Boulevard, Austintown, Ohio 44515 (telephone: 330-270-0453 or 800-435-2388).

Since the Board of Trustees is the Administrator of the Fund and has the full authority and control of the program, the existing levels of benefits are subject to modification unilaterally by the Trustees from time to time, as shall in their sole judgment and discretion, be deemed proper for the maximum welfare of the beneficiaries of the Fund and protection of the assets of the Fund. The Trustees shall also have the sole power to interpret and determine the benefits payable under this Plan at all times and in case there is a controversy, the Board of Trustees' decision in all matters will be final, binding and conclusive.

Changes in the Plan may also be required in order to preserve the Fund's tax exempt status under the Internal Revenue Service rules and regulations. These rules and regulations may change and as a result, the Trustees may find it necessary to change the Plan provisions so that the Trust does not lose its tax exempt status. In the event of a change that would result in the reduction of any benefit provided by the Plan, the Trustees will endeavor to review the change with the Participants prior to initiating such change.

All benefits under the Plan shall be payable through Participants or agents of the Trustees acting under their authority. Benefits as authorized under the Plan are not vested and will be paid as long as the Fund can operate on a sound financial basis. No benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against any participating Union, the Association, any Employer or the Trustees. The Trustees, the Employers, the Association and the Participating Union shall not be held liable for any benefits or contracts except as provided in the agreement between the Employers and the Participating Union.

Only the Board of Trustees has the power to interpret and construe the Plan, determining all questions of eligibility and status under the Plan and determine all questions arising in the administration of the Plan, including the power to determine the rights or eligibility of Participants, participants and their dependents and benefits. This includes the authority and right to make findings of fact relating to these decisions.

No union or management representative, individual trustee, business agent or other individual has the authority to answer questions or make decisions concerning the provisions of the Health and Welfare Fund unless such individual has been given the authority by the Board of Trustees and is acting on their behalf. Do not rely on any oral description of the Fund; the written Plan document controls.

This new SPD contains an outline of how you should file claims, benefits provided in the Plan, and in the event an application for benefits is denied, a procedure in which you can file to appeal the denial.

This booklet supersedes and replaces any booklet previously issued to you under the Plan. Therefore, we ask that you read this SPD very carefully and submit any questions you may have regarding it to the Administrative Office listed in this SPD, ensuring any misunderstandings can be resolved in a timely manner.

Sincerely,

THE BOARD OF TRUSTEES

SCHEDULE OF BENEFITS FOR ALL ELIGIBLE MEMBERS AND THEIR DEPENDENTS

The Schedule of Benefits is a summary of the deductibles, co-payments and other limits when you and your covered dependents receive Covered Services from a provider. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this SPD, including any attachments or riders. This Schedule of Benefits lists the Member's responsibility for Covered Services. Benefits for Covered Services are based on Usual, Customary, and Reasonable charges. When you utilize a non-network provider you are responsible for any balance due between the non-network provider's charge and the Usual, Customary, and Reasonable charges in addition to any co-payments, deductibles, and non-covered charges.

Medical Benefit Overview

We have contracted to use the SuperMed Plus PPO offered by Medical Mutual of Ohio (MMO) for Ohio Providers, the Devon PPO for Pennsylvania and the Multi-Plan PPO for all remaining states. To verify whether a doctor or hospital participates, Ohio residents may contact Medical Mutual at 1-800-601-9208, Pennsylvania residents may contact Devon at 1-800-431-2273, outside Ohio and Pennsylvania residents may contact MultiPlan at 1-800-530-0621, or visit the Website at www.supermednetwork.com or ask the medical provider.

Dependent Age Limit

Effective January 1, 2011, children are eligible for medical coverage up to age 26, regardless of full-time student status, residency, financial support, marital status or access to other employer-sponsored coverage. However, children who have employer-based coverage available to them prior to January 1, 2014 are ineligible for Plan coverage.

COVERED SERVICES

Medical Expense Benefits

The plan benefit period is based on the Calendar Year, and covers the following services:

- Inpatient hospital services
- Surgical fees
- X-ray and lab
- Outpatient hospital services
- Anesthesia
- Physician office services
- Chiropractic benefits
- Durable medical equipment
- Ambulance services
- Inpatient physician visits and consultations

All Medical Expenses Are Subject to the Usual, Customary, and Reasonable Charges.

Medical Plan Highlights

Plan Provision	In-Network	Out-of-Network
Deductible	Single: $300 Family: $1,200	Single: $600 Family: $2,400
Office Visit Copay	$20 *(not subject to deductible)*	Regular coinsurance/deductible applies
Emergency Room Copay	$100 *(not subject to deductible)*	Regular coinsurance/deductible applies
Coinsurance	20% of $10,000 per person	30% of $13,333.33 per person
Out-of-Pocket Maximum	$2,000 per person *(after deductible)*	$4,000 per person *(after deductible)*
Annual Maximum Benefit		
Annual Limit	**Dates In Effect**	
$750,000	January 1, 2011 – December 31, 2011	
$1,250,000	January 1, 2012 – December 31, 2012	
$2,000,000	January 1, 2013 – December 31, 2013	
No Annual Limit	January 1, 2014 and after	
Other Benefits	**Description**	
TMJ	Temporomandibular joint disorder treatment; lifetime maximum $400	

Hospital Room and Board

The daily hospital room and board benefit is the actual charge made by the hospital, if you are confined in semi-private or ward accommodations. If you are confined in a private room, the benefit will equal the hospital's charge for its highest priced semi-private accommodations. For all other covered expenses, which are described below under "Covered Expenses", payment will be made as follows/per person:

Amount of Covered Expenses	**Amount Fund Will Pay** ***In-Network*** *(after deductible)*	**Amount Fund Will Pay** ***Out-of-Network*** *(after deductible)*
First $10,000	80%	70%
$10,000 +	100%	100%

No Lifetime Limit for Essential Benefits

Effective January 1, 2011, essential benefits are no longer subject to lifetime maximum benefit limits. Essential benefits as currently defined under the Patient Protection and Affordable Care Act are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

The following **annual limits** still apply:

- $750,000 from January 1, 2011 through December 31, 2011
- $1,250,000 from January 1 2012 through December 31, 2012
- $2,000,000 from January 1, 2013 through December 31, 2013
- Effective January 1, 2014, the annual limit on essential benefits is discontinued.

Covered Expenses

Expenses incurred for any of the following, to the extent, the charge is **reasonable and customary,** will be paid by the fund in accordance with the above Benefit Schedule, (see also ***What is Not Covered*** (page 11), ***Limitations and Exclusions*** (page 11), and ***Coordination of Benefits*** (page 21) of this booklet).

1) Hospital Confinement

   a) Board and room charges up to the maximum daily board and room allowance shown above.

   b) Charges for other services and supplies furnished by the hospital for use during confinement (but not for special nursing services or physician's services).

2) Medical treatment or surgical procedure by a physician.

3) Private duty nursing service by a registered or licensed nurse, if the physician recommends such service, provided the nurse is not a member of the immediate family or household.

4) Local use of ambulance.

5) Certain services and supplies:

   a) Anesthetics and oxygen and their administration.

   b) Rental of iron lung, oxygen tent, hospital bed, wheel chair, and similar durable medical equipment designed primarily for use in a hospital for therapeutic purposes. (The fund, at its option, may purchase in lieu of rental).

   c) Blood and blood plasma, and their administration, to the extent not replaced by donations.

   d) Braces, crutches, and prostheses necessitated by injury or disease occurring while eligible (not including repair and maintenance).

   e) X-ray examinations and laboratory tests.

   f) Physiotherapy.

6) Diagnosis and treatment of nervous and mental conditions by a psychologist, to the extent they would be covered if made by a psychiatrist.

7) Extended Care Facility. Expenses incurred in extended care facilities for the following services and supplies will be covered by the fund:

   a) Board and room and nursing care (but not private duty nurse or attendant).

   b) Physical therapy, occupational therapy and speech therapy.

   c) Medical social service.

   d) Biologicals, supplies. appliances and equipment ordinarily provided by the facility for care of patients.

   e) Medical care by an intern or resident-in-training of a hospital and other diagnostic and therapeutic services furnished to extended care facilities patients by a hospital.

   f) Other necessary services generally provided to patients by extended care facilities.

   Confinement in an extended care facility must begin before the 65th birthday of the individual confined and must occur by means of direct transfer from a hospital in which the individual was confined for at least three (3) days, and must be for the same condition that caused the hospital confinement.

Maternity

Coverage for inpatient hospital maternity services is treated as any other illness or injury. Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy and miscarriage are covered. If you or your spouse are admitted to the hospital for maternity services, your hospital stay cannot be restricted to less than forty-eight (48) hours (ninety-six hours for cesarean section) in accordance with the legislation passed by the Newborn and

Mothers Health Protection Act of 1996; provided, however, if both the physician and mother consent, the stay can be shortened.

This Plan does not cover the expenses incurred due to the pregnancy of a Dependent Child of any Participant.

Drug and Alcoholism Treatment Facilities

Charges for rooms with two or more beds, general nursing care, and other services, and supplies are covered.

If you are admitted as an inpatient for a prescribed course of treatment for alcoholism or drug abuse dependency to a hospital or to an approved Rehabilitation Facility (including detoxification in an Approved Rehabilitation Facility) approved by the Board of Trustees, benefits on account of such treatment will be subject to deductibles and co-insurance.

If you are initially confined in hospital but are then transferred to an Approved Rehabilitation Facility approved by the Board of Trustees, both periods of confinement shall constitute a single confinement.

Services cannot be limited to detoxification but, rather, must include a program of rehabilitation and therapy. Coverage shall be provided only where the eligible person completes the prescribed program of rehabilitation and therapy.

Mental and Nervous Disorders Treatment

If you are admitted as an inpatient for a prescribed course of treatment for mental and/or nervous disorder to a hospital or to an approved Rehabilitative Facility approved by the Board of Trustees, benefits on account of such treatment will be subject to deductibles and coinsurance.

The following services provided by or under the direct supervision of a physician or a licensed psychologist are covered:

1) Individual, group and family psychotherapeutic counseling, electroshock treatment, psychological testing and psychiatric consultation for treatment of mental disorders.

2) Individual, group, and family counseling. The attending physician or psychologist must certify the need for treatment after the first three months before additional benefits can be covered.

The following services will not be covered: treatment of drug addiction, developmental or perceptual therapy, primal therapy, cathecathon therapy, and collaborative therapy.

Ohio law sets certain requirements for a facility or doctor. Be sure to check the status of your doctor or facility before receiving services.

PRESCRIPTION DRUG BENEFITS

The Prescription Drug benefit is administered by Express Scripts and covers charges for drugs prescribed by a physician, dispensed by a pharmacist and not available over the counter without a prescription. The plan offers lower prices for generic drugs, a mail order option for maintenance medications and coverage for specialty drugs. The plan also requires mandatory generic substitution.

Covered expenses include:

- **Federal Legend Drugs** - Any medicinal substance which bears the legend "Caution: Federal Law prohibits dispensing without a prescription."
- **State Restricted Drugs** - Any medicinal substance which may be dispensed by prescription only according to state law.
- **Compounded Medication** - Any medicinal substance which has at least one ingredient that a Federal Legend or State Restricted Drug in a therapeutic amount.
- **Insulin** - Available by prescription only (includes insulin syringes)

Prescription Drug Benefit Highlights

Prescription Drug Benefits		
Drug Category	**Your Cost** ***Retail*** ***(up to 30 day supply)***	**Your Cost** ***Mail Order*** ***(up to 90-day supply)***
Generic	$8.00	$16
Preferred Brand	20% of cost ($15 minimum)	20% of cost ($30 minimum)
Non-Preferred Brand	30% of cost ($30 minimum)	30% of cost ($60 minimum)

Express Scripts has contracted with the Youngstown Area Electrical Welfare Fund to provide an efficient and cost effective program that will be easy for you and your dependents to use when you purchase your prescriptions at a Network Pharmacy. Please check with the Fund Office or call the Prescription Drug Administrator at 800-467-2006 directly for a participating pharmacy location near you.

Generic Substitution

Since a generic drug substitute is the same chemically and usually costs less than the brand name drug, if you choose a brand name (preferred or non-preferred) when a generic alternative is available, you will be subject to a higher copay as shown in the table on the previous page. To maximize your cost savings under the Plan, you may want to talk to your doctor about generic alternatives to any brand drugs you use.

Mandatory Mail Order

Effective August 1, 2006, you are required to use the mail order program for any maintenance medications you use. Maintenance medications include prescription drugs for ongoing conditions such as diabetes or high blood pressure. Under the program, you can get up to a one-month supply of maintenance medication two times from a local pharmacy. After that, the Plan will cover the medication only if you order it from the Express Scripts Pharmacy mail order program ("Express Scripts").

When you use Express Scripts, you'll save money on copayments (refer to the table on the previous page), plus you will receive:

1) Free home delivery of your medication

2) Up to a 3-month supply of medication with each order

3) 24-hour access to a pharmacist

If you or a covered dependent use a maintenance medication, visit www.express-scripts.com or call Compensation Programs of Ohio at 1-800-435-2388 to request a mail order form.

Step Therapy Program

Step Therapy is a program for individuals who take prescription drugs regularly for an ongoing condition like arthritis, asthma or high blood pressure. The program is a new approach to getting you the prescription drugs you need with safety, cost and your good health in mind. It allows you and your family to receive the treatment you need while making prescription drugs more affordable for you.

The program moves you along a series of steps. Your doctor is consulted, and approves your prescriptions based on the Step Therapy drugs covered by the Plan. Your path starts with "first step" drugs, which are typically generic drugs which have been proven safe and effective. "Second step" drugs, which are more expensive brand name drugs, may be covered if you have first tried first step drugs without success.

Injectables and Other Specialty Medications

Specialty medications are high cost oral or injectable medications used to treat complex conditions such as Hepatitis C and Multiple Sclerosis. Unlike traditional medications, specialty medications typically cost $1,400 or more per month. The Plan requires you to purchase specialty medications through CuraScript, a partner of Express Scripts.

CuraScript is a leading provider of specialty medications, providing the most comprehensive and convenient specialty pharmacy services available at no additional cost to you. CuraScript and the CareLogic program specialize in oral and injectable specialty medications. CuraScript offers many products and services that you don't get from other pharmacies, including:

1) A Patient Care Coordinator who serves as your personal advocate and your primary point of contact;

2) A complete specialty pharmacy inventory with many specialty medications that aren't readily available at a local pharmacy;

3) Home delivery or delivery to your doctor; and

4) Supplies you need to administer your medications, at no additional cost.

Effective August 1, 2006, you may get one fill of a specialty medication at the retail pharmacy; all additional fills must be through CuraScript.

What is Not Covered?

The Fund is able to cover most facilities and types of care. The decision about non-covered care will be made by the Trustees based on medical information supplied by physicians, facilities, or a medical foundation or utilization review committee.

The Fund covers only services and supplies which are medically necessary as determined by the Trustees. The fact that a physician or another provider has furnished, ordered, or approved a service does not, of itself, make that service medically necessary.

Medically necessary services and supplies, as determined by the Trustees, are those which are:

1) Consistent with your symptoms, or diagnosis and treatment of your condition,

2) Appropriate according to standards of good medical practice, and

3) Performed in the least costly setting where services can safely and appropriately be provided.

The determination of medically necessary will be made by the Trustees based on a review of your medical records. The Fund will not cover any unnecessary services beyond the date that your care was no longer necessary.

Services and supplies rendered for any of the following are not covered:

1) Admissions beginning prior to the effective date, or after the cancellation of your coverage.

2) Inpatient hospitalization principally for observation or diagnostic evaluation, physical therapy; or radiotherapy.

3) Services for convalescent or custodial care.

4) Inpatient dental admissions unless as specified necessary to safeguard the patient's health.

5) Care for occupational injury or disease for which any workers' compensation benefits are available.

6) Services for which benefits are available under federal, state or other laws.

7) Services which are not needed to diagnose or treat the patients' illness or condition.

Limitations and Exclusions

The following listed items are specifically excluded from coverage under this plan, and therefore no payments will be made for charges for these services

1) General health examinations or eye examinations for astigmatism, myopia or hyperopia

2) Exams, supplies or fitting/cost of eye glasses or hearing aids, except as a result of any

injury covered by the fund

3) The prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids, or any other care, repair, removal, replacement, or treatment of the teeth, or surrounding tissues, except:

   a) when necessitated by damage to sound natural teeth or surrounding tissues as a result of an injury which occurs while the employee or dependent is insured under this coverage (damage to teeth by chewing is not considered a covered accident), or

   b) for the excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst, or

   c) for any other oral surgical procedure not involving any tooth structure, alveolar process, or gingival tissues

4) Surgical procedure, treatment or hospital confinement primarily for beautification

5) Transportation or travel other than local use of ambulance

6) Injury or disease resulting from war or any act of war, whether declared or undeclared, occurring while insured

7) No benefits will be payable for expenses incurred in connection with an accidental bodily injury arising out of or in the course of any occupation or employment for wage or profit, or any sickness compensable under any workmen's compensation act of law

8) The Fund will provide a lifetime maximum benefit payment of up to $400 for medical expenses incurred in the treatment of temporomandibular joint (TMJ) syndrome

Benefits are not provided for services, supplies or charges for the following:

1) Which are not prescribed by or under the direction of a Physician or Professional Provider

2) Which are not performed within the scope of the Provider's license

3) Received from other than the Provider

4) Which are experimental/investigative

5) Which are not medically necessary, as determined by the Plan

6) To the extent governmental units or their agencies provide benefits

7) For an injury, ailment, condition, disease, disorder or illness that occurs as a result of any act of war, or during the commission of a felony by the Covered participant

8) For which you have no legal obligation to pay in the absence of this or like coverage

9) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group

10) Received from a member of your immediate family

11) Which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness

12) For surgery and other services only to improve appearance but not to restore body function or correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes

13) Primarily for education, vocational or training purposes

14) For the treatment of obesity, including dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss

15) For marital counseling

16) For transsexual surgery or any treatment leading to or in connection with transsexual surgery

17) For birth control devices

18) For artificial insemination or in-vitro fertilization

19) For the treatment of sexual problems not caused by organic disease

20) For reverse sterilization

21) For personal hygiene and convenience items

22) For hypnosis and acupuncture

23) For telephone consultations, missed appointments, or failure to complete a claim form

24) For fraudulent or misrepresented claims

25) For expenses of care for conditions that State or local law require be treated in a public facility

26) For topical anesthetics or stand-by anesthesia

27) For penile implants or any treatment leading to or in connection with penile implants

28) Evaluation and treatment of sleep disorders

29) Any loss sustained or contracted as a result of an Eligible Participant or Eligible Dependent being under the influence of any narcotic or other drug or as a consequence of the use thereof, unless administered upon the advice of a legally qualified Physician

30) Charges related to massotherapy

31) Exercise equipment, health club memberships

32) Air conditioners, purifiers, humidifiers, dehumidifiers, whirlpools, hypoallergenic pillows/mattresses or waterbeds

33) Milieu therapy

34) Chelation therapy except for arsenic, gold, mercury or lead poisoning

Additionally, each person covered by Medicare under the Social Security Act shall be considered to have full coverage for all benefits provided under Medicare, including benefits made available on an optional basis. Any person having coverage under Medicare shall not be

eligible for any coverage under this plan providing hospital or surgical or medical expenses, except those awarded total and permanent disability by Social Security, commencing with the date Medicare coverage becomes effective. However, termination of coverage under this plan for hospital, surgical, or medical expenses shall not affect the individual's eligibility for any other benefits under this plan provided he has not retired and remains active at the trade, and shall not affect the eligibility under this plan.

HOW TO FILE A CLAIM FOR BENEFITS AND APPEAL A CLAIM DENIAL

The procedures which you need to follow in order to properly file a claim are constantly changing in order to ensure more efficient and timely processing of your benefits. The process described here applies to all claims filed on or after January 1, 2003. You will be provided with any future changes to the procedures in a separate document. Please make sure you review all correspondence about your Fund and keep these additional procedures with your booklet.

How to File Claims for Medical Benefits

When you receive health care services:

1) Show your identification card to the service provider.

2) Ask the provider to file a claim for you.

If your provider of the medical service is a Participating Provider in the Medical Mutual Network, he/ she will submit all necessary claim information to Medical Mutual on your behalf. Medical Mutual will forward the claims to the Fund's Administrative Office to be reviewed and paid. The Fund's Administrative Office will provide reimbursement from the Fund to the provider directly.

If you do not use a provider who is part of the Medical Mutual Network, you may have to submit a claim for benefits directly to the Fund. If you must submit a claim for health care services received, you should:

1) Obtain an itemized bill from the hospital, doctor, medical facility, dentist or vision facility. An itemized bill generally includes all of the following:

    a) Participants name and address

    b) Patient's name and address

    c) Date of Service

    d) Type of Service and diagnosis

    e) Itemized charges

    f) Provider's complete name, address and tax identification number

2) Obtain a claim form from the Fund's Administrative Office

3) Complete the claim form and attach the itemized bill to the form

4) Send the claim form and bill to the address on the claim form

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

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

When certain expenses are not eligible for payment under the Fund, you will be notified by the Fund's Administrative Office that the claim is denied in whole or part with an explanation of the reasons for the denial. This notification which is called a Notice of the Adverse Benefit Determination shall be in writing and will contain the following:

1) The specific reasons for the adverse benefit determination;

2) The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;

3) A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;

4) The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;

5) A notice of your right to a written explanation of any exclusion which affects your claim; and

6) A description of this Fund's Appeals Procedure set forth below.

Prescription Claims under Express Scripts Program

At a Participating Express Scripts Pharmacy

You will receive a personalized Express Scripts Identification Card with eligible dependents listed on the card once you become eligible in this Fund. You must present your Express Scripts Identification Card along with your Doctor's prescription to any participating Express Scripts pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will generally ask you to sign the form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase of a prescription is not a claim for benefits.

If you elect to have your prescription filled by a pharmacy other than a participating Express Scripts pharmacy, do not use your Express Scripts Identification Card. Follow the Claim Reimbursement Procedure described herein to obtain reimbursement of prescription expenses.

You can obtain an Express Scripts claim form from the Fund's Administrative Office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach an itemized receipt that includes all of the requested information. Pay the charge for the prescription in full to the pharmacy and mail the completed form to Express Scripts 's address on the form. Reimbursement will be made directly to you by Express Scripts on the same basis as benefits would have been paid to a participating Express Scripts pharmacy.

If you are not eligible for benefits at the time you contact the Express Scripts pharmacy or in the event that the prescription is not a covered drug under the Fund, you must contact the Fund's Administrative Office for additional information. The Fund's Administrative Office will review your claim for benefits and if the claim is denied in whole or part, provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

1) The specific reasons for the adverse benefit determination;

2) The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;

3) A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;

4) The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

5) A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and

6) A description of this Fund's Appeals Procedure set forth below.

At a Participating Express Scripts Pharmacy

If you fill your prescription at a non-Express Scripts pharmacy, your cost will most likely be greater, and you will need to file a claim directly with Express Scripts for reimbursement. Your reimbursement will be based on the amount you would have paid at an Express Scripts pharmacy.

How to File a Claim for Weekly Indemnity benefits

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund's Administrative Office to be completed by you and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

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

If the Fund's Administrative Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund's Administrative Office receives the information from you, you will be notified of the decision on the claims within 30 days.

In the event that your claim for benefits is denied in whole or part, the Fund's Administrative Office will provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

1) The specific reasons for the adverse benefit determination;

2) The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;

3) A description of any additional materials or information necessary for you to perfect you claim and an explanation of why such materials or information is necessary;

4) The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

5) A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and

6) A description of this Fund's Appeals Procedure set forth below.

How to File Claims for Life Insurance and Accidental Death & Dismemberment Benefits

Claims should be submitted to the Fund's Administrative Office as soon as possible: do not delay in filing any claims. Claims for Death, Accidental Death and Accidental Dismemberment benefits will be provided through the Fund's Administrative Office. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. This will generally include a death certificate and documentation to establish the death or dismemberment is the result of an accident.

Generally, the Fund's Administrative Office will notify your beneficiary of the decision on the claim for benefits within 90 days. In the event that the Fund's Administrative Office needs additional time to review the claim for benefits or needs additional information, he/she will be provided with the information on the status prior to the expiration of the initial 90 day period.

When the claim for life insurance benefits falls within the Fund's exclusions, your beneficiary will be notified by the Administrative Office that the claim is denied with an explanation of the reasons for the denial. He/she will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

1) The specific reasons for the adverse benefit determination;

2) The sections of the Plan and/or Summary Plan Description upon which the adverse benefit determination was based;

3) A description of any additional materials or information necessary for him/her to perfect the claim and an explanation of why such materials or information is necessary;

4) The notice of any internal guidelines or protocols used in making the decision, if applicable, and his/her right to receive a copy;

5) A notice of his/her right to a written explanation of any exclusion which affects his/her claim, if applicable; and

6) A description of the Fund's Appeals procedures set forth below.

Proof of Claims

Written proof of claims for payment of Covered Services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim

form. **All claims must be submitted by you or the Provider no later than 90 days from the date on which the services were incurred.** Failure to furnish the claim within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of the claim within that time period and that written proof was provided as soon as reasonably possible. **However, all claims must be filed within one (1) year from the date the claim was incurred and if they are not submitted, they will be denied as untimely.**

No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeals procedures set forth in this Section. Additionally, no action shall be brought at all unless brought within three (3) years from the expiration of the time which the proof of claim is required.

Physical Examination

The Fund at its own expense shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Fund when and as often as the Trustees may reasonably require while a claim is pending. The Trustees have the right to ask for an autopsy in the case of death, provided this is not forbidden by law.

Review Procedure for Claims under the Fund

You or your authorized representative may appeal the decision by the Fund's Administrative Office to deny any claim for medical, weekly indemnity or life insurance/ accidental death and dismemberment benefits in whole or part. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure. If you are not handling your own claim, then an "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

First Level Review

You may file a written notice of appeal to the Administrative Manager for the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number, phone number, and the fact that you are appealing from the decision of the Fund's Administrative Office, giving the date of the Notice. The Appeal should be addressed as follows:

Administrative Manager
Youngstown Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

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

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

The Administrative Manager will consider your appeal of a claim for payment of services which

you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Administrative Manager within thirty (30) days of the date the request for a First Level review is received.

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

1) The specific reason for the denial;

2) The sections of the Plan and/or Summary Plan Description upon which the denial was based;

3) A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

4) A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and

5) A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

Second Level Review

You may file a written notice of appeal to the Benefits Committee for the Board of Trustees at any time within sixty (60) days after the mailing of the Notice of Denial of the First Level Review. The written notice only needs to state your name, address, phone number, social security number and the fact that you are appealing from the decision of the Fund's Administrative Manager, giving the date of the Notice. The Appeal should be addressed as follows:

Benefits Committee
Youngstown Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

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

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

The Benefits Committee will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Benefits Committee within thirty (30) days of the date the request for a Second Level review is received.

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

1) The specific reason for the denial;

2) The sections of the Plan and/or Summary Plan Description upon which the denial was based;

3) A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

4) A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and

5) A notice of your right to file a lawsuit under ERISA Section 502(a).

The decision of the Benefits Committee for the Board of Trustees is final and binding.

Voluntary Appeal to the Board of Trustees

Once you have filed your appeal through the two levels of review, you have the right to file a lawsuit in federal court. However, prior to instituting federal court action, you can file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing Notice of Final Decision by the Benefits Committee. The Appeal should be addressed as follows:

Board of Trustees
Youngstown Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

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

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

1) The Fund will not assert a failure to exhaust administrative remedies.

2) The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process.

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

4) You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:

   a) A statement that using this procedure will have no effect on your right to receive other benefits under this Fund;

   b) A statement that you have the right to have a personal representative with regard to your claim; and

c) A notice of any circumstances which may impair the impartiality of the Board of Trustees.

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

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

   a) The specific reason for the denial;

   b) The sections of the Plan and/or Summary Plan Description upon which the denial was based;

   c) A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

   d) A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and

   e) A notice of your right to file a lawsuit under ERISA Section 502(a).

COORDINATION OF BENEFITS

All benefit provisions of the Plan are subject to this provision.

Quite frequently, when a husband and wife both work, members of a family are covered under more than one group plan of employee benefits. Thus, in some instances, benefits are received under two group plans in a total amount greater than the Medical Expense actually incurred.

To avoid duplication of benefits for Allowable Expenses, the benefits payable under the Group Plan shall be reduced so that the total benefits under all plans shall not exceed the Allowable Expense incurred during any calendar year.

"Allowable Expenses" means any necessary, reasonable and customary item of expense for medical care or treatment covered under at least one of such plans covering the individual for whom a claim is made.

The group health benefits will be coordinated with any other plan providing benefits or services for Allowable Expenses. If another plan, covering an individual insured under this Group Plan does not have a coordination of benefits provision, benefits payable for Allowable Expenses under the other plan will be paid in full before any benefits are paid under this Group Plan.

Where both group plans contain a coordination of benefits provision, our Plan will pay first or second based on the following rules:

1) A plan covering a person as an employee will pay benefits first. A plan covering a person as a dependent will pay second.

2) If a dependent child is covered by both parents' plans, the benefits of the plan which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined first. The benefits of the plan which covers the child of the parent whose date of birth, excluding year of birth, occurs later in a calendar year, will be determined second.

3) When the parents are divorced or separated, the order is:

   a) The plan of the parent with custody pays first (1st).

   b) The plan of the parent without custody pays second (2nd).

   c) If the parent with custody has remarried, the order is:

      i) the plan of the parent with custody;

      ii) the plan of the step parent;

      iii) the plan of the parent without custody.

   d) If there is a court decree which states that one of the parents is responsible for the child's health care expenses, the plan of that parent will pay first. That order will supersede any order given in (a) or (b).

4) If a person is covered under more than one plan, the plan he or she was covered under longer pays first. The exception to this rule is:

   a) A group plan that covers a person other than as a laid-off or retired employee, or dependent of such person, will determine the benefits that are paid first. A group plan that covers a person as a laid-off or retired employee, or dependent of such person, will determine the benefits that are paid second.

SUBROGATION

The Youngstown Area Electrical Welfare Fund exercises its rights of subrogation if you or your dependent is paid benefits by the Plan due to any injury or illness which arises out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provision, collectively referred to as "Other Coverage").

In other words, if you or one of your dependents receives benefits through your Fund plan for injuries caused by another person or organization, the Fund has the right, through subrogation, to seek repayment from the other person or organization or any applicable insurance company for benefits already paid.

The term "Covered Person" as used hereinafter shall include the employee, participant, or any eligible dependent as defined elsewhere in the Plan.

Rights of Subrogation

In the event of any payment under the Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person which arise out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provision, collectively referred to as "Other Coverage"). **The Plan is subrogated to all rights of recovery of a Covered Person regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan's subrogation interest shall take priority over any and all rights of recovery held by a Covered Person against such person, entity, or Other Coverage arising out of the event which triggered the Plan's payment of Medical Benefits. The Plan's subrogation interest shall apply regardless of whether the Covered Person has incurred fees or costs in order**

to obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule shall not apply.

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

In the event a Covered Person pursues a claim against any person, entity, or Other Coverage, the Covered Person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against any person, entity, or Other Coverage, the Plan shall have the right to pursue, sue, compromise, or settle any such claims in the Covered Person's name and to execute any and all documents necessary to pursue said claim in the Covered Person's name.

Reimbursement

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

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

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

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

You are also advised that when you or your eligible Dependents submit a claim to this Plan for injury or illness, you will be required to complete and execute a form requesting the following information:

1) How the injury or illness occurred.

2) The identity of any potentially responsible third parties, including their insurer, adjuster, and claim numbers.

3) Accident reports.

4) An assignment of your beneficial interest in any monetary recovery as a result of such injury or illness, to the extent of the Plan's subrogated interest.

You may also be required to sign other documents and do whatever is reasonably necessary to secure this Plan's Right of Subrogation. The Plan is entitled to full reimbursement prior to any other disbursement of any recovery, including fees and/or expenses.

You or your eligible Dependent shall not do anything to impair or negate this Plan's Right of Subrogation. If you or your eligible Dependent(s) perform any act or fail to act, and such should compromise the Plan's Right of Subrogation in full, this Plan will immediately seek reimbursement of all benefit amounts paid in that regard either by legal action or otherwise.

Furthermore, the Plan shall have the right to offset any future benefit payments to either you or your eligible Dependent(s) in the amount of any outstanding lien.

The Plan may recover mistaken payments in any other lawful manner, as well.

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RULES OF ELIGIBILITY FOR EMPLOYEE COVERAGE

The eligibility rules now in effect are shown below. They may be changed from time to time as the Trustees, in their discretion, may deem necessary.

You are eligible for coverage if you are employed under the jurisdiction of the union and if sufficient contributions have been made on your behalf by participating employers.

INITIAL ELIGIBILITY

You become eligible for coverage under the plan on the first day of the month following the month in which 142 hours of contributions have been made to the fund on your behalf. The coverage of an employee who is not able and available for work on the date his coverage would otherwise become effective shall not become effective until the date he is able and available for work.

Pre-existing Condition Rule

The Board of Trustees, in order to protect your Group Medical Fund, adopted a pre-existing condition rule that will, under certain circumstances, limit the benefits paid to members and/or their dependents who have become eligible in the Group Medical Fund on or after May 1, 1989. **This rule will be in effect as described below until January 1, 2014, at which time the pre-existing condition rule will be eliminated.**

A pre-existing condition is an illness, injury, or medical condition which exists on the effective date of coverage and for which the member or dependent has received medical treatment or advice within six (6) months prior to becoming eligible for benefits under the Plan. To that end, the trustees have amended the benefit provisions of the Group Medical Plan to include the following provision:

No payment will be made for services related to a pre-existing condition for a period of twelve (12) months after the effective date of coverage. If you receive services, no payment will be made for twelve (12) months after the effective date. This period is reduced, however, by counting certain prior coverage toward the Exclusion period. Participants with twelve (12) months of coverage with one employer may, therefore, move to a new employer with new coverage without becoming subject to the pre-existing condition exclusion of the new employer.

A participant is credited for prior coverage under a wide variety of health plans, including group health plans, individual policies, HMO's Medicare and various governmental programs. Coverage is not counted toward the exclusion period of the new plan however, if there has been an intervening break in coverage of 63 days or more, only coverage after the break may be credited.

No pre-existing condition exclusion may apply to pregnancy-related conditions, newborn or adoptees enrolled during the period, or to children under the age of nineteen. **Effective January 1, 2014, the pre-existing condition rule will no longer be in effect for all enrollees.**

HOUR BANK

When contributions are received for hours in excess of the minimum number of hours required to maintain your eligibility in the fund (presently 142 hours), the excess hours will be credited to your hour bank account.

In periods of unemployment, your hour bank hours will be used by the fund to maintain your eligibility for coverage under the plan, subject to the limitation set forth below under "Self-Contributions."

Self-Contributions

If you have accumulated less than the minimum required number of hours of contributions for continuation of eligibility (presently 142 hours), you may make a self-contribution at the current contribution rate for the number of hours needed to meet the eligibility minimum requirements. Self-contributions may only be used to maintain eligibility for a period of eighteen months.

Donating Hours

Active Fund Participants shall be permitted to donate bank hours to another Fund Participant who has exhausted his or her hour bank, to help that individual maintain coverage in the plan. If you wish to donate hours, you must execute a written authorization providing for the transfer of hours, and waive any right to reclaim the hours. Furthermore, if you are married, you must obtain your spouse's written consent before transferring any hours.

Self-Employed

In no event may a self-employed individual make self-contributions to maintain eligibility.

Re-Assignment to Non-Bargaining Unit

Effective January 1, 2005, if you would lose coverage in the Plan because of your transfer or reassignment to non-bargaining unit work with a signatory employer, you may continue to use your hour bank to maintain eligibility for coverage under the plan. The maximum period of coverage is eighteen (18) months, although this period of coverage may be extended for good cause, with Trustee approval.

Induction into the Armed Forces

The Trustees wish to provide notice to you that if you are called up for active duty in the armed services, you are entitled to the protection of the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA). The Fund will allow you the choice of using your Hour Bank to continue coverage for you and/or your dependents or freezing your Hour Bank until your reinstatement in the Plan. The provisions for reinstatement are based on your application for re-employment and will vary depending on your length of stay in the uniformed services. You need to contact the Fund Office to discuss your options to continue coverage for you and your dependents. In most instances, when you are called to active duty, coverage is provided to you through Tri Care which offers several plans to persons on active duty and, under certain conditions, his/her dependents.

It is extremely important, if you wish to have a continuation of benefits under USERRA, that immediately upon learning of your armed service related absence for any period, you discuss your options with the Fund Office.

Suspension of Eligibility

If you are eligible for coverage under this plan, but also qualify for benefits under another Welfare plan in another Local Union's jurisdiction, and there is no reciprocity in effect between this plan and the other plan, you may elect to suspend participation under this plan.

You must make written notice by certified mail of your desire to suspend benefits under this plan. The Board of Trustees will consider your application and advise you of the terms and conditions of your suspended benefits.

Frozen Hour Bank

The Trustees have amended the rules and will allow a participating member to freeze his hour bank when that member finds it to his advantage to do so (i.e., when his spouse's insurance will cover him and he is in a self-payment situation with the Welfare Fund). The freezing of a participant's hour bank will be allowed once per calendar year. His hour bank will remain frozen until employer contributions are reported to the Welfare Fund on his behalf. At that time, the member's hour bank account will become unfrozen. Remember, to freeze his hour bank account, a member must do so in writing. A certified letter must be signed and mailed to the Fund requesting that his hour bank be frozen.

Reciprocity Agreements

Payment of benefits to employees covered by reciprocity agreements shall be governed by the terms of such agreements.

Early Retired and Permanently Disabled Employee Programs

Employees who retire early, i.e., prior to attainment of their 65th birthday, may elect to continue the active employee program for which they were last eligible exclusive of the weekly indemnity benefit and accidental death and dismemberment benefits until they attain the age 65, by paying the required monthly payment, at which time coverage would be provided pursuant to the terms of the program for retired employees age 65 and over. The monthly payments are announced from time to time by the Board of Trustees and are always subject to review. The current rates can be obtained upon written request from the Fund Office.

Employees who qualify for extended life insurance coverage under the waiver of contribution coverage provided to employees who become totally disabled while eligible for benefits under the active employee program may elect to continue the active employee program exclusive of the weekly indemnity benefits and accidental death and dismemberment benefits by making the required monthly payment. The monthly payments are announced from time to time by the Board of Trustees and are always subject to review. The current rates can be obtained upon written request from the Fund Office. Coverage will terminate at age 65.

Normal Retirement Program

Upon retirement at or after age 65, a covered employee who is eligible for benefits under the active program will have those benefits terminated. A normal retiree may continue coverage for his qualified dependents that are under the age of 65 and not otherwise eligible for Medicare benefits by paying a specified additional monthly premium. The monthly payments are announced from time to time by the Board of Trustees and are always subject to review. The current rate can be obtained upon written request from the Fund Office.

DEPENDENT COVERAGE

Rules of Eligibility for Dependents' Coverage

An employee is eligible for Dependents' coverage on the day he becomes eligible for employee coverage, or on the day he acquires his first dependent, whichever is later.

However, the effective date of coverage will be postponed for any dependent who is confined as a bed patient in any institution providing medical or nursing care, or confined at home or elsewhere, so as to be unable to carry on any substantial part of the regular and customary activities of a person of the same age and sex in good health, on the date benefits for that dependent would have become effective. Coverage for a dependent in this circumstance will become effective upon the expiration of 30 days following the date the dependent ceases to be so confined.

In no event will the provisions of the preceding paragraph apply to any dependent child born while the employee is eligible for dependents' coverage.

Termination of Dependents' Coverage

An employee will cease to be eligible for dependents' coverage on the earliest of the following dates:

1) the date the employee's coverage for himself terminates

2) the date the employee ceases to be in a class of employees eligible for dependents' coverage

3) the date dependents' coverage is discontinued

4) the date your dependent commences active duty in the armed forces of any country or state or international organization or becomes a member of any civilian force auxiliary to military force

5) date the dependent ceases to qualify as a dependent

A spouse's eligibility will be continued for a period of twenty-four months following the death of the active eligible employee.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 - (HIPAA) SPECIAL ENROLLMENT

If you were eligible to enroll under this Plan and declined this plan's coverage because you were covered under a group health plan, Medicaid, or under other health insurance coverage, and lose the other coverage, you and your Eligible Dependent(s) will be permitted to enroll in this Plan during a special enrollment period. However, you must notify the Fund of your request for special enrollment within thirty (30) days after the coverage ends. The Fund may require you to provide it with written documentation of the termination of the other coverage. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be eligible to enroll yourself and your Eligible Dependent(s) in this Plan. However, you must provide the Fund with notice of your intent to enroll yourself and your eligible dependent(s) in this Plan within thirty (30) days of the event (having or becoming a new Dependent). Coverage under these special enrollment provisions will be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

If you or your Eligible Dependent(s) are eligible for coverage under Medicaid or a State Children's Health Insurance Program, and you or your Eligible Dependent(s) were denied enrollment in this Plan due to the other coverage, you may request special enrollment in this Plan if either: (i) your own or your Eligible Dependent(s)' coverage under Medicaid or a State Children's Health Insurance Program terminates due to a loss of eligibility; or (ii) you or your Eligible Dependent(s) become eligible for premium assistance from Medicaid or a State Children's Health Insurance Program allowing you or your eligible Dependent to enroll in a group health plan. In either situation, however, you must provide this Plan with notice of your intent to enroll yourself or your Eligible Dependent(s) within sixty (60) days.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidate Omnibus Budget Reconciliation Act requires that the Trustees offer those eligible Participants and dependents, whose Health Benefits are scheduled to be terminated, the opportunity of continuing their Group Health Benefits through a series of monthly direct payments for a limited period of time. The following paragraphs are intended to explain and summarize your rights and those of your dependents under this new law.

Rights to Self Payment

Member: If you are an active member whose benefits are scheduled to be terminated due to having failed to work the required number of hours, you have the right to continue your Group Health Benefits through a series of monthly direct payments for a period of up to eighteen (18) months, starting with the date your regular eligibility under the plan was scheduled to be terminated due to failure to work the required number of hours.

Dependents: Your spouse (husband or wife) also has the right to continue his or her Group Health benefits on a direct payment basis under any of the following circumstances:

1) Upon your Death (providing you were eligible at time of death).

2) Upon your termination from the Plan due to failure to work the required number of hours.

3) Upon divorce or legal separation from you.

4) When you become eligible for Medicare and your regular Group Health Benefits are terminated.

Your dependent children (as described in the Plan) may also continue their Group Health Benefits on a direct payment basis under any of the following circumstances:

1) Upon your death (providing you and such dependent child were covered for benefits at the time of your death).

2) Upon termination of your employment (providing your child was covered at the time of such termination).

3) Upon your divorce or legal separation

4) Upon the date your eligibility (and that of your dependent child) due to becoming eligible for Medicare

5) The date your dependent child ceases to be dependent (due to age, change in student status, etc.).

You, your spouse or your dependent child (where applicable) will have the option to continue Group Health Benefits for the period shown below.

Person Losing Coverage	Reason for Termination	Period Benefits May Continue
Participant	Failure to work the required number of hours in covered employment	18 months
Spouse	• Death of the participant • Divorce or legal separation • Participant becomes eligible for Medicare	36 months
Dependent Child	No longer qualifies as a dependent child under the Group Plan	36 months

The Group Health coverage will cease immediately in the event:

1) Self-Payments are not received when due.

2) The date you or any of your dependents become covered under another Group Health Plan (including Medicare).

3) The date a divorced spouse remarries and becomes covered under another Group Health Plan.

Notification and Filings

In the event your coverage is scheduled to be terminated due to failure to work the required number of hours in covered employment, you will be notified as to your right to make a direct payment to continue your Group Health Benefits. In all other cases, you or a family member are responsible for giving notice to the Plan administrator of any divorce, legal separation, or change in a dependent child's status (attainment of maximum age, change in student classification, etc.) which results in a loss of Group Health Coverage.

FAMILY AND MEDICAL LEAVE ACT OF 1993

The Family and Medical Leave Act of 1993 (FMLA) was enacted on February 5, 1993. Generally, FMLA requires your employer to provide you with up to 12 weeks of unpaid leave during any 12-month period for specified family and medical reasons, if you are eligible. During this period, your employer must provide health coverage for you on the same terms and conditions that you receive if you continue to work.

To be eligible for leave under FMLA, you must work for the same contributing employer for at least 12 months and for at least 1,250 hours during the 12-month period before the leave begins. Generally, your employer is obligated to provide Family and Medical leave only if your employer employs 50 or more Participants each working day during each of 20 or more work weeks during the current or preceding calendar year. During the FMLA leave, your employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you receive continued eligibility.

A covered employer must grant an eligible participant up to a total of 12 work weeks of unpaid

leave during any 12-month period for one or more of the following reasons:

1) For the birth or placement of a child for adoption or foster care;

2) To care for an immediate family member (spouse, child or parent) with a serious health condition; or

3) To take medical leave when the participant is unable to work because of a serious health condition.

Arrangements will need to be made for participants to pay their share of health insurance premiums while on leave.

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

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

Repayment of Contributions to Employer

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

DEATH BENEFIT (EMPLOYEES ONLY)

BENEFIT

In the event of your death, $5,000 will be paid to the beneficiary named by you.

Continuation of Death Benefit Coverage If Disabled

If, because of total disability which continues for nine months or more, you should terminate your employment before age 60, your death benefit will remain in force without payment for a period of twelve months, and thereafter as long as you are continuously totally disabled. All such continuations must be approved by the Board of Trustees of the Fund and are subject to yearly proof of continuance of your disability.

Change of Beneficiary

You may change your beneficiary at any time by making written request to the Welfare Fund on the form prescribed by the Trustees. The change will take effect as of the date you sign the request.

ACCIDENTAL DEATH AND DISMEMBERMENT (EMPLOYEES ONLY)

BENEFIT

If you suffer any of the losses shown below as a result of bodily injuries caused directly and exclusively by accident, the following benefits, based upon a full benefit of $5,000 will be payable:

1) The full benefit of $5,000 will be paid for loss of (1) life, (2) two hands, or (3) two feet, or (4) sight of two eyes, or (5) on hand and one foot, or (6) one hand and sight of one eye, or (7) one foot and sight of one eye;

2) One-half benefit, or $2,500, will be paid for loss of (1) one hand or one foot, or (2) sight of one eye.

Loss of hands or feet means loss by severance at or above the wrist or ankle joints. Loss of sight means total and irrecoverable loss of the entire sight.

The total amount payable for all losses suffered in any one accident may not exceed the maximum $5,000.00 benefit. Sufficient proof of losses must be presented to the Trustees within ninety (90) days after the date of injury.

Payment for loss of life will be made to the beneficiary you have designated. Payment for any other losses will be made to you.

Losses not covered

No benefits are payable for loss resulting from:

1) disease, or bodily or mental infirmity, or medical or surgical treatment thereof; or

2) ptomaines, or bacterial infections, except infection introduced through a visible wound accidentally sustained; or

3) suicide while sane or insane, or intentionally self-inflicted injuries; or

4) war or any act of war, whether declared or undeclared; or the commission of or attempt to commit a felony.

Change of Beneficiary

You may change your beneficiary at any time by making written request to the Welfare Fund on the form prescribed by the Trustees. The change will take effect as of the date you sign the request.

ACCIDENT AND SICKNESS WEEKLY DISABILITY BENEFITS (EMPLOYEES ONLY)

BENEFIT

Weekly disability income is payable if you are wholly disabled and are unable to work because of an accident occurring off the job, or a sickness not connected with employment. The maximum amount of weekly disability income is $300 per week. However, in no event will the amount of weekly benefit payment exceed 66-2/3% of your regular weekly earnings, exclusive of overtime pay.

Benefits begin with the **1st day of disability due to an accidental bodily injury, or the 8th day of disability due to a sickness,** and no benefits will be paid for any day prior to the 15th day. The maximum number of weeks payable for each disability is twenty six (26) weeks.

Limitations

No benefits will be payable:

1. For any period during which the employee is not under the care of a licensed medical doctor;

2. For any accidental bodily injury arising out of or in the course of any occupation or employment for wage or profit, or any sickness compensable under any workmen's compensation act or law.

Successive Periods of Disability

Successive periods of disability due to the same or related causes will be considered one period of disability unless they are separated by a two week period during which the employee is not absent from active full time work. Successive periods of disability due to entirely unrelated causes will be considered one period of disability unless they are separated by complete recovery and return to active full time work.

IMPORTANT NOTICES

EMPLOYEE PROTECTION POLICY

This policy shall apply not only to the Youngstown Area Electrical Welfare Fund ("Fund") employees but also to the employees of the Third Party Administrator hired by the Fund.

If any employee reasonably believes that some policy, practice, or activity of the Fund is in violation of law, a written complaint must be filed by that employee with the Fund Administrator or any Fund Trustee.

It is the intent of the Fund to adhere to all laws and regulations that apply to the Fund, and the underlying purpose of this policy is to support the Fund's goal of legal compliance. The support of all employees is necessary to achieve compliance with various laws and regulations. An employee is protected from retaliation only if the employee brings the alleged unlawful activity, policy, or practice to the attention of the Fund and provides the Fund with a reasonable opportunity to investigate and correct the alleged unlawful activity. The protection described below is only available to employees that comply with this requirement.

The Fund will not retaliate against an employee who in good faith has made a protest or raised a complaint against some practice of the Fund, or of another individual or entity with whom the Fund has a business relationship, on the basis of a reasonable belief that the practice is in violation of law, or a clear mandate of public policy.

The Fund will not retaliate against employees who disclose or threaten to disclose to the Fund Administrator or any Fund Trustee or a public body, any activity, policy, or practice of the Fund that the employee reasonably believes is in violation of a law, or a rule, or regulation mandated pursuant to law or is in violation of a clear mandate of public policy concerning the operation of the Fund in compliance with ERISA, Department of Labor and/or Internal Revenue Service policies, regulations or requirements.

Following the receipt of any complaints submitted, the Trustees of the Fund will investigate each matter as it is reported and take corrective and/or disciplinary actions where appropriate.

The Trustees may enlist the Administrator or employees of the Fund and/or outside legal, accounting or other advisors as appropriate, to conduct any investigation of complaints regarding financial reporting, accounting, internal accounting controls, auditing matters or any other form of misconduct, dishonesty, or fraud. In conducting any investigation, the Trustees shall use reasonable efforts to protect the confidentiality and anonymity of the complainant.

No employee who in good faith reports a violation shall suffer harassment, retaliation or an adverse employment consequence. An employee who retaliates against someone who has reported a violation in good faith is subject to discipline up to and including termination of employment. This policy is intended to encourage and enable employees and others to raise concerns about the Fund's operation without fear of reprisal.

Additionally, no employee shall be adversely affected because they refuse to carry out a directive which, in fact, constitutes fraud, or is a violation of federal or state laws.

Violations or suspected violations may be submitted on a confidential basis by the complainant or may be submitted anonymously. Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate

investigation. Every effort will be made to protect the complainant's identity.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order made pursuant to a state relations law (including community property law) setting forth provisions regarding the support for a child of a Participant (alternative recipient) and which:

1) Creates or recognizes the existence of an Alternative Recipient's right to, or assigns to an Alternative Recipient the right to receive benefits for which a Participant or beneficiary is eligible under this Plan; and

2) Specifies (i) the name and last known mailing address (if any) of the participant and each Alternative Recipient covered by the Order, and (ii) a reasonable description of the type of coverage to be provided by the Plan or the manner in which the coverage is to be determined; and

3) Does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of any law relating to medical child support as describe in Section 1908 of the Social Security Act.

Upon receipt of any judgment, decree of order (including approval of a property settlement agreement) relating to the provision of payment by the Plan to an Alternative Recipient pursuant to a state domestic relations law, the Board shall promptly notify the affected Participant and any Alternative Recipient of the receipt of such judgment, decree or order and shall notify the affected Participant and any Alternative Recipient of the Board's procedures for determining whether or not the judgment, decree or order is a Qualified Medical Child Support Order.

The Board shall adhere to the following procedures for determining the status of a judgment, decree or order as a QMCSO, and for administering plan benefits in accordance with QMCSO:

1) Upon receipt of any judgment, decree, or order (including approval of property settlement agreement) relating to the provision of payment by the Plan to an Alternative Recipient pursuant to a state domestic relations law, the Board shall promptly notify the affected Participant and any Alternative Recipient of such receipt. This notification shall include a description of these procedures for determining the status of a judgment, decree or order as a QMSCO, and for administering plan benefits.

2) An Alternative Recipient may designate a representative for receipt of communications from the Board.

3) The Board shall determine whether the received judgment, decree or order is a QMSCO as defined in ERISA, Section 609 (a) and paragraph A, above, and shall notify the affected Participant and any Alternative Recipient or their representative(s) of this determination within a reasonable time. This notification shall include an explanation of the Board's determination.

4) The Board shall further comply with any future requirement imposed by the Department of Labor or the Internal Revenue Service (executed in accordance with their rule making powers) in its administration of matters involving QMSCO's.

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

As a participant in the Youngstown Area Electrical Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Participant benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries. No one, including your employer, your union, or any other

person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a 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 your claim is frivolous.

Assistance with Your Questions

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Plan has been amended as a result of the Women's Health and Cancer Rights Act. This federal legislation requires that, as a result of consultation with a physician, the Plan cover mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedemas. This coverage is subject to the Plan's annual deductibles and coinsurance provisions.

DEPENDENT ELIGIBILITY

Effective January 1, 2011, children are eligible for medical coverage up to age 26, regardless of full-time student status, residency, financial support, marital status or access to other employer-sponsored coverage. However, children who have employer-based coverage available to them *prior to* January 1, 2014 are ineligible for Plan coverage.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Under the Genetic Information and Nondiscrimation Act (GINA), the Plan will not require, request or purchase anyone's genetic information before enrollment or use such information to detemrine eligiblity for enrollment or continued coverage, to impose pre-existing condition exclusions, to vary individual group premiums or contribution rates, or to conduct Plan-sponsor related activities, unless allowed under such law. When released by the federal government, a statutory notice regarding the applicable provisions of this law wil be posted. If you would like more information about the GINA's required coverage, you can contact the plan administrator at (800) 435-2388.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009, the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 added a new enrollment right under the plan. If you or your dependent(s) are eligible, but not enrolled, for coverage under the terms of the plan, you may enroll in the plan upon becoming eligible for a state premium assistance subsidy under Medicaid or CHIP or upon the loss of the Medicaid or CHIP subsidy. You must request plan enrollment within 60 days after eligibility for the state subsidy is determined.

NOTICE OF PRIVACY PRACTICES (HIPAA)

This Notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. Please review this information carefully.

Section 1: Purpose of This Notice and Effective Date Effective date.

The effective date of this Notice is April 14, 2003.

This Notice is required by law. The Youngstown Area Electrical Welfare Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1) The Fund's uses and disclosures of Protected Health Information (PHI),

2) Your rights to privacy with respect to your PHI,

3) The Fund's duties with respect to your PHI,

4) Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services, and

5) The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI Defined)

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Fund in oral, written, electronic or any other form.

When the Fund May Disclose Your PHI

The Fund Sponsor has amended its Fund Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent or authorization in the following cases:

1) **At your request.** If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.

2) **As required by an agency of the government.** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

3) **For treatment, payment or health care operations.** The Fund and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:

   a) Treatment,

   b) Payment, or

   c) Health care operations.

Definitions of Treatment, Payment or Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. *For example:* The Fund may disclose to a treating physical therapist the name of your treating physician so that the physical therapist may ask for your x-rays from the treating physician.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making coverage determinations and payment. These actions include billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization. *For example:* The Fund tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.

Healthcare Operations keep the Fund operating soundly	Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business Funding and development, business management and general administrative activities. **For example:** The Fund uses information about your medical claims to project future benefit costs or to audit the accuracy of claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Fund must generally obtain your written authorization before it will use or disclose psychotherapy notes about you from your psychotherapist. However, the Fund may use and disclose such notes when needed to defend itself against litigation filed by you.

Use or Disclosure of Your PHI That Requires You be Given an Opportunity to Agree or Disagree before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

1) The information is directly relevant to the family or friend's involvement with your care or payment for that care, and

2) You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required

The Fund is allowed under federal law to use and disclose your PHI without your consent, authorization or request under the following circumstances:

1) When required by law.

2) Public health purposes. To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease of condition, if authorized by law.

3) Domestic violence or abuse situations. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

4) Health Oversight activities. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for

example, to investigate Medicare or Medicaid fraud).

5) Legal proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

6) Law enforcement health purposes. When required for law enforcement purposes (for example, to report certain types of wounds).

7) Law enforcement emergency purposes. For law enforcement purposes including:

   a) identifying or locating a suspect, fugitive, material witness or missing person, and

   b) disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8) Determining cause of death or organ donation. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9) Funeral purposes. When required to be given to funeral directors to carry out their duties with respect to the decedent.

10) Health or safety threats. When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11) Workers' compensation programs. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures

The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Fund may disclose protected health information to the sponsor of the Fund for reviewing your appeal of a benefit claims or for other reasons regarding the administration of this Fund. The "Fund Sponsor" of this Fund is the Youngstown Electrical Welfare Fund Board of Trustees.

Section 3: Your Individual Privacy Rights

For information on or to exercise your Individual Privacy Rights contact: Privacy Official, Youngstown Area Electrical Welfare Fund, 33 Fitch Boulevard, Austintown, Ohio 44515.

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1) Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

2) Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request if the Fund Administrator or Privacy Official determines it to be unreasonable.

In addition, the Fund will accommodate an individual's reasonable request to receive communications of PHI **by alternative means or at alternative locations** where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

Designated Record Set: includes your medical records and billing records that are maintained in paper form or electronically by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health Fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to Fund and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy for a list of exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI. This accounting period starts as of April 14, 2003 and allows you to request an accounting for up to six years of disclosures after that date. The maximum period of time you can request is six years. Please contact the Fund Office for a complete listing of the contents of an accounting. You should request a copy of the Fund's Accounting for Disclosure Policy.

If you disagree with the record of your PHI, you may amend it.

If the Fund denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI. Forms are available for these purposes.

The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address provided at the beginning of this Section 3.

Your Personal Representative

You may designate a personal representative by completing a form that is available from the Fund Office.

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider spouses covered under the Fund as the Personal Representatives for each other. Additionally, the Fund will consider a covered parent, guardian, or other person acting in loco parentis as the Personal Representative of any dependent covered by the Fund unless applicable law requires otherwise. A parent may act on an individual's behalf, including

requesting access to their PHI. Covered Dependents, including your spouse may, however, request that the Fund restrict information that goes to family members as described above at the beginning of Section 3 of this Notice. Additionally, the Fund will automatically consider any person designated under a Power of Attorney which is on file with the Fund as a Personal Representative.

You or your spouse may elect not to have one another as your Personal Representative. You or your spouse must fill out an Opt-out of Personal Representation Form and submit the Form to the Privacy Official. Your covered dependent children also have the right to submit an Opt-out Form if they do not wish to have one or both of their parents as their deemed Personal Representative. All requests are reviewed by the Privacy Official who may deny the requests, especially those based upon State law restrictions.

Section 4: The Fund's Duties *Maintaining Your Privacy*

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on April 14, 2003, and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. This revised notice will be mailed to the covered participant and dependents.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

1) The uses or disclosures of PHI,

2) Your individual rights,

3) The duties of the Fund, or

4) Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

The Fund must limit its uses and disclosures of PHI or requests for PHI to the **minimum necessary** amount to accomplish its purposes.

You have the right to file a complaint if you feel your privacy rights have been violated. The Fund may not retaliate against you for filing a complaint.

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

1) Disclosures to or requests by a health care provider for treatment,

2) Uses or disclosures made to you,

3) Disclosures made to the Secretary of the U.S. Department of Health and Human Services pursuant to its enforcement activities under HIPAA,

4) Uses or disclosures required by law, and

5) Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

1) Does not identify you, and

2) With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund Privacy Official at the address provided in Section 3.

You may also file a complaint with: Secretary of the U.S. Department of Health and Human Services Hubert H. Humphrey Building 200 Independence Avenue S.W., Washington, D.C. 20201. The Fund will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the address provided in Section 3.

Section 7: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

This notice is written to inform you of the Fund's obligation to maintain the privacy of your PHI.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), employees required to leave their job to perform military service may elect to continue coverage in effect under the ACS program for themselves and eligible dependents. If a military leave is for 30 days or less, the coverage may be continued at the active employee rates. For longer leaves, coverage may be continued for up to 24 months from the effective date of the military leave. This extended leave works like COBRA and runs concurrently with any COBRA rights.

Military Leave of Absence

If you take a leave of absence in order to serve in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act (USERRA) gives you the right to continue group health care coverage for yourself and your covered dependents for up to 24 months from the date your leave of absence begins.

1) Your USERRA continuation coverage will end earlier if any of the following events occurs:

2) You fail to pay the required contributions on time

3) You lose your USERRA rights due to a discharge status that is other than honorable or other conduct specified in USERRA

4) You fail to report to work or to apply for reemployment following the completion of your service in the uniformed services within the time required by USERRA as described in the chart below.

If Your Period of Uniformed Service is:	You Must Report to Work/Submit an Application for Reemployment Not Later Than:
Less than 31 days (or if you are absent for purposes of an examination to determine your fitness to perform uniformed services)	The beginning of the first regularly scheduled work period on the day following completion of your service, after allowing for safe travel home and an eight-hour rest period. Or, if that is unreasonable or impossible through no fault of your own, as soon as possible[1]
More than 30 days but less than 181 days	14 days after completion of your military service or, if that is unreasonable or impossible through no fault of your own, as soon as possible[1]
More than 180 days	90 days after completion of your service[1]

[1]*If you are hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service, the applicable time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. The maximum period for recovery is generally two years from completion of service.*

USERRA and COBRA

USERRA and COBRA coverage run concurrently, which means that they begin at the same time. However, COBRA coverage can continue for up to 18 months (and for longer periods under certain circumstances) while as noted previously, USERRA coverage can continue for up to 24 months. In addition, COBRA coverage is subject to early termination for additional reasons that do not apply to USERRA coverage. COBRA is explained in detail in a previous section.

Payment of Contributions

If you elect to continue health coverage under USERRA, you will be required to pay 102 percent of the full premium for the coverage elected (the same rate as COBRA). However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount that you pay as a regular active employee.

Other Information

If you leave employment to enter military service, you should contact The Fund Office to answer any questions you may have regarding continued coverage under USERRA and to provide notification of any changes in marital status or address.

MEDICARE PRESCRIPTION DRUG NOTICE

Important Notice from the Youngstown Area Electrical Welfare Fund about Your Prescription Drug Coverage and Medicare

Please read this notice carefully, and keep it where you can find it. This notice has information about your current prescription drug coverage with The Youngstown Area Electrical Welfare Fund and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this section.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2) The Youngstown Area Electrical Welfare Fund has determined that the prescription drug coverage offered by The Youngstown Area Electrical Welfare Fund is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage**. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from The Youngstown Area Electrical Welfare Fund. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3) You can keep your current coverage from The Youngstown Area Electrical Welfare Fund. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you decide to drop your current coverage with The Youngstown Area Electrical Welfare Fund, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under The Youngstown Area Electrical Welfare Fund.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under The Youngstown Area Electrical Welfare Fund is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The Youngstown Area Electrical Welfare Fund coverage will be affected. Under our Plan, all participants who reach age 65 are no longer covered by the Plan because they are eligible for Medicare. Certain participants under age 65 may still be covered by the Plan and may also be eligible for Medicare Part D. Your current coverage pays for other health expenses, in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your current [Insert Name of Entity] coverage, be aware that you and your dependents will not be able to get this coverage back.

See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information or call The Youngstown Area Electrical Welfare Plan, please call the Fund Office at 1 -800-435-2388. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through The Youngstown Area Electrical Welfare Plan changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

1) Visit www.medicare.gov for personalized help,

2) Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number), or

3) Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY users should call 1-800-325-0778).

DEFINITIONS

Active Service

An employee will be considered in active service with an employer on a day which is one of the employer's scheduled work days, if he is performing in the customary manner all of the regular duties of his employment with the employer on a full-time basis on that day, either at one of the employer's business establishments or at some location to which the employer's business requires him to travel. An employee will be considered in active service on a day which is not one of the employer's scheduled work days only if he was performing in the customary manner all of the regular duties of his employment on the next preceding scheduled work day.

Dependent

The term dependent means:

1) The lawful spouse of an employee

2) Any child of the employee who is:

   a) less than 26 years of age and not enlisted in the armed forces of this or any other country;

   b) 26 years of age or over and mentally or physically incapable of earning a living, provided the child became so incapable prior to the attainment of age 26. The Trustees have the right to require proof of incapacity when claim is first made for benefits after attainment of age 26 by a dependent child and also, at any time, to require proof of the continuation of such incapacity.

The term child will include a child born of the employee, a child legally adopted by the employee, or a stepchild of the employee living with the employee in a normal parent-child relationship.

No one may be a dependent who is eligible for coverage as an employee and no one may be a dependent of more than one employee. Additionally, to be eligible for dependent coverage, proof may be required that the dependent meets the requirements stated above.

It is important that you give prompt written notice on the prescribed form of any change in your family status, such as marriage or divorce, birth of a child, marriage of any of your dependent children.

Employee

The term employee means an employee employed under the jurisdiction of the union by an employer making contributions to the Welfare Fund in accordance with the terms of a collective bargaining agreement.

Extended Care Facility

The term Extended Care Facility means an institution, or a distinct part of an institution, which:

1) provides for inpatients (a) 24-hour nursing care and related services for patients who require medical or nursing care, or (b) service for the rehabilitation of injured or sick persons;

2) has policies developed with the advice of, and subject to review by, professional personnel to cover nursing care and related services;

3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

4) requires that every patient be under the care of a physician and makes a physician available to furnish medical care in case of an emergency;

5) maintains clinical records on all patients, and has appropriate methods for dispensing drugs and biologicals;

6) has at least one registered professional nurse employed full time;

7) provides for periodic reviews by a group of physicians to examine into the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients;

8) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing.

The term Extended Care Facility does not include a place which is primarily for custodial care.

Hospital

The term hospital means (1) an institution constituted, licensed and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of injury and sickness, and which provides such treatment for compensation, by or under the supervision of physicians on an inpatient basis with continuous 24-hour nursing service by registered graduate nurses, or (2) an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, and is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals.

The term hospital will not include a hotel, rest home, nursing home, convalescent home, place for custodial care, home for the aged, or a place primarily devoted to the treatment of drug addicts or alcoholics.

Hospital Confinement

A person shall be considered to be confined in a hospital under the following conditions:

1) The individual remains in the hospital for 18 consecutive hours or longer, or

2) a board and room charge is made, or

3) The individual enters the hospital before midnight of the day following the day of an injury requiring emergency care, or

4) The individual enters the hospital for a surgical procedure.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Physician

The term physician means an individual who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery.

Reasonable and Customary Charges

Charges made for medical services or supplies essential to the care of the individual will be considered reasonable and customary if they are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are reasonable and customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which required additional time, skill or experience.

Surgical Procedure

The term surgical procedure means only the following: (a) a cutting operation; (b) suturing of a wound; (c) treatment of a fracture; (d) reduction of a dislocation; (e) radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumor; (f) electrocauterization; (g) diagnostic and therapeutic endoscopic procedures; (h) injection treatment of hemorrhoids and varicose veins.

Total Disability

An employee will be considered totally disabled during any period when, as a result of injury or sickness, is completely unable to perform the duties of their occupation and is not performing any other work or engaging in any other occupation or employment for wage or profit. A dependent will be considered totally disabled during any period when, as a result of injury or sickness, they are unable to engage in normal activities of a person of the same age and sex.

Uniformed Service

"Uniformed Service" means the Armed Forces, the Army National guard and 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 of persons designated by the President in time of war or national emergency.

"Service in the Uniformed Services" means the performance of duty on a voluntary or involuntary basis in a uniformed service, under competent authority. It includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purpose of an exam to determine their fitness to perform any duty, and a period for which a person is absent from employment for the purpose of performing funeral honors duty.