NOTES

TEAMSTERS LOCAL No. 377 HEALTH AND WELFARE FUND

1223 Teamsters Drive • Youngstown, Ohio 44502 • (330) 744-3148

BOARD OF TRUSTEES

UNION TRUSTEES	EMPLOYER TRUSTEES
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FUND ADMINISTRATOR

Compensation Programs of Ohio, Inc.

FUND CO-COUNSEL

Green, Haines, Sgambati, Murphy & Macala Co., L.P.A.
Marus & Shapira, LLP

FUND AUDITOR

Anness Gerlach & Williams, Certified Public Accountants

Revised 03/11/2008

To All Active Participants and Their Families:

The Board of Trustees is pleased to provide this updated Summary Plan Description of the Benefits available through Teamsters Local No. 377 Health and Welfare Fund. Effective June 1, 1996, this booklet replaces any and all booklets that were previously issued. Please read this booklet and keep it in a safe place for future reference. It explains when you and your dependents are eligible for benefits, what your benefits are and how claims are processed for your benefits. This program was adopted by the Board of Trustees and involves some important cost management measures for you and your dependents.

This booklet describes the health and welfare benefits available to you and has been issued according to the terms of the Group Contract. The actual Group Contract is between Medical Mutual of Ohio and the Fund.

ADVANTAGES

Your health benefit plan gives you the option to choose your own personal physician, specialist and hospital facility from the provider network directory. For maximum benefits, utilize the SuperMed Plus™ providers at identified locations only.

Throughout this booklet you will be informed of network and non-network health care benefits available to you and your family. Medical Mutual works with contracting hospitals, physicians and other providers in order to make quality medical care readily accessible and affordable.

You will receive the maximum benefits for physician and hospital care, when you choose a contracting physician or hospital. By selecting a personal physician, you can establish a comfortable, personal relationship with a physician who is familiar with your medical history and personal needs. Your personal physician is better able to direct you to specialists or other providers and help you control your health care costs.

This does not mean you cannot see your current physician or specialist if he or she is not listed in the directory. You do have the freedom to seek care outside the network and still receive part of your benefits.

Professional Providers – Only the following persons or entities which are licensed as required:

- Physical Therapists
- Podiatrist
- Psychologist
- Registered Nurse (R.N.)
- Certified Nurse Midwife (C.N.M.)
- Licensed Practical Nurse (L.P.N.)
- Licensed Vocational Nurse (L.V.N.)
- Laboratory (must be Medicare approved)
- Dentist
- Doctor of Chiropractic Medicine
- Mechanotherapist (licensed or certified prior to November 3, 1973)

Provider – A Hospital or Other Facility Provider.

Skilled Care – Care which requires the skill, knowledge and training of a physician or a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a physician.

SuperMed Plus – The name of the health care coverage option offered by Medical Mutual of Ohio. This option consists of a network of hospitals, physicians and other providers. Maximum benefits are obtained by using SuperMed Plus network providers.

Usual, Customary, Reasonable Charges (UCR) – The maximum amount allowed for covered services provided charged by a physician or other professional health care provider. Charges must also be reasonable in light of the complexity of the treatment of a particular case.

Utilization Review – The evaluation and promotion of efficient use of professional medical care services, procedures and facilities.

Medicare – The program of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Negotiated Rate – The amount the provider has agreed with Medical Mutual to accept as payment in full for covered services.

Network Provider – Any hospital, physician, specialist, laboratory or other health care provider who has been selected by Medical Mutual of Ohio to participate in the SuperMed Plus network.

Non-Participating/non-contracting Provider – Any hospital, physician, specialist or other health care provider who has no contractual relationship with Medical Mutual of Ohio.

Other Facility Provider – The following licensed facilities where covered services are provided: Alcoholism Treatment, Ambulatory Surgical, Day/Night Psychiatric, Dialysis, Drug abuse Treatment, Home Healthcare, Psychiatric and Skilled Nursing.

Outpatient – A covered person who receives services or supplies at a hospital, clinic, physician's office or treatment facility, but does not occupy a bed or stay overnight.

Participant – A person covered under a Collective Bargaining Agreement who is employed by an employer who must make contributions on their behalf to the Fund. Also, a person employed by a Local Union or a person employed by the Fund, who is otherwise covered under this Plan.

Physician – A doctor or surgeon licensed to practice medicine.

Plan – Your Health and Welfare Benefits. This booklet is your Summary Plan Description.

PReview Managed Care – The name for the utilization review and cost management programs available through Medical Mutual of Ohio.

Services obtained from a physician or other professional provider who is not part of the network, will be paid based on Usual, Customary and Reasonable (UCR) rates as established by Medical Mutual. You will be responsible for any difference between the UCR payment and the Provider's normal charge if you go to a non-participating, non-network provider. If you go to a non-network provider, you will be responsible for the non-network coinsurance and deductible.

HOSPITAL CARE

All contracting hospitals have agreed to provide specific services at a negotiated rate, so you will receive the maximum benefit amount by having your physician select a network contracting hospital.

All non-emergency, scheduled hospitalizations must be reviewed and certified by the PReview managed care department at Medical Mutual before you go into a hospital or other treatment facility. This procedure is called pre-admission review. When you use a contracting hospital, the hospital will take care of the pre-admission review and notification process for you.

In emergency situations, always go to the nearest hospital for treatment.

When using a non-contracting or out-of-state hospital, you have the responsibility to contact Medical Mutual prior to admission; unless it is an emergency situation, at which point you should seek are at the nearest facility.

Please read the following summary carefully. It has been written in simple, non-technical language, and is intended to help you understand how this ***Plan*** will benefit you and your eligible dependents.

Sincerely,

BOARD OF TRUSTEES

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Hospital – Any institution which is an approved and accredited hospital recognized as such by the American Hospital Association, which operates in caring and treating for sick and injured persons with surgical and diagnostic facilities and having 24-hour nursing service.

Identification Card – The health care card provided to you by the Plan. It shows your identification number and effective date of coverage.

Incurred – A charge will be considered incurred on the date a covered person receives the service or supply for which the charge is made.

Inhospital Benefit Period – A period of time beginning when you enter the hospital and ending when you have been out of the hospital for 90 consecutive days.

Inpatient – A covered person who receives care as a registered bed patient in a hospital or other facility for whom a room and board charge is made.

Lesser Amount – The lesser of the negotiated rate or the covered charges for contracting providers. For non-contracting providers, it means the UCR amount.

Major Medical Expense Benefit – After satisfaction of a deductible, a benefit which covers certain expenses for illness, injury or pregnancy in a calendar year.

Medically Necessary (or Medical Necessity) – A service or supply that is required to diagnose or treat an injury, ailment, condition, disease, disorder or illness and which the Plan determined is:

- Appropriate with regard to the standards of good medical practice
- Not primarily for the convenience of you or a provider
- The most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or condition require that the services cannot be safely or adequately provided to you as an Outpatient

Deductible – The amount of covered expenses that a participant must satisfy before being eligible for Major Medical Expenses Benefit.

Dependent – For the purpose of the Plan, your legal spouse and your children to the age of 19 (See definition of Child). Permanently physically handicapped or mentally retarded children may have coverage after age 19.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a physician or other approved professional. These services are limited to the Diagnostic Services listed in the Schedule of Benefits.

Emergency Care – An emergency refers to a sudden and serious accidental injury or illness which, if without immediate care, could permanently endanger your health, seriously impair your bodily function or cause serious and permanent damage to any of your bodily organs or parts.

Employer – An employer who has a Collective Bargaining Agreement with the union and who meets the Trustees' requirements for participation in the Fund.

ERISA (Employee Retirement Income Security Act of 1974) – As a participant of the Plan, you have a number of rights under ERISA as outlined in this booklet.

Excess Charge – The amount of billed charges less non-covered charges, in excess of the covered charges determined by Medical Mutual for a non-contracting provider.

Experimental/Investigative – Any treatment, procedure, facility, equipment, drug, device or supply which we do not recognize as accepted medical practice or which did not have required governmental approval when you received it. Determination will be made by the Plan in its sole discretion and will be conclusive.

Fund – The Administrator of your Plan is Teamsters Local No. 377 Health and Welfare Fund.

PAGE

TEAMSTERS LOCAL #377
HEALTH AND WELFARE FUND
SUMMARY OF BENEFITS

BENEFIT	MAXIMUM PAYABLE
Life Insurance	**$ 25,000.00**
Accidental Death & Dismemberment	**$ 25,000.00**
Accident and Sickness Time Loss Benefit Maximum Term	**$ 200.00 per week – maximum of 26 weeks**

****Above benefits apply to Employee only****

MAJOR MEDICAL LIFETIME MAXIMUM: **$ 250,000.00 Per individual**

TOTAL LIFETIME MAXIMUM: **$1,000,000.00 Per individual (Major Medical & Basic benefits combined)**

HOSPITAL SERVICES	SuperMed Plus™ Network Provider	Non-Network Provider
Hospital Expense Benefit Room & Board and Other Hospital Services	**100% of Covered Charges, Unlimited days semi-private**	**$200 non-network sanction per admission, 100% of the negotiated rate, for covered services thereafter**
Surgical Expense (Inpatient or Outpatient)	**100% of Covered Charges**	**$200 non-network sanction per admission, 100% of the negotiated rate, for covered services thereafter**
Emergency Accident/Illness Benefit	**100% of Covered Charges**	**100%**
Non-Emergency Accident/Illness Benefit	**80% of Covered Charges**	**$200 non-network sanction per admission, 80% of the negotiated rate, for covered services thereafter**
Outpatient Diagnostic X-Ray and Laboratory Expense Benefit	**100% of Covered Charges**	**$200 non-network sanction per admission, 100% of the negotiated rate, for covered services thereafter**

Coinsurance Limit – A specified dollar amount of coinsurance expense incurred in a benefit period.

Collective Bargaining Agreement – The agreement between your union and employer which governs the wages and conditions of your work.

Contracting/Participating Provider – The status of a hospital or other facility which has an agreement with Medical Mutual about payment for covered services.

Coordination of Benefits – This plan will coordinate its payment of benefits if a participant is covered by another group plan for health care. This will allow complete claim reimbursement, without providing duplicate payments.

Cosmetic Surgery – Reconstructive or plastic surgery done primarily to improve the physical appearance of a patient, but does not correct or improve a medical condition.

Covered Person – The participant, and if Family Coverage is in force, the eligible Dependents.

Covered Service – A provider's service or supply described in this booklet for which benefits will be paid as listed in the Schedule of Benefits.

Custodial Care – Care which does not require the constant supervision of skilled medical personnel to assist the patient in meeting his/her activities of daily living; such care can be taught to and administered by a lay person. Custodial care includes but is not limited to:

- administration of medication which can be self-administered or administered by a lay person with training; or
- help in walking, bathing, dressing, feeding or the preparation of special diets.

Custodial Care does not include care provided for its therapeutic value in the treatment of an injury, ailment, condition, disease, disorder or illness.

DEFINITIONS

Here are some definition of terms used in this booklet, as they apply to your Plan.

Accidental Death – A death directly resulting from an accident, as defined, from an external cause, as opposed to death caused or contributed to by a disease or sickness.

Alcoholism – A condition classified as a mental disorder and described in the International Classification of diseases of the United States Department of Health and Human Services (ICD-9-CM), as alcohol dependence, abuse or alcoholic psychosis.

Appeal Process – If you are dissatisfied with the processing or decision regarding your claim, there is a claims appeal process which is outlined on page 69. The appeal process allows you to have a separate review of your claim.

Application – All questionnaires and forms required by the Plan to determine your eligibility and insurability.

Authorization – Approval from Medical Mutual of Ohio (Medical Mutual) for non-contracting provider services, out-of-area services and elective hospital admissions and surgeries.

Benefit Period – The period of time during which you receive covered services as listed in the Schedule of Benefits.

Charges – The provider's list of charges for services or supplies before any adjustments for discounts, allowances, incentives or settlements.

Child – Your natural child, adopted child, step-child or child for whom you are the legal guardian, who is dependent on you for support and maintenance and for whom your are legally required to provide medical coverage.

Coinsurance – A percentage of the lesser amount for contracting providers and physicians of the covered charges for non-contracting providers for which you are responsible.

HOSPITAL SERVICES	SuperMed Plus™ Network Provider	Non-Network Provider
Skilled Nursing Facilities	100% of Covered Charges	$200 non-network sanction per admission, 100% of the negotiated rate, for covered services thereafter
Ambulance Service Benefit (Hospital initiated)	100% of Covered Charges	$200 non-network sanction per admission, 100% of the negotiated rate, for covered services thereafter
Organ Transplant	100% of Covered Charges	$ 1,000,000 lifetime maximum
Durable Medical Equipment (Hospital Charges Only)	100% of Covered Charges	$200 non-network sanction per admission, 100% of the negotiated rate, for covered services thereafter
Inpatient Psychiatric Days	100% of Covered Charges (70 days per year)	$200 non-network sanction per admission, 100% of the negotiated rate, for covered services thereafter
Inpatient Substance Abuse	100% of Covered Charges Two Confinements per lifetime (45 days each confinement)	$200 non-network sanction per admission, 100% of the negotiated rate, for covered services thereafter

PROFESSIONAL SERVICES SUBJECT TO DEDUCTIBLE AND COINSURANCE

	SuperMed Plus™ Network Provider	Non-Network Provider
Individual Deductible	**$ 100**	**$ 100**
Family Deductible	**$ 200**	**$ 200**
Coinsurance	**$ 2,000**	**$ 2,500**
Total Out-of-Pocket Expense per individual, per Year	**$ 2,100**	**$ 2,600**

Note: The maximum amount each individual may be required to pay each year for medical services received by a contracting provider, *will not exceed the Total Out-of-Pocket Expense,* as noted.

PROFESSIONAL SERVICES	SuperMed Plus™ Network Provider	Non-Network Provider
Inpatient Medical Visits	**100% of Covered Charges**	**80% UCR**
Inpatient Consultations	**100% of Covered Charges**	**80% UCR**
Inpatient Psychiatric and Substance Abuse	**100% of Covered Charges**	**80% UCR**
Anesthesia	**100% of Covered Charges**	**80% UCR**
Assistant Surgery (25% of Surgeon's Fee)	**100% of Covered Charges**	**80% UCR**
Emergency Accident/Illness	**100% of Covered Charges**	**100% UCR****
Non-Emergency Accident/Illness	**80% of Covered Charges**	**60% UCR**
Ambulance Service Benefit	**80% of Covered Charges**	**80% UCR**

**** Services payable at 100% are not subject to deductible and coinsurance**

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file a suit in Federal Court. In such a case, the court may require the Plan Administrator to provide you with the material and pay you up to $100 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. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The Court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay court 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. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, you should contact the nearest Area Office of the Pension/Welfare Benefit Programs, U.S. Department of Labor.

STATEMENT OF RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Teamsters Local No. 377 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

2. Obtain copies of all documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for copies.

3. 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 the summary annual report.

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

PROFESSIONAL SERVICES	**SuperMed Plus™ Network Provider**	**Non-Network Provider**
Maternity and Abortion (Exclude dependent children)	**100% of Covered Charges**	**80% UCR**
Initial Newborn Exam ($100 maximum)	**100% of Covered Charges**	**80% UCR**
Home and Office Calls	**$10 Co-Pay**	**60% UCR**
Outpatient Consultations	**80% of Covered Charges**	**60% UCR**
Adult Routine Physical Exams (One exam per year/$300 maximum)	**100% of Covered Charges**	**80% UCR**
Allergy Shots	**80% of Covered Charges**	**60% UCR**
Routine Pap Smear, chest x-ray, SMA12, CBC, Urinalysis, mammogram and EKG (One per year/ Combined with hospital services)	**100% of Covered Charges**	**80% UCR**
Well Child Visits and Immunizations to age 19 or age 23 if full-time student at an accredited college $300 maximum	**100% of Covered Charges**	**80% UCR**
Diagnostic Services, Radiology, Pathology and Allergy Testing	**First $1,000 paid at 100%, thereafter subject to deductible, then 80% of Covered Charges (Combined in-network and out-of-network $1,000 maximum paid)**	**First $1,000 paid at 80%, thereafter subject to deductible, then 60% UCR**

**** Services payable at 100% are not subject to deductible and coinsurance.**

PROFESSIONAL SERVICES	SuperMed Plus™ Network Provider	Non-Network Provider
Cardiac Rehabilitation, Chemotherapy, Dialysis, Podiatry, Occupational Therapy, Speech Therapy & Radiation	80% of Covered Charges	60% of UCR
Chiropractic and Physical therapy	80% of Covered Charges First 10 visits do not require medical approval; remaining visits will be based on medical necessity. (subject to deductible after first 10 visits)	60% of UCR
Skilled Nursing Facility (Medical visits)	80% of Covered Charges	60% of UCR
Durable Medical Equipment	80% of Covered Charges	60% of UCR
Hearing Aids and related services	80% of Covered Charges Up to a $1,500 maximum per appliance over a 36 month period (not subject to annual deductible).	60% of UCR
Hearing Aid fitting or exam	80% of Covered Charges Up to $75 maximum over a 36 month period (not subject to annual deductible)	60% of UCR
Dental Services for Accidental Injury	100% of Covered Charges	80% of UCR
Outpatient Psychiatric services.	50% of Covered Charges Limited to 30 visits per calendar year.	30% of UCR Limited to 30 visits per calendar year.
Outpatient Substance Abuse services.	50% of Covered Charges Limited to 30 visits per calendar year. $10,000 Lifetime Maximum for hospital/professional services combine.	30% of UCR Limited to 30 visits per calendar year. $10,000 Lifetime Maximum for hospital/professional services combine.

****Services payable at 100% are not subject to deductible and coinsurance.**

Plan Sponsor and Administrator - The Board of Trustees is both the Plan Sponsor and Plan Administrator.

Identification Number – The Plan number assigned to this Trust by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The identification number assigned to the Board of Trustees by the Internal Revenue Service is 34-6726358.

Agent for Service of Legal Process – The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents may be served upon the Board of Trustees or any individual Trustee at the address of the Fund shown above, or upon any Trustee at his own address.

Collective Bargaining Agreements – This Plan is maintained pursuant to collective bargaining agreements. Plan Participants and beneficiaries may examine these collective bargaining agreements and may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees at the address listed at the front of this booklet.

Source of Contribution – The Plan's benefit for eligible employees are provided through employer contributions. The amount of the employer contributions is determined by the provisions of collective bargaining agreements. Under certain circumstances, employee contributions are received by the Plan.

Insurance Companies – Self-funded medical benefit claims are administered pursuant to a group contract issued by Medical Mutual of Ohio. Life insurance, accidental death and dismemberment, weekly disability, chiropractic, podiatry, dental and vision are self-insured by the Plan.

Trust Fund – All assets are held in trust by the Board of Trustees, and insurance premiums are paid from the Trust. The Plan Administrative Office pays all benefits which are self-insured by the Plan.

Fiscal Year – The Plan year for purposes of maintaining the Plan's Fiscal records is the twelve-month period beginning September 1st and ending August 31st.

STATEMENT OF RIGHTS (ERISA)

Name of Plan – ***Teamsters Local No. 377 Health and Welfare Fund***

Board of Trustees – The Board of Trustees, which consists of an equal number of employer and union representatives, is responsible for the operation of the Plan. If you wish to contact the Board of Trustees, you may use the address and phone number below.

Board of Trustees
Teamsters Local No. 377
Health and Welfare Fund
1223 Teamsters Drive
Youngstown, OH 44502

(330) 744-3148
(330) 744-4764 – FAX

Union Trustees:

Charles M. Byrnes
Teamsters Local Union No. 377
1223 Teamsters Drive
Youngstown, OH 44502-1348
(330) 743-3111
(330) 743-1821 – FAX

Doug Norris
Teamsters Local Union No. 377
1223 Teamsters Drive
Youngstown, OH 44502-1348
(330) 743-3111
(330) 743-1821 – FAX

Employer Trustees:

Carmen Forde
Tamarkin Company
375 Victoria Rd.
Youngstown, OH 44515
(330) 792-3811
(330) 792-8914 - FAX

Joseph McHenry
Superior Beverage Group / Mars Distributing
425 – 427 Victoria Road
Austintown, OH 44515
(330) 793-9321
(330) 793-8773 - FAX

BENEFITS PROVIDED BY THE FUND OFFICE

COMBINED DENTAL AND VISION SERVICE BENEFIT

Effective 01/01/2007

Maximum for single policy	**80% of $1,250.00 per year**
Maximum for family policy	**80% of $1,250.00 per year**

ORTHODONTIC BENEFIT

Lifetime maximum	**$1000 per individual**

PRESCRIPTION DRUG BENEFIT

Generic Drugs	**$ 10 co-pay**
Brand Name Drugs	**$ 20 co-pay**

Annual maximum $25,000.00 per individual

CAREBRIDGE CORPORATION, EMPLOYEE ASSISTANCE (EAP)

Effective 04/01/2007

The Fund offers an Employee Assistance Program through Carebridge Corporation for family, financial, legal, and emotional or other personal problems for all eligible members and their eligible dependents who DO NOT have an employee assistance program available to them through their employer.

ELIGIBILITY

This section tells how to apply for coverage, how and when you become eligible for coverage, who is considered a Dependent, and when your coverage starts. This section also explains when you should change from individual to family coverage and how you should apply for the change.

To enroll you must complete an application card, but no physical examination is required. You can enroll for either individual or family coverage. You will receive an identification card from Medical Mutual of Ohio, which shows your identification number. If you have family coverage, it is important for you to know which family members are eligible for benefits.

You can become eligible for the benefits provided under the Teamsters Local No. 377 Health and Welfare Fund if:

- You are a member of the bargaining unit represented for purposes of collective bargaining by Local No. 377, and
- Your employer has entered into a collective bargaining agreement with Local No. 377 of the International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers, providing for contributions to be made to the Health and Welfare Fund, and is required to and actually makes the necessary contributions on your behalf to the Health and Welfare Fund, and
- Your employer has signed a written agreement with the Board of Trustees authorizing the necessary contributions to be made on your behalf.

You are not eligible if you are an employer, partner, self-employed person, proprietor, or a dependent of such an individual.

Coverage Begins

Coverage starts on your effective date, which is determined as follows:

If you begin work for a contributing employer who has participated in the Fund for at least three months, your effective date will be contingent upon the receipt of two full consecutive monthly contributions from a contributing employer on your behalf. (Most employers pay contributions based on weeks worked. Therefore, a full contribution includes all weeks for that month). The following schedule reflects a participants effective date based on the first month of contributions made.

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 work at the end of your leave of absence under the FMLA.

WOMEN'S HEALTH AND CANCER RIGHTS ACT of 1998

Did you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? Call your Plan Administrator at (330) 744-3148 for more information.

FAMILY AND MEDICAL LEAVE ACT OF 1993

THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) was enacted on February 5, 1993. FMLA became generally effective on February 5, 1994. FMLA requires your employer to provide you with up to 12 weeks of unpaid leave during any 12-month period for specified family and medical reasons, if you are eligible. During this period, your employer must provide health coverage for you on the same terms and conditions that you would receive if you continued to work.

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

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

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

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

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

Example: Employer's initial contributions are the full months of December and January participants' effective date is March 1st.

First full monthly contribution:	First month of coverage will be:
December	March
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February

You can also become eligible if the Fund has received 9 weeks of contributions within a 12-month period from a contributing employer. The corresponding chart below reflects a participant's eligibility date based on the 9th weekly contribution.

Example: Employer's 9th week of contributions is the week ending 01/11/03 participants' effective date is 03/09/03

TERMINATION/REINSTATEMENT OF COVERAGE

When an employer is not responsible to make contributions, coverage will actually be extended through the end of the 9th week immediately following the last full weekly contribution. You will then be given self-pay options to continue their coverage.

Example: Employer ceases to make contributions the week ending 01/11/03 benefits will terminate 03/09/03

If you return to work for a contributing employer within 24 months of the date on which your eligibility was terminated your coverage will be reinstated immediately following the end of the 9th week following your return to work. (Or the corresponding week two months ahead)

Example: Employer begins making contributions the week ending 01/11/03 for an employee returning from lay-off benefits will be reinstated 03/09/03.

If initial 9 weeks, layoff or return from layoff occurs:	9th week of initial eligibility last contribution or return to work: (weeks ending)	Date coverage will begin, end or reinstate:
January	04,11,18,25	03/02,09,16,23
February	01,08,15,22	03/30, 04/06,13,20
March	01,08,15,22,29	04/27, 05/04,11,18,25
April	05,12,19,26	06/01,08,15,22
May	03,10,17,24,31	06/29, 07/06,13,20,27
June	07,14,21,28	08/03,10,17,24
July	05,12,19,26	08/31, 09/07,14,21
August	02,09,16,23,30	09/28, 10/05,12,19,26
September	06,13,20,27	11/02,09,16,23
October	04,11,18,25	11/30, 12/07,14,21
November	01,08,15,22,29	12/28, 01/ 04,11,18,25
December	06,13,20,27	02/01,08,15,22
Weeks based on 2003 calendar for example only		

Continuing Eligibility:

In order to remain eligible for coverage for each month, your employer must make contributions for all weeks of that month. Otherwise, you must make self-contributions for coverage as described in the section on self-contributions.

Self-Contribution:

You may continue your benefits in force for an additional period of 24 months immediately following your termination date, if you pay in advance the contribution the contribution required by the collective bargaining agreement applicable to your employment. Payment must be made to the Fund Office by the date indicated on the continuation of coverage options notification.

Effective January 1, 2006 the self-pay period of 24 months will be reduced to two (2) consecutive months. The amount of payment required for these two months will be calculated at 50% of the current Cobra Rate. This limit of two consecutive months will be upon each unemployment period with no limit on the number of two-month periods.

As an example, let's assume you are laid off on January 14, 2006. Once your eligibility period ends on March 19, 2006, you will be entitled to pay the remainder of that month at the current employer rate or begin your self-payment period. At the end of your second month of self-payments, you will be entitled to continue your benefits through COBRA or, if eligible for the Retiree Plan, begin the retiree self-pay program. If you become re-employed and establish eligibility, you will become eligible again for the two-month self-pay period.
Those individuals currently under the self-payment program will be permitted to complete the 24-month self-payment option. Future self-payment periods will be based upon the new self-payment rules.

If you wish to continue eligibility for the Plan's hospitalization, surgical, medical and major medical benefits only, you will be notified by the Fund Office of your options and the cost of such coverage as soon as your employer has ceased to make contributions on your behalf. At the time of your termination of coverage you must elect the amount of coverage you wish to continue and you cannot change the coverage you elected during the self-contribution period.

This self-contribution privilege is not available to you if the reason that you are no longer insured is because your employer is no longer required to make contributions to the Fund. In other words, if your employer has left the Fund and is therefore no longer considered a contributing employer, you become ineligible to self-contribute to maintain benefits, unless the contributing employer left the Fund due to the termination of business, or unless you were already self-contributing at the time the employer terminated his contributions to the Fund.

Regardless of which continuation period applies, ***COBRA*** provides that an individual's continuation of coverage may be cut short for reasons including:

1. This Fund no longer provides group health coverage.

2. The self payment for continuation of coverage is not timely paid (within 30 days of the due date);

3. You or an eligible dependent become under another employer-sponsored group health plan as an employee, dependent or spouse and the other plan does not contain any exclusion or limitation with respect to your or your dependent's pre-existing condition; or

4. You or an eligible dependent become entitled to Medicare.

You do not have to show that you are insurable to choose continuation of coverage.

Under COBRA, the participant or a family member has the responsibility to inform the Fund Office within 60 days of a "qualifying event", such as divorce, legal separation, or a child losing dependent status. While it is the responsibility of the participant's employer to notify the Fund Office within 30 days of the employee's death, termination of employment, disability, layoff, reduction of hours, retirement or entitlement to Medicare, the participant or other family member should notify the Fund Office if any of these qualifying events occur in order to assure timely notification of eligibility for, and processing of, an election of continuation of coverage.

When the Fund Office is notified in writing that one of these events has occurred, you will be notified within 14 days after loss of coverage that you have the right to choose continuation of coverage. Under COBRA, you have at least 60 days from the later of the date your coverage terminated, or will terminate under the Plan, or the date of the notice advising you of your right to continuation of coverage, to inform the Fund Office that you want continuation of coverage.

If you do not choose continuation of coverage, your group health insurance coverage will end.

If you choose continuation of coverage, this Fund is required to give you group health coverage which, at the time coverage is being provided, is identical to the coverage provided under the Fund to similarly situated covered participants and their families in the same benefit plan. However, life insurance benefits, accidental death and dismemberment coverage and weekly income and sickness benefits will not be available under COBRA. In addition, under COBRA, you and/or your dependents will be allowed to choose continuation of either health coverage only or health coverage plus dental, prescription drug and vision benefits.

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

Termination:

When you stop being an eligible person or do not pay the required contribution, coverage stops for all covered persons at the end of the period for which payment was made. Coverage stops for a dependent on the date that person no longer meets the definition of dependent.

You will stop being an eligible person upon the occurrence of any of the following:

- The date you enter the military;
- The date you cease to be a member in good standing with the Local Union;
- The end of the 9th week immediately following the last full weekly contribution received from your employer
- The last day of the month for which you cease to make self contributions
- The Fund has the right to void the coverage of any covered person who engages in fraudulent conduct relating to claims or application for coverage, as determined by the Fund

You are responsible for notifying the ***Plan*** of any of these above-mentioned terminating events.

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

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

Changes in Coverage:

If you applied for individual coverage, you can change to family coverage if you marry or add a child. The date coverage is effective for a spouse or child depends upon when the Fund is notified, so tell us promptly. **Failure to promptly notify the Fund office about adding a spouse or child can result in a long delay in that person's eligibility for coverage.**

Family coverage should be changed to individual coverage when only the employee is eligible. In addition, the Fund should be notified when a covered person becomes eligible for Medicare.

Dependent Eligibility:

Your Dependents are:

- Your wife or husband, unless you are divorced or legally separated:
- Your unmarried dependent children;
- Your unmarried legally adopted child (including a child living with you during the period of probation for that child being placed for adoption, but only to the extent coverage is not available and provided by another individual or agency);
- Your unmarried stepchild residing in your household, solely supported by you (evidenced by federal income tax returns) and provided a divorce decree does not obligate the other natural parent to provide health care or health insurance coverage;
- Your unmarried child permanently residing in the household, of which you are head and actually being supported solely by you, provided you have been granted legal custody of the child.
- Your unmarried dependent children are eligible for coverage if they have not reached the last day of the month of their 19th birthday, or the last day of the month of their 23rd birthday, if they are a full-time student at an accredited school or college.

Eligibility will be continued past the age limit for unmarried children who can't work to support themselves due to mental retardation or physical handicap, if they are allowed as federal tax exemptions. The disability must have started before the end of the month in which the child reaches the age limit when eligibility would otherwise have ended. You must give a physician's written medical certification of such disability within 31 days of the date the child reaches such age limit. Annually, the Fund or Medical Mutual may request proof of continued disability and dependency.

NOTE: Dependent **CHILDREN** who acquire their **OWN** medical coverage from an employer through gainful employment, will be terminated under your coverage through this Plan.

CONTINUATION OF COVERAGE

Coverage May Continue for:	**If:**	**Maximum Duration of Coverage**
You and your eligible dependents	Your employment ends for any reason (except gross misconduct), including layoff, total disability, or retirement	18 months*
You and your eligible dependents	Your hours of employment are reduced	18 months*
You and your eligible dependents	You become absent from employment by reason of service in the military	24 months†
Your eligible dependents	You die	36 months
Your eligible dependents	You become eligible for Medicare	36 months
Your eligible dependents	You are divorced or legally separated from your lawful spouse	36 months
Your eligible dependent children	Your eligible dependent children ceased to be qualified as eligible dependents (for example, they reach age 19 and are no longer eligible under the Fund **Plan**)	36 months

*If you or one of your eligible dependents are disabled, COBRA coverage may continue for that person only for up to 29 months. Timely proof of eligibility for Social Security Disability Benefits is required for continuation of the additional 11 months of coverage.

†The right to election exists even if the eligible employee will also be covered under a military health plan.

When one of these situations occur, the Fund Office, upon notification, will give you or your eligible dependents all the details regarding continuation coverage, including the cost. It is your responsibility, however, to inform the Fund Office of a divorce, legal separation or of a child losing eligible status under the **Plan**.

CONTINUATION OF COVERAGE – COBRA

A Federal law requires the Fund to offer you and your eligible dependent(s) the opportunity for a temporary extension of health coverage at group rates, when coverage under the Fund would otherwise end. Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you may continue health care coverage identical to the benefits the ***Plan*** provides to you at the time your coverage is terminated. You and your eligible dependent(s) will be required to pay the full cost of the coverage in order to continue it.

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

If you do not choose continuation of coverage, your group health insurance coverage will end.

The following information will summarize your rights and obligations under the continuation of coverage provisions of COBRA. *You and your eligible dependents covered under the Fund* should take the time to read this information carefully.

Eligibility For Retirees

The following eligibility rules must be met in order for a Retiree between the ages of 57 and 65 to qualify for Retiree Health Insurance Benefits. These benefits are being provided in part through current contributions being paid on behalf of active members covered under this Welfare Fund and direct Retiree contributions.

In order for a Retiree to be eligible for these benefits, it is necessary to meet the following requirements:

1. The Retiree must be at least age 57 and have been an eligible active employee under the Health and Welfare Fund for at least 9 full years of the 12 years immediately prior to his termination as an active employee on or after age 57. The Retiree must have been covered by this Health and Welfare Fund for a period of at least 2 full years as an active employee immediately prior to age 57, if previously covered by another Teamster Industry health insurance fund or employer paid plan negotiated with Teamsters Local 377.

2. The Retiree must have been in covered employment as an active employee for which contributions were paid under the Teamsters Central States Pension Fund, other teamster pension fund or Local No. 377 negotiated employer pension plan immediately prior to age 57, and earned sufficient credit to retire at that date or at a later date.

3. The Retiree must pay the required monthly contribution established by the Board of Trustees within the required time.

Coverage For Participants Retiring On Or After The Age Of 50

If you choose to retire on or after the age of 50 coverage is available to bridge the gap until the Fund's Retiree Coverage is available at age 57. After the 24-month self-pay option you will be able to continue coverage up to 60 months prior to the age of 57. The coverage and monthly premium will be calculated at 75% of your choice of COBRA options available. The Plan does not provide any coverage to Medicare-eligible individuals who do not enroll in Medicare Part A and Part B. The bridge gap program will pay its benefits only after Medicare has paid its benefits.

For further information regarding retirement eligibility requirements please contact the Fund office.

LIFE INSURANCE BENEFIT (For Employees Only)

In the event of your death at any time or place while you are covered under the Fund, a benefit in the amount indicated on the Summary Of Benefits will be paid in a lump sum to the beneficiary you have named. However, no benefit will be paid for death by suicide.

Should you fail to name a beneficiary, or if the beneficiary you have named is not living at the time of; your death, this benefit will be paid in the following order of preference to:

1. Your spouse
2. Your children,
3. Your parents

YOU MAY CHANGE YOUR BENEFICIARY WHENEVER YOU WISH BY COMPLETING THE APPROPRIATE FORM AVAILABLE AT THE FUND OFFICE. YOU MUST DO THIS IN PERSON.

Should you die within 31 days after your eligibility ends, the death benefit will be paid just as if you were eligible at the time of your death.

If prior to 60 you become totally and permanently disabled, your life insurance will continue without cost for a period of twelve months. Proof of total and permanent disability must be presented within the twelve-month period, and yearly thereafter, to continue the insurance in force. No hospitalization coverage is allowed at this time.

Because of the self-insured status of the Fund, this life insurance benefit cannot be converted to individual coverage.

The Fund is not obligated to notify you or your beneficiary of any termination of coverage.

MILITARY SERVICE PROVISION

The Trustees wish to provide notice to you that if you are called up for active duty in the armed services, the Fund will provide you with the ability to retain coverage during the time you are in qualified military service. If you are in qualified military service for less than 31 days, the cost of continuation coverage will be the responsibility of the Fund, provided you meet the conditions for re-employment. If you are in qualified military service for more than 31 days, the cost of providing continuation of coverage will be your responsibility.

If you are in qualified military service for more than 31 days and elect to continue coverage under this Fund for you and your dependents, if applicable, you will be entitled to continue coverage by making self-payments for a maximum period of eighteen (18) months.

If you served between 31 and 81 days in qualified military service, your coverage will be reinstated on your re-employment with any Employer under this Fund if you apply for re-employment within 14 days after your honorable discharge. If your service exceeded 181 days, you must apply for re-employment within 90 days after your honorable discharge.

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 that immediately upon learning of your armed service related absence for any period, you discuss your options with the Fund Office.

VOLUNTARY APPEAL TO THE BOARD OF TRUSTEES

Once you have filed your appeal through Medical Mutual as detailed above, you have the right to file a lawsuit in federal court. However, prior to initiating federal court action you can also file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within 60 days of the mailing of the Notice of Final Decision on your appeal.
The Appeal should be addressed as follows:

Board of Trustees
Teamsters Local No. 377 Health and Welfare Fund
1223 Teamsters Drive
Youngstown Ohio 44502

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

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

1. The Plan will not assert a failure to exhaust administrative remedies;
2. The Plan agrees that any Statute of Limitations applicable to pursing the claim in court will be tolled during the period of the voluntary appeal process;
3. The Plan requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);
4. You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:

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

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

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

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

(Participant Only)

If you are involved in an accident on or off the job which results in loss of life, loss of limbs or loss of sight within 90 days following the accident, and the accident occurs while you are eligible for benefits, a benefit in the amount indicated in the Summary Of Benefits is payable in addition to the life insurance benefit.

If you die, the benefit will be paid to your beneficiary in the same manner as your life insurance benefit. In the event of dismemberment, the benefit will be paid to you.

No payment will be made for losses resulting from suicide or any attempt at suicide, or as a result of committing or attempting to commit a felony.

Depending on the extent of the loss, the following benefits are payable:

Benefit	*Maximum Payable*
Loss of Life	Full Amount
Both hands or both feet, or sight of both eyes	Full Amount
Any combination of foot, hand, or sight of one eye	Full Amount
One hand, one foot or sight of one eye	1 / 2 Full Amount

EXCLUSIONS TO LIFE INSURANCE, ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Benefits shall not be payable for any death/loss due to:

1) ***Self-destruction or any self-inflicted injury / death while sane or insane. Including any intentional abuse or misuse of any drug, alcohol, poison or fumes taken or inhaled, or***
2) ***Insurrection, participation in a riot, police duty as a member of any military organization, war or any act of war declared or undeclared, or***
3) ***Participation in or as the result of the commission of a criminal or otherwise unlawful act, or***
4) ***Disease, bodily or mental illness, or medical or surgical treatment.*** *(Accidental Death and Dismemberment Benefit only.)*

CLAIM PAYMENTS

LIFE INSURANCE BENEFIT

If you have not named a beneficiary or if the beneficiary you have named is no longer living, the benefit amount will be paid to:

1. Your surviving spouse, if any,
2. Your surviving children equally, if there is no surviving spouse,
3. Your surviving parents equally, if there is no surviving spouse or children.

If none of the above survive you, no benefit will be paid.

ACCIDENTAL DEATH BENEFIT

This benefit will be paid the same as your Life Insurance Benefit. The Fund has the right to have an autopsy conducted in connection with a claim for accidental death.

DISMEMBERMENT BENEFIT

Benefits will be paid to you immediately after the Fund receives satisfactory proof of loss. The Fund has the right to require an examination in connection with a claim for dismemberment.

CLAIM FILING FOR BENEFITS

All claims for Life Insurance and other benefits described in this section must be filed through your Fund Office.

All claims should be filed as soon as possible. Life Insurance and Accidental Death and Dismemberment claims must be filed within one year of the date of loss. The beneficiary of the Participant should bring a certified copy of the Death Certificate to the Fund Office.

REVIEW PROCEDURE FOR DENTAL, VISION, PRESCRIPTION, DEATH, DISMEMBERMENT AND WEEKLY DISABILITY BENEFITS

You or your authorized representative may appeal the decision by the Fund Office to deny any claim for dental, vision, death, accidental death, accidental dismemberment or weekly disability 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.

You may file a written notice of appeal to the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number, telephone 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:

Board of Trustees
Teamsters Local No. 377 Health and Welfare Fund
1223 Teamsters Drive
Youngstown Ohio 44502

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

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

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

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

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

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

LEGAL ACTION

No attempt to recover more benefits from the Plan through legal action may be instituted until the eligible person completes the appeals procedure.

APPEAL PROCESS

REVIEW PROCEDURE FOR MEDICAL CLAIMS PROVIDED THROUGH MEDICAL MUTUAL

You or your authorized representative may appeal the decision by Medical Mutual to deny any claim for medical benefits in whole or in part. 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.

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

Medical Mutual Services
2060 East Ninth Street
Cleveland, OH 44115-1355

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, Medical Mutual shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

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

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

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

WEEKLY DISABILITY BENEFIT

This benefit is payable as a wage replacement if you become totally disabled and cannot work due to either an accidental bodily injury or a sickness, not connected with your employment. You must be under the regular and direct care of a licensed physician or surgeon who certifies that you are totally disabled. Benefit payments will begin with the first day of disability in the event of an accident or the eight consecutive day in the event of sickness, but will not be paid for more than 26 weeks for each period of disability.

Successive periods of disability will be considered as one continuous period of disability if they are due to the same or related causes and are not separated by a return to active work for at least six weeks. However, if you return to active work for at least six weeks between periods of disability which are due to the same or related causes, or if the periods of disability are separated by return to active work and are due to different and unrelated causes, then each disability will be considered separately, and benefits will be payable up to 26 weeks for each disability.

If you are on layoff, you will be entitled to receive weekly accident and sickness benefits if you become disabled and lose unemployment benefits as a result of the disability, but you shall only be entitled to receive weekly accident and sickness benefits during those months for which the weekly contributions are paid for a full month. In other words, if you stop making self-payments of the necessary weekly contributions which had been previously paid by your contributing employer, you will be terminated from the weekly accident and sickness benefits. This does not apply to an employee who becomes disabled while actively working for a contributing employer.

EXCLUSIONS FOR WEEKLY DISABILITY BENEFITS

Disabilities not covered are those for any period that you are entitled to primary benefits under the Federal Social Security Act and amendments thereto.

Disabilities not covered are those that result from attempted suicide or self-inflicted injury or illness, injury sustained during or as a result of the commission, or attempt to commit a criminal act, as determined by the Board of Trustees.

HOSPITAL SERVICES

HOSPITAL EXPENSE BENEFIT

If you are hospitalized because of an illness, injury or pregnancy, the Hospital Expense Benefit covers the hospital bill for your room and board and for miscellaneous expenses related to treatment you receive while you are an inpatient in the hospital.

Covered Expenses Include:

1) Room and board in a semi-private room, an intensive care unit, coronary care unit, burn unit or isolation room, if medically required. If no rate for a semi-private room is available at the hospital where you are confined, the ***Plan*** will pay a rate based on the average charge for a semi-private room in the surrounding area.

   NOTE: **If you choose to stay in a private room you must pay the difference** between the private and the semi-private room rate. If you are put into a private room because you are contagious to other patients, the private room rate will be paid.

2) Miscellaneous expenses such as medicines, laboratory tests, X-rays, oxygen, anesthesia and other similar services are provided for you in a hospital.

The ***Plan*** will pay 100% of Negotiated Rate for the length of the hospital confinement.

Services Not Covered By This Benefit:

1) Personal comfort items, such as hair appointments, magazines, telephone or television service in your room.

2) All taxes and surcharges.

3) Difference between private and semi-private room rate.

HOW TO FILE A CLAIM FOR WEEKLY DISABILITY BENEFITS

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

The Fund Office will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time, 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 Office notifies you of the delay.

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

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

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A description of the Fund's Appeals Procedure 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 one year from the date on which the services were incurred. Any claims submitted after one year shall result in denial of your claim**. A health service shall be considered as Incurred on the date services or supplies are rendered or received.

PHYSICAL EXAMINATION AND AUTOPSY

The Fund reserves the right to have the eligible person examined, at its own expense, as often as reasonably necessary while a claim is pending. The Fund further reserves the right to have an autopsy performed unless the same is forbidden by law.

event that the prescription is not a covered drug under the Plan, you must contact the Fund Office for additional information (and to make a claim for coverage of the prescription benefits). The Fund Office will review the claim and if the claim is denied in whole or in part, will provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

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

HOW TO FILE CLAIM FOR DEATH, ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Claims should be submitted to the Fund Office as soon as possible; do not delay in filing any claims.
Claims for Death, Accidental Death and Dismemberment benefits will be provided through the Fund Office. Your beneficiary must submit the completed claim form. 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 Office will notify your beneficiary of the decision on the claim for benefits within 90 days. In the event that the Fund Office needs additional time to review the claim for benefits or needs additional information, your beneficiary will be provided with the information on the status prior to the expiration of the initial 90 day period.

When the claim for death benefits falls within the Funds exclusions, your beneficiary will be notified by the Fund Office that the claim is denied in whole or part with an explanation of the reasons for the denial.

He/she will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

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

On-Line Certification For Hospitals

Teamsters Local No. 377 Health and Welfare Fund has an on-line certification system through Medical Mutual of Ohio, which is available to contracting hospitals. Your identification card information will allow contracting providers to electronically submit bills to speed up the claim payment process.

SURGICAL EXPENSE BENEFIT FOR HOSPITAL SERVICES ONLY
The Surgical Expense Benefit covers surgery services billed by a hospital. In addition, coverage is provided for the following specified services:

- sterilization, regardless of medical necessity
- removal of bony impacted teeth;
- surgery to correct deformity caused by disease, trauma, birth defects, growth defects or prior therapeutic processes; and
- surgery to improve a functional deficiency.

Services Not Covered By This Benefit:

1) Surgical procedures which are performed for cosmetic reasons are not covered unless as a result of an accidental injury.

Examples of cosmetic surgery include, but are not limited to:

a) Surgery for Obesity, including gastric by-pass, gastric stapling, intestinal bypass, lipectomy, suction lipectomy, or any other surgical procedure which is simply to remove fat tissue.

b) Reduction Mammoplasty – (breast reduction surgery).

c) Augmentation Mammoplasty – (breast enlargement surgery), unless part of reconstruction following breast surgery due to cancer.

d) Rhinoplasty – (plastic surgery on the nose) unless the result of an accident or chronic nasal obstruction.

e) Otoplasty – (plastic surgery on ears).

f) Blepharoplast – (repair of drooping eyelids) unless the droop restricts field of vision as verified by an ophthamlologist.

g) Keratectomy – for diagnosis of Myopia (near-sightedness) when Myopia is correctable by lenses.

h) Rhytidectomy – (face lift)

i) Dyschromia – (tattoo removal)

j) Panniculectomy – sometimes called “tummy-tuck”

k) Genioplasty – (chin augmentation)

2) If you have two separate operations, the ***Plan*** will consider the charge for each operation. If however, you have two surgical procedures performed through the same incision or body opening, the ***Plan*** will only consider the procedure with the highest reasonable charge limitation.

3) Charges for care, treatment, services and supplies which are not uniformly and professionally endorsed by the general medical community as standard medical care; including care, treatment, services and supplies which are experimental in nature.

4) Reversal of sterilization procedures.

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

When certain expenses are not eligible under the Plan, you will be notified by the Fund Office that the claim is denied in whole or part with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) in writing which contains the following:

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

HOW TO FILE A CLAIM FOR PRESCRIPTION BENEFITS UNDER THE NPA PROGRAM

You will receive a personalized National Prescription Administrators (N.P.A.) Prescription Benefits Identification Card with eligible family status listed on the card. You must present your Prescription Benefits Identification Card along with your Doctor’s prescription to any participating NPA pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will generally have you sign a 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 is not a claim for benefits. If you do not receive your prescription at the NPA retail pharmacy due to denial of coverage, you need to contact the Fund Office to make a claim for benefit coverage.

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

You can obtain a NPA Direct Reimbursement form from the Fund Office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach 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 the address on the form. Reimbursement will be made directly to you by NPA on the same basis as benefits would have been paid to a participating NPA pharmacy.

If you are not eligible for benefits at the time you contact the NPA pharmacy or in the

When certain expenses are not eligible for payment under the Plan, you will be notified by Medical Mutual that the claim is denied in whole or in part with an explanation of the reasons for the denial. You will receive a Notice of the Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) in writing which contains the following:

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

HOW TO FILE A CLAIM FOR DENTAL AND VISION BENEFITS

When you receive dental or vision services, show the provider your Identification Card. The provider may submit a claim form on your behalf to the Teamster's Fund Office or may require you to pay for the services in full and submit the claim for reimbursement yourself. However, if you have exceeded the annual maximum on your dental benefits, you will be responsible to pay the remainder of the bill to the provider directly once the Fund issues payment.

If you must submit a claim for Dental and Vision serves you should:

- Obtain an itemized bill from the provider
- Obtain a claim form from the Fund Administrator Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

An itemized bill generally includes all of the following:

- Participant's name and address
- Patient's name and address
- Date of Service
- Type of Service and diagnosis
- Itemized charges
- Provider's complete name, address and tax identification number

Please note: If you have already made payment for the services you received, you must also submit proof of payment with your claim form.
Remember: Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

You must submit originals of all itemized bills. You should make copies of the itemized bills for your own records. Once your claim is received, itemized bills cannot be returned.

In the event you do not provide proof of your payment to the provider, the payment from the Fund will be made to the provider directly on your behalf.

EMERGENCY ACCIDENT/ILLNESS BENEFIT

This benefit covers treatment you receive in an emergency room or a physician's office due to an accidental injury and medical emergency. The ***Plan*** will pay 100% UCR for services under this benefit if, without immediate care, the injury or illness could:

- permanently endanger your health;
- cause other serious conditions;
- seriously impair your body functions; or
- cause serious and permanent damage to any part of your body.

Services Not Covered By This Benefit:

Charges for the emergency treatment of an illness and/or injury that do not meet the definition of emergency care, as defined herein, are not covered under the Medical Emergency Benefit.

Portions of an expense paid under another benefit of this ***Plan.***

Charges in connection with a surgical procedure.

NON-EMERGENCY ACCIDENT/ILLNESS BENEFIT

When you receive medical treatment in an emergency room or doctor's office due to a sudden or unexpected medical condition that is not life or limb threatening. Services for this benefit will be paid according to the Summary Of Benefits schedule listed on page 1 of this booklet.

OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY EXPENSE BENEFIT

Diagnostic Services Include:

- Radiology, ultrasound and nuclear medicine.
- Laboratory and pathology services, when provided on an outpatient basis.
- EKG, EEG and other electronic diagnostic medical procedures.

The ***Plan*** will pay 100% of Negotiated Rate for these services, when performed in a network hospital or network provider. **If you choose to receive services from a provider who is not in the network with Medical Mutual of Ohio, the claim will be paid based on the Summary Of Benefits on page 1.**

The Outpatient Diagnostic X-ray and Laboratory Expense Benefit covers charges for X-Ray and/or Laboratory work done at your Physician's request, on an outpatient basis, because of illness, injury or pregnancy. The ***Plan*** will pay 100% of Negotiated Rate for X-Ray and/or Laboratory procedures, including the related physician's visit when performed by a network provider.

Services Not Covered By This Benefit:

Routine dental X-Rays and Laboratory work.

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 following rules will apply to all claims and/or appeals filed on or after September 1, 2002, except as otherwise provided. Please review this correspondence and keep with your booklet issued June 1, 1996. You will be provided with any future changes to the procedures in a separate document.

HOW TO FILE A CLAIM UNDER THE MEDICAL MUTUAL MEDICAL PLAN

When you receive health care services:

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

In the case that you and your dependents use Providers who participate in the Medical Mutual Network, the provider will submit a claim for you directly to Medical Mutual for payment. Payments will then be made directly to the provider.

If you and your dependents use providers that do not participate in the Medical Mutual network it is your responsibility to submit the claim to Medical Mutual for payment. In some instances the provider will submit the claim to Medical Mutual.

If you must submit a claim for health care services received, you should:

- Obtain an itemized bill from the hospital, doctor or medical facility
- Obtain a claim form from the Fund's Administrative Office
- Complete the claim form and attach the itemized bill to the form
- Send the claim form and bill to the address on the claim form

An itemized bill generally includes all of the following:

- Participant's name and address
- Patient's name and address
- Date of Service
- Type of Service and diagnosis
- Itemized charges
- Provider's complete name, address and tax identification number

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

Payment for these Non-Participating or Out of Network Providers will be made to you directly once you have met your deductibles, copayment and coinsurance obligations. It is your responsibility to provide this payment to your provider.

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

CLAIM FILING AND CLAIM PAYMENT

A claim must be filed for you to receive benefits. If services have been supplied by contracting provider (hospital, physician, or other provider), the provider will submit the claim for you. You will have no claim forms to file and will not be balanced billed for the difference between Usual, Customary and Reasonable Charge (UCR) and billed charges.

If you choose to receive services from any hospital, physician, specialist, laboratory or other health care provider who has not contracted with Medical Mutual of Ohio, that provider may also submit a claim for you. However, some non-contracting providers will not and you may have to file your own claim. You can obtain a claim form from the provider or from the Fund Office.

File your claim as soon as possible. Fill out your part of the form by following the instructions and be sure the other portions of the form are completed accurately by the appropriate person, when necessary. Also check your social security number on the form to insure its accuracy. Mail the completed form to Medical Mutual, along with any items requested on the form. If additional information is needed, you will be contacted.

The claim will be reviewed to ensure that the service was medically necessary and that all other conditions for coverage were satisfied. Payments will be made directly to the provider, if the provider is contracting or participating with Medical Mutual. You cannot assign your right to payment to anyone else.

Hospitals, physicians and other providers are designated as contracting and non-contracting or network and non-network. The amount of benefits which you will receive for covered services may vary depending on the status of the provider. You will receive the maximum benefits by seeking covered services from a network provider. See the Summary Of Benefits schedule on page 1.

SKILLED NURSING FACILITY BENEFIT

Benefits will be payable for charges incurred for Skilled Nursing Care if services are performed in a Skilled Nursing Facility (SNF) and can only be performed by, or under the supervision of, licensed nursing personnel. The care in a SNF includes room and board charges, registered nursing services, physical therapy, drugs, supplies and equipment.

Services are not covered unless you or your dependents have spent at least three (3) consecutive days in a hospital for a related condition, prior to your transfer to the SNF. Medicare coverage is limited to 100 days of inpatient care in the SNF for the same spell of illness. The services in the SNF must be skilled nursing services and not custodial care. Medicare payment is reduced by a coinsurance that the patient must pay after the 20th day of covered SNF care.

In determining whether these services are required under the extended care benefit, three criteria must be met:

1) Skilled Nursing Services or Skilled Rehabilitation Services must be required on a daily basis;
2) Services must be furnished for a condition for which the beneficiary received inpatient hospital services or which arose while he/she was receiving care in an SNF for such a condition;
3) Service can only be provided in a Skilled Nursing Facility on an inpatient basis.

Skilled Nursing and/or Skilled Rehabilitation Services are those furnished by request of your primary care physician's orders which:

1) Require skills of technical or professional personnel, e.g., registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech pathologist, or audiologist;
2) Are provided by directly or under the supervision of such personnel.

HOME HEALTH CARE BENEFIT

Benefits will be payable for charges incurred for Home Healthcare made by a home healthcare agency, provided the services are prescribed by a physician and reviewed and approved by the physician on an on-going basis.

Home Healthcare includes skilled nursing and home health aide services and other covered services which would have been included under the ***Plan*** if you or your dependents were confined in a hospital or a nursing home.

Home Healthcare does not include housekeeping or custodial care.

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 Dependent(s) 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.

SUBROGATION

The Teamsters Local #377 Health and 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").

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

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 the 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.

HOSPICE CARE BENEFIT

A ***Plan*** Participant who is eligible for regular ***Plan*** benefits will be eligible for Hospice Care benefits if certified by a physician to have a life expectancy of six months or less.

The eligible person must submit an election statement to the Fund Office choosing Hospice Care in lieu of all other ***Plan*** benefits. However, expenses for any illness or injury which is not related to the terminal illness will be covered under regular ***Plan*** benefits.

A treatment plan must be developed and submitted for approval by the Participant's physician and the provider of the Hospice Care services. All covered services must be provided by a licensed Hospice organization or a Hospice program sponsored by a Hospital or Home Healthcare Agency.

The Fund will pay for the following services, up to the amount of the allowance permitted for Hospice Care by the federal Medicare law in the geographic area in which the Hospice is located:

- Acute inpatient Hospice Care
- Respite care
- Dietary guidance
- Durable medical equipment
- Home Health Aide visits
- Bereavement counseling for family members, limited to two visits

Approved Prescription Drugs will be limited to a 34-day supply per Prescription Order or Refill. These Prescription Drugs must be required for supportive care.

Exclusions under this benefit include:

- Volunteer services
- Spiritual counseling

AMBULANCE SERVICE HOSPITAL BENEFIT

The ***Plan*** will pay for licensed ambulance services as listed in the Summary of Benefits, to transport an individual to and from a hospital for medical treatment only.

Services Not Covered By This Benefit

- Transportation in any privately owned vehicle.
- Services and supplies which the covered individual is not legally required to pay
- Transportation for reasons other than receiving needed medical treatment.
- Transportation to receive medical treatment which is available at the current location.

WORKERS COMPENSATION

Any benefits paid by the ***Plan*** which are also covered by Workers Compensation laws entitles the Fund to full reimbursement, as provided in the Subrogation section of this document. Furthermore, if an accident or sickness is related to your employment, and is compensable under state Workers Compensation laws or similar laws, any resulting expenses and/or benefits are excluded from payment by this ***Plan***. See page 47, General Exclusions. Your Summary of Benefits (including Prescription Drug Benefit) does not replace Workers Compensation Benefits.

Workers Compensation is a state fund to which your employer contributes and which pays for work-related injuries or illnesses. It is to your advantage to know what kind of protection Workers Compensation provides you.

State Workers Compensation laws vary from state to state. You should know about the law in your state. To find out, call your State Bureau of Workers Compensation (each state has one) or a local office. It is their job to see that your claim is handled quickly and efficiently.

The most important thing to remember is don't wait. Act immediately! Often there are time limits on how long you can take to file a claim. If you miss the time limit, you may not be able to file at all.

Here are some suggestions to help you get the benefits that belong to you:

1. Let your employer know when you are insured or think that you are ill because of conditions on the job.
2. See a physician right away, preferably one who has taken Workers Compensation cases and knows your industry.
3. Get in touch with your Fund Office. They can help you contact the right offices and people.
4. Contact your state Workers Compensation office or a local office to get your claim started.

   NOTE: If a claim is denied under this section, and you are appealing a ruling by the Compensation Commission, you may receive benefits under a Subrogation Agreement. If you believe that you qualify for such an Agreement, you may write the Fund and request one. Such requests are reviewed on an individual basis.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

Starting January 1, 2006, prescriptions drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15th through December 31st.
** On average for all plan participants.*

If you decide to enroll in a Medicare prescription drug plan, you can keep your current prescription drug coverage with Teamsters' Local No. 377 Health and Welfare Fund which will remain primary to Medicare. If you choose not to enroll in a Medicare prescription drug plan at this time, you may enroll in the future during Medicare's annual enrollment period.

If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage….
Contact the Fund Office at (330 744-3148) for further information about your current prescription coverage

For more information about your options under Medicare prescription drug coverage ….

More detailed information about Medicare Plans that offer prescription drug coverage will be available in October 2005 in the "Medicare & You 2006" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visiting www.medicare.gov for personalized help,
- Calling your State Health Insurance Assistance Program (see you copy of the "Medicare & You" handbook for its telephone number)
- Calling 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 1-800-325-0778).

Remember: If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

ORGAN TRANSPLANT SERVICES

This benefit covers charges for medical treatment received for the donation of an organ. The transplant program must be approved through the predetermination program and all covered services must medically necessary.

Your coverage includes benefits for the following human organ transplants:

heart;
lung;
heart and lung;
liver;
kidney; and
cornea

These services will be covered if they are provided during the transplant benefit period. A transplant benefit period is a period of time which starts five days before the day you receive your first covered transplant and ends 12 months later. A new transplant benefit period starts only when the next covered transplant occurs 12 months after the last covered transplant was performed.

Organ Transplant Pre-Certification

In order for an Organ Transplant to be a covered service, the proposed course of treatment must be pre-certified and approved by Medical Mutual of Ohio. No benefits will be paid for Organ Transplant Services which have not been pre-certified.

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

1. The proposed course of treatment for the transplant program;
2. The name and location of the proposed Transplant; and
3. Copies of your medical records, including diagnostic reports for Medical Mutual to determine the suitability and medical necessity of the transplant services.

This determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ.

You may also be required to undergo an examination by a physician chosen by Medical Mutual. You and your physician will then be notified.

If the donor and the recipient of the organ are both covered under a plan, each individual will receive the available benefits under their respective plans.

If the recipient is covered under this ***Plan*** and the organ donor is not, all charges for the organ transplant services related to the removal of the donor organ will be paid as if the donor is covered under this ***Plan***.

DURABLE MEDICAL EQUIPMENT (Hospital Charges Only)

Supplies and equipment are covered under this benefit when prescribed by your physician and billed by the hospital. The supplies and equipment must serve a specific, therapeutic purpose in the treatment of a condition. Your physician must provide a written treatment plan that shows how the prescribed equipment is medically necessary for the diagnosis and treatment or how it will improve a specific body function.

The ***Plan*** will pay 100% of negotiated Rate for these supplies, when utilized by a network hospital or network provider. **If you choose to receive services from a provider who is not in the network with Medical Mutual of Ohio, the claim will be paid based on the Summary Of Benefits schedule on page 2.**

COORDINATION WITH MEDICARE

The Plan will pay its benefits before Medicare on for:

1. An active Participant who is age 65 or older;
2. An active Participant's dependent spouse who is age 65 or older;
3. The first 30 months of treatment in the case of any covered person entitled to Medicare solely on the basis of end-stage renal disease;
4. Any person covered under the benefit program for active Participants who is less than 65 years of age and who is receiving Medicare benefits because of disability.

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

IMPORTANT: The ***Plan*** does not provide any coverage to Medicare-eligible individuals who do not enroll in Medicare **Part A and Part B**.

If you are participating in the bridge gap program and are eligible for Medicare **Part A** and **Part B** the ***Plan*** will pay its benefits only after Medicare has paid its benefits.

If you receive treatment at a Hospital operated by the Veterans Administration for an illness or injury which is not related to military service, the medical benefits paid by the *Plan* will be the amount you would have received had the service been provided in a non-governmental facility, with Medicare as the primary payor.

For Participants or Dependents who are eligible for Medicare

The following is information about your current prescription drug coverage with the Teamsters' Local No. 377 Health and Welfare Fund (the Welfare Fund) and new prescription drug coverage available January 1, 2006, for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.
2. Teamsters' Local No. 377 Health and Welfare Fund has determined that the prescription drug coverage offered by the Plan is expected to pay out as much as the standard Medicare prescription drug coverage will pay.*
3. Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. The Welfare Fund has determined that your prescription drug coverage with the Plan is expected to pay out as much as the standard Medicare prescription drug coverage will pay.

The healthcare plan of the parent with the first birthday in a calendar year is always primary for the children. For example: If your birthday is in January and your spouse's birthday is in March, your health care plan will be primary for all of your children.

When this ***Plan*** has primary responsibility, you or your covered dependents will receive full ***Plan*** Benefits without regard to any coverage that you or your dependents have under another plan.

When the other plan has primary responsibility, it must first pay its full benefit. This ***Plan*** will then pay any remaining covered expenses up to the amount that it would have paid if it had primary responsibility, unless payment is excluded by a provision of the Plan.

5. Spouse
   If the spouse of a ***Plan*** participant is employed by an employer that provides, or will provide upon proper application, healthcare benefits for either single or family coverage, said spouse must apply for and accept such coverage if: The monthly premium rate payable by such spouse for health care coverage (single or family) is no more than the non-Medicare, monthly premium cost then in effect under the applicable provisions of the Health and Welfare Plan. Failure to obtain such health coverage shall result in this Fund providing only secondary coverage.

In the event your spouse's employer includes in its program a provision that health insurance is not provided to your spouse because other health insurance may be available to them through this Fund, the Board of Trustees will deny any benefits to your spouse, and he or she will not be considered an eligible dependent for purposes of the ***Plan***.

NOTE: Please be sure to include Coordination of Benefit information when completing any forms for services received or initially, when you complete your enrollment forms. This will include the name of your legal spouse's employer and the identification of any other group insurance plan. Incomplete information will only delay the processing of your claim.

Each year, all ***Plan*** participants will be asked to update this information by completing a questionnaire supplied by the Fund.

INPATIENT PSYCHIATRIC BENEFIT

This benefit covers treatment of psychiatric related conditions. The following services are payable for treatment:

- Individual psychotherapy
- Group psychotherapy
- Electroshock therapy and related anesthesia only if given in a hospital or psychiatric hospital.
- Psychological testing, limited to one battery of tests per covered person per calendar year.

Services extended beyond the time necessary to evaluate or diagnose mental deficiency or retardation are not covered.

Inpatient care rendered outside the state of Ohio must be pre-approved prior to admission.

If you are being treated by a network psychiatrist or licensed psychologist, in a psychiatric treatment facility or alcoholism or drug abuse treatment facility, the Plan will pay for services listed in the Summary of Benefits.

Services excluded under the benefits for mental health, drug abuse and alcoholism treatment (Outpatient services) include:

- Treatment not prescribed and performed by a physician or licensed psychologist.
- Legal services, recreational, vocational, financial or education counseling, except as part of a chemical dependency treatment program.
- Detoxification or drug withdrawal programs not rendered by a hospital or as part of a maintenance program.
- Personal comfort items.

- Marriage or family counseling except as part of a psychiatric treatment program.

- Charges for services provided by a Social Worker.

- Others licensed by the state, under supervision of an MD.

Services obtained from a physician, hospital or other professions provider who is not a Medical Mutual network physician or network hospital, will be subject to the deductible and co-pay. You will be responsible for any difference between the amount the ***Plan*** pays and the provider's normal charge, when you go to non-contracting non-network provider. The ***Plan*** and Medical Mutual reserve the right to limit the amount paid for covered services to a non-contracting provider.

INPATIENT SUBSTANCE ABUSE BENEFIT

This service covers the treatment of drug abuse and alcohol related conditions. The following services are payable for treatment.

- Detoxification and rehabilitation services provided for the treatment of drug abuse or alcoholism.

Inpatient care rendered outside the state of Ohio must be pre-approved prior to admission.

If you are being treated by a network physician in a network treatment facility or alcoholism or drug abuse treatment facility, the ***Plan*** will pay 100% of the Negotiated Rate.

COORDINATION OF BENEFITS

If you have coverage under more than one plan, this ***Plan*** will coordinate with your other plan.

Coordination of Benefits provides complete payment of your allowable expenses while preventing duplicate payments for the same service. The objective is to make sure the combined payments of all healthcare plans are no more than your actual bills.

Coordination of Benefits does not apply to your Life Insurance Benefit, nor does it apply when you or your dependents have individual health policies.

Coordination of Benefits does take place when you and your dependents are covered by this ***Plan*** and another plan that provides group health and welfare benefits. This is especially common when both you and your spouse work, with each of you covered as a dependent under the other person's group health insurance plan.

Primary responsibility, when there is coverage under more than one group plan, is decided by these rules, in the following order:

1. If you have coverage under another group plan that does not coordinate benefits, that group plan will **always** be primary.

2. Participant
   The plan which covers you as a Participant has primary responsibility before the plan covering you as a Dependent.

3. Children (Parents Divorced or Separated)
   If the court decree makes one parent responsible for health care expenses, that parent's plan is primary.

   If the court decree gives joint custody and does not mention health care, we follow the birthday rule as discussed on the following page:

4. Children and the Birthday Rule
   When your children's healthcare expenses are involved, we follow the "birthday rule."

26. For the treatment of cysts or abscesses associated with the teeth, dental X-rays, dentistry or any other dental processes, except as specified.
27. For or related to the treatment of temporal mandibular joint syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the treatment of temporal mandibular joint dysfunction not caused by documented organic disease or physical trauma.
28. For detecting and correcting by manual or mechanical means (including incidental X-ray) structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column unless a specific diagnosis is provided.
29. For personal hygiene and convenience items.
30. For hypnosis and acupuncture.
31. For telephone consultations, missed appointments or completion of a claim form.
32. For fraudulent or misrepresented claims.
33. For expenses of care for conditions that state or local law require be treated in a public facility.
34. For topical anesthetics or stand-by anesthesia.
35. For penile implants or any treatment leading to or in connection with penile implants for a condition not caused by a physiological disorder.
36. For amounts you must pay as a deductible or copayment.
37. For work-related injury and/or illness, compsenable and otherwise covered under state Workers Compensation laws and/or similar laws.
38. The portion of any charge for a service or supply in excess of the reasonable and customary charge.
39. Blood or blood plasma that is replaced by or for the patient.

Services excluded under the benefits for drug abuse and alcoholism treatment include:

- Treatment not prescribed and performed by a licensed physician,
- Legal services, recreational, vocational, financial or educational counseling, except as part of a chemical dependency treatment program.
- Detoxification or drug withdrawal programs not rendered by a hospital or as part of a maintenance program.
- Personal comfort items.
- Marriage or family counseling except as part of psychiatric treatment program.

Services obtained from a physician, hospital or other professional provider who is **not** a Medical Mutual network physician or network hospital, will be subject to the deductible and co-pay. You will be responsible for any difference between the amount the ***Plan*** pays and the provider's normal charge, when you go to a non-contracting non-network provider. The Plan and Medical Mutual reserve the right to limit the amount paid for covered services to non-contracting provider.

PROFESSIONAL SERVICES

You have the advantages of lower costs for medical care when you use network providers and the flexibility to use non-network providers if you wish. The Summary Of Benefits schedule on page 3 shows you how benefits are actually paid for both network and non-network providers.

The deductible amount of covered expenses you pay each year, before we will pay benefits, is also described in the schedule. The maximum amount that will be applied toward the family deductible is one individual deductible for each covered person. However, when expenses far all family members totals $200 for the year, no additional deductible payments will be required, even if an individual has not met his or her individual deductible amount.

Once the deductible is satisfied, you may be responsible to pay a coinsurance amount as your share of the eligible expenses. In addition, if you use a non-contracting provider, you are responsible for paying the difference between the UCR amount and the provider's charge.

IMPORTANT

As long as you utilize a Medical Mutual contracting provider, your total out-of-pocket expense will not exceed the total of your annual deductible amount plus the maximum coinsurance amount, regardless of whether you choose a network provider or non-network provider; up to the lifetime maximum amount payable under this Plan, as indicated in the Summary Of Benefits schedule.

17. For organ transplant services:
    - Which are not furnished through a course of treatment which has been approved by Medical Mutual.
    - Which are not provided during a Transplant Benefit Period.
    - For other than a legally obtained human organ or for a human organ acquired outside the United States or Canada.
    - For travel time and the travel-related expenses of a provider.
18. For arch supports and other foot care or foot support devices only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bond surgery), calluses, toenails and the like.
19. For the treatment of obesity, including dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss. The only exception to this exclusion would be if surgery is medically necessary because your weight is at least twice the ideal amount.
20. For marital counseling. (The Employee Assistance Program is designed to address this type of counseling, please see page 43 for more information.)
21. For transsexual surgery or any treatment leading to or in connection with transsexual surgery.
22. For birth control devices.
23. For artificial insemination or in vitro fertilization.
24. For the treatment of sexual problems not caused by organic disease.
25. For reverse sterilization.

11. Incurred before your effective date.
12. For which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
13. Which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness.
14. For Surgery and other services only to improve appearance but not to restore a body function or correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes.
15. For inpatient admissions, the primary purpose of which is:
    - Diagnostic Services;
    - Custodial Care;
    - Rest care;
    - Environmental change; or
    - Treatment by physical means.

    When these services could have been performed on an outpatient basis and it was not medically necessary that you be an Inpatient to receive them.
16. Primarily for educational, vocational or training purposes.

INPATIENT MEDICAL VISITS

Services are covered under this benefit when a covered person receives care by a licensed physician or other licensed provider, as a registered bed patient in a hospital or other provider facility where a room and board charge is made.

INPATIENT CONSULTATIONS

Bedside examinations by another licensed physician or other professional provider is covered when requested by your attending physician

SURGERY BENEFIT (INPATIENT OR OUTPATIENT PROFESSIONAL SERVICES)

The surgery benefit covers the physician's bill for surgery performed in a hospital, qualified outpatient surgical facility or a physician's office, as indicated in the Summary Of Benefits schedule. The surgery must be the result of illness, injury or pregnancy. In addition, coverage is provided for the following specified services:

- sterilization, regardless of medical necessity;
- removal of bony impacted teeth;
- surgery to correct deformity caused by disease, trauma, birth defect, growth defects or prior therapeutic processes; and
- surgery to improve a functional deficiency.

ANESTHESIA BENEFIT

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

ASSISTANT AT SURGERY

Coverage for another licensed physician's help to your surgeon in performing covered surgery, when a hospital staff member, intern or resident is not available.

EMERGENCY ACCIDENT/ILLNESS BENEFIT

You are covered for emergency accident/illness care when treated by a licensed physician or other profession provider. These services include medical treatment that if not given immediate care, the condition could permanently endanger your health; cause other serious conditions; seriously impair your body functions; or cause serious and permanent damage to any part of your body.

AMBULANCE SERVICE BENEFIT

The Plan will pay 80% of Usual Customary and Reasonable Charges for professional licensed ambulance service under this benefit.

The Ambulance Service Benefit covers transportation charges for professional licensed ambulance service that is needed only for medical treatment. In addition, the Reasonable Charges for air ambulance services will also be covered, provided all the following conditions are met:

- The transportation is by a vehicle designed and equipped and used only to transport the sick and injured.
- The transportation is from the scene of an accident or medical emergency to a hospital or between hospitals.
- The trip is to the closest facility that can give the appropriate services for the condition.
- Certification by an attending physician must be received indication that transportation using ground facilities would not have been appropriate due to the life threatening and emergency nature of the accident or illness.

NON-EMERGENCY ACCIDENT/ILLNESS BENEFIT

When you receive medical treatment in an emergency room or doctor's office due to a sudden or unexpected medical condition that is not life or limb threatening.
Physician's services for this benefit will be paid according to the Summary Of Benefits schedule listed on page 3 of this booklet.

GENERAL EXCLUSIONS

We do not provide benefits for services, supplies or charges:

1. Which are not prescribed by or performed 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 a provider.
4. Which are experimental/investigative drugs, devices, medical treatments or procedures.
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, work related incident, 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.

USUAL, CUSTOMARY AND REASONABLE CHARGE

The Usual, Customary and Reasonable (UCR) maximum is the highest allowable expense that your ***Plan*** will cover for a given treatment or procedure.

The amount the ***Plan*** will pay will be based on the amount for a service or supply most often charged by the majority of health providers. The Usual, Customary and Reasonable covered charges are reviewed and updated annually.

All SuperMed Plus Network Providers have agreed to provide services at a guaranteed allowable rate. When you use provider services within the network, the ***Plan*** will pay 100% of this allowable amount. When you choose to use provider services by a non-network provider (any hospital, physician, specialist, laboratory or other health care provider who has not been selected to be a member of the SuperMed Plus Network), the claim will be paid based on the Usual, Customary and Reasonable rates and you will be responsible for the deductible and co-payments. If you go to a non-participating provider, you will be responsible for any difference between the UCR payment and the provider's normal charge in addition to the deductible and co-payments.

NOTE: The amount you pay for any difference between the UCR payment and the provider's normal charge, <u>will not</u> be applied towards the out-of-pocket maximum.

MATERNITY AND ABORTION BENEFIT

Medial and surgical services for a normal pregnancy, complications of pregnancy and miscarriage are covered. Therapeutic and elective abortions are also covered services.

INITIAL NEWBORN EXAM

Coverage includes the inpatient medical care visits to examine a newborn.

HOME AND OFFICE CALLS

Coverage includes evaluation and management services provided in a physician's office or in an outpatient or an ambulatory facility.

ADULT ROUTINE PHYSICAL EXAMS

An annual routine physical exam is covered under this benefit up to the allowable maximum amount.

ALLERGY TESTS AND TREATMENTS

Allergy tests which are performed and related to a specific diagnosis are covered services.

IMMUNIZATIONS

The following immunizations are covered under this benefit:

- tetanus toxoid
- rabies vaccine; and
- meningococcal polysaccharide vaccine.

ROUTINE PAP SMEAR, CHEST X-RAY, SMA12, CBC, URINALYSIS, MAMOGRAM AND EKG

These routine services are covered under this benefit, once per year.

WELL CHILD VISITS AND IMMUNIZATIONS

Regardless of medical necessity, coverage for child health supervision services will be provided for eligible dependent children up to the age of 19 or up to age 23, if dependent is a full-time student at an accredited school or college. The services will be paid up to the maximum amount established in the Summary Of Benefits schedule.

DIAGNOSTIC SERVICES, RADIOLOGY, PATHOLOGY AND ALLERGY TESTING

A diagnostic service is a test or procedure performed by a licensed physician or other professional provider, when you have specific symptoms, to detect or monitor your condition. Covered services are limited to the following:

- radiology, ultrasound and nuclear medicine;
- laboratory and pathology services; and
- EKG, EEG, MRI and other electronic diagnostic medical procedures.

UTILIZATION REVIEW

Most inpatient care is reviewed before you go into a hospital or other treatment facility. This procedure is called pre-admission review.

All non-emergency, scheduled hospitalizations must be reviewed and certified by the PReview Managed Care Department at Medical Mutual.

When you choose a contracting hospital, the hospital will take care of the pre-admission review and notification process for you.

When using a non-contracting or out-of-state hospital, you have the responsibility to contact Medical Mutual prior to an elective admission. **Utilization Review Management information can be obtained by calling the member services department numbers listed on the back of your Medical Mutual identification card.**

A physician advisor will review whether an inpatient or outpatient setting is most appropriate. If inpatient care is required, pre-admission testing is mandatory. If the same procedure can be safely performed on an outpatient basis, the patient can be spared the inconvenience and cost of an inpatient admission by having the procedure done on an outpatient basis.

Whenever the medical necessity of inpatient hospitalization is questioned, a Medical Mutual physician advisor will contact your physician or your dependent's physician to discuss the case. To assure services are medically necessary and care is delivered in the most appropriate setting, the evaluation includes pre-admission certification, admission and continuing stay reviews.

Carebridge Corporation Employee Assistance (EAP)

From time to time virtually everyone encounters problems and conflicts, which can feel overwhelming. Carebridge Employee Assistance Program (EAP) provides confidential consultations to help you successfully manage life's challenges. EAP counselors will listen to your concerns, help identify the source of your problems, and work with you to bring about practical solutions as quickly as possible.

Carebridge and its network of skilled EAP counselors offer you a choice of either face-to-face or convenient scheduled telephone consultations. Each counselor is trained, credentialed, and experienced in helping you or your eligible dependent. **Carebridge can help** *with issues such as:*

- Marital Relationships
- Alcohol Problems
- Stress Management
- Family/Parenting Relationships
- Drug Problems
- Depression and Anxiety
- Grief and Loss
- Financial Pressures
- Difficult Emotional Issues
- Spousal/Child/Parent Abuse
- Work Relationships
- Smoking Cessation

Along with accessibility 24 hours a day, 7 days per week, Carebridge also maintains a website at www.myliferesource.com with additional information to support the counseling services. The assistance you receive is completely confidential and there is no cost to you or your eligible dependents for using this service. You do not have to complete an Enrollment Form to participate in the Carebridge Employee Assistance Program. ***Beginning April 1, 2007, you are automatically covered for this benefit if you do not have an EAP program available to you through your employer. Contact the Fund office for availability of this benefit.***

Carebridge can help….

800-437-0911

www.myliferesource.com

access code: KF7M5

24 hours per day, 7 days per week

THERAPY SERVICES (INPATIENT AND OUTPATIENT)

Coverage for therapy services and supplies used to promote recovery from a condition, will be paid according to the Summary Of Benefits schedule. Therapy services must be ordered by a licensed physician or other professional provider to be covered. Covered services are limited to the therapy services listed:

- Cardiac Rehabilitation
- Chemotherapy
- Dialysis Treatments
- Hyperbaric and Pulmonary Therapy
- Physical Therapy
- Radiation Therapy
- Respiratory Therapy
- Speech Therapy

SKILLED NURSING FACILITY (MEDICAL VISITS)

These services must be skilled care and authorized and provided according to your physician's plant of treatment. Your physician must certify initially and every two weeks, thereafter, that you your eligible dependent are receiving skilled care and not custodial care.

No benefits will be provided:

- once a patient can no longer significantly improve from treatment for the current condition unless it is determined to be medically necessary.
- for custodial care, rest care or care which is only for someone's convenience; and
- for the treatment of mental illness, drug abuse or alcoholism.

DURABLE MEDICAL EQUIPMENT

Supplies and equipment are covered under this benefit when prescribed by your physician. The supplies and equipment must serve a specific, therapeutic purpose in the treatment of a condition. Your physician must provide a written treatment plan that shows how the prescribed equipment is medically necessary for the diagnosis and treatment or how it will improve a specific body function.

OUTPATIENT PSYCHIATRIC AND SUBSTANCE ABUSE BENEFIT

The following are covered services for the treatment of psychiatric care by your licensed physician or other professional provider.

- individual and group psychotherapy;
- electroshock therapy and related anesthesia;
- psychological testing;
- family counseling

Detoxification and rehabilitation services are provided for the treatment of drug abuse or alcoholism. In addition, the following services are also covered for the treatment of drug abuse or alcoholism:

- individual and group psychotherapy;
- psychological testing; and
- family counseling

Your physician or other professional provider must certify that there is a reasonable likelihood that the treatment will be of substantial benefit and improvement likely.

CO-PAY AMOUNTS

Generic drugs	**$ 10.00**
Brand name drugs	**$ 20.00**

ANNUAL MAXIMUM

$ 25,000.00 per individual (E.S.I. and C.F.I. combined)

MAIL ORDER PRESCRIPTION DRUG PROGRAM

The CFI Mail Order Program was designed to allow member to receive large quantities of maintenance medication (E.G. heart medication, blood pressure medications, diabetic medication etc.), at your home. You can obtain a 90 day supply of your prescription, if prescribed by your physician. The CFI Mail Order Program is easy to use. Just fill out the order form, attach your physician's prescription and a check, made payable to CFI for the cost of your co-payment or if you wish to charge, complete a CFI Credit Card Information Slip for each prescription. You may contact CFI at 1-800-628-0717 prior to mailing your prescription to obtain the cost of your medication. Please supply CFI with your Sponsor No. (829), the name of the medication, the strength, and quantity.

CO-PAY AMOUNTS

Generic drugs	**$ 20.00**
Brand name drugs	**$ 40.00**

$25,000.00 ANNUAL MAXIMUM (E.S.I. and C.F.I. combined)

Prescription Drug Coverage and Medicare

Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. Teamsters' Local No. 377 Health and Welfare Fund has determined that the prescription drug coverage offered by Plan A is expected to pay out as much as the standard Medicare prescription drug coverage will pay.*

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. However because you have existing prescription drug coverage that, on average is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15th through December 31st.

If you decide to enroll in a Medicare prescription drug plan, you can keep your current prescription drug coverage with Teamsters Local No. 337 Health and Welfare Fund which will remain primary to Medicare. For additional information regarding your prescription drug coverage and Medicare please contact the Fund office.

**On average for all plan participants*

PRESCRIPTION DRUG BENEFIT

Administered by Express Scripts, Inc. (ESI) formerly National Prescription Administrators (NPA)

You will be issued plastic identification card or cards directly from N.P.A. Please review the information on the card for any discrepancies, report them to the Fund office.

Your card is not transferable and remains the property of ESI. Improper or fraudulent use of this card to obtain prescription drugs is punishable by law. This card is void when your eligibility is terminated. The loss of your card should be reported immediately to the Fund Office.

You can use your Teamsters Local No. 377 E.S.I. card at any E.S.I. participating pharmacy.★ Should you have any questions regarding participating pharmacies please contact ESI's toll free pharmacy locator number at 1-800-887-1044 option #2.

THE BENEFIT AND HOW TO USE IT

Simply present your card and your prescription to the pharmacist. The prescription benefit allows for a 30 day supply with refills, as prescribed by your physician. The plan will cover all Federal Legend drugs, State Restricted drugs, Compound medications, Insulin on prescription, Needles and Syringes on prescription, Injectables, Allergy Serums, Federal Legend Vitamins, Prescription Prenatal Vitamins, Initrex and Imitrex Auto Injector, Diabetic Supplies, Diabetic Tablets and Bee Sting Kits.

EXCLUSIONS

Fertility drugs, Smoking cessation drugs, Genetically Engineered drugs, Immune Altering drugs and Federal Legend Oral Contraceptives will be excluded. (Some exceptions apply. Please contact the Fund Office for further information).

✯ **Effective 02/01/2005** The Trustees have approved changing the pharmacy network under the prescription drug program administered by Express Scripts Inc. (ESI), formerly NPA, to **EXCLUDE** the following pharmacy chains. These pharmacy providers, by their policies and actions, have demonstrated hostility towards organized labor and the millions of working people represented by organized labor.

⃠ Wal-Mart ⃠ Walgreens ⃠ Marc's

The ESI card is not valid at these pharmacy chains nor will there be any reimbursement eligibility for non-emergency prescriptions.

In the event that a network pharmacy is not available for medical emergencies a claim may be submitted for consideration of reimbursement minus the applicable co-payment directly to the Fund office.

DENTAL SERVICES FOR AN ACCIDENTAL INJURY

Dental services will only be covered when due to an accidental injury. The accidental injury must have caused damage to the jaws, sound natural teeth, mouth or face. The injury must have occurred on or after your effective date. Dental services must begin within one year from the date of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury.

* A SUPERMED PLUS PROVIDER SHOULD BE USED FOR THE SURGICAL EXTRACTION OF BONY IMPACTED WISDOM TEETH AND FOR DENTAL SERVICES FOR AN ACCIDENTAL INJURY. CLAIMS SHOULD BE FILED WITH MEDICAL MUTAL OF OHIO UNDER YOUR MEDICAL SURGICAL OR ACCIDENTAL INJURY BENEFIT. FAILURE TO USE A SUPERMED PLUS PROVIDER COULD CAUSE A SUBSTANIAL BALANCE TO YOU WITH REGARDS TO THE DIFFERENCE BETWEEN BILLED CHARGES AND MEDICAL MUTAL OF OHIO'S UCR AMOUNT.

COMBINED DENTAL AND VISION SERVICE BENEFIT

Effective 01/01/2007

The following benefits are available to all employees and their Eligible dependents covered under Plan A:

The fund will consider all dental and vision services with no restrictions on frequency or covered procedures provided by a licensed Dentist, Physician or Vision Supplier up to the maximum allowance stated in the schedule of benefits.

Example:

Service	Total Cost	Benefit payment @ 80%	Your cost @ 20%	Combined annual benefit remaining
Eye exam, lenses, frames, contact fitting & contacts.	$ 400.00	$ 320.00	$ 80.00	$ 680.00
Dental exam, cleaning & x-rays	$ 100.00	$ 80.00	$ 20.00	$ 600.00
Major dental procedure i.e. crown, bridge, root canal,	$ 750.00	$ 600.00	$ 150.00	$ 0.00
	$ 1,250.00	$ 1,000.00	$ 250.00	
****ANY ADDITIONAL SERVICES INCURRED DURING THE CALENDAR YEAR FOR YOU OR ANY DEPENDENTS WILL BE YOUR RESPONSIBILITY****				

Special prescription lenses or contact lenses, which are required to correct cataract surgery, and extensive eye examinations by an ophthalmologist because of a disease of the eye, are covered separately under the major medical benefit.

Eligibility rules for dental and vision benefits are the same as those for other benefits under the Plan. Benefits will be paid only for services, which are performed while the covered person is eligible.

ORTHODONTIC SERVICES

Orthodontic services will be covered for all eligible participants and their dependents up to a maximum **Lifetime** benefit of $1,000 effective 07/01/2001.

CLAIM PROCEDURES:

To file a claim for vision or dental benefits, you should request a claim form from the Fund Office. This form must be completed by the employee and by the provider of the services. Originals or copies of all relevant bills or receipts, showing the type of service performed, the name and address of the provider, and an itemized statement of cost, must be attached to the form and submitted to the Fund Office. The claim form and all supporting documentation must be filed within 90 days of the date of service.

Benefits are not provided for services that exceed the annual maximum allowance under this benefit.