OHIO CARPENTERS' HEALTH PLAN

January 1, 2013

LIFE EVENTS AT A GLANCE

There are several significant events that may occur while you are covered under the Plan. Please contact the Benefit Office, in writing, if any of the following occurs:

- **YOUR ADDRESS OR TELEPHONE NUMBER CHANGES.**
- **YOU MARRY OR DIVORCE**. You must also submit the appropriate legal documents (for example: marriage certificate or divorce decree).
- **THE STATUS OF A DEPENDENT CHANGES.**
- **YOU BECOME A PARENT**. You must also submit the child's state-certified birth certificate, decree of adoption or placement for adoption or a Qualified Medical Child Support Order.
- **YOU GO INTO OR RETURN FROM MILITARY SERVICE**.
- **YOU BEGIN RECEIVING WORKERS' COMPENSATION BENEFITS.**
- **YOU BECOME ELIGIBLE FOR MEDICARE.**
- **YOU RETIRE.**

Failure to furnish timely written notice to the Benefit Office may result in a reduction in or loss of coverage.

OHIO CARPENTERS' HEALTH PLAN

PLAN AND SUMMARY PLAN DESCRIPTION

(ACTIVES AND RETIREES AND THEIR ELIGIBLE DEPENDENTS)

Effective January 1, 2013

TABLE OF CONTENTS

January 1, 2013

TO Our Eligible Employees, Retirees and Their Dependents

We are pleased to provide you with this revised Summary Plan Description and Plan as adopted by the Plan's Board of Trustees. This document describes in detail the benefits provided for you and your Eligible Dependents under the Ohio Carpenters' Health Plan. This Plan replaces all previous booklets and letters on benefit changes.

It is important to read this Plan so that you will know how you become and stay eligible, and to understand the types of benefits provided. For your convenience, terms defined in the Plan are capitalized throughout the booklet.

INITIAL ELIGIBILITY DATE To qualify for active employee coverage or requalify after termination of coverage requires that you be credited with $768 of net contributions (or such other amount as might be determined by the Trustees from time to time). See page 2. Your eligibility questions should be directed to the Benefit Office at (855) 837-3528

DEPENDENT COVERAGE You must complete an Enrollment form timely for coverage of your Dependents. See page 6.

SELF-PAYMENTS When you do not have adequate Employer contributions or Dollar Bank credits to continue coverage, self-payments should be sent to P. O. Box 74192, Cleveland, Ohio 44194-0265.

BENEFITS Eligible Employees are provided with Weekly Disability and Life Insurance Benefits. Eligible Employees, Early Retirees, and Eligible Dependents are provided with Comprehensive Medical Benefits, Vision Benefits, Prescription Drug Benefits, a Dental Benefit Plan, and a Medical Reimbursement Account if the participant has adequate Dollar Bank credits. Early Retirees are also Eligible for Life Insurance. Medicare-Eligible Participants are provided with Supplemental Major Medical Coverage, Prescription Drug Benefits, Life Insurance, and a Medical Reimbursement Account.

PLAN CHANGES From time to time, you will receive supplemental bulletins about changes to this Plan. You should review these bulletins, place them in the pocket part of this booklet, and refer to them.

IDENTIFICATION CARDS Identification wallet cards are issued--one for medical and one for prescription drugs from Participating Pharmacies. These cards are to be given to Physicians, Hospitals, and Pharmacies from whom you seek services. An identification card is not needed for dental services.

YOUR RESPONSIBILITY TO PRECERTIFY If you do not use a Contracting Provider, you are responsible for precertifying your Inpatient Confinement in a Hospital or other Facility.

However, decisions about your medical care are to be made by you and your Physician. Those decisions are separate from coverage determinations under the Plan.

BENEFIT NETWORKS Your benefit networks are:

- For **comprehensive medical expense benefits**:

  Medical Mutual
  Customer Service 1 (877) 330-6664
  www.medmututal.com

- For **prescription drug care benefits**:

  www.express-scripts.com

- For **dental care benefits**:

  www.deltadentaloh.com

FILING CLAIMS

Medical, vision, and hearing aid claims should be filed with Medical Mutual:

Medical Mutual
Group No. 233252
P. O. Box 6018
Cleveland, Ohio 44101-1018

Dental claims should be filed with:

Delta Dental
P. O. Box 9085
Farmington Hills, MI 48333-9085

Weekly Disability, Life Insurance, and Medical Reimbursement Account claims **should be filed** with the **Benefit Office**:

Ohio Carpenters' Health Plan
c/o BeneSys – Specialty Claims
P. O. Box 1257
Troy, Michigan 48099-1257
(855) 837-3528 or (248) 641-4967

Prescription Drug Claims should be filed, as shown on pages 55-58.

REASONABLE CHARGES

Where you are using a Participating Provider (for example, a provider in the Medical Mutual Network or a Participating Dentist within the Delta Dental network), the allowable charges have been pre-negotiated. You are not responsible for Covered Medical Expense above your Deductible and Co-payments noted in the Schedule of Benefits.

Where, however, you use a Provider who is Non-Participating (for example, a non-network provider or non-participating dentist), you are responsible for any charges which are greater than contracted Network charges.

TRUSTEE DECISIONS

The Board of Trustees maintains the sole and exclusive right to determine the eligibility requirements for participation in the Plan. The Trustees maintain the sole and exclusive right to alter, amend or terminate any or all portions of the benefit program provided through the Plan and to determine the cost to be charged for the benefits and coverage provided. No Eligible Person--active, disabled or retired--has any vested rights to benefits or coverages.

PLAN REPRESENTATIONS

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

MEDICAL REIMBURSEMENT ACCOUNTS

Medical, dental and prescription drug expenses not covered under the Schedule of Benefits--such as Deductibles and Co-insurance--may be covered by a Medical Reimbursement Account. See page 27. The Medical Reimbursement Account is subject to the Plan's terms and section 213 of the Internal Revenue Code.

CHANGES OF ADDRESS

You **must** keep the Benefit Office advised every time you change your address. Do not depend on anyone but yourself to make this notification. If we do not have your current address, you may miss important announcements, notices of eligibility for or termination of coverage, and mailing of your identification cards.

While the Benefit Office will do everything it can to get your notices to you, it is your responsibility to know your eligibility standing and to keep us current on your address.

YOUR RECORDS

To assist you in filing claims and/or any appeals, you should maintain a file of your pay stubs, Explanation of Benefit Forms (EOB's) from the Benefit Office or other plans, eligibility status reports, medical bills sent directly to you, and other relevant records.

PREDETERMINATIONS

The Benefit Office will try to answer your general questions. However, coverage or denial of a claim always remains subject to the detailed information furnished by providers. **Predeterminations for specific services will be recognized only where acknowledged by the Claims Processor in writing. Precertification of the Medical Necessity of a claim is <u>not</u> a determination that a claim will be covered under the Plan.**

COVERED EXPENSE

For an expense or service to be eligible for a reimbursement or a payment under your Plan, it must be:

A Covered Expense,
Medically Necessary, and
A Reasonable Charge,

as these terms are defined in the Plan's "Definitions" section.

Fraternally,
The Board of Trustees

OHIO CARPENTERS' HEALTH PLAN

PLAN AND SUMMARY PLAN DESCRIPTION

IMPORTANT NOTE:	This booklet is the Plan in effect at January 1, 2013. From time to time, you will receive supplemental bulletins about changes to this Plan. It is your responsibility to review these bulletins, file them in the pocket part of this booklet, and refer to them.

YOUR PROVIDERS FOR CLAIM SERVICE

MEDICAL MUTUAL

For filing Comprehensive Medical, Vision, and Hearing Aid Claims

Medical Mutual – Group No. 233252
P. O. Box 6018
Cleveland, Ohio 44101-1018

Customer Service

(877) 330-6664

Appeals

Medical Mutual
Member Appeals – Group 233252
P. O. Box 94580
Cleveland, OH 44101-4580
Fax: (216) 687-7990; (866) 691-8260

BENEFIT OFFICE

For Eligibility, and filing of Medical Reimbursement Account, Death Benefit, And Life Insurance Claims:

Ohio Carpenters' Health Plan
c/o BeneSys Health Care Department
P. O. Box 1257
Troy, Michigan 48099-1257
(855) 837-3528 or (248) 641-4967

PRECERTIFICATION

Inpatient Confinements, Skilled Nursing:

Please see the telephone number on your identification card.

DENTAL BENEFITS

Claims:

Delta Dental
P. O. Box 9085
Farmington Hills, MI 48333-9085

Customer Service:

P. O. Box 9089
Farmington Hills, MI 48333-9089
(800) 524-0149
www.deltadentaloh.com

Review:

Customer Service Department
Delta Dental
P. O. Box 9089
Farmington Hills, MI 48333-9089

Formal Appeal:

Dental Director
Delta Dental
P. O. Box 30416
Lansing, MI 48909-7916

PRESCRIPTION DRUG BENEFITS

Information about Participating Pharmacies and Formularies, Lost or Inaccurate Identification Cards: (800) 716-2932

Claims for Reimbursement Where Drug Purchased from Non-Participating Pharmacy or Without Identification Card: Medco
P. O. Box 14711
Lexington, Kentucky

Mail Order:

All Actives and Early Retirees	Niles Plan Medicare Retirees	Cleveland & Southwest Medicare Retirees
Mail Order Address: Express Scripts P. O. Box 30493 Tampa, FL 33630-3493	Mail Order Address: Express Scripts P. O. Box 14711 Lexington, KY 40512	Mail Order Address: Express Scripts P. O. Box 747000 Cincinnati, OH 45274-7000
Customer Service: (800) 716-2932	Customer Service: (800) 378-4879	Customer Service: (800) 311-2757
Website Address: www.express-scripts.com	Website for plans covering Medicare eligible members: www.express-scriptsMedicare.com	

Physician line for calling in mail-order prescriptions: (888) 327-9791

Mail Order Refills: Register at **express-scripts.com**
(800) 716-2932

Appeals:

Non-Medicare Participants:	Medicare Participants:
Express Scripts P. O. Box 631850 Irving, Texas 75063-0000 ATTN: Administrative Reviews	Express Scripts P. O. Box 630406 Irving, Texas 75063-0114 ATTN: Medicare Administrative Appeals

RETIREE PRESCRIPTION DRUG PLANS

Employer Group Waiver Plan:

(Former Cleveland or Southwest Plan retirees) (800) 311-2757

Prescription Plan (electing Niles Plan retirees) (800) 378-4879

LIFE INSURANCE & ACCIDENTAL DEATH & DISMEMBERMENT CARRIER Consumers Life, Medical Mutual Company
(However, you should send your claim, including death certificate, to the Benefit Office shown above).

BOARD OF TRUSTEES

Union Trustees

Donald Crane
Indiana/Kentucky/Ohio Regional Council of Carpenters
755 Boardman Canfield Road, Suite H1
Youngstown, Ohio 44512-7320

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Indiana/Kentucky/Ohio Regional Council of Carpenters
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Ashland, KY 41101

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Warsaw, IN 46581

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Vienna, Ohio 44473

PLAN'S ADVISORS

Benefit Office	BeneSys, Inc. Troy, Michigan
Consultant/Actuaries	Buck Consultants,LLC Cleveland, Ohio
Legal Counsel	Shumaker, Loop & Kendrick Toledo, Ohio
Financial Auditor	Ciuni & Panichi Cleveland, Ohio

SCHEDULE OF BENEFITS

ACTIVES AND NON-MEDICARE RETIREES		
COMPREHENSIVE MEDICAL BENEFITS (See page 30)		
	In-Network	**Out-of-Network**
PPO Network	**Medical Mutual – SuperMed PPO**	
Benefit Period	**January 1 to December 31**	
Annual Maximum	**$1,250,000 / $2,000,000 effective 5-1-2013/unlimited effective 5-1-2014**	
Deductible **Single** **Family**	 **$400** **$800**	 **$800** **$1,600**
Out-of-Pocket Maximum (including deductible) **Single** **Family**	 **$3,000** **$6,000**	 **$6,000** **$12,000**
Hospital Inpatient	**80% After Deductible**	**60% After Deductible**
Hospital Outpatient	**80% After Deductible**	**60% After Deductible**
Surgical Benefits / Anesthesia	**80% After Deductible**	**60% After Deductible**
Physician Office Visits	**$20 Primary / $40 Specialist**	**60% After Deductible**
Wellness & Preventive Services	**100%, No Deductible**	**Not Covered**
Urgent Care	**$50 Co-Pay--80% After Co-Pay**	**$100 Co-Pay--60% After Co-Pay**
Emergency Room	**$100 Co-Pay, Waived if Admitted**	**$100 Co-Pay, Waived if Admitted**
Occupational, Physical and Speech Therapy	**80% After Deductible**	**60% After Deductible**
Chiropractic Care Maximum	**80% After Deductible**	**60% After Deductible**
	Up to 25 Visits Per Year	
Speech Therapy	**80% After Deductible**	**60% After Deductible**
Ambulance	**80% After Deductible**	**60% After Deductible**
Home Health Care Maximum	**80% After Deductible**	**60% After Deductible**
	40 Visits Per Year	
Skilled Nursing Maximum	**80% After Deductible**	**60% After Deductible**
	60 Days	
Hospice	**80% After Deductible**	**60% After Deductible**
Mental Health / Substance Abuse	**80% After Deductible**	**60% After Deductible**
VISION PLAN (See page 62)		
Maximum (not applicable under age 19)		**$50 exams and $100 materials**
Frequency		**12 months--exam and 24 months--materials**
HEARING AID BENEFIT (See page 37)		
Frequency		**Once every four (4) years**
Maximum		**$2,000 per Eligible Person**

ACTIVES AND NON-MEDICARE RETIREES CONT'D	
PRESCRIPTION DRUG CARD FOR ACTIVE MEMBERS AND EARLY RETIREES (See Page 55)	
Benefit Period	**January 1 to December 31**
	Eligible Person Pays
Card Program for Each Eligible Person--Use of Retail Pharmacy	
Tier 1--Generic Equivalent--per prescription order or refill	**$10--Minimum**
Tier 2--Preferred Formulary Name Brand RX--per prescription order or refill	**$30**
Tier 3--Non-Preferred/Non-Formulary Brand--per prescription order or refill	**$75**
Tier 4--Specialty--per prescription order or refill	**$100**
Maximum Supply	**30 days**
Use of Non-Participating Pharmacy	
Benefit for Covered Prescription Drug--per prescription order or refill	**Excess Charges PLUS co-payment deduction**
Maximum Supply	**30 days**
Mail Order Co-payment	
Tier 1--Generic Equivalent--per prescription order or refill	**$20--Minimum**
Tier 2--Preferred Formulary Name Brand RX--per prescription order or refill	**$60**
Tier 3--Non-Preferred/Non-Formulary Brand--per prescription order or refill	**$150**
Tier 4--Specialty--per prescription order or refill	**$200**
Maximum Supply	**90 days**
DENTAL PLAN (See page 59)	
Benefit Period	**January 1 to December 31**
Deductible	
PPO or Premier Dentist	**$0**
Non-Participating	**$50 Eligible Person/$100 Family (For other than Class I or Class IV services)**
General Maximum (All Services, Except Orthodontics) (not applicable under age 19)	**$1,000 per Eligible Person per Benefit Period**
Lifetime Maximum (Orthodontics Only) (not applicable to Medically Necessary Orthodontia under age 19)	**$1,000 per Eligible Person per Lifetime**
Covered Services	
Class I – Diagnostic & Preventive Services	
Exams & Cleanings	**100%**
Fluoride Treatments	**100%**
Space Maintainers	**100%**
Emergency Palliative Treatment	**100%**
Sealants	**100%**
Brush Biopsy	**100%**
Radiographs	**100%**
Class II – Basic Services	
Minor Restorative	**80%**
Endodontics	**80%**
Periodontics (Non-Surgical)	**80%**
Periodontics (Surgical)	**80%**
Oral Surgery	**80%**
Other Basic Services	**80%**
Relines & Repairs	**80%**
Class III – Major Services	
Major Restorative	**50%**
Prosthodontic Services	**50%**
Class IV – Orthodontic Services	
Orthodontic Services (to age 19)	**50%**

ACTIVES AND NON-MEDICARE RETIREES CONT'D	
MEDICAL REIMBURSEMENT ACCOUNTS **(See page 27)**	
WEEKLY DISABILITY BENEFITS **For Temporary Non-Occupational Disability** **(Eligible Employees Only)** **(See page 53)**	
Benefit Amount	**$200/week**
Maximum Period of Payment (Subject to Medical Necessity)	**26 weeks**
Waiting Periods:	
For Disability Due to Disease or Illness	**7 Days**
For Disability Due to Accident or Injury	**None**
Return to Work: **Two full weeks (80 hours) of continuous Covered Employment within a 30-day period are required between periods for which Weekly Disability is payable; one week (40 hours of continuous Covered Employment) is required if the Disability is unrelated to the prior accident or sickness.**	
LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS **(See page 64)**	
Eligible Active Employee	
Death Benefits--Principal Sum	**$10,000**
Accidental Death & Dismemberment Benefit--Principal Sum	**$10,000**
Eligible Retiree (Early Retire or Medicare Retiree)	
Death Benefits--Principal Sum	**$5,000**
Accidental Death & Dismemberment Benefit	**N/A**

MEDICARE-ELIGIBLE RETIREES		
SUPPLEMENTAL MAJOR MEDICAL		
Benefit Period Calendar Year	**Calendar Year**	
Covered Services	**Covered Medicare Services**	
Accepted Providers	**Providers Accepting Medicare Assignment**	**Other Providers**
Part A Services		
Inpatient Hospital	**100%**	**70%**
Skilled Nursing Facility	**First 100 days, 100%**	**70%**
Part B Services		
Medicare Part B Deductible	**100%**	**Reasonable & Customary, Less Medicare**
Professional Services	**100%**	**Reasonable & Customary, Less Medicare**
Supplemental Major Medical		
Deductible	**$400**	**$400 or 80% after Deductible**
Co-Insurance	**80% after Deductible**	**$400 or 80% after Deductible**
Out-of-Pocket Limit (including deductible)	**$1,200**	**$1,200**
	$1,000/yr.	**$1,000/yr.**
Private duty nursing maximum	**$2,500,000 (Unlimited at 5/1/2014)**	**$2,500,000 (Unlimited at 5/1/2014)**
Annual Maximum Benefit		

Part A of Medicare pays part of your Inpatient care in a Hospital or Skilled Nursing Facility, home health care services, and hospice care services. Part B of Medicare pays toward certain professional charges, Outpatient Hospital services, and a number of other medical services and supplies not covered by Part A of Medicare. Medicare does not pay the full cost of this care. You are responsible for certain Deductibles and Coinsurance when you receive Medicare Covered Services. For more information on what Medicare covers, read Medicare & You. You can get a copy from any Social Security office.

This Plan supplements your Medicare benefits. It provides you with the coverage for the Deductibles and Coinsurance which Medicare does not pay.

Part A Benefits – Inpatient Benefits

In the United States, the Plan will provide benefits for Covered Services received only in Hospitals and Skilled Nursing Facilities approved by Medicare. When you are outside of the United States, the Plan will provide benefits for Covered Services received in Hospitals if such services would have been covered by Medicare and this Plan if you had received them within the United States.

If, after your Effective Date, you are admitted to a Hospital as an Inpatient, the Plan will provide coverage for the following benefits not covered by Medicare:

1. **The Part A Deductible for the first 60 days of Hospital care per Medicare Benefit Period.**
2. **The Part A Coinsurance for the 61st through the 90th day of Hospital care per Medicare Benefit Period.**
3. **The Part A Coinsurance for lifetime reserve days.**
4. **The first three pints of blood that you receive each calendar year.**
5. **After you have used all of the Hospital days provided to you by Medicare, the Plan will provide benefits for 365 additional days of Hospital care per In-hospital Benefit Period. The Plan will provide 100% of the Lesser Amount to a Contracting Institutional Provider. You are responsible for 30% of the Covered Charges to a Non-Contracting Institutional Provider.**

   Note: Benefits paid to Non-Contracting Providers will pay the same as Benefits to Contracting Providers, but you may be subject to balance billing and/or Excess Charges. Payments to Contracting Providers are based on the Lesser Amount. Payments to Non-Contracting Providers are based on Covered Charges.

If, after your Effective Date, you are admitted to a Skilled Nursing Facility and the admission is eligible for Medicare payments, Medical Mutual will provide benefits for the Part A Coinsurance for the 21st through the 100th day of care in a Skilled Nursing Facility. (Medicare provides benefits, in full, for the first 20 days.)

Part A Benefits--Outpatient Benefits

The Plan will provide benefits for the Part A Coinsurance for hospice care services and home health care services.

MEDICARE-ELIGIBLE RETIREES CONT'D
Part B Medicare Eligible Expenses
For Part B Medicare Eligible Expenses: • **The Plan will provide benefits for the Part B Deductible which Medicare does not cover;** • **The Plan will provide benefits for the Part B blood deductible for the first three pints of blood each calendar year;** • **The Plan will provide benefits for the Part B Coinsurance for Medicare Eligible Expenses; and** • **When your Provider does not accept the Medicare Assignment, the Plan will provide benefits for the Part B Coinsurance. If the Traditional Amount is higher than the Medicare Reasonable Charge, the Plan will provide benefits for the difference, subject to balance billing limits established by the state or federal laws or regulations.** **For health care services and supplies received while traveling outside the United States, the Plan will provide benefits for the Traditional Amount if services or supplies are Part B Medicare Eligible Expenses when received within the United States.**
Changes In Medicare Deductibles and Coinsurance
The Plan will continue to cover the Part A and Part B Deductibles and Coinsurance even if they are changed by Medicare, that is, if Medicare changes Deductible amounts and Coinsurance percentages, the benefits designed to cover these cost sharing amounts will be changed automatically.

MEDICARE-ELIGIBLE RETIREES CONT'D

PRESCRIPTION DRUGS
(See Page 55)

Medicare Eligible Participants(★)

EMPLOYER GROUP WAIVER PLAN ("EGWP")

Deductible Stage

You pay a $200 yearly deductible

Initial Coverage stage

After you pay your yearly deductible, you will pay the following until your total yearly drug costs (what you and the plan pay) reach $2,970.

Tier	Retail One-Month (31-day) Supply	Retail Three-Month (90-day) Supply	Mail Three-Month (90-day) Supply
Tier 1: Generic Drugs	$10 copayment	$30 copayment	$20 copayment
Tier 2: Preferred Brand Drugs	$30 copayment	$90 copayment	$60 copayment
Tier 3: Non-Preferred Brand Drugs	$75 copayment	$225 copayment	$150 copayment
Tier 4: Specialty Tier	$100 copayment	$300 copayment	$200 copayment

Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please refer to your *Pharmacy Director* or contact Express Scripts Customer Service at the numbers on the back of this document for more information.

You may receive up to a 90-day supply of certain maintenance drugs medications taken on a long-term basis) through our mail-order pharmacy. There is no charge for standard shipping.

Coverage Gap stage

After your total yearly drug costs reach $2,970, you will pay the following until your yearly out-of-pocket drug costs reach $4,750.

Tier	Retail One-Month (31-day) Supply	Retail Three-Month (90-day) Supply	Mail Three-Month (90-day) Supply
Tier 1: Generic Drugs	$10 copayment	$30 copayment	$20 copayment
Tier 2: Preferred Brand Drugs	$30 copayment	$90 copayment	$60 copayment
Tier 3: Non-Preferred Brand Drugs	$75 copayment	$225 copayment	$150 copayment
Tier 4: Specialty Tier	$100 copayment	$300 copayment	$200 copayment

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $4,750, you will pay **the greater of 5% coinsurance or:**

- a $2.65 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard copayment during the Initial Coverage stage
- a $6.60 copayment for all other covered drugs, with a maximum not to exceed the standard copayment during the Initial Coverage stage.

OUT-OF-NETWORK COVERAGE

You must use Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan's service area where there is no network pharmacy. You may incur additional costs for drugs received at an out-of-network pharmacy. Please contact Express Scripts Customer Service at the numbers on the back of this document for more details.

IMPORTANT PLAN INFORMATION

- The service area for this plan is all 50 states, the District of Columbia, and Puerto Rico. You must live in one of these areas to join this plan. We may reduce our service area and no longer offer services in the area in which you reside.
- Your plan uses a formulary—a list of covered drugs. Express Scripts may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug. If any formulary change limits your ability to fill a prescription, you will be notified before the change is made.
- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.
- Your health care provider must get prior authorization from Express Scripts Medicare for certain drugs.
- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.
- If you request an exception for a drug and Express Scripts Medicare approves the exception, you will pay the Non-Preferred Brand Drug cost-share for that drug.
- You must continue to pay your Medicare Part B premium, if not otherwise paid for under Medicaid or by another third party, even if your Medicare Part D plan premium is $0.

(★) **Medicare Eligible Participants that had self-insured post-65 prescription drug coverage in 2012 from either the former Cleveland Hospitalization Plan or Southwest Ohio Carpenters' Health Plan.**

MEDICARE-ELIGIBLE RETIREES CONT'D				
Medicare Eligible Participants (★)				
PRESCRIPTION DRUG PLAN ("PDP")				
Deductible Stage	The amount you pay before your insurance starts **$325.00**			
Initial Coverage stage	Once the deductible is reached, you pay a copayment or coinsurance for drugs until the total yearly drug costs (what you pay, plus what your plan pays) reach $2,970.			
	Tier	**Retail 30 days**	**Retail 90 days**	**Preferred Mail 90 days**
	Tier 1: Generic Drugs	$4	$12	$8
	Tier 2: Preferred Brand Drugs	$6[1]	$18[1]	$12[1]
	Tier 3: Non-Preferred Brand Drugs	25%	25%	25%
	Tier 4: Specialty Tier	27% - 50%	27% - 50%	27% - 50%
	Tier 5: Specialty Tier Drugs	25% for a 30-day supply (Retail or Preferred Mail)		
Coverage Gap Stage:	You remain in this stage until your yearly out-of-pocket costs reach $4,750. No coverage beyond the standard benefit.			
	Standard Medicare	79% of Generic Drug cost 47.5% of Brand Drug cost[2]		
Catastrophic Coverage Stage	After your yearly out-of-pocket costs exceed $4,750, you pay a small copayment for each covered prescription.			
	Generic Drugs (including Brand Drugs treated as Generics).	The greater of $2.65 or 5% of drug cost.		
	All Other Drugs	The greater of $6.60 or 5% of drug costs.		

(1) Tier 2 drug copayments vary by region: $6 - $8 for a 31-day supply at retail, $18 - $24 for a 90-day supply at retail; $12 - $16 for a 90-day supply with preferred mail. Tier 4 co-insurance varies by region.

(2) Available from manufacturers who agree to pay a 50% discount on the negotiated price, excluding the dispensing and vaccine administration fees. The plan pays 2.5%.

The benefit information provided is a brief summary, not a complete description of your benefits. For more information, contact the Plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premiums and/or co-payments/co-insurance may change on January 1 of each year.

(*) All Ohio Carpenters' Health Plan Medicare- Eligible Retirees who did not previously have post-65 prescription drug coverage from the Ohio Carpenters' Health and Welfare (Niles) Plan in 2012 and elected to receive fully-insured Express Scripts Medicare (PDP) coverage for 2013 and agreed to pay a monthly premium toward the cost of coverage.

MEDICAL REIMBURSEMENT ACCOUNTS Where Retiree has Dollar Bank Credit (See page 27)	
LIFE INSURANCE (Eligible Retiree Only) (See page 64)	
Death Benefits--Principal Sum	**$5,000**
Accidental Death & Dismemberment Benefit--Principal Sum	**Not Applicable**
*These benefits do not apply to Niles' member retiring before January 1, 2013 and retirees electing the Express Scripts PDP plan	

YOUR ELIGIBILITY FOR BENEFITS

Eligibility Class

You are in an Eligible Class under the Plan if you have worked sufficient Covered Employment and are

- Represented by the Union and an Employee of an Employer in the Plan;
- A full-time Employee of the Union or related organization, or an eligible salaried Employee of an Employer based on Rules determined by the Trustees from time to time; or
- A Retiree or Surviving Spouse meeting the Eligibility Rules determined by the Trustees from time to time.

The Board of Trustees reserves the right to decline to accept and to terminate the participation of individuals other than Employees represented by a Union participating in the Plan and who are employed by Participating Employers.

Self-employed persons (for example, partners and sole proprietors) cannot become eligible for benefits.

Covered Employment

Covered Employment is any hours you have worked for an Employer for which the Employer is required by the terms of a Collective Bargaining Agreement with the Union to make a contribution into the Fund to provide benefits. The Benefit Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of employees working under the Collective Bargaining Agreements, and, if so, the address of such Employer.

For nonbargaining unit Employees, Covered Employment is any period of time you have worked on a full-time basis for a Union or an Employer, for which the Union or the Employer have agreed in writing to provide a contribution into the Fund for benefits under rules and regulations established from time to time by the Board of Trustees.

Enrollment Procedure

An enrollment form completed and signed by you must be given to the Benefit Office before the Effective Eligibility Date (see p. 7) for your Eligible Dependents to become enrolled for benefits. Until the Benefit Office receives this completed form, you will have single coverage for yourself only. An enrollment form has been included at the back of this booklet.

You will not be eligible to receive benefits until a completed enrollment form is filed with the Benefit Office.

Changes in Enrollment Information

You must notify the Benefit Office in writing if:

- You move (please furnish your new address);
- Your marital status changes (please furnish a marriage certificate or divorce decree);
- You need to add or remove dependents (please have available birth certificates, adoption decrees, or qualified medical child support order); or
- You desire to change your beneficiary (life insurance can only be paid based on the beneficiary designated in your latest written notification to the Life Insurance Carrier before your death).

Effective Eligibility Date of Eligible Employee Coverage
Employer contributions will be credited towards an Employee's Initial Eligibility. Each month, $25 of Employer Contributions will be deducted, as a Plan subsidy, from contributions credited to an Employee's Account. Employees will become eligible for benefits on the first day of the second calendar month after the Employee has net contributions for Covered Employment credited to his Account of at least $768. For example, you will become eligible March 1 if you are hired in October, work during the three-month period of October through December, and have contributions of at least $843 ($768 + ($25 x 3)) made on your behalf by the end of January. (The amount of net contributions to be credited to an Employee's Account for Initial Eligibility ($768 at January 1, 2013) may be modified by the Trustees from time to time.)

When the above requirements are completed, coverage starts as follows:

For hours worked through	For which Net Contributions of at least $768 will be credited to your Account through the month of:	Your Effective Eligibility Date Is:
October	November	January 1
November	December	February 1
December	January	March 1
January	February	April 1
February	March	May 1
March	April	June 1
April	May	July 1
May	June	August 1
June	July	September 1
July	August	October 1
August	September	November 1
September	October	December 1

If you are employed by a Union or Employer as a non-bargaining unit employee under a written participation agreement with the Board of Trustees, you will become covered on the first of the second calendar month coinciding with or next following the date you complete one calendar month of Covered Employment. Your Employer must have promptly advised the Benefit Office of your date of employment, and made the proper contributions on your behalf as established by the Board of Trustees.

Your Dollar Bank
After you have contributions necessary to attain Initial Eligibility, any "excess contributions" will be placed in a "Dollar Bank" on your behalf. "Excess contributions" are monthly employer contributions in excess of the minimum amount necessary to establish and maintain eligibility, plus up to a $25.00 Plan subsidy (or other amount determined by the Trustees). When contributions from Covered Employment are inadequate to continue your eligibility, your Dollar Bank may be used together with any additional required self-payments. For months where you are required to draw-down your Dollar Bank or to make self-payments to continue eligibility, no $25 deduction will be made. For example:

Work Month(s)	Eligibility Month	Contributions	Monthly Cost	Dollar Bank Deposit
Jan	Initial Eligibility at April 1	$904	$768 + $25, or $793	$111 ($111 balance)
Feb.	Continued Eligibility at May 1	$850	$768 + $25, or $793	$57 ($168 balance)
March	Continued Eligibility at June 1	$730	$768	($38) ($130 balance)
April	Continued Eligibility at July 1	$680	$768	($42 balance)

See also examples of "Continuing Eligibility" at page 6. Employees accumulating Dollar Bank Credits in excess of the cost of three months' eligibility may use those excess Credits for unreimbursed medical expenses. See page 27.

The Trustees may reduce or otherwise adjust the number of Credits in Dollar Banks from time to time based on medical inflation and other factors so that the Plan can remain financially healthy. You will lose any credit in your Dollar Bank upon the earlier of the following:

- The date you become employed in this jurisdiction in a trade or craft (including supervision) covered by the Union, but you are an employee of an employer who does not participate in this Plan; or
- You remain employed by an Employer who withdraws from the Plan; or
- You cease to be available for covered employment, whether because you have ceased to be a member of the Union in good standing or otherwise; or
- The Trustees cancel Dollar Credits.

Dollar Bank Credits are not available to individuals in the Monthly Pay or Shop Plans.

Periodic Statements for Your Review
You will receive periodic statements of employer contributions made on your behalf. Please review these carefully. If there are any errors in these statements, please contact the Benefit Office promptly. If you have worked any hours which have not been reported, please let the Benefit Office know.

Immediate Eligibility for Employees of New Employers and New Employees
The Plan may establish rules for immediate eligibility for employees of new Employers and newly organized employees. Please contact the Benefit Office for details.

Monthly Pay Plan
Upon approval of the Benefit Office, a Monthly Pay Plan may be available for nonbargaining unit employees of an Employer who has a collective bargaining agreement with the Union for its bargaining unit employees. The Employer will be required to sign a Participation Agreement generally providing for non-discriminatory participation on behalf of all of its employees. The dollar bank, weekly disability benefits, monthly self-payments and retiree programs are **not** available. Any extended eligibility is through COBRA continuation coverage only.

Military Service and Reinstatement
To protect your rights, you must notify the Benefit Office before you leave the Plan's jurisdiction for military service.

If your military service is for 30 or fewer days, you and your family can continue coverage under the Plan at the same cost as before your short service. For example, if you are in the middle of a benefit period, your coverage is not affected. Likewise, if a self-payment is owed to continue coverage, that self-payment would still be owed.

If your reduced hours from active duty of more than 30 days will result in your becoming ineligible under the Plan, you can continue your coverage under the Plan for you and your dependents by making payments in the amount required for COBRA continuation coverage. COBRA Continuation Coverage is available for up to 24 months. **You must notify the Benefit Office of your service before you leave.**

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

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

If you choose to let your coverage in this Plan lapse while you are on active duty, but return to work for a participating Employer directly after your discharge, as described below, your health coverage will be reinstated to the same status as before you began your military service. Any dollar bank you had before your military service will be re-activated.

Deadline for Applying for Work with a Participating Employer

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

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

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

Eligible Dependents--Family Coverage
Dependents become eligible when you become eligible. If you acquire a new Dependent, you should notify the Benefit Office within 30 days. However, you **must** enroll the new Dependent within 60 days of acquiring that Dependent in order for eligibility to be retroactive to the date of marriage, birth, adoption, etc. If enrollment is made after 60 days, the new Dependent's eligibility begins on the date of enrollment. Similarly, you must notify the Benefit Office in writing within 60 days of any other Special Enrollment Event. Documentation shall be required. Dependents may include:

- **Your legal Spouse**. This means the person who is married to you in a legally recognized civil or religious ceremony. Marriage is recognized only as a legal union between one man and one woman as husband and wife. The person must be of the opposite sex and be a husband or wife. You may be required to furnish a copy of your marriage certificate. Common-law relationships are not recognized except to the extent they are recognized in your state of residence and you have furnished a satisfactory affidavit to the Board of Trustees under applicable state law.

  If you become **divorced** or legally separated, **your spouse loses eligibility**. You are **required** to **notify** the Benefit Office with **60 days** of your **divorce**.
- **Your children**. Children may be covered from the date of birth and may be Eligible Dependents as long as they are less than twenty-six (26) years of age and provided they are not otherwise entitled to benefits under the Plan.

For a Child to be your Eligible Dependent:

- You may be required to furnish birth certificates, adoption decrees, divorce decrees, or other documentation to establish your Child's status as an Eligible Dependent.

The term **Child** or **Children** may include:

- Your natural child,
- Your adopted child or child legally placed for adoption,
- Your stepchild, and
- Your eligible Foster Child.

The Plan also includes among Eligible Dependents children for whom you are required to furnish medical coverage under a Qualified Medical Child Support Order, OR National Medical Child Support Notice or Order.

Coverage for handicapped children can be continued after age 26 if the child became incapable of self-sustaining employment because of a physical handicap or mental retardation which began before age 19 and continues. You must submit proof of the Child's incapacity to the Benefit Office not later than 31 days after the date such child attains the age at which their coverage would otherwise terminate. Proof of continued incapacity must be furnished to the Benefit Office from time to time upon request.

You cannot be both an Eligible Employee and an Eligible Dependent under the Plan.

A Dependent's coverage will be terminated on the Dependent's 26th birthday.

If another plan is primary under this Plan's coordination of benefits rules and it contains a provision capping its benefits for an eligible individual or his dependents having the effect of shifting primary coverage liability to this Plan in a manner designed to avoid the usual operation

of the coordination of benefit rules under this Plan and the National Association of Insurance Commissioners, this Plan will not be liable to provide benefits until the primary plan provides its customary benefits determined without regard to such a cap.

The Trustees reserve the right to require you to furnish proof of your Dependents' continued eligibility under the Plan's rules.

Effective Eligibility Date of Eligible Dependent Coverage
An Employee, upon becoming initially eligible or upon acquiring an Eligible Dependent, should notify the Benefit Office within thirty (30) days of the event and submit such proof of dependent status as is required to obtain coverage for such Dependent(s). The Employee ***must*** notify the Benefit Office within sixty (60) days.

CONTINUING ELIGIBILITY

Once eligible, you will remain eligible for each succeeding one-month period so long as you have sufficient credits in your Dollar Bank or make self-payments.

Active Employee Self-Payments
You remain eligible for each succeeding one-month period with a Dollar Bank credit of ***at least*** $768 (which may be adjusted by the Trustees from time to time.)

If contributions to the Fund on your behalf and your Dollar Bank balance are not enough to qualify you for continued coverage, you may make full or partial self-payments at the rate determined by the Trustees to continue your eligibility under this Plan. The $25 Plan subsidy is not charged for months in which the Eligible Employee is required to make a self-payment or to use his Dollar Bank to maintain eligibility. However, if an Eligible Employee fails to make a self-payment and loses eligibility, $25 will be deducted monthly from any balance remaining in his Account.

Work Month(s)	Eligibility Month	Contributions	Monthly Cost	Required Self-Payment
January	April	$793	$768 + $25 or $793	
February	May	$693	$768	$75
March	June	$593	$768	$175
April	July	$893	$768 + $25 or $793	$100 deposited to Dollar Bank
May	August	$600	$768	$68 + $100 Dollar Bank balance

Payments are due in the Benefit Office not later than the 11th calendar day of the month (or postmarked by the 8th day of the month) for which you failed to have a sufficient Dollar Bank. Allowed self-payments must continue on an uninterrupted basis. Failure to make self-payments in the amount required and within the time specified will result in loss of coverage until you can again satisfy Initial Eligibility requirements or timely elect COBRA.

Full self-payments are permitted for 12 months only. Thereafter, you must again meet the requirements for the rules for Initial Eligibility, or elect COBRA continuation coverage.

Retired Employee Self-Payments
If a bargained Employee has contributions in his Dollar Bank Account when he retires, he may use his Dollar Bank Account to purchase benefits under the Retiree Program. When his Dollar Bank Account is depleted, the Retiree will be required to self-pay for the Retiree Program. Once an Employee retires and enters the Retiree Program, he will not be allowed to reenter the active Employee program unless he becomes eligible by meeting the rules for Initial Eligibility. If a retiree returns to work, he must notify the Benefit Office.

The retiree self-payments are due in the Benefit Office no later than the 5th calendar day of the month or must be postmarked by the 2nd of the month ***before*** the benefit month. Self-payments must be made by check, money order, or cashier's check. Cash will not be accepted. Certain pension funds may also allow deductions from a benefit to go directly to this Fund for such payments.

Allowed self-payments must continue on an uninterrupted basis. Failure to make self-payments in the amount and within the time specified will result in a permanent loss of coverage under the Retiree Programs.

Changing Employers--Bargaining Unit Employees
When you move from one participating Employer to another, your protection will continue if you are not unemployed between jobs for any period which would not be covered by your Dollar Bank. You should make sure that any new Employer is contributing to this Plan.

Travel--Bargaining Unit Employees
When you are asked to perform work outside the Plan area, you should ask whether your Employer will continue to make contributions on your behalf to this Plan, based on collective bargaining provisions for travelers.

Reciprocity Agreements with Other Plans--Bargaining Unit Employees
The Trustees have entered into Reciprocity Agreements with the Trustees of certain other plans in an effort to address the problem of employees working under the jurisdiction of other locals or Councils. Under these Agreements, contributions due on your behalf while working under another local's jurisdiction may be transferred from that local's fund to this Plan, if you make advance written request on a proper form.

Those employees eligible under this Plan who work in another jurisdiction that has a signed Agreement with this Plan may continue their coverage under this Plan. Those coming from other jurisdictions to work here and requesting reciprocity will not become eligible under this Plan but will continue their coverage, if any, under their home Plan.

Reciprocity payments will be credited only after they are received by the Benefit Office. Until payments have been confirmed to this Plan, you may be required to make timely self-payments to continue your eligibility. Self-payments made in excess of the minimum amount required to maintain eligibility for a particular month shall remain credited to a Self-Payment Bank for you when reciprocity payments are later confirmed. Alternatively, self-payments will be refunded to you upon request.

Delinquent Contributions
If you will otherwise lose Eligibility because Employer contributions are delinquent, you may use any balance in your Dollar Bank Account or make self-payments to continue your eligibility. When Employer contributions are made, any self-payments may be refunded to you upon your request.

If You Cannot Work Because You Are Temporarily Disabled--Bargaining Unit Employees
If you are temporarily Disabled and cannot work, you are given Dollar Bank Credits to help maintain your eligibility for benefits if you are not retired and otherwise remain a member of the Union in good standing. For each day that you are Disabled, your Dollar Bank will be credited at the prorated active monthly rate ($35.48 or such other amount as may be established by the Trustees). Credits are available up to a maximum of 26 weeks. This credit is given if you:

- Are receiving Weekly Disability benefits from this Fund, or are entitled to benefits under any Workers' Compensation or occupational disease law; **and**
- Are seen by a Physician on a regular basis who states you are Disabled; **and**
- Make separate written application to the Benefit Office for such credits within 6 months after the Disability starts.

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

TERMINATION OF ELIGIBILITY

Termination of Coverage
Coverage for you and your Eligible Dependents will terminate on the earliest of the following dates:

- The last day of an Eligibility Month if you have insufficient contributions or Dollar Bank Credits, and fail to make timely self-payments; or
- At the end of the month in which you begin active duty in the armed forces, except as otherwise provided in Plan Rules; or
- The last day of an Eligibility Month in which you die except that your Eligible Dependents will be allowed to remain eligible until any of your accumulated Dollar Bank Credits are exhausted; or
- The date you become employed in this geographic jurisdiction in the Union's covered trade or craft (including supervision) with a non-participating employer; or
- The date you cease to be available for Covered Employment (see page 1 above); or
- The Effective Date of your Withdrawal from the Plan (see below); or
- The date the Plan terminates.

Dependent coverage may also terminate for your Eligible Dependent on the earliest of the following:

- Your Dependent's 26th birthday;
- The day your dependent becomes an Eligible employee under this Plan; or
- The day your dependent begins full-time active duty in the armed forces; or
- The day that class of coverage is terminated.

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

- A balance in a Dollar Bank Account in this Plan--see page 6.

- By making self-payments to continue your eligibility--see page 6.
- An election of COBRA continuation coverage--see page 9.
- Disability credits towards maintenance of eligibility because you have been unable to work--see page 8.
- Enrollment in one of the Plan's programs for retirees, widows or disabled persons--see page 11.

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

Withdrawals--Effect on Coverage
Employees who remain with Employers who withdraw from Plan participation and employees who cease to be available for Covered Employment are treated as having withdrawn from Plan participation. Coverage will not extend beyond the Effective Date of Withdrawal, nor is there any right to or interest in Plan assets.

Certificate of Creditable Coverage
Under the Health Care Portability and Accountability Act, the length of time that a new plan will be allowed to exclude coverage for preexisting conditions will be reduced by the number of months that you had coverage for the condition under previous health plans (unless there is a 63-day gap in coverage). If you need to show a new health plan how long you were covered under this Plan in order to reduce or avoid the new plan's preexisting coverage exclusion, you may request from the Benefit Office for up to 24 months after your coverage ceases under this Plan a written statement, certifying to the length of your coverage under this Plan; and, if needed, the general categories of conditions that this Plan covers. **Beginning January 1, 2014, however, plans can no longer apply a preexisting condition provision so certificates will no longer be necessary.**

Optional Continuation Coverage Under COBRA--Federal Rules
Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), all employees and qualified beneficiaries (Eligible Dependents) covered under the Plan are eligible for continued coverage if certain conditions are met.

If you are an Employee eligible under the Plan, you have a right to choose continuation coverage for up to 18 months if you lose eligibility because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

The law also requires that the Plan provide you and your qualified beneficiaries with continued health care coverage for a period of 29 months if you become Disabled (as determined by Social Security) within the first 60 days of continuation coverage. You must inform the Benefit Office of your Social Security Disability determination and of your desire to choose continuation coverage within 60 days of the Disability determination.

If you are the spouse of an Eligible Employee, you have the right to choose continuation coverage for up to 36 months for yourself if you lose health care coverage for any of the following reasons:

- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment; or
- Divorce or legal separation from your spouse; or
- Your spouse's entitlement to Medicare; or
- Your spouse's death.

For a Dependent child of an Employee covered by the Plan, he or she has the right to continuation coverage for up to 36 months if eligibility is lost for any of the following reasons:

- The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment; or
- Parents' divorce or legal separation; or
- A parent's entitlement to Medicare; or
- A parent's death; or
- Loss of eligibility because the dependent ceases to be a "Dependent Child" as defined in this Plan.

At the end of the 18-month, 29-month, or 36-month continuation coverage period, you must be allowed to enroll in any individual conversion plan which might be available. However, this Plan does not maintain a conversion program.

Under the law, **the employee or a family member has the responsibility to inform the Benefit Office in writing within 60 days** of a **divorce, legal separation, or a child losing dependent status** under the Plan. Your Employer has the responsibility to notify the Benefit Office of the Employee's death, termination of employment, reduction in hours, or Medicare eligibility.

When the Benefit Office is notified that one of these events has happened, it will in turn notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the date you would lose coverage to inform the Benefit Office that you want continuation coverage. It is important that you keep the Benefit Office informed of the current addresses of all qualified beneficiaries.
If you do not choose continuation coverage, your health care benefits will end.

If you choose continuation coverage, the Plan is required by law to offer you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members (but not weekly disability, life insurance, and accidental death and dismemberment benefits, none of which are available).

Your coverage terminates in any of these five circumstances:

- The Plan no longer provides health care coverage; or
- The contribution for your continuation coverage is not paid timely; or
- You become covered under another health care plan after you elect continuation coverage (unless there is a preexisting condition limitation that would result in denial of benefits).

NOTE: There are limitations on plans imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act.

- You become enrolled in Medicare after you elect continuation coverage; or
- You were divorced from an Eligible Employee and subsequently remarry and are covered under your new spouse's health care plan (unless there is a preexisting condition limitation that would result in a denial of benefits).

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you have to pay the cost plus an administrative fee for continuation coverage. Disabled persons may pay a larger fee because of the cost to provide this coverage.

Should you have any questions about continuation coverage, please contact the "Eligibility Administrator" at the Benefit Office (855) 837-3528.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPPA), and other laws affecting group health plans, visit the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

RETIREE PROGRAMS

Note on Medicare and Retirement:

- The provisions below are subject to frequent change. Please contact the Benefit Office about current Schedules of Benefits available and the most current Rules governing the Retiree Programs.
- Your local Social Security office should be contacted at least 90 days before you or your spouse would qualify for Medicare.
- If you or any of your Dependents become Disabled, you should promptly consider the availability of Social Security Disability benefits.
- At January 1, 2013, the Board of Trustees continues to provide coverage for retirees who meet certain eligibility rules and make required self-payments. **There are no vested rights in any of the Retiree Programs.**

Eligibility for Retirees and Dependents

You are able to continue your coverage as a Retiree and coverage for your Dependents through timely self-payments if you:

- Are receiving a pension from a plan affiliated with the United Brotherhood of Carpenters and Joiners of America; and
- Were an active, Eligible Employee in the Health Plan for a total of five (5) of the last ten (10) years; and
- Have had at least 9 months' eligible participation in this Health Plan out of the 12 months immediately before retirement; and
- Are eligible under the Health Plan at the time of your retirement other than through self-payments or COBRA continuation; and
- Remain a member of the Union in good standing (if your coverage under the Plan was based on Covered Employment as a bargaining unit member).

You must notify the Benefit Office in writing that you want to maintain eligibility through the retiree program **within 30 days of the last month in which you are covered under the Plan**.

You will be notified by the Benefit Office of the amount due. Self-payments must be made from the date coverage was lost**. If you fail to make a self-payment, you lose your coverage and it cannot be reinstated**.

Coverage available to Retirees will be determined by Rules and Regulations adopted by the Trustees from time to time.

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

Eligibility for Surviving Spouses

Benefits for the Surviving Spouse of a Retiree shall terminate at the end of the benefit month in which the Retiree last obtained eligibility. The Spouse of a Retiree may continue coverage through any Dollar Bank Account. After Dollar Bank Credits are exhausted, the Surviving Spouse will be permitted to make self-payments during the period such spouse continues to receive benefits from the deceased Retiree's Carpenter Pension Plan(s). In any event, however, the Surviving Spouse shall be permitted to make pay self-payments for a period of at least 36 months following the Retiree's death. This 36-month period runs concurrently with any required COBRA continuation coverage.

Coverage for Surviving Spouses would also cease on the earliest of the following:

- The date they no longer meet the definition of a Dependent; or
- The date they become covered by another group plan; or
- The date the Spouse remarries; or
- The date the Spouse dies.

Coverage for other dependents of Deceased Employees or Retirees may be continued for this same 36-month period.

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

OPTIONS IF NO FURTHER COVERAGE IS AVAILABLE UNDER THE PLAN

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan). See below.

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

- Any special enrollment right available to you under your spouse's health plan based on your loss of group health coverage (generally available for only 30 days after your loss of coverage under this Plan); and/or
- Enrolling in a health maintenance organization or HMO (health insuring corporation); and/or

- A health insurance exchange; and/or
- Enrolling in Medicare based on your age, a Total and Permanent Disability, or end-stage renal disease; and/or
- Purchasing Supplementary Medicare Coverage.

You may lose valuable legal rights if you delay consideration.

If you have questions about protecting your health coverage or your options, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272. For free publications ask for publications concerning the changes in health care laws. You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's Interactive web pages – Health *E*laws, or http://www.hhs.gov/ocr/privacy/index.html.

RESCISSION OF COVERAGE

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

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

REMINDER: TERMINATION OF COVERAGE

YOU WILL LOSE COVERAGE IF, AMONG OTHER THINGS YOU WORK IN COVERED EMPLOYMENT (INCLUDING SUPERVISION) FOR A NON-PARTICIPATING EMPLOYER, OR CEASE TO BE AVAILABLE FOR COVERED EMPLOYMENT (INCLUDING CEASING TO BE A MEMBER OF THE UNION IN GOOD STANDING). SEE PAGES 8-9.

HOW TO OBTAIN INPATIENT HOSPITAL SERVICES OR PROFESSIONAL SERVICES--PRECERTIFICATION

Your Plan has adopted a special rule regarding the ability to obtain Inpatient Hospital services or professional services. You must follow the Pre-Hospital Admission Certification Program PRIOR to obtaining any Inpatient treatment, with the exception of medical Emergency treatment. If you have an Emergency Admission, you or your Authorized Representative must use the precertification program within 48 hours following admission.

Contracting providers will seek precertification on your behalf. If you are seeking services outside of Ohio or through a Non-Contracting Provider, you are responsible for obtaining pre-certification of your claim. Once the precertification vendor is contacted, that vendor will contact your Physician to determine the appropriateness of your hospitalization. This review will be performed as quickly as possible. A decision will be made on the request as soon as possible, but within 15 days. Urgent care claims will be decided more quickly.

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

If the precertification vendor does not approve the admission as requested, this would be considered a “denial.” You will receive a notice of the denial in writing. That denial may be appealed as shown at page 19 below.

HOW TO FILE CLAIMS

Medical, Vision and Hearing Aid Benefits
When you receive health care services:

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

If you and your Dependents use Providers who participate in the Medical Mutual Network, the provider will submit a claim for you directly to Medical Mutual for payment.

However, if you use a Non-Participating Physician or Non-Contracting Hospital, it is your responsibility to submit the claim form to Medical Mutual for payment.

Medical Mutual Group No. 233252
P. O. Box 6018
Cleveland, OH 44101

Generally, you may have to file a claim under the following circumstances:

- When services are provided in Hospitals or other health care institutions that do not contract with Medical Mutual;
- When Outpatient services are provided by Hospitals outside of the geographic area served by Medical Mutual;
- When a provider has charged you for a service that you believe should be submitted to Medical Mutual; and
- When you believe that the provider's claim submitted to Medical Mutual was inaccurate.

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

- Obtain an itemized bill from the Hospital;
- Obtain a claim form from the Benefit Office or Medical Mutual (or you may print a claim form from www.Medical Mutual.com under the Members' section);
- Complete the claim form and attach the itemized bill to the form; and
- Send the claim form and bill to the address on the claim form.

If you fail to receive a claim form within 15 days after you notify Medical Mutual, you may send Medical Mutual your bill or a written statement of the nature and extent of your loss; this must have all the information that Medical Mutual needs to process your claim.

Claims must be filed within 90 days unless there was a reasonable basis for the delay. **Claims MUST be filed within <u>365 days</u> of being Incurred. Otherwise, they will be denied.**

All claims for payment must include the following information:

- Name and Social Security Number of the Eligible Person;
- Name and address of the provider of service (doctor, Hospital, etc.);
- Patient's Name and relationship to the Eligible Person;
- Date of service;
- Diagnosis Codes;

- Type of service; and
- Amount Charged for each service.

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

Payment for Non-Participating Physicians or Non-Network Providers will be made to you directly once you have met your Deductibles, Co-payment, and Coinsurance obligations. It is your responsibility to provide this payment to your Provider.

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

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

Medicare Parts A and B
All bills must be processed by Medicare before the Plan can provide benefits for Covered Services. A claim must be filed for you to receive benefits. Send your claim form and Medicare Explanation of Benefits form to the address shown on your Medical Mutual identification card.

Part A Claims
Many Hospitals or Skilled Nursing Facilities will submit your claim for you. If not, you must send an itemized copy of the bill with a diagnosis and your Explanation of Medicare Benefits (EOMB) form.

Part B Claims
A claim will usually be submitted for you by the organization responsible for processing your Medicare Part B claim. Medical Mutual has the right to accept this information in any form, including any automated method.

If the Medicare Part B claim is not submitted by the organization responsible for processing your Medicare Part B claim, you must send Medical Mutual a copy of your EOMB and a completed Medical Mutual claim form. In many cases you can obtain a claim form from your Provider. If your Provider does not have a claim form, Medical Mutual will send you one. Call or write to Medical Mutual, and Medical Mutual will send you a form; or you may print a claim form from Medical Mutual's Website: www.MedMutual.com, under the Members' section.

If Medical Mutual fails to send you a claim form within 15 days after you notify Medical Mutual, you may send Medical Mutual your bill or a written statement of the nature and extent of your loss; this must have all the information which Medical Mutual needs to process your claim.

Part A and Part B Claims for Emergency Care in a Foreign Country
For services received outside the United States, you must send Medical Mutual an itemized bill with a diagnosis for Part A and Part B claims and a claim form for Part B

claims. Itemized bills should be translated into English whenever possible. If a translation is not available, include a letter describing the services you received. Generally, Medicare does not cover services received in a foreign country so an EOMB will not be available. However, if you receive an EOMB from Medicare for services received in Canada or Mexico, include a copy of your EOMB when filing a claim to Medical Mutual.

Proof of Loss
Medical Mutual must receive the claim form and a copy of the EOMB within the same time limits set for submitting your Part A and Part B claims to Medicare.

Benefit Office
Claims for Weekly Disability, Life and Accidental Death and Dismemberment and Medical Expense Reimbursement Benefits should be filed with the Benefit Office:

Ohio Carpenters' Health Plan
c/o BeneSys – Health Care Department
P. O. Box 1257
Troy, Michigan 48099-1257
(855) 837-3528

Weekly Disability Benefits
You must obtain a claim form from the Benefit Office and have the form completed. **Claims must be filed within 90 days after they are Incurred. Otherwise, they will be denied.**

If the Benefit 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 Benefit Office receives the information from you, you will be notified of the decision on the claims within **30 days**.

Life and Accidental Death and Dismemberment Benefits
Claims for Life, Accidental Death and Dismemberment benefits will be provided through an Insurance Provider. Your beneficiary must contact the Benefit Office in order to obtain a claim form. Notice of loss is to be furnished to the Insurance Provider within **20 days.** Your beneficiary must submit the completed claim form with all required documentation to the Benefit Office. The Benefit Office will forward the claim with the documentation to the Insurance Provider. The claims for death benefits will not be considered received until the completed application is received by the Insurance Provider. **It is the beneficiary's responsibility to have a completed death claim form and certified copy of the Death Certificate filed with the Insurance Provider within 365 days from the date of death in order for benefits to be payable.**

Generally, the Insurance Provider will notify your beneficiary of the decision on the claim for benefits within 90 days. If the Insurance Provider needs additional time to review the claim for benefits or needs additional information, the beneficiary will be provided with the information on the status prior to the expiration of the initial **90-day** period.

Medical Expense Reimbursement Benefits
See pages 27-28.

Dental Benefits
Your Delta Dental dentist will file your claims for you. If you choose to use a non-Delta dentist, you may have to file your own claim form. That form is available from www.deltadentaloh.com or by calling 1 (800) 524-0149. Claims should be sent to:

Delta Dental
P. O. Box 9085
Farmington Hills, Michigan 48333-9085

Claims must be filed within **365 days** after they are Incurred.

Prescription Drug Benefits
How to File Claims for Prescription Benefits Under the Prescription Solutions Program
You will receive a personalized Identification Card once you become eligible in this Plan. You must present your Prescription Identification Card along with your Physician's prescription to any Participating Pharmacy.

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

If you use a Non-Participating Pharmacy or do not use your identification card, you will be required to pay for the drug at the time of purchase, then obtain a Prescription Drug Reimbursement Form from the Benefit Office or Express Scripts and file the completed form and itemized receipt with:

Medco
P. O. Box 14711
Lexington, KY 40512

Mail order prescription orders should be sent to:

All Actives and Early Retirees	Niles Plan Medicare Retirees	Cleveland & Southwest Medicare Retirees
Mail Order Address:	**Mail Order Address:**	**Mail Order Address:**
Express Scripts P. O. Box 30493 Tampa, FL 33630	Express Scripts P. O. Box 14711 Lexington, KY 40512	Express Scripts P. O. Box 747000 Cincinnati, OH 45274-7000

Deadline for Filing Claims
Claims should be filed within 90 days unless there was a reasonable basis for the delay. **Claims MUST be filed within 365 days after they are Incurred. Otherwise, they will be denied.**

Where Additional Information is Needed
If additional information is needed to make a decision, you will be notified as to what information must be submitted. You generally will have at least 45 days to submit the additional information. When that information is submitted, your claim will be processed.

DENIAL OF CLAIMS

If your claim is denied, in whole or in part, you will receive a notice of the denial in writing, which contains:

- The specific reasons for the denial and your right to appeal;
- The specific reference to the Plan provisions on which the denial was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such material 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; and
- A notice of your right to a written explanation of any exclusion which affects your claim.

APPEALS

Medical, Vision, and Hearing Aid Benefits through Medical Mutual
You or your Authorized Representative may appeal the decision by Medical Mutual to deny any claim for medical, vision, or hearing aid benefits in whole or in part.

Filing an Appeal
If you are not satisfied with a benefit determination decision, you may file an appeal at any time within **180 days** after your claim is denied. No more than two appeals for any one claim will be considered in accordance with the procedures explained below.

To file an appeal, please call the Customer Service Telephone number on your identification card or write a letter with the following information: Full name of Eligible Employee or Eligible Retiree; patient's full name; identification number; claim number, if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or records, X-rays, or photographs you would like considered in the appeal. Send or fax the letter to:

Medical Mutual Group No. 233252
Member Appeals Unit
P.O. Box 94580
Cleveland, Ohio 44101-4580
FAX: (216) 687-7990
or (866) 691-8260

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section.

First Level Mandatory Appeal
Medical Mutual offers all Eligible Persons a first level mandatory appeal. You must complete this first level of appeal before any action is taken in a court of law.

First level mandatory appeals related to a claim decision must be filed within **180 days** from your receipt of the notice of denial of benefits. All requests for appeal may be made by calling Customer Service or in writing as described above.

You will be notified of Medical Mutual's benefit determination of your appeal orally, as allowed, or in writing, as follows:

- For an appeal of an Urgent Care Claim, not later than 72 hours after Medical Mutual receives your request for an appeal.
- For an appeal of a Pre-Service Claim, not later than 30 days after Medical Mutual receives your request for an appeal.
- For an appeal of a Post-Service Claim, not later than 30 days after Medical Mutual receives your request for an appeal.

Under the appeal process, there will be a full and fair review of the claim. The internal appeal process is a review of your appeal by an Appeals Coordinator, a Physician consultant, and/or other licensed health care professional. The appeal will take into account all comments, documents, records, and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based in whole or in part on a medical judgment are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

You may submit written comments, documents, records, and other information relating to the claim being appealed. Upon written request, you may have reasonable access to and copies of documents, records, and other information used to make the decision on your claim for benefits that you are appealing.

All notices of a denial of benefits will include the following:

- The specific reasons for the denial;
- Reference to the specific plan provisions on which the denial is based;
- Your right to bring a civil action under federal law following the denial of a claim upon review;
- If an internal rule, guideline, protocol, or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request;
- If the claim was denied based on Medical Necessity or Experimental treatment, or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination in applying the terms of the Plan to the circumstances will be provided free of charge upon request;
- Upon specific written request from you, provide the identification of the medical or vocational expert whose advice was obtained on behalf of Medical Mutual in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. You will receive continued coverage pending the outcome of the appeals process. This means that the Plan may not reduce or eliminate coverage of ongoing treatment until your appeal is exhausted. If Medical Mutual has not substantially complied with the internal claim appeals process, you may choose to initiate the external appeal process.

Voluntary Second Level Appeal

If your first level mandatory appeal is denied, you have the option of a voluntary second appeal with Medical Mutual. All requests for appeal may be made by calling or writing to Customer Service. You may submit additional written comments, documents, records, X-rays, photographs, and other information relating to the claim being appealed.

This second level is voluntary, which means this level of appeal is available but not required before pursuing any civil action. Any statute of limitations will be applicable during the period of the voluntary appeal process.

The voluntary second level of appeal may be requested at the conclusion of the first level mandatory appeal. The request for the voluntary second level of appeal must be received by Medical Mutual within 60 days from your receipt of the first appeal decision. Medical Mutual will complete its review of the voluntary second level within 30 days from receipt of the request.

The voluntary second level of appeal provides a full and fair review of the claim. There will be a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, records, and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the first level mandatory appeal. All determinations of Medical Necessity that are based in whole or in part on a medical judgment are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.

Weekly Disability, Medical Reimbursement Accounts, Plan Eligibility, and Rescissions of Coverage

You or your Authorized Representative may appeal the decision by the Benefit Office to deny any claim for Weekly Disability Benefits, Reimbursement under your Medical Reimbursement Account, Plan eligibility, or rescission of coverage in whole or in part.

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 denial. The written notice needs to state your name, address, social security number, and the fact that you are appealing the decision of the Benefit Office, giving the date of the notice. Your appeal should include the reason you are appealing and any documentation in support. The Appeal should be addressed as follows:

Board of Trustees
Ohio Carpenters' Health Plan
c/o BeneSys – Health Care Department
P. O. Box 1257
Troy, Michigan 48099-1257
(855) 837-3528

Appeals not received within thirty (30) days before a Board of Trustees' meeting will be considered at the next scheduled Board meeting thereafter.

Prescription Drugs
When a claim for a Covered Drug is rejected, you may request that Express Scripts reconsider the rejection by requesting an appeal within **180 days** after the date you first request coverage. Appeals for coverage of drugs that are not covered under the program (see Exclusions on Page 56-57) will not be considered. In addition, certain Covered Drugs that are subject to quantity limitations cannot be appealed.

Non-Medicare participants should request an appeal by calling Express Scripts toll-free at (866) 685-2792. Upon receipt of your request for appeal, Express Scripts will send you a Prescription Claim Appeals Form. You and/or your Physician should complete the form and mail or fax it to Express Scripts. Express Scripts' mailing address and fax number are noted below.

Express Scripts, Inc.
P. O. Box 631850
Irving, Texas 75063-0000
ATTN: Administrative Review

Medicare participants should call (800) 413-1328 for initial review. Written appeals should be filed with**:**

Express Scripts, Inc.
P. O. Box 630406
Irving, Texas 75063-0119
ATTN: Medicare Administrative Appeals

Upon receipt of your completed Prescription Claim Appeals Form, Express Scripts will conduct an internal review of your appeal request. You will receive written notification of the outcome of Express Scripts' internal review within 30 days of the date Express Scripts received your completed Prescription Claim Appeals Form. If the original rejection is overturned on appeal and coverage is granted, coverage will be authorized by Express Scripts. If the appeal is rejected, coverage will not be provided under the Plan; however, you may obtain the drug on your own at your own expense. A second request for internal review will be honored only if your condition changes and you supply new clinical information that was not available at the time of the original request.

Dental Claims
For informal review of your dental claim in order to attempt to review the problem quickly, you or your Dentist may contact Delta Dental by calling the customer service department at (800) 524-0149 or by sending written correspondence to:

Customer Service Department
Delta Dental
P. O. Box 9089
Farmington Hills, MI 48333-9089

When writing, please enclose your Explanation of Benefits form, nature of problem, and any information about the problem you would like considered, plus your name, your telephone number, and the date.

Whether or not you have chosen to seek informal review, you are also entitled to a formal appeal of your claim. You must appeal with **180 days** of the denial you are seeking Delta Dental to review. That appeal must be sent to:

Dental Director
Delta Dental
P. O. Box 30416
Lansing, MI 48909-7916

Please include your name and address, Subscriber's Member ID number, the reason you believe your claim was wrongly denied, any information which you believe supports your claim, and state that you are requesting a formal appeal. If you desire proof of receipt of your appeal, it should be sent by certified mail, return receipt requested. You are also entitled to review the formal Dental Plan certificate in connection with that appeal.

The Dental Director will make his decision within thirty (30) days of receiving a pre-service claim, or sixty (60) days of receiving a post-service claim. If you remain dissatisfied with the Director's decision after the completion of your appeal, you have the right to seek to have your claim paid by filing suit in federal court. You must do so within **365 days** of the Director's final decision.

Death Benefits

For Life Insurance, Accidental Death and Dismemberment claims, your beneficiary must appeal a denial of benefits within **sixty (60) days** to the address shown on the denial notice. If that denial involves the member's eligibility, the appeal should be made to the Benefit Office. The eligibility appeal must be made within **180 days** of the denial.

External Review

Generally

External review may be available on claims involving any medical judgment, other than claims under Parts A and B of Medicare. You may file a request for external review with the Benefit Office or Medical Mutual, as applicable. This request must be filed within four (4) months after your receipt of a notice of denial from the internal mandatory appeal. Within five (5) business days after receiving your request, the Plan will review that request to determine preliminarily whether:

- You were eligible at the time the health care item or service was requested, or, in the case of a retrospective review, were eligible at the time the health care item or service was provided; and
- The denial relates to a failure to meet the Plan's eligibility requirements (external review would not apply); and
- You have exhausted the Plan's internal appeal process unless under applicable law you are not required to exhaust the internal appeal process; and
- You have provided all of the information necessary to process an external review; and
- The appeal relates to claims that involve medical judgment (excluding those that involve only contractual or legal interpretation without use of medical judgment).

Within one day of this preliminary review, you will be advised whether the claim is eligible for external review. If your claim is eligible for external review, the Plan will assign an Independent Review Organization (IRO) on a random basis or use some other unbiased method of selection. After the IRO advises you that your claim is eligible and has been accepted for external review, you have ten (10) business days to furnish additional information which you desire the IRO to consider when conducting the review. Within five (5) business days of assigning your claim to an IRO, the Plan will provide the IRO with the documents and information considered in denying the claim. (The failure to provide documents may not delay external review, but may result in the

IRO reversing the denial.) Similarly, the IRO must forward to the Plan within one (1) business day any information it receives from you. After receipt of information from you, the Plan may reconsider its denial, reverse that determination and provide coverage or payments. The Plan must notify the IRO within one (1) business day of such reversal. Absent favorable reconsideration by the Plan, the IRO will review the claim. The IRO will not be bound by any decisions or conclusions reached during the Plan's internal claim and appeal process. The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. This notice must be furnished to you and the Plan, and contain:

- A general description of the reason for the external review, including information sufficient to identify the claim;
- The date the IRO received the assignment and the date of the IRO's decision;
- References to the evidence or documentation the IRO considered in reaching its decision;
- A discussion of the principal reasons(s) for the IRO's decision;
- A statement that the determination is binding and that judicial review may be available to the claimant; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

Upon receipt of notice that the IRO has reversed the Plan's denial, the Plan must provide coverage or payment for the claim immediately.

Expedited

The Plan must make expedited external review available if you or your Dependent receives:

- A denial involving an Urgent Care Claim, and the claimant has filed a request for an expedited internal review; or
- A final denial, if it involves an Urgent Care Claim or a health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

The Plan must determine whether the request meets reviewability requirements immediately and send a notice of the Plan's eligibility determination. After assigning an IRO, the Plan will furnish necessary documents and information to the IRO expeditiously--for example, by e-mail, fax, phone, or overnight mail.

The IRO must consider all information under the procedure and in the manner described above in "External Review – Generally". The IRO's decision must be furnished within 72 hours after the IRO receives the request. If the decision is not in writing, the IRO must furnish written confirmation to the Plan and claimant within 48 hours after initial communication of the decision.

Consent to Release of Medical Information – Denial of Coverage

You consent to the release of medical information to Medical Mutual and the Plan when you enroll and/or sign an Enrollment form.

When you present your identification card for Covered Services, you are also giving your consent to release medical information to Medical Mutual and the Plan. Medical Mutual and the Plan have the right to refuse to reimburse for Covered Services if you refuse to consent to the release of any medical information.

Right to Review

When a claim is submitted, Medical Mutual and/or the Plan will review the claim to ensure that the service was Medically Necessary and that all other conditions for coverage are satisfied. The fact that a Provider may recommend or prescribe treatment does not mean that is automatically a Covered Service.

Definitions & General Information

Urgent Care Claims

An **Urgent Care Claim** is a claim for Medical Care or treatment where applying the timeframes for non-urgent care could (a) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (b) in the opinion of a Physician with knowledge of the claimant's Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If your Physician believes a claim is "urgent," this must be shown clearly on the claim/appeal.

Determination of ***urgent*** can be made by (a) an individual acting on behalf of the Plan and applying the judgment of a prudent layperson that possesses an average knowledge of medicine, or (b) any Physician with knowledge of the claimant's Condition who can determine that a claim involves urgent care.

If you file an Urgent Care Claim in accordance with the Claims Processor's claim procedures and all of the required information is received, the Processor will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after the Processor's receipt of the claim.

When you request an internal appeal for an Urgent Care Claim, you may also file a request at the same time for an external appeal.

Concurrent Care Claims

A Concurrent Care Claim is any claim for ongoing treatment, including the Plan's approval for a number of treatments. The decision may be treated as a "denial" if the Plan decides to reduce or terminate benefits for the ongoing treatment (unless it's due to a health plan amendment or plan termination).

A request for an extension to an ongoing course of treatment must be filed in accordance with claim procedures and must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Medical Mutual or other Claims Processor will notify you of any benefit determination concerning the request to extend the course of treatment promptly after its receipt of the claim.

If Medical Mutual reduces or terminates a course of treatment before the end of the course previously approved, the reduction or termination is considered a denial. Medical Mutual will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

When you request an internal appeal for a concurrent care claim that is urgent, you may also file a request at the same time for an external appeal.

Pre-Service Claims
A Pre-Service Claim is a claim for a benefit which requires some form of preapproval or precertification by Medical Mutual or other Claims Processor.

If you file a Pre-Service Claim in accordance with claim procedures and all of the required information is received, Medical Mutual or the other Claims Processor will notify you of its benefit determination within 15 days after receipt of the claim. Medical Mutual or Claims Processor may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of Medical Mutual or the Claims Processor. Medical Mutual or the Claims Processor will notify you of such an extension and the date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual or the other Claims Processor will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Post-Service Claims
A return Post-Service Claim is any claim that is not a Pre-Service Claim. If you file a Post-Service Claim in accordance with claim procedures and all of the required information is received, Medical Mutual or the other Claims Processor will notify you of its benefit determination within 30 days after receipt of the claim. Medical Mutual or other Claims Processor may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Claims Processor.

If an extension is needed because you did not provide all of the necessary information to process your claim, Medical Mutual or the other Claims Processor will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Independent Review Organization
An Independent Review Organization is accredited for external review by URAC (a nonprofit organization promoting healthcare quality by accrediting health care organizations) or a similar nationally recognized accrediting organization. Medical Mutual and the Plan contract with multiple IROs. These IROs are assigned on a random basis or by using some other unbiased method of selection.

IMPORTANT DEADLINES

YOUR CLAIMS FOR MEDICAL, VISION, HEARING AID, LIFE INSURANCE, DEATH, DENTAL AND PRESCRIPTION DRUG BENEFITS MUST BE FILED WITHIN 365 DAYS AFTER THEY ARE INCURRED. WEEKLY DISABILITY CLAIMS MUST BE FILED WITHIN 90 DAYS. OTHERWISE, YOUR CLAIMS WILL BE DENIED.

MEDICAL REIMBURSEMENTS--USING YOUR DOLLAR BANK FOR EXPENSES

(Active Employees, Non-Medicare Retirees, and Medicare-Eligible Retirees)

When You Can Use Your Dollar Bank for Medical Expenses

Your medical expenses should be submitted promptly to this Health Plan and any Spousal health plan for processing. When you have unpaid medical expenses after processing – for example, deductibles and copayments – you may be able to use your Dollar Bank for reimbursement of those expenses. Retirees may also submit those out-of-pocket expenses for reimbursement from their Dollar Bank. Active employees may submit those expenses if they have ***Dollar Bank Credits in excess of three months' eligibility (at the active rate***). Those excess Credits may be used to reimburse employees for most expenses.

Deadline for Seeking Reimbursement

The deadline for seeking reimbursement of unreimbursed medical expenses is **March 31 of the year following the Plan Year in which the expense was incurred**.

What Expenses Are Eligible

Reimbursable medical expenses are those medical expenses identified in Internal Revenue Code ("Code") Section 213 but which have not been paid under this Plan. Unreimbursed medical expenses eligible for reimbursement under the Code include:

- Deductibles and co-payments applied to covered medical expenses under this Plan or a qualified plan of your Spouse;
- Unreimbursed hospital service fees (lab work, therapy, nursing services, surgery, etc.);
- Unreimbursed medical service fees (from doctors, chiropractors, dentists, surgeons, registered nurses, specialists, and other medical practitioners);
- Unreimbursed special items (artificial limbs, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.);
- Unreimbursed transportation for needed medical care;
- Unreimbursed dental expenses;
- Capital expenses for equipment or improvements to your home needed for medical care;
- Cost and care of guide dogs or other animals aiding the blind, deaf, and disabled;
- Cost of lead-based paint removal;
- Expenses of an organ donor;
- Oxygen equipment and oxygen;
- Part of life-care fee paid to retirement home designated for medical care;
- Unreimbursed prescription medicines (prescribed by a doctor) and insulin, including co-pays;
- Psychiatric care at a specially equipped medical center (includes meals and lodging);
- Legal abortion;
- Legal operation to prevent having children;
- Unreimbursed meals and lodging provided by a hospital during medical treatment;
- Special school or home for mentally or physically disabled persons;
- Unreimbursed treatment at a drug or alcohol center (includes meals and lodging provided by the center);
- Wages for nursing services; or
- Any other medical expenses identified in Internal Revenue Code section 213.

What Medical Expenses Are NOT Eligible
The following expenses are not eligible for reimbursement:

- Medical expenses for which reimbursement is available under another plan or program;
- Expenses related to cosmetic surgery;
- Expenses for which the Employee claimed or will claim a medical expense deduction on the Employee's tax returns;
- Expenses incurred before the Employee became Initially Eligible for medical benefits under this Plan;
- Bottled water;
- Diaper service;
- Expenses for general health (even if following doctor's advice) such as--
  - Health club dues;
  - Household help (even if recommended by a doctor);
  - Social activities, such as dancing or swimming lessons;
  - Trip for general health improvement; or
  - Weight loss program;
- Funeral, burial or cremation expenses;
- Illegal operation or treatment;
- Life insurance or income protection policies, or policies providing payment for loss of life, limb, sight, etc.;
- Maternity clothes;
- Medical insurance included in a car insurance policy covering all persons injured in or by the Employee's car;
- Nursing care for a healthy baby;
- Surgery for purely cosmetic reasons;
- Toothpaste, toiletries, cosmetics;
- Medical services in a U.S. Government Hospital; or
- Medical services provided at no cost through any public program.

How to Obtain Reimbursement
When you have Dollar Bank Credits greater than three months' eligibility, you may apply for payment of unreimbursed medical expenses from excess Credits in your Account. After your expenses have been processed under the Health Plan, submit

- A completed reimbursement form (available from the Benefit Office), and
- The explanation of benefits form you received when your claims were processed or, if applicable, original receipt and proof of payment to the Ohio Carpenters' Health Plan Benefit Office, P. O. Box 1257, Troy, Michigan 48099-1257. **Unreimbursed amounts must total at least $20 before you seek reimbursement**. Separate bills may be itemized on the same claim form.

The Benefit Office processes reimbursement claims weekly. Reimbursement checks will be sent to you, or, if preferred, benefits may be assigned directly to Providers.

Reimbursement of Employees will not be allowed if it would reduce the Employee's Dollar Bank Account to less than three months' eligibility (at the active rate).

Surviving Dependents
The Dollar Bank Account is for use by the Member. In the event of your death, however, the Account may be used by your Surviving Spouse or, if you have no Spouse, your Eligible Dependent Children. (The Internal Revenue Code does not allow individuals other than your Eligible Dependents to obtain any reimbursement from your Account.)

Suspension or Cancellation of Account
Your Account will be cancelled if there is no activity (employer contributions or claims) in your Dollar Bank Account for a period of three years. Additionally, your Medical Reimbursement Account will be cancelled on the date you become employed in this geographic jurisdiction in the same trade or craft (including supervision) for an employer who does not participate in this Plan; you cease to be available for Covered Employment (whether because you cease to be a member of the Union in good standing or otherwise); or if you remain employed by an employer who withdraws from the Plan. Forfeited account balances will revert to the Plan's general assets.

The Trustees reserve the right to suspend or cancel your Account if you cease to be enrolled in Comprehensive Medical Benefits under the Plan, and may take into consideration requirements of the Patient Affordability and Accountability Act.

IMPORTANT DEADLINE

YOUR CLAIMS FOR UNREIMBURSED MEDICAL EXPENSES MUST BE SUBMITTED BY MARCH 31 OF THE YEAR FOLLOWING THE PLAN YEAR IN WHICH THE EXPENSE WAS INCURRED.

COMPREHENSIVE MEDICAL BENEFITS--GENERALLY

(Active Employees, Non-Medicare Retirees, and Dependents)

NOTICE: **If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and Hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.**

Comprehensive Medical Expense Benefits are currently processed by Medical Mutual under a self-funded arrangement with the Plan.

How Claims are Paid

Medical Mutual pays for benefits on behalf of the Plan for Covered Services through agreements with Contracting Institutional Providers, Participating Physicians, and Other Professional Providers based on Negotiated Amounts. For Non-Contracting Institutional Providers, Medical Mutual pays for benefits based on the Non-Contracting Amount that is determined payable by Medical Mutual. For Non-Participating Physicians and Other Professional Providers, Medical Mutual pays for benefits based on Traditional Amounts.

Benefit Period Deductible

Each Benefit Period, you must pay the dollar amount that may be specified in the Schedule of Benefits as the Deductible before the Plan will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before the Plan starts to provide benefits. If a benefit is subject to a Deductible, only expenses for Covered Services under that benefit will satisfy the Deductible. To satisfy your Deductible, the Plan records must show that you have Incurred claims totaling the specified dollar amount, so submit copies of all your bills for Covered Services. Your Deductible accumulations do not necessarily occur in the same order that you receive services, but in the order in which Medical Mutual receives and processes your claims. Copayments will not apply to the Deductible. Deductibles and Copayments do not apply to the Coinsurance Limit.

The Schedule of Benefits specifies a single Deductible and a family Deductible. The single Deductible is the amount each Eligible Person must pay, but the total amount the family must pay is limited to the family Deductible.

Only the amount of the Deductible required per Eligible Person will be required for Covered Services that result directly from an accident during the Benefit Period in which the accident occurred if two or more Eligible Persons in your family are injured in the same accident and each of the following conditions are met:

- At least two of these Eligible Persons receive Covered Services; and
- The Covered Services are Incurred within 90 days after the accident; and
- The combined Lesser Amount for Covered Services for all Eligible Persons involved in the accident is at least equal to one Eligible Person's Deductible.

Coinsurance

After you meet any applicable Deductible, you may be responsible for Coinsurance amounts as specified in your Schedule of Benefits, subject to any limitations set forth in the Schedule of Benefits. The amount of Coinsurance you have to pay may vary depending upon the status of your Provider.

Copayments
For some Covered Services, you may be responsible for paying a Copayment at the time services are rendered. Covered Services that require Copayments may or may not be subject to Deductible and or Coinsurance requirements as specified in your Schedule of Benefits. These Copayments are your responsibility, and they are not reimbursed by the Plan. Please refer to your Schedule of Benefits for specific Copayment amounts that may apply.

Schedule of Benefits
The Deductibles, Coinsurance Limits and Non-PPO Network Coinsurance Limits that may apply will renew each Benefit Period. Some of the benefits offered in this Plan have maximums. In addition, there may be an Annual Maximum for all Covered Services.

The Schedule of Benefits shows your financial responsibility for Covered Services. The Plan covers the remaining liability for Covered Charges after you have paid the amounts indicated in the Schedule of Benefits, subject to benefit maximums and Medical Mutual's Negotiated Amounts.

Your Financial Responsibilities
You are responsible for paying Non-Covered Charges and Excess Charges for services and supplies rendered by Non-Contracting and Non-Participating Providers. Your financial responsibilities include the Deductible amounts specified in the Schedule of Benefits. Copayments, Coinsurance and Non-PPO Network Coinsurance are also your responsibility. You are responsible for payment for services that are not Medically Necessary and for incidental charges.

For Covered Services rendered by Contracting Institutional Providers, Physicians, and Other Professional Providers, Medical Mutual will calculate your Deductible, Coinsurance, Non-PPO Network Coinsurance, and benefit maximum accumulations based on the Lesser Amount. Your financial responsibility to the Provider for Covered Services will also be based on the Lesser Amount. For Non-Participating Physicians and Other Professional Providers, you may be responsible for Excess Charges.

For Covered Services received from Contracting Institutional Providers, Participating Physicians, and Other Professional Providers, the Provider has agreed not to bill for any amount of Covered Charges above the Negotiated Amount, except for services and supplies for which the Plan has no financial responsibility due to a benefit maximum.

For Covered Services rendered by Non-Contracting Institutional Providers, Medical Mutual will calculate your Deductible, Coinsurance, and benefit maximum accumulations based on the Non-Contracting Amount as determined by Medical Mutual. You may be responsible for Excess Charges.

For Covered Services received from Non-PPO Network Providers, you may be responsible for the Non-PPO Network Coinsurance. The Non-PPO Network Coinsurance continues until your Non-PPO Network Coinsurance Limit is reached.

Deductibles, Copayments, Coinsurance, and amounts paid by other parties do not accumulate towards benefit maximums.

Provider Status and Direction of Payment
Medical Mutual has agreed to make payment directly to Contracting Institutional Providers, Participating Physicians, and Other Professional Providers for Covered Services.

Some of Medical Mutual's contracts with Providers, including Institutional Providers, allow discounts, allowances, incentives, adjustments, and settlements. These amounts are for the sole benefit of Medical Mutual and/or the Plan, and Medical Mutual and/or the Plan will retain any payments resulting therefrom; however, the Deductibles, Copayments, Coinsurance, Non-PPO Network Coinsurance, and benefit maximums, if applicable, will be calculated as described in this Plan.

The choice of a Provider is yours. After a Provider performs a Covered Service, Medical Mutual will not honor your request to withhold claim payment. Medical Mutual and the Plan do not furnish Covered Services but only pay for Covered Services you receive from Providers. Neither Medical Mutual nor the Plan is liable for any act or omission of any Provider. Neither Medical Mutual nor the Plan has any responsibility for a Provider's failure or refusal to give Covered Services to you.

Medical Mutual has and retains the sole right to choose which Providers it will contract with, and on what terms, and to amend and terminate those contracts. Medical Mutual has and retains the sole right to designate Providers as Contracting and/or PPO Network.

You authorize Medical Mutual to make payments directly to Providers who have performed Covered Services for you. Medical Mutual also reserves the right to make payment directly to you. When this occurs, you must pay the Provider; and neither Medical Mutual nor the Plan is legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you, including your Provider.

If Medical Mutual has incorrectly paid for services or it is later discovered that payment was made for services which are not considered Covered Services, then Medical Mutual has the right to recover payment on behalf of the Plan; and you must repay this amount when requested.

Any reference to Providers as PPO Network, Non-PPO Network, Contracting, Non-Contracting, Participating, or Non-Participating is not a statement about their abilities.

Selection of a Primary Care Provider

You have the right to designate any primary care provider who participates in Medical Mutual’s network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Medical Mutual at the phone number shown on your ID card or at MedMutual.com.

Direct Access to Obstetricians and Gynecologists
You do not need prior authorization to obtain access to obstetrical or gynecological care from a health care professional in Medical Mutual's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, or following a pre-approved treatment Plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Medical Mutual at the phone number shown on your ID card or at MedMutual.com.

Pre-Authorization of Non-PPO Network Benefits
In some cases, Medical Mutual may determine that certain Covered Services can only be provided by a Non-PPO Network Provider. If Covered Services provided by a Non-PPO Network Provider are pre-authorized by Medical Mutual, benefits will be provided as if the Covered Services were provided by a PPO Network Provider.

To pre-authorize treatment by a Non-PPO Network Provider, your Physician must provide Medical Mutual with:

- The proposed treatment plan for the Covered Services;
- The name and location of the proposed Non-PPO Network Provider;
- Copies of your medical records, including diagnostic reports; and
- An explanation of why the Covered Services cannot be provided by a PPO Network Provider.

Medical Mutual will determine whether the Covered Services can be provided by a PPO Network Provider, and that determination will be final and conclusive. Medical Mutual may elect to have you examined by a Physician of its choice and will pay for any required physical examinations. You and your Physician will be notified if Covered Services provided by a Non-PPO Network Provider will be covered as if they had been provided by a PPO Network Provider.

If you do not receive written pre-authorization for Covered Services, benefits will be provided as described in the Schedule of Benefits for Covered Services received from a Non-PPO Network Provider.

COMPREHENSIVE MEDICAL BENEFITS--COVERAGE

This section describes the services and supplies covered if provided and billed by Providers, subject to the Exclusions at page 67. All Covered Services must be Medically Necessary unless otherwise specified. Please refer to the Definitions section of this booklet for terms used in this section.

Please refer to the Pre-Authorization of Non-PPO Network Benefits section immediately above for information regarding services received from Non-PPO Network Providers.

Allergy Testing and Treatments
Allergy testing performed and related to a specific diagnosis is covered. Desensitization treatments are also covered.

Ambulance Services
Transportation services via ambulance must be certified by your Physician and are subject to medical review to determine Medical Necessity. Ambulance services include local ground transportation by a vehicle equipped and used only to transport the sick and injured:

- From your home, scene of an accident or Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and a Skilled Nursing Facility;
- From a Hospital or Skilled Nursing Facility to your home; or
- From a Physician's office to a Hospital.

Trips must be to the closest facility that is medically equipped to provide the Covered Services that are appropriate for your Condition.

Transportation will also be covered when provided by a professional ambulance service for other than local ground transportation only when special treatment is required and the transportation is to the nearest Hospital qualified to provide the special treatment.

Transportation services provided by an ambulette or a wheelchair van are not Covered Services.

Case Management
Case management is an economical, common-sense approach to managing health care benefits. Medical Mutual's case management staff evaluates opportunities to cover cost-effective alternatives for the patient's current health care needs. Case management has proven to be very effective with catastrophic cases, long-term care, and psychiatric and substance abuse treatment. In such instances, benefits not expressly covered in this Plan may be approved. All case management programs are voluntary for the patient.

Coverage for these services must be approved in advance and in writing by Medical Mutual. To learn more about these services, you may contact Medical Mutual's case management staff.

Clinical Trial Programs
Benefits are provided for routine patient care administered to an Eligible Person participating in any stage of an eligible cancer clinical trial, if that care would be covered under the Plan if the Eligible Person was not participating in a clinical trial.

"Eligible cancer clinical trial" means a cancer clinical trial that meets all of the following criteria:

- A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;
- The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes;
- The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and
- The trial does one of the following:
    - Tests how to administer a health care service, item, or drug for the treatment of cancer;
    - Tests responses to a health care service, item, or drug for the treatment of cancer;

- Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
- Studies new uses of a health care service, item, or drug for the treatment of cancer;
- The trial is approved by one of the following entities:
  - The national institutes of health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
  - The United States Food and Drug Administration;
  - The United States Department of Defense; or
  - The United States Department of Veterans' Affairs.

"Routine patient care" means all health care services consistent with the coverage provided under the Plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

"Subject of a cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not routine patient care.

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; and
- A service, item, or drug that is eligible for reimbursement by an entity other than Medical Mutual, including the sponsor of the cancer clinical trial.

Dental Services for an Accidental Injury
Dental services will only be covered for initial injuries sustained in an accident. The Accidental Injury must have caused damage to the jaws, sound natural teeth, mouth, or face. Injury as a result of chewing or biting shall not be considered an Accidental Injury.

Diagnostic Services
A diagnostic service is a test or procedure performed when you have specific symptoms, to detect or monitor your Condition. It must be ordered by a Physician or Other Professional Provider. Covered diagnostic 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.

Drug Abuse and Alcoholism Services
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: counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Eligible Persons under this Plan. Charges will be applied to the Eligible Person who is receiving family counseling services, not necessarily the patient receiving treatment for Drug Abuse or Alcoholism.

Inpatient care must be approved by Medical Mutual prior to admission.

Residential care rendered by a Residential Treatment Facility is not covered.

Drugs and Biologicals
You are covered for Prescription Drugs and biologicals that cannot be self-administered and are furnished as part of a Physician's professional service, such as antibiotics, joint injections, and chemotherapy, in the course of the diagnosis or treatment of a Condition. Other drugs that can be self-administered or that may be obtained under Prescription Drug Coverage, if applicable, are not covered but the administration of the drug may be covered.

Drugs that can be covered under your supplemental prescription drug plan need to be obtained under your Prescription Drug Card.

Durable Medical Equipment
See Medical Supplies and Durable Medical Equipment.

Emergency Care Services
You are covered for Medically Necessary Emergency Care in a Hospital emergency department. Conditions are not considered to be Emergencies unless an acute, life-threatening attack occurs. Emergency Care is available 24 hours a day, 7 days a week. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital to obtain Emergency Services. Care and treatment once you are Stabilized is not Emergency Care. Continuation of care beyond that needed to evaluate or Stabilize your Condition in an Emergency will be covered according to your Schedule of Benefits.

Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from a Non-PPO provider. However, a Non-PPO Provider of Emergency Services that does not have a contract with Medical Mutual may send you a bill for any Excess Charges remaining after your Plan has paid (this is called “balance billing”).

Your Plan will apply the same Copayments and Coinsurance for Non-PPO Emergency Services as it generally requires for PPO Emergency Services. A Deductible may be imposed for Non-PPO Emergency Services, only as part of the Deductible that generally applies to Non-

PPO benefits. Similarly, any out-of-pocket maximum that generally applies to Non-PPO benefits will apply to Non-PPO Emergency Services.

Your Plan will calculate the amount to be paid for Non-PPO Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to PPO Providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with PPO Providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for Non-PPO services (the Non-Contracting Amount) but substituting PPO copayments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any network Copayments or Coinsurance.

Health Education Services
Benefits are provided for educational, vocational and training services while an Inpatient of a Hospital or Other Facility Provider.

Hearing Benefits
This section describes the services and supplies covered if provided and billed by Participating Hearing Coverage Providers acting within the scope of their licenses.

To be eligible for benefits, you must obtain a medical exam of the ear by a Physician-Specialist. This exam must result in a determination that a hearing aid would compensate for the loss of hearing acuity.

The Plan will cover:

Audiometric Examination--This examination must be performed by:

- A Physician-Specialist; or
- An Audiologist; and
- Be performed after or in conjunction with the most recent medical examination of the ear by a Physician-Specialist.

The Plan will provide coverage for audiometric examination limited to one every four years for each ear. After a Copayment, you will be responsible for 0% of the Lesser Amount.

Hearing Aid Evaluation Tests---These tests must be performed by:

- A Physician-Specialist; or
- An Audiologist; and
- May include the trial and testing of various makes and models of hearing aids to determine which will best compensate for the loss of hearing. This evaluation testing must be indicated by the most recent Audiometric Examination.

The Plan will provide coverage for hearing aid evaluation tests limited to one every four years for each ear. You will be responsible for 0% of the Lesser Amount.

Hearing Aids---One of the following hearing aids will be covered:

- In-the-ear;
- Behind-the-ear (including air conduction and bone conduction types); or
- On-the-body.

The Plan will provide coverage for hearing aids limited to one every four years for each ear at 100% of the Lesser Amount to a combined maximum for both ears. You will be responsible for 0% of the Lesser Amount.

This coverage provides a maximum hearing aid benefit toward the purchase of a hearing aid.

Conformity Evaluation

This follow-up visit must be to the:

- Prescribing Physician-Specialist; or
- Audiologist; and
- Is an evaluation of the performance of the prescribed hearing aid to determine the conformance of the hearing aid to the prescription.

The Plan will provide coverage for conformity evaluations limited to one every four years for each ear. You will be responsible for 0% of the Lesser Amount.

If you request unusual services from a Hearing Coverage Provider, you must pay the full additional charge whether or not such services are expressly excluded from coverage.

Exclusions

In addition to the General Exclusions, coverage is not provided for the following services and supplies:

1. For medical examination of the ear by a Physician-Specialist to determine possible loss of hearing acuity.
2. For a hearing examination or materials ordered as a result of a hearing examination prior to your Effective Date.
3. For hearing aids ordered while the person is an Eligible Person but delivered more than 60 days after your coverage ends.
4. For eyeglass-type hearing aids, to the extent the charge for such hearing aid exceeds the covered hearing aid expense for one hearing aid.
5. For replacement of hearing aids that are lost or broken, unless at the time of such replacement, 48 months have elapsed since you last received a hearing aid for which coverage was provided.
6. For replacement parts for and repairs of hearing aids.
7. For medical or surgical treatment.
8. For services not prescribed by or performed by, or upon the direction of, a Hearing Coverage Provider.
9. For non-covered services or services specifically excluded in the text above.

Home Health Care Services

The following are Covered Services when you receive them in your home, from a Hospital or a Home Health Care Agency:

- Professional services of a registered or licensed practical nurse;
- Treatment by physical means, occupational therapy, and speech therapy;
- Medical and surgical supplies;
- Prescription Drugs;

- Oxygen and its administration;
- Medical social services, such as the counseling of patients; and
- Home health aide visits when you are also receiving covered nursing or therapy services.

The Plan will not cover any home health care services or supplies which are not specifically listed in this Home Health Care Services section. Examples include but are not limited to:

- Homemaker services;
- Food or home delivered meals; and
- Custodial Care, rest care, or care which is only for someone's convenience.

All Home Health Care services must be certified initially by your Physician and your Physician must continue to certify that you are receiving Skilled Care and not Custodial Care as requested by the Plan. All services will be provided according to your Physician's treatment plan and as authorized as Medically Necessary by Medical Mutual.

Hospice Services
Hospice services consist of health care services provided to a terminally ill Eligible Person. Hospice services must be provided through a freestanding Hospice Facility or a hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Eligible Person in a private residence.

Benefits for hospice services are available when the prognosis of life expectancy is six months or less.

The following Covered Services are considered hospice services:

- Professional services of a registered or licensed practical nurse;
- Treatment by physical means, occupational therapy, and speech therapy;
- Medical and surgical supplies;
- Prescription Drugs, limited to a two-week supply per Prescription Order or refill. (These Prescription Drugs must be required in order to relieve the symptoms of a Condition, or to provide supportive care);
- Oxygen and its administration;
- Medical social services, such as the counseling of patients;
- Home health aide visits when you are also receiving covered nursing or therapy services;
- Acute Inpatient hospice services;
- Respite care;
- Dietary guidance, including counseling and training needed for a proper dietary program;
- Durable medical equipment; and
- Bereavement counseling for family members.

Non-covered hospice services include but are not limited to:

- Volunteer services;

- Spiritual counseling;
- Homemaker services;
- Food or home delivered meals;
- Chemotherapy or radiation therapy if other than to relieve the symptoms of a Condition; and
- Custodial Care, rest care, or care which is only for someone's convenience.

Inpatient Hospital Services
The Covered Services listed below are benefits when services are performed in an Inpatient setting, except as specified. The following bed, board, and general nursing services are covered:

- A semiprivate room or ward;
- A private room, when Medically Necessary; if you request a private room, the Plan will provide benefits only for the Hospital's average semiprivate room rate;
- Newborn nursery care; and
- A bed in a special care unit approved by Medical Mutual. The unit must have facilities, equipment, and supportive services for the intensive care of critically ill patients.

Covered ancillary Hospital services include but are not limited to:

- Operating, delivery, and treatment rooms and equipment;
- Prescription Drugs;
- Whole blood, blood derivatives, blood plasma, and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation, and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded. Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;
- Anesthesia, anesthesia supplies, and services;
- Oxygen and other gases;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic services;
- Therapy services; and
- Surgically inserted prosthetics, such as pacemakers and artificial joints.

Non-covered Hospital services include but are not limited to:

- Gowns and slippers;
- Shampoo, toothpaste, body lotions, and hygiene packets;
- Take-home drugs;
- Telephone and television; and
- Guest meals or gourmet menus.

Coverage is not provided for an Inpatient admission, the primary purpose of which is:

- Diagnostic services;
- Custodial Care;

- Rest care;
- Environmental change;
- Physical therapy; or
- Residential treatment for psychiatric care, substance abuse, or eating disorders.

Coverage for Inpatient care is not provided when the services could have been performed on an Outpatient basis, and it was not Medically Necessary, as determined by Medical Mutual, for you to be an Inpatient to receive them.

Inpatient admissions to a Hospital must be precertified. The telephone number for precertification is listed on the back of your identification card. Contracting Hospitals in Ohio will assure this precertification is done; and since the Hospital is responsible for obtaining the precertification, there is no penalty to you if this is not done. For Non-Contracting or Out-of-State Hospitals, you are responsible for obtaining precertification. If you do not precertify a Hospital admission and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges. However, if your Inpatient stay is for an organ transplant, please review the requirements under the Organ and Tissue Transplant Services section.

Maternity Services
Hospital, medical, and surgical services for an eligible Employee or eligible Spouse for a normal pregnancy, complications of pregnancy, miscarriage, and routine nursery care for a well newborn are covered.

Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a caesarean section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care.

If requested by the mother, coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the attending Physician, or the nurse midwife in applicable cases, determines further Inpatient postpartum care is not necessary for the mother or newborn child, provided the following are met:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
  - The antepartum, intrapartum, and postpartum course of the mother and infant;
  - The gestational stage, birth weight, and clinical condition of the infant; and
  - The availability of post discharge follow up to verify the condition of the infant after discharge.

When a decision is made to discharge a mother or newborn before the expiration of the applicable number of hours of Inpatient care required to be covered, at home post delivery follow up care visits are covered for you at your residence by a Physician or nurse when performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

- Parent education;
- Physical assessments;

- Assessment of the home support system;
- Assistance and training in breast or bottle feeding; and
- Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

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

Maternity Services are not available for Dependent Children.

Medical Care

Concurrent Care--You are covered for care by two or more Physicians during one Hospital stay when you have two or more unrelated Conditions. You are also covered for care for a medical Condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.

Inpatient Medical Care Visits--The examinations given to you by your Physician or Other Professional Provider while you are in the Hospital are Covered Services. Benefits are provided for one visit each day you are an Inpatient.

Inpatient Consultation--A bedside examination by another Physician or Other Professional Provider is covered when requested by your attending Physician.

If the consulting Physician takes charge of your care, consultation services are not covered. When this occurs, the consulting Physician is considered to be the new attending Physician.

Coverage is not provided for both the new attending Physician and the Physician who was initially treating you for services rendered at the same time.

Staff consultations required by Hospital rules are not covered.

Intensive Medical Care--Constant medical attendance and treatment is covered when your Condition requires it.

Newborn Exam--Your coverage includes the Inpatient Medical Care Visits to examine a newborn Dependent. Refer to the Eligibility section for information about enrolling for family coverage.

Office Visits--Office visits to examine, diagnose and treat a Condition are Covered Services.

Medical Supplies and Durable Medical Equipment

This section describes supplies and equipment that are covered when prescribed by your Physician. These supplies and equipment must serve a specific therapeutic purpose in the treatment of a Condition.

Disposable supplies which serve a specific therapeutic purpose are covered. These include:

- Needles;
- Oxygen;
- Surgical dressings and other similar items; and

- Syringes.

Items usually stocked in the home for general use are not covered, including but not limited to:

- Corn and bunion pads;
- Elastic bandages;
- Jobst stockings and support/compression stockings; and
- Thermometers.

Durable Medical Equipment (DME)
Equipment which serves only a medical purpose and must be able to withstand repeated use is covered. Upon request, your Physician must provide a written treatment plan that shows how the prescribed equipment is Medically Necessary for the diagnosis or treatment of a Condition or how it will improve the function of a malfunctioning body part. If you need to use this equipment for more than six months, your Physician may be required to recertify that continued use is Medically Necessary.

You may rent or purchase DME; however, for each Condition, the Plan will not cover more in total rental costs than the customary purchase price as determined by Medical Mutual. For example, if you submit claims for the monthly rental fee and by the third month the total in rental dollars meets or exceeds the customary purchase price, you will have exhausted your benefit for that piece of durable medical equipment.

When it has been determined that you require DME, before you decide whether to rent or purchase, estimate what the rental cost will be for the time period during which you will use the DME. If the estimated rental cost exceeds the purchase price, then you should consider purchasing the DME.

Covered DME includes:

- Blood glucose monitors;
- Crutches;
- Home dialysis equipment;
- Hospital beds;
- Mastectomy bra;
- Respirators; and
- Wheelchairs.

Non-Covered equipment includes but is not limited to:

- Rental costs if you are in a facility which provides such equipment;
- Repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;
- Physician's equipment, such as a blood pressure cuff or stethoscope;
- Deluxe equipment such as specially designed wheelchairs for use in sporting events;

- Items not primarily medical in nature such as:
  - An exercycle, treadmill, bidet toilet seat, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters;
  - Items for comfort and convenience;
  - Disposable supplies and hygienic equipment;
  - Self-help devices such as: bed boards, bathtubs, sauna baths, overbed tables, adjustable beds, special mattresses, telephone arms, air conditioners, and electric cooling units;
  - Jobst stockings and other compression devices.

Orthotic Devices
Rigid or semirigid supportive devices which limit or stop the motion of a weak or diseased body part are covered. These devices include:

- Braces for the leg, arm, neck, or back;
- Trusses;
- Back and special surgical corsets.

Non-covered devices include but are not limited to:

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

Prosthetic Appliances
Your coverage includes the purchase, fitting, adjustments, repairs and replacements of prosthetic devices which are artificial substitutes and necessary supplies that:

- Replace all or part of a missing body organ or limb and its adjoining tissues; or
- Replace all or part of the function of a permanently useless or malfunctioning body organ or limb.

Covered prosthetic appliances include:

- Artificial hands, arms, feet, legs, and eyes, including permanent lenses;
- Appliances needed to effectively use artificial limbs or corrective braces.

Non-covered appliances include but are not limited to:

- Dentures, unless as a necessary part of a covered prosthesis;
- Dental appliances;
- Eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;
- Replacement of cataract lenses unless needed because of a lens prescription change;
- Taxes included in the purchase of a covered prosthetic appliance;

- Deluxe prosthetics that are specially designed for uses such as sporting events;
- Wigs and hair pieces.

Mental Health Care Services
The following are Covered Services for the treatment of Mental Illness:

- Individual and group psychotherapy;
- Electroshock therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;
- Psychological testing;
- Family counseling: counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Eligible Persons under this Plan. Charges will be applied to the Eligible Person who is receiving family counseling services, not necessarily the patient.

In addition, as provided in Medical Mutual's medical policy guidelines, certain behavioral assessment and intervention services for individual, family, and group psychotherapy will also be covered for a medical Condition.

Services for Mental Illness which cannot be treated are not covered. However, services to determine if the Mental Illness can be treated are covered. Services for mental deficiency or retardation, other than those necessary to evaluate or diagnose mental deficiency or retardation, are not covered. Services for the treatment of attention deficit disorder are covered. Residential care rendered by a Residential Treatment Facility is not covered.

Your Physician or Other Professional Provider must certify that there is a reasonable likelihood that your treatment will be of substantial benefit and improvement is likely. The course of treatment which your Physician or Other Professional Provider recommends must be acceptable to Medical Mutual. Inpatient care must be approved by Medical Mutual prior to admission.

Organ and Tissue Transplant Services
Your coverage includes benefits for the following Medically Necessary human organ/tissue transplants in an approved Transplant Center:

- Bone marrow;
- Cornea;
- Heart;
- Heart and lung;
- Kidney;
- Liver;
- Lung;
- Pancreas; and
- Pancreas/kidney

Coverage is only available if such services take place during a 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 if the next covered transplant occurs more than 12 months after the last covered

transplant was performed. No transplant waiting periods and/or organ transplant maximums will apply to kidney, pancreas/kidney, bone marrow, tissue, or cornea transplants.

Additional organ/tissue transplants will be considered for coverage provided that the transplant is Medically Necessary, not Experimental, and is considered accepted medical practice for your Condition.

Organ/Tissue Transplant Pre-Certification
In order to receive full benefits for an organ/tissue transplant, the proposed course of treatment must be pre-certified and approved by Medical Mutual. If you do not obtain precertification, and your organ transplant is determined to not be Medically Necessary or is determined to be Experimental/Investigational, you may be responsible for all Billed Charges for that organ transplant.

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

- The proposed course of treatment for the transplant;
- The name and location of the proposed Transplant Center; and
- Copies of your medical records, including diagnostic reports for Medical Mutual to determine the suitability and Medical Necessity of the transplant services. This determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ/tissue.

You may also be required to undergo an examination by a Physician chosen by Medical Mutual. You and your Physician will then be notified of Medical Mutual's decision.

Obtaining Donor Organs or Donor Tissue
The following services will be Covered Services when they are necessary in order to acquire a legally obtained human organ/tissue:

- Evaluation of the organ/tissue;
- Removal of the organ/tissue from the donor; and
- Transportation of the organ/tissue to the Transplant Center.

Donor Benefits
Benefits necessary for obtaining an organ/tissue from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions. Donor benefits include treatment of immediate post-operative complications if Medically Necessary as determined by Medical Mutual. Such coverage is available only so long as the recipient's coverage is in effect.

The Plan does not provide organ/tissue transplant benefits for services, supplies or Charges:

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

Outpatient Institutional Services
The Covered Services listed below are covered when services are performed in an Outpatient setting, except as specified.

Covered Institutional Services Include But Are Not Limited To:

- Operating, delivery, and treatment rooms and equipment;
- Whole blood, blood derivatives, blood plasma, and blood components, including administration and blood processing. The Plan will cover the cost of administration, donation, and blood processing of your own blood in anticipation of Surgery, but charges for the blood are excluded. Autotransfusions or cell saver transfusions occurring during or after Surgery are not covered;
- Anesthesia, anesthesia supplies and services, and surgically inserted prosthetics such as pacemakers and artificial joints.

Pre-Admission Testing
Outpatient tests and studies required before a scheduled Inpatient Hospital admission or Outpatient surgical service are covered.

Post-Discharge Testing
Outpatient tests and studies required as a follow-up to an Inpatient Hospital stay or an Outpatient surgical service are covered.

Outpatient Therapy Services
Therapy services are services and supplies used to promote recovery from a Condition. Therapy services must be ordered by a Physician or Other Professional Provider to be covered. Covered Services are limited to the therapy services listed below:

Chemotherapy
The treatment of malignant disease by chemical or biological antineoplastic agents.

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

Dialysis Treatments
The treatment of an acute or chronic kidney ailment by dialysis methods, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine.

Hyperbaric Therapy
The provision of pressurized oxygen for treatment purposes. These services must be provided by a Hospital.

Physical Therapy
The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury, or loss of a body part. These Covered Services include physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles, and may include devices. Braces and molds are not covered under this benefit.

All physical therapy services must be performed by a certified, licensed physical therapist.

No benefits are provided once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by Medical Mutual.

Radiation Therapy
The treatment of disease by X-ray, radium, or radioactive isotopes.

Respiratory/Pulmonary Therapy
Treatment by the introduction of dry or moist gases into the lungs.

Speech Therapy
In order to be considered a Covered Service, this therapy must be performed by a certified, licensed therapist and be Medically Necessary due to a medical Condition such as:

- A stroke;
- Aphasia;
- Dysphasia; or
- Post-laryngectomy.

Physical Medicine and Rehabilitation Services
Coverage is provided for acute Inpatient care from a Provider for physical rehabilitation services received in a rehabilitation facility.

Preventive Services

Child Health Supervision Services and Well Child Care
Regardless of Medical Necessity, coverage for child health supervision services will be provided for Eligible Dependent children.

Child health supervision services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination (examinations covered to age 21) and developmental assessment. Vision tests and the developmental assessment must be included as part of the physical examination in order to be provided as part of this benefit. This review also includes anticipatory guidance, laboratory tests (covered for Eligible Dependent children to age 21), and appropriate immunizations (covered for Eligible Dependent children to age 21). Routine hearing examinations are also covered for Eligible Dependent children to age 21.

Immunizations
The following immunizations are covered:

- Hemophilis influenza B (HEPB-HIB);
- Hepatitis A, B, A & B and hepatitis b;
- Human papillomavirus vaccine (HPV);
- Influenza;
- Measles;
- Measles and rubella;
- Mumps;
- MMR (measles, mumps and rubella);
- Meningococcal vaccine;
- Pneumonia;
- Pneumococcal conjugate vaccine;
- Polio;
- Rabies;
- Rotavirus (Rota) (under age 21);
- Rubella;
- Tetanus toxoid;
- Varicella (VSV);
- Zoster (age 19 and older).

Routine Gynecological Services

- PAP tests; and
- Examinations in conjunction with PAP tests.

Obesity Services

- Office visits;
- Diabetic management programs, including dietician visits;
- Nutritional guidance;
- Nutritional counseling;
- Medical nutrition therapy;
- Weight management classes; and
- Nutrition classes.

Routine Physical Examinations Received from a PPO Network Provider
Routine physical examinations are covered for Eligible Persons 21 years of age and older.

Routine Physical Examinations Received from a Non-PPO Network Provider
Routine physical examinations are covered for Eligible Persons 40 years of age and older.

Routine Testing
The following services are covered:

- Blood glucose tests;
- Cholesterol tests;
- Complete Blood Count (CBC) (covered for ages 21 and older);
- Comprehensive Metabolic Panel (covered for ages 21 and older);
- Endoscopic services, meaning: anoscopy, colonoscopy, proctosigmoidoscopy and sigmoidoscopy;
- Fecal occult blood tests;
- Hematocrit tests;
- Hemoglobin tests;
- Human Papilloma Virus (HPV) tests;
- Mammogram services for both men and women;
- Prostate Specific Antigen (PSA) tests;
- Routine x-ray, laboratory and medical testing services;
- Urinalysis (UA) (covered for ages 21 and older); and
- Venipuncture

Additional Preventive Services
If not shown elsewhere in the Plan, the following services will also be covered without regard to any Deductible, Copayment, or Coinsurance requirements that would otherwise apply:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Tax Force.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Eligible Person involved.
- With respect to Eligible Dependents who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration;
- With respect to Eligible Persons who are women, such additional preventive care and screenings not described in the first bullet point above in this section, but as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Services may be modified annually.

Private Duty Nursing Services
The services of a registered nurse, licensed vocational nurse, or licensed practical nurse are covered when ordered by a Physician. These services include skilled nursing services received in a patient's home or as an Inpatient. Your Physician must certify all services initially and continue to certify that you are receiving skilled care and not Custodial Care as requested by Medical Mutual. All Covered Services will be provided according to your Physician's treatment plan and as authorized by Medical Mutual.

Inpatient private duty nursing services include services that Medical Mutual decides are of such a degree of complexity that the Provider's regular nursing staff cannot perform them. When private duty nursing services must be received in your home, nurse's notes must be sent in with your claim.

Private duty nursing services do not include care that is primarily nonmedical or custodial in nature, such as bathing, exercising, or feeding. Also, the Plan does not cover services provided by a nurse who usually lives in your home or is a member of your Immediate Family.

All private duty nursing services must be certified by your Physician initially and every two weeks thereafter, or more frequently if required by Medical Mutual, for Medical Necessity.

Skilled Nursing Facility Services
The benefits available to an Inpatient of a Hospital listed under the Inpatient Hospital Services section are also available to an Inpatient of a Skilled Nursing Facility. These services must be Skilled Care, and your Physician must certify all services initially and continue to certify that you are receiving Skilled Care and not Custodial Care as requested by Medical Mutual. All Covered Services will be provided according to your Physician's treatment plan and as authorized by Medical Mutual.

No benefits are provided:

- Once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by Medical Mutual;
- 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.

Surgical Services

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

- Sterilization, regardless of Medical Necessity;
- Therapeutic and elective abortions;
- Removal of bony impacted teeth;
- Maxillary or mandibular frenectomy;
- Reconstructive Surgery following a mastectomy, including coverage for reconstructive Surgery performed on a non-diseased breast to establish symmetry as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas;
- Surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects, or prior therapeutic processes as determined by Medical Mutual, subject to any appeal process. Surgery to correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is not covered.

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

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

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

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

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

Anesthesia
Your coverage includes the administration of anesthesia, performed in connection with a Covered Service, by a Physician, Other Professional Provider, or certified registered nurse anesthetist who is not the surgeon or the assistant at Surgery or by the surgeon in connection with covered oral surgical procedures. This benefit includes care before and after the administration. The services of a stand-by anesthesiologist are only covered during coronary angioplasty Surgery.

Second Surgical Opinion
A second surgeon's opinion and related diagnostic services to help determine the need for elective covered Surgery recommended by a surgeon are covered but are not required. The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the Surgery. This benefit is not covered while you are an Inpatient of a Hospital.

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

WEEKLY DISABILITY BENEFITS
(Active Employees Only)

Weekly Disability Benefits are weekly payments which you will receive from the Fund if you are unable to work because you are Disabled due to a Non-Occupational Accidental Injury or an Illness. The amount of payment and the maximum number of weeks the benefit is payable are listed in the Schedule of Benefits. To be eligible for these benefits, you must be under the continuous care of a Physician.

Weekly Disability Benefits will be payable to you as of the first day of a Disability that is due to an Accident or Injury, or the eighth day of a Disability which is due to sickness. To receive these benefits, a certification from your Physician is required. No Disabilities, including those resulting from accidents, will be considered as beginning more than two days before you first receive treatment by a Physician.

Benefits will continue to be paid during the time you are Disabled, up to the maximum number of weeks allowed for any one continuous period of disability. Unless successive periods of disability are separated by at least 14 days (80 hours) of continuous eligible employment, they will be considered one continuous period for purposes of determining the maximum of weeks during which the benefit is payable. However, if you have a second period of Disability which is less than 14 days after a prior period of Disability, but the Disability **is not related to the prior** accident or sickness, and if you have completed at least seven (7) days (40 hours) of active work between the two periods, then the second period will be a new period for purposes of determining the maximum number of weeks during which the benefit is payable.

Benefit Payments

You do not have to wait until you return to work to file for your Weekly Disability Benefits. You need only complete a claim form and have your Physician indicate the diagnosis, dates of Disability, and the date the Physician was first consulted for the Disability. Employment status must be confirmed. Once all of this information has been received by the Benefit Office, you will receive a check for a period of time to be determined by the Benefit Office according to your Disability and the information on the claim form.

The Plan will also send you a Supplementary Report of Attending Physician form. If you are still Disabled, you should submit this form, completed by you, by your Employer confirming that you have not returned to work, and by your Physician confirming that you are still Disabled. Additional benefits will then be determined, and you will receive another check and another Supplementary Report of Attending Physician form to file if you are still Disabled. This process is repeated until you are able to return to work or have received the maximum benefits payable for that period of disability.

Benefit Exclusions and Limitations

Weekly Disability benefits are not payable for any disabilities due to exclusions listed in the "General Exclusions and Limitations" section of this booklet (see pages 67 - 69), nor for:

- Any period of Disability during which you are not under the regular care of a Physician; or
- Any Disability due to sickness which is covered by a Workers' Compensation Act or similar legislation, or due to injury arising out of or in the course of any employment for wage or profit; or

- Any period during which you are making full self-payments to continue eligibility (unless you are available for work and otherwise eligible); or
- Any day for which you work for compensation or profit or for which you continue to receive compensation through an Employer, including unemployment benefits; or
- Claims for persons who have retired, including those persons who return to employment; or
- Any intentionally self-inflicted injury of any kind, while sane or insane; or
- Claims submitted more than ninety (90) days after the onset of the disability.

PRESCRIPTION DRUG BENEFITS

(Active Employees and Early Retirees and their Dependents)

Covered Benefits

The Plan will generally cover up to a consecutive 30-day supply (90 days for mail order) prescribed by your Physician or Dentist of:

- Legend drugs--A drug approved by the Food and Drug Administration (FDA) and which is required to be labeled: "Caution: Federal Law prohibits dispensing without prescription"; and
- Compound prescriptions of which at least one ingredient is a legend drug; and
- Injectable insulin and insulin syringes: and
- Diabetic supplies and test strips; and
- Generic contraceptives; and
- Prenatal vitamins; and
- Multiple and Pediatric Vitamins; and
- Accutane through age 24.

NOTE:
SPECIALITY MEDICATIONS
MUST BE AUTHORIZED BY
EXPRESS SCRIPTS.

Formulary Information to Share with Your Physician

When you go to your Physician or dentist, you should take the drug formulary pamphlet that was furnished to you and your drug identification card. The formulary is a list of preferred drugs selected by a panel of physicians and pharmacists. Your Physician may wish to keep a copy of these items in your file. For updated Preferred Prescriptions, you can visit www.express.scripts.com, or you may call Customer Service.

Co-Payments

A co-payment must be made by you for each prescription or refill. This co-payment is:

- **Lowest** for generic drugs (Tier One);
- **Higher** for preferred/formulary brand-name drugs (Tier Two);
- **Highest** for non-preferred, non-formulary brand-name drugs (Tier Three) and Specialty Drugs(Tier Four).

If you don't have your prescription filled at a participating Express Script Retail Pharmacy, your costs will not be limited to the Co-payments.

Co-payments and other costs are shown in the Schedule of Benefits.

Using Participating Pharmacies

You will receive a list of Participating Pharmacies which are Express Scripts Retail Pharmacies. These are local and national pharmacies which "participate" in the drug card program selected by the Plan. You may also check with the Benefit Office, call Customer Service, or visit www.express.scripts.com to determine which pharmacies are "participating."

To have your prescription filled, simply present your drug identification card and make your Co-payment.

Using Non-Participating Pharmacies

To have your prescription filled at a non-participating pharmacy, you must pay for the entire cost at the time of your purchase. Then you may seek partial reimbursement by submitting your itemized prescription drug receipt to the Benefit Office, together with your social security number. You must include your original receipts with the form.

In addition to the Co-payment, you will be responsible for any Excess Charges.

Mail Order Program

To take advantage of the Mail Order Program, obtain a copy of the "Participant Pharmacy Profile" card from the Express Scripts and complete the form.

Ask your Physician for a prescription for a 90-day supply with refills on your medication, and mail the prescription with the profile card to the applicable address shown on page xii. The profile information is only required with your first order. After your first order with Express Scripts, you may call in your refills by phoning the number shown on your prescription drug card, or you may visit www.express.scripts.com. You can charge your co-pays to a VISA, Mastercard, or Discover. See page xi.

MANDATORY MAIL ORDER

You may pay more for your long-term drugs (such as those used to treat high cholesterol, high blood pressure, depression, or diabetes) unless you order your prescriptions by mail from the *Medco Pharmacy* (now a part of the Express Scripts family of pharmacies). Here is some key information about your plan:

- **AFTER YOUR THIRD PURCHASE OF A PRESCRIPTION DRUG AT RETAIL, YOU MAY PAY MORE**. THE FIRST THREE TIMES THAT YOU PURCHASE A LONG-TERM DRUG AT A PARTICIPATING RETAIL PHARMACY, YOU WILL PAY YOUR RETAIL CO-PAYMENT. **AFTER THE THIRD PURCHASE, YOU WILL PAY THE ENTIRE COST** IF YOU CONTINUE TO PURCHASE IT AT RETAIL.*

- **TO AVOID PAYING MORE, USE THE MEDCO PHARMACY AND PAY YOUR MAIL-ORDER CO-PAYMENT FOR UP TO A 90-DAY SUPPLY**. THAT MEANS YOU'LL PAY LESS OVER TIME. YOUR MEDICATIONS WILL BE DELIVERED RIGHT TO YOU, AND STANDARD SHIPPING IS FREE. ONCE YOU GET STARTED, YOU CAN REQUEST REFILLS EASILY BY MAIL, ONLINE, OR OVER THE PHONE.

TWO EASY WAYS TO START SAVING WITH THE MEDCO PHARMACY:

1. **BY MAIL:**
   - ASK YOUR DOCTOR FOR A NEW PRESCRIPTION FOR UP TO A 90-DAY SUPPLY, PLUS REFILLS FOR UP TO 1 YEAR (IF APPROPRIATE).
   - MAIL THE NEW PRESCRIPTION TO MEDCO.

2. **BY DOCTOR FAX:**
   - ASK YOUR DOCTOR FOR A NEW PRESCRIPTION FOR UP TO A 90-DAY SUPPLY, PLUS REFILLS FOR UP TO 1 YEAR (IF APPROPRIATE).
   - PROVIDE YOUR DOCTOR WITH YOUR MEMBER ID NUMBER (SHOWN ON YOUR ID CARD) AND ASK HIM OR HER TO CALL 1 888 327-9791 FOR INSTRUCTIONS ON HOW TO USE THE FAX SERVICE. YOU'LL BE BILLED LATER.

YOUR MEDICATION WILL USUALLY ARRIVE WITHIN 8 DAYS AFTER EXPRESS SCRIPTS RECEIVES YOUR ORDER.

For Short-Term Medication
You should continue to get all your *short-term* drugs, such as antibiotics, at a participating retail pharmacy. You'll pay your retail pharmacy co-payment for these medications.

Before you send your first mail-order prescription, please make sure you have a 2-week supply of medication on hand while waiting for your new medication to arrive. If necessary, ask your doctor for a prescription that you can fill at a participating retail pharmacy.

To find out whether other medications are affected by these plan limits, visit Express-Scripts.com and select "Price a medication" from the left-hand menu after you log in. If you are a first-time visitor to the Medico website, please take a moment to register and have your member ID number and a recent prescription number handy. You can also have Medco transfer your long-term retail prescriptions to mail by going to Express-Scripts.com. Upon log-in, scroll down the Order Page to the "Transfer your retail prescriptions to the **Medco Pharmacy**" section to select the medications you'd like to transfer to the **Medco Pharmacy**."

You can also call Member Services at 1 (800) 716-2932.

Participants eligible for **Medicare Part D** should contact the Benefit Office to learn of options available to you and for additional information about Medicare Part D prescription drug coverage.

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

- Appetite suppressants or weight loss drugs unless Medically Necessary for attention deficit disorders or narcolepsy; or
- Compounded prescription medications with ingredients not requiring a Physician's authorization by state or federal law; or
- Allergens; or
- Growth hormones; or
- Investigational or Experimental medications; or
- Fertility medications; or
- Medications for cosmetic purposes only (for example, Retin-A for aging or Rogaine for hair loss; however, Retin-A is available for acne up to age 24); or
- Medications for smoking cessation; or
- Medications used for Experimental indications and/or dosage regimens determined to be Experimental (e.g. Progesterone suppositories or suspension, or Nystatin oral powder); or
- Medications with no approved FDA indications (e.g. yohimbine); or
- Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law, and any prescription medication that is available as an OTC medication; or
- Contraceptives for Dependents other than a Spouse, unless your Physician prescribes as Medically Necessary; or
- Prescription refills dispensed after one year from original date of dispensing; or
- Replacement prescriptions resulting from loss, theft, or breakage; or
- Devices or equipment of any type; or

- Oral medications for treatment of sexual dysfunction; or
- Fluoride preparations; or
- Miscellaneous medical supplies; or
- Injectable drugs (other than insulin); or
- For any drugs provided while you or a dependent are an Inpatient or Outpatient at a Hospital or other Facility if benefits are payable for such drugs under any other part of this Plan; or
- For any drug refill if it is more than the number of refills specified. (The Plan or its designee, before recognizing charges for claim payment, may require a new prescription or evidence as to need, if the number of refills has not been specified or if the frequency or number of prescriptions or refills appears excessive under accepted medical practice standards).

See also General Exclusions and Limitations at pages 67-69.

Your Drug Identification Card and Card Replacement
When you become eligible for prescription drug benefits, you should receive two drug identification cards.

You may request new cards at no charge to you through your Benefit Office for any of the following reasons:

- There is a change in personal information, such as a name change due to marriage; or
- Some of the information is wrong, such as a misspelled name or an incorrect identification number.

The Benefit Office may charge you for replacement of lost or stolen cards.

Medicare Eligible Retirees
Prescription Drug Plan
Participants retiring under the former Ohio Carpenters Welfare Fund (Niles) before January 1, 2013 and continuously participating in that Plan as Medicare Eligible Retirees may be eligible for an insured Prescription Drug Plan ("PDP"). Please contact the Benefit Office for details.

Employer Group Waiver Plan
An Employer Group Waiver Plan ("EGWP") may be available to participants retiring under the Cleveland Hospitalization Fund or Southwest Ohio Carpenters Health Plan, and continuously participating in the Plan as Medicare Eligible Retirees. The EGWP is available to all persons retiring after January 1, 2013 who are Medicare eligible.

DENTAL BENEFITS

(Active Employees, Non-Medicare Retirees, and Dependents)

Deductible

A Deductible will be applied, as shown in the Schedule of Benefits, if you choose to use a Dentist who does not participate in Delta Dental programs. (This Deductible will not, however, be applied to Class I or Class IV Benefits).

Annual Maximum

The Annual Maximum per Eligible Person is shown in the Schedule of Benefits.

Covered Charges of Participating and Non-Participating Dentists

If you choose a Dentist who participates in Delta Dental's PPO or Premier programs, the Dentist agrees to accept Delta Dental's Maximum Approved Fee as payment in full for Covered Services. Also, Delta Dental may limit the services which can be charged to you.

If you choose a Non-participating Dentist, you are responsible not only for payment of the Deductible but also, the difference between Delta Dental's allowed fee and the fee actually billed by the Dentist. Also, Delta Dental has no control over the services charged to you.

Predeterminations

A Dentist may submit a proposed treatment plan to Delta Dental before providing services. This is recommended for any service expected to cost more than $200. Delta Dental will review the treatment plan and advise you and your Dentist of what services are covered by your Plan, and what Delta Dental's payments may be. Since you may be responsible for any cost not covered under your Plan, this is likely to be useful information for you.

Covered Benefits

Class I

- **Diagnostic and Preventive**
  - Examinations/evaluations (twice per calendar year).
  - Teeth cleaning (twice per calendar year).
  - Space maintainers (up to age 14).
  - Sealants (for the first permanent molars to age 9; second permanent molars to age 14).
  - Fluoride treatments (twice per calendar year up to age 19).
- Brush biopsy to detect oral cancer.
- Emergency palliative treatment to temporarily relieve pain.
- Radiographs: (Bitewing X-rays are payable once per calendar year. Full mouth x-rays (including bitewings) are payable once in any five-year period. A panographic x-ray (including bitewings) is considered a full mouth x-ray.

Class II

- Oral surgery--extractions and dental surgery, including preoperative and post-operative care.
- Endodontic services--treatment of teeth with diseases or damaged nerves (for example, root canals).
- Periodontic Services--treatment of diseases of the gums and supporting structures of the teeth.
- Relines and repairs-to bridges, partial dentures, and complete dentures.

- Minor Restorative Services-to rebuild and repair natural tooth structure damaged by disease or injury, including fillings and crown repair.

Class III

- Major Restorative Services-including crowns and onlays-- limited to once per tooth in any 5-year period.
- Prosthodontic Services-to replace missing natural teeth (such as bridges, endoseal implants, and partial and complete dentures)--limited to once per tooth in any 5-year period.

Class IV

- Orthodontic services to correct malposed teeth (to age 19).

Exclusions

In addition to limitations imposed by Delta Dental and the General Exclusions set forth at page 67-69, the following exclusions apply to Dental Benefits:

- Services for correction of congenital or developmental malformations, cosmetic surgery, or dentistry for aesthetic reasons.
- Services or appliances started before a person became eligible under this Plan, other than orthodontic treatment in progress.
- Prescription drugs (except intramuscular injectable antibiotics), medicaments/solutions, premedications, and relative analgesia.
- General anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless Medically Necessary.
- Charges for hospitalization, laboratory tests, and histopathological examinations.
- Charges for failure to keep a scheduled visit with the Dentist.
- Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.
- Those benefits excluded by the policies and procedures of Delta Dental, including the Processing Policies.
- Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
- Services that are covered under a hospital, surgical/medical, or prescription drug program.
- Services that are not within the classes of benefits that have been selected and that are not in the contract.
- Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
- Preventive control programs (including oral hygiene instruction, carries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.)
- Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
- Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
- Veneers.

- Prefabricated crowns used as final restorations on permanent teeth.
- Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion, or for periodontal splinting. This exclusion will not apply to orthodontic services as limited by the terms and conditions of the Plan.
- Paste-type root canal fillings on permanent teeth.
- Replacement, repair, relines, or adjustments of occlusal guards, or more than one occlusal guard per lifetime.
- Chemical curettage.
- Services associated with overdentures.
- Metal bases on removable prostheses.
- The replacement of teeth beyond the normal complement of teeth.
- Personalization/characterization of any service or appliance.
- Temporary appliances.
- Posterior bridges in conjunction with partial dentures in the same arch.
- Precision attachments.
- Specialized implant surgical techniques.
- Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
- Diagnostic photographs and cephalometric films, unless done for orthodontics.
- Myofunctional therapy.
- Mounted case analyses.

VISION EXPENSE BENEFITS

(Active Employees, Non-Medicare Retirees, and Dependents)

Coverage

Covered employees and Covered Dependents are eligible for Vision Expense Benefits, subject to the Maximums set forth in the Schedule of Benefits. Benefits are payable as follows:

- Examination--Once every 12 months.
  - A case history;
  - An external examination of the eye and adnexa;
  - An ophthalmoscopic examination;
  - A determination of refractive status;
  - Binocular balance testing;
  - Tonometry, as needed;
  - Gross visual fields;
  - Color vision testing;
  - Summary findings; and
  - Recommendations, including prescribing Lenses.

When obtaining a contact lens examination, you will also be responsible for payment of any amount over the cost of an examination for glasses.

- Materials--Once every 24 months.
  - Single vision lenses;
  - Bifocal lenses;
  - Trifocal lenses;
  - Lenticular lenses;
  - Frames; and
  - Contact lenses.

Exclusions

In addition to the General Limitations and Exclusions section in this booklet, the Plan will not cover the following:

- For diagnostic services, drugs, or medications not part of a vision examination.
- For an eye examination or materials ordered as a result of an eye examination prior to your Effective Date.
- For Lenses which are not prescribed.
- For medical or surgical treatment.
- For the replacement of Lenses or Frames.
- For safety glass and safety goggles.
- That Medical Mutual determines are special or unusual, such as orthoptics, vision training, and low vision aids.
- For tints other than Number One or Two.
- For tints with photosensitive or antireflective properties.

- Eye examination required by:
  - An Employer as a condition of employment or by virtue of a labor agreement; or
  - A government body or agency.
- Any service or material for which the Eligible Person may be compensated under Workers' Compensation laws, or which is available from a governmental body without cost.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

(Active Employee or Retiree Only)

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS ARE SUBJECT TO THE TERMS OF ANY LIFE INSURANCE POLICY IN EFFECT.

Designation of Beneficiary

To designate a beneficiary, an Eligible Employee or Retiree must complete the Plan's "Designation of Beneficiary" form. The initial designation (and any later changes) is effective when received by the Life Insurance carrier. However, no designation or change will be effective if received by the Life Insurance carrier after date of death.

The beneficiary may be changed at any time by completing a Designation of Beneficiary form available from the Benefit Office. However, such change shall not take effect until received by theLife Insurance carrier. When the change is received, it will take effect as of the date of execution. However, the Fund will not be liable for any payment made or any action taken or permitted by the Fund before receipt of the change.

If the Person has named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated by the Eligible Person when the Beneficiaries were named. If a beneficiary dies before the Eligible Person, that beneficiary's share will be divided equally between remaining beneficiaries unless the Eligible Person has specified otherwise.

If there is no named Beneficiary, or if no named Beneficiary is surviving at the time of death of the Eligible Person, payment will be made to the first surviving class in the following order of preference:

- The surviving Spouse; or
- The Employee's children, in equal shares; or
- The Employee's parents, in equal shares; or
- The Employee's brothers and sisters, in equal shares; or
- The executors or administrators of the Employee's estate.

To determine which class of individuals is entitled to the death benefit, the Trustees may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, the Plan and the insurance carrier funding the death benefit will be discharged of their liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

If any benefits are paid to an estate, up to $2,000 may be paid to those whom the Plan deems to be equitably entitled by reason of having incurred funeral or other expenses incidental to the death of the Eligible Employee or Retiree. The Plan will be fully discharged up to the amount of such payment.

Life Insurance
(Eligible Employees and Eligible Retirees)

Benefit

If an Eligible Employee or Retiree dies, that Person's Beneficiary will receive the Principal Amount shown in the Schedule of Benefits. The certified death certificate is to be furnished to the Benefit Office.

Conversion Privilege
The Plan may maintain a conversion privilege from time to time for Life Insurance. If the Plan is maintaining a conversion privilege at the time the Eligible Employee's eligibility terminates, the Employee can convert death benefit coverages to certain types and amounts of individual life insurance policies, if the Employee has been covered under the policy for the required period of time and makes written application (including tendering of premium) within thirty-one (31) days of eligibility termination.

Accidental Death and Dismemberment Benefits
(Eligible Employees Only)

Upon receipt of due proof of loss, Accidental Death and Dismemberment Benefits will be paid if:

- An Eligible Employee suffers an Accidental Injury; and
- As the direct result of the accident, and independent of all other causes, the Person suffers a Covered Loss within 365 days after the accident.

Table of Losses	% of Principal Sum Payable
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Speech and Hearing	100%
Quadriplegia	100%
Paraplegia	75%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Hemiplegia	50%
Loss of Thumb and Index Finger (on same hand)	25%
Uniplegia	25%

Loss, with respect to hand or foot, means actual and permanent severance form the body at or above the wrist or ankle joint, as applicable. With respect to sight, speech, and hearing, Loss means entire and irrecoverable loss of sight, speech, or hearing. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

Quadriplegia means total Paralysis of both arms and legs. Paraplegia means total Paralysis of both legs. Hemiplegia means total Paralysis of one arm and one leg on the same side of the body. Uniplegia means total Paralysis of one limb.

Paralysis means loss of use without severance of a limb which resulted from an Accident. Paralysis must be determined by a Medical Provider to be permanent, total, and irreversible.

If the Employees suffers more than one loss in any accident, payment shall be made only for that loss for which the largest amount is payable.

Exclusions

No Accidental Death or Dismemberment benefit will be paid for any loss that is caused directly or indirectly, in whole or in part, by any of the following:

- Suicide or attempted suicide;
- Intentionally self-inflicted injury, including but not limited to Russian roulette;
- Bodily or mental disease or treatment of these;
- The Insured's participation in, or as a result of his having participated in, the commission of an assault or felony;
- Bacterial infection except pyogenic infection which occurs through or with an Accidental cut or wound;
- War or any act of war, whether declared or undeclared;
- Travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft;
- The Insured's being under the influence of any drug (except those prescribed by a physician and used in the manner prescribed), including narcotics, hallucinogens, and gas or fumes, which are taken or inhaled voluntarily;
- Voluntary poisoning;
- The Insured's being Intoxicated;
- Any loss or Injury as a result of autoerotic asphyxiation;
- Any period which an Insured is confined to a penal or correctional institution;
- Riding, driving, or testing a Motorized Vehicle used in a race or speed contest;
- Taking part in the sports of scuba diving, bungee jumping, sky diving, parachuting, hang gliding, or ballooning.

Additional Benefits

Certain additional benefits may be claimed if the insured was wearing his seatbelt, there was an airbag inflated in a vehicle in which the participant's death occurred, death occurred more than 75 miles from the participant's residence, the decedent has children approaching the age to enter a school of higher education, or the participant becomes comatose. These additional benefits may not be available unless notice is given to the carrier within **20 days** after the loss occurs.

Notice of Loss

Proof of the loss for which a claim is made must be given to the Benefit Office no later than 20 days after the date of loss.

Payment of Claims

For a Covered Loss, benefits shall be paid directly to the Eligible Employee. For loss of life, benefits will be made to the Eligible Employee's Beneficiary. See 'Designation of Beneficiary' provisions.

Cleveland Hospitalization Plan

Certain additional death benefits may be available to participants in the former Cleveland Hospitalization Plan. Please contact the Benefit Office for details.

GENERAL EXCLUSIONS AND LIMITATIONS

The Plan contains certain general exclusions and limitations. However, the Plan will not deny benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or a health condition (including both physical and mental health conditions). In addition to the exclusions and limitations explained in the Comprehensive Medical Benefits section, no benefits are provided under this Plan of Benefits for services and supplies:

- Which are not Medically Necessary;
- Not prescribed by or performed by or under the direction of a Physician or Other Professional Provider;
- Not performed within the scope of the Provider's license;
- Received from other than a Provider;
- For Experimental or Investigational equipment, drugs, devices, services, supplies, tests, medical treatments, or procedures;
- To the extent that governmental units or their agencies provide benefits, except Health Departments, as determined by Medical Mutual;
- For a Condition that occurs as a result of any act of war, declared or undeclared;
- For which you have no legal obligation to pay in the absence of this or like coverage;
- 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;
- Received from a member of your Immediate Family;
- Incurred after you stop being a Eligible Person except as specified in the Plan;
- For any injury suffered or loss sustained while an Eligible Person was participating in a felonious criminal activity;
- For the following:
    - Physical examinations or services required by an insurance company to obtain insurance;
    - Physical examinations or services required by a governmental agency such as the FAA and DOT;
    - Physical examinations or services required by an employer in order to begin or to continue working;
    - Premarital examinations;
    - Screening examinations, except as specified; or
    - X-ray examinations made without film.
- For a Condition occurring in the course of employment, if whole or partial benefits or compensation could be available under the laws of any governmental unit. This applies whether or not you claim such compensation or recover losses from a third party;
- 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;
- Received in a military facility for a Condition related to military service;

- For Surgery and other services primarily to improve appearance or to treat a mental or emotional Condition through a change in body form (including cosmetic Surgery following weight loss or weight loss Surgery), except as specified;
- For Surgery to correct a deformity or birth defect for psychological reasons where there is no functional impairment;
- For the removal of tattoos;
- For dietary and/or nutritional guidance or training, except as specified;
- For Outpatient educational, vocational, or training purposes except as specified;
- For treatment of Conditions related to an autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems, or mental retardation, except as specified;
- For topical anesthetics;
- For minor non-operative endoscopic procedures which include, but are not limited to, anoscopy and colonoscopy, unless Medically Necessary or prescribed by the Patient Affordability and Accountability Act;
- For arch supports and other foot care or foot support devices only to improve comfort or appearance which include, but are not limited to, care for flatfeet, subluxations, corns, bunions (except capsular and bone Surgery), calluses, and toenails;
- For weight loss drugs;
- For treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss;
- For weight loss Surgery and any repairs, revisions, or modifications of such Surgery, including weight loss device removal;
- For water aerobics;
- For residential care rendered by a Residential Treatment Facility;
- For marital counseling;
- For the medical treatment of erectile dysfunction or other sexual problems not caused by a biological Condition;
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery;
- For Contraceptives, except as specified;
- For reverse sterilization;
- For artificial insemination, or in vitro fertilization, or embryo transfer procedures;
- For any Eligible Person acting as or contracting to be, a surrogate parent;
- For oral implants considered part of a dental process or dental treatment including preparation of the mouth for any type of dental prosthetic, except when due to trauma, accident, or as deemed Medically Necessary, except to the extent covered under the Dental Benefits section of the Plan;
- For treatments associated with teeth, dental X-rays, dentistry, or any other dental processes, including orthognathic (jaw) Surgery, except as specified or as covered under the Dental Benefits section of the Plan;
- For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension;
- For treatment of the vertebral column unless related to a specific neuromusculoskeletal related diagnosis;
- For personal hygiene and convenience items;

- For eyeglasses, contact lenses, or examinations for prescribing or fitting them, except those for aphakic patients, keratoconus, and soft lenses or sclera shells for use as corneal bandages when needed as a result of Surgery, or as otherwise covered in the Vision Benefits section of the Plan;
- For any surgical procedure for the correction of a visual refractive problem including, but not limited to, radial keratotomy and LASIK (laser in situ keratomileusis);
- For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them, except as specified;
- For immunizations, other than those specified as covered in the Preventative Services section of the Plan;
- For massotherapy or massage therapy;
- For hypnosis and acupuncture;
- For After Hours Care;
- For telephone consultations, online consultations, missed appointments, completion of claim forms, or copies of medical records;
- For fraudulent or misrepresented claims;
- For blood which is available without charge. For Outpatient blood storage services;
- For Prescription Drugs, except as specified;
- For over-the-counter drugs, vitamins, or herbal remedies;
- For Outpatient occupational therapy services;
- For specialized camps;
- For Routine Services, except as specified;
- For a particular health service in the event that a Non-PPO Network Provider waived Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period); no benefits are provided for the health service for which the Copayments, Non-PPO Network Coinsurance (and/or the Non-PPO Network Deductible per Benefit Period) are waived;
- For Non-Covered Services or services specifically excluded in the text of this Plan; and
- In connection with treatment of Temporomandibular Joint Syndrome (TMJ).

COORDINATION OF BENEFITS

Coordination of Benefits
Coordination of Benefits ("COB") is the procedure used to pay health care expenses when you or an Eligible Dependent is covered by more than one health care plan (including medical dental and prescription drug benefits). The Plan follows rules established by Ohio law to decide which health care plan pays first and how much the other health care plan must pay. The objective is to make sure the combined payments of all health care plans are no more than your actual bills.

When you or your Eligible Dependents are covered by another Plan in addition to this one, the Plan will follow Ohio coordination of benefit rules to determine which health care plan is primary and which is secondary. You must submit all bills first to the primary health care plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary health care plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary health care plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expenses.

The Plan pays for health care only when you follow the Plan's rules and procedures. If the Plan's rules conflict with those of another health care plan, it may be impossible to receive benefits from both health care plans, and you will be forced to choose which health care plan to use.

Definitions

- A Plan is any of the following that provides benefits or services for medical care, dental care, vision benefits, or prescription drugs. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

    - Plan includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans, or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

    - Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- This **Plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

- The order of benefit determination rules determine whether **this Plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

  When this **Plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When this **Plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.
- **Allowable expense** is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging an Eligible Person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses:**

- The difference between the cost of a semi-private Hospital room and a private Hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private Hospital room expenses.
- If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
- If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
- If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the Provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
- The amount of any benefit reduction by the **Primary plan** because an Eligible Person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- **Closed panel plan** is a **Plan** that provides health care benefits to Eligible Persons primarily in the form of services through a panel of providers that has contracted with or are employed by the **Plan,** and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules
When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The **Primary plan** pays or provides its benefit's according to its terms of coverage and without regard to the benefits under any other **Plan**.
2. a. Except as provided in Paragraph “b” below, a **Plan** that does not contain a coordination of benefits provision that is consistent with **this Plan** is always primary unless the provisions of both **Plans** state that the complying plan is primary.

   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** is not primary. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
3. A **Plan** may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. Each **Plan** determines its order of benefits using the first of the following rules that apply:
   a. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
   b. **Dependent child covered under more than one plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan, the order of benefits is determined as follows:
      - For a dependent child whose parents are married or are living together, whether or not they have ever been married:
        - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
        - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
        - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

5. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

   a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

   b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Rule 4b above shall determine the order of benefits;

   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Rule 4b above shall determine the order of benefits; or

   d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      - The **Plan** covering the **Custodial parent;**
      - The **Plan** covering the spouse of the **Custodial parent;**
      - The **Plan** covering the **non-custodial parent;** and then
      - The **Plan** covering the spouse of the **non-custodial parent.**

6. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Rules (4) or (5) above shall determine the order of benefits as if those individuals were the parents of the child.

7. **Active employee or retired or laid-off employee:** The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

8. **COBRA or state continuation coverage:** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber, or retiree, or covering the person as a dependent of an employee, member, subscriber, or retiree, is the **Primary plan;** and the COBRA or state or other federal continuation coverage is the **Secondary Plan**. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

9. **Longer or shorter length of coverage:** The **Plan** that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the **Primary plan,** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

10. **If the preceding rules do not determine the order of benefits:** T**he Allowable expenses** shall be shared equally between the Plans meeting the definition of Plan. In addition, **this Plan** will not pay more than it would have paid had it been

the **Primary plan**. When another plan contains an "**always secondary**" provision, and that **plan** would be required to pay **primary benefits** under the rules stated above, or contains a provision capping its benefits for an eligible individual or his dependent having the effect of shifting primary coverage liability to this Plan in a manner designed to avoid the usual operation of the **National Association of Insurance Commissioner's and this Plan's** coordination of benefits rules, **this Plan** will estimate what the **Primary benefits** would be and will pay secondary benefits before the other **Plan's** benefits are paid.

Effect on the Benefits of this Plan

1. When **this Plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
2. If an **Eligible Person** is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one **Closed panel plan, COB** shall not apply between that Plan and other **Closed panel plans**.

Coordination with Medicare

The Plan will pay its benefits **before** Medicare **only**

- For an active employee who is age 65 or older (unless the employee works for an employer with less than 20 employees);
- For an active employee's dependent spouse who is age 65 or older (unless the employee works for an employer with less than 20 employees);
- The first 30 months of treatment for end-stage renal disease received by an Eligible Person;
- For Disabled, Eligible Dependents of Active Employees; and
- Where otherwise explicitly required by federal law.

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

NOTE: **MEDICARE ELIGIBILITY**

IF YOU ARE ELIGIBLE FOR MEDICARE, THE PLAN WILL PAY BENEFITS ONLY UP TO THE AMOUNT THAT WOULD BE PAID UNDER THE ABOVE RULES, WHETHER OR NOT YOU HAVE APPLIED FOR MEDICARE PART A AND PART B BENEFITS. BECAUSE YOUR BENEFITS MAY BE AFFECTED BY MEDICARE, YOU MAY WANT TO CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE FOR INFORMATION ABOUT MEDICARE. THIS SHOULD BE DONE BEFORE YOUR 65TH BIRTHDAY OR THAT OF YOUR SPOUSE, OR IF YOU OR ONE OF YOUR DEPENDENTS BECOME DISABLED.

Coordination Disputes
If you believe that the Plan has not paid a Coordination of Benefits claim properly, you should attempt to resolve the problem by contacting Medical Mutual, Delta Dental, Express Scripts, or your Benefit Office, as applicable.

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. Medical Mutual or others may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Medical Mutual or other Claims Processor need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Medical Mutual or other Claims Processor any facts to apply those rules and determine benefits payable.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, Medical Mutual or other Claims Processor may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Medical Mutual or other Claims Processor will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by Medical Mutual or other Claims Processor is more than they should have paid under this COB provision, they may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Eligible Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

SUBROGATION, RECOUPMENT, AND REIMBURSEMENT

Subrogation

The Plan reserves the right of subrogation. This means that, to the extent we provide or pay benefits or expenses for Covered Services, we assume your legal rights to recover the value of those benefits or expenses from any person, entity, organization, or insurer, including your own insurer and any underinsured or uninsured coverage, that may be legally obligated to pay you for the value of those benefits or expenses. The amount of the Plan's subrogation rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of subrogation shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of subrogation for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive a full or partial recovery or whether or not you are "made whole" by any reason of any recovery from any other person or entity. This provision is intended to and does reject and supersede the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to asserts its right of subrogation.

Reimbursement

The Plan also reserves the right of reimbursement. This means that, to the extent we provide or pay benefits or expenses for Covered Services, you must repay the Plan any amounts recovered by suit, claim, settlement, or otherwise, from any third party or his insurer and any underinsured or uninsured coverage, as well as from any other person, entity, organization, or insurer, including your own insurer, from which you receive payments (even if such payments are not designated as payments of medical expenses). The amount of the Plan's right of reimbursement shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of reimbursement for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of reimbursement.

Your Duties

- You must provide the Plan or its designee any information requested by the Plan or its designee within five (5) days of the request.
- You must notify the Plan or its designee promptly of how, when, and where an accident or incident resulting in personal injury to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan or its designee in the investigation, settlement, and protection of the Plan's right.
- You must send the Plan or its designee copies of any police report, notices, or other papers received in connection with the accident or incident resulting in personal injury to you.
- You must not settle or compromise any claims unless the Plan or its designee is notified in writing at least thirty (30) days before such settlement or compromise and the Plan or its designee agrees to it in writing.

Discretionary Authority

Medical Mutual, the Plan, and other Claim Processors shall have discretionary authority to interpret and construe the terms and conditions of the Subrogation and Reimbursement provisions and make determination or construction that is not arbitrary and capricious. Medical Mutual's and/or the Plan's determination will be final and conclusive.

SUMMARY PLAN INFORMATION

Board of Trustees
The responsibility for the Plan is held by a joint Board of Trustees who are representative of both Employers and the Union. The Board makes all policy decisions concerning the Plan, including eligibility requirements, benefits to be offered, and contribution levels. Using actuarial, legal, and health policy information, the Board attempts to provide a financially sound and responsive Plan. The Board is also the "Plan Administrator" and "Plan Sponsor."

Plan Year
The Plan Year for this Trust Fund is May 1 to April 30. The records are kept consistent with the Plan Year.

IRS Identification Number
The employer identification number assigned by the Internal Revenue Service to the Fund is 45-0593187. The Plan number is 501.

Collective Bargaining Agreements
The Ohio Carpenters' Health Plan is maintained pursuant to collective bargaining agreements. Eligible Persons may receive from the Benefit Office, upon written request, information as to whether a particular Employer or Union Local is a sponsor of the Plan, and if the Employer or Local is a Plan sponsor, the sponsor's address. A copy of the collective bargaining agreement may be obtained by Eligible Persons upon written request to the Benefit Office. A reasonable charge may be made for copies. As an alternative, participants and beneficiaries may examine a copy of the bargaining agreement at the Union and at each location where at least 50 participants are customarily working or notify the Benefit Office in writing and the bargaining agreement will be made available at the job site within 10 days. There is no charge for examining the bargaining agreement.

Funding
The Plan is generally funded by Employer contributions made by Employers in accordance with collective bargaining agreements. Modest additional funding is through Employee self-payments.

Agent for Service of Legal Process
The Board of Trustees or any individual Trustee may receive service of legal process.

About Lines of Coverage
Coverage for the Life Insurance and Accidental Death and Dismemberment Benefit is insured by Consumers Life, a Medical Mutual Company.

The Medical Benefit Coverage for the Plan is a Preferred Provider Organization (PPO) administered by Medical Mutual. The PPO is a network of doctors, hospitals, and other facilities that provide medical care at lower rates to the Plan when the Eligible Person uses the PPO network. If the Eligible Person chooses not to utilize the PPO network, benefits will still be paid according to the schedule of benefits for Non-Network services and the Eligible Person will be responsible for any additional out-of-pocket expenses. The medical plan is self-funded.

Vision Benefits are self-funded and are also administered by Medical Mutual.

Dental Benefit coverage is self-funded and administered by Delta Dental.

The Prescription Drug Benefit is self-funded and administered by Express Scripts.

ADMINISTRATION OF THE FUND

Construction by Trustees

Under the Plan of Benefits and the Trust Agreement creating the Plan, the Trustees or persons acting for them, such as a Committee of the Trustees or Claims Processors, have the sole and exclusive authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement, the Plan document, or any other rules, regulations, procedures, or administrative rules adopted by the Trustees. Any questions or interpretations about the Plan or Trust Agreement, or disputes about eligibility for and amount of benefits, shall be resolved by the Board of Trustees. Decisions of the Trustees or, where appropriate, decisions of those acting for the Trustees in such matters, are final, binding, and conclusive on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the further intention of the parties to the Trust that such a decision is to be upheld unless it is determined to be arbitrary and capricious.

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

Amendment or Termination of Plan or Benefits

The Trustees may change or terminate this Plan, or any part thereof, in their sole and exclusive discretion. Benefits will terminate when the Plan, or any applicable portion thereof, is terminated.

Recovery of Overpayment

If the Benefit Office or Claims Processor ascertains that an Eligible Person has received an erroneous overpayment of a benefit, the Office or Processor shall immediately notify such Eligible Person in writing, explaining the nature of the erroneous overpayment and requesting return of the amount of such overpayment. If the initial request for restitution is not successful, the Benefit Office or Processor shall renew the demand in writing upon the Eligible Person; and may take other reasonable actions to obtain reimbursement of the erroneous overpayment.

If taking reasonable steps to obtain repayment of the overpayment has been unsuccessful, the Benefit Office or Claims Processor may treat the overpayment of benefits as an advance payment of benefits due to the Eligible Person and offset the amount of such overpayment against any Plan benefits due or which may become due to the Eligible Person until the full amount of the overpayment has been repaid to the Plan.

Payment of Claims and Assignment of Benefits

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

Payment of Unassigned Benefits in Event of Death
If an Eligible Employee or Retiree expires before the payment to him of any and all unassigned benefits, the Claim Processor may pay the amount of the unassigned but unpaid benefits as follows:

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

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

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

Physical Examination
The Trustees or the Benefit Office has the right to ask that you be examined by a Physician of their choice if there is a question about your coverage. For death, the Trustees and the Plan's life insurance carrier reserve the right to request an autopsy, if it is not forbidden by law. However, the Plan does not require a physical exam for enrollment, even if you enroll late. You cannot be denied eligibility because of any health factor.

Presentment of Claims on Behalf of Person Who is Incapacitated
If an Eligible Person shall become incapacitated and be unable to prepare, complete, and/or execute the forms and documents prescribed by the Trustees and/or their Benefit Office for the filing of claims and/or receipt of benefits, the forms and documents may be signed for and on behalf of the Eligible Person by other persons, as follows:

- Authorized Representative;

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

- If there is no Authorized Representative and no guardian has been appointed, then by the persons in the following order of priority and upon evidence acceptable to the Benefit Office of status and priority: (1) spouse; (2) a child; (3) a parent; or (4) a brother or sister.

Claims for Medical Service Rendered Outside of the United States
Due to the increasing mobility of Eligible Persons in the Plan, claims may be paid which arise from medical treatment received outside the United States and its territories, provided certain conditions are first met:

- If there has been Emergency medical care, the Eligible Person, upon returning to the United States, should submit the bills which have been paid for the Emergency

treatment in order to be reimbursed according to the provisions and limitations within the Plan.

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

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

- Eligible Persons living or traveling outside the United States and its territories for more than six consecutive months do not qualify for coverage hereunder.

Legal Actions

No action at law or in equity shall be brought to recover any benefits provided under this Plan before the expiration of one hundred and twenty (120) days after written proof of loss has been furnished nor shall any such action be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Patient Affordability and Accountability Act ("PACCA")

This Plan is to be interpreted in accordance with provisions of PACCA for non-grandfathered plans. In the event of any conflict between this Plan and binding interpretations of PACCA, those binding interpretations are to prevail.

DEFINITIONS

Accidental Injury--A trauma to the body resulting from an accident, such as a strain, sprain, abrasion, or contusion.

After Hours Care--Services received in a Physician's office at times other than regularly scheduled office hours, including days when the office is normally closed (e.g., holidays or Sundays).

Alcoholism--A Condition classified as a mental disorder and described in the International Classification of Diseases, ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as alcohol dependence, abuse, or alcoholic psychosis.

Authorized Representative--An individual or entity designated in writing to act on your behalf. The extent of authority must be clearly indicated in the authorization.

Benefit Office--The office of the Plan's third-party administrator.

Benefit Period--The period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, and Coinsurance Limits are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

Billed Charges--Charges for all services and supplies that the Eligible Person has received from the Provider, whether they are a Covered Service or not.

Charges--The Provider's list of charges for services and supplies before any adjustments for discounts, allowances, incentives, or settlements. For a Contracting Hospital in the State of Ohio, charges are the master charge list uniformly applicable to all payors before any discounts, allowances, incentives, or settlements.

Claims Processor--Medical Mutual, Delta Dental, Express Scripts, or the Benefit Office, as applicable.

Coinsurance--A percentage of the Lesser Amount for Contracting Institutional Providers and Physicians and Other Professional Providers, or a percentage of the Non-Contracting Amount for Non-Contracting Institutional Providers, for which you are responsible after you have met your Deductible or paid your Copayment.

Coinsurance Limit--A specified dollar amount of Coinsurance expense Incurred in a Benefit Period by an Eligible Person for Covered Services received from a PPO Network Provider.

Condition--An injury, ailment, disease, illness, or disorder.

Contraceptives--Oral, injectable, implantable, or transdermal patches for birth control.

Contracting--The status of a Hospital, or Other Facility Provider:

- That has an agreement with Medical Mutual or Medical Mutual's parent company about payment for Covered Services; or
- That is designated by Medical Mutual or its parent as Contracting.

Copayment--A dollar amount, if specified in the Schedule of Benefits, that you may or may not be required to pay at the time Covered Services are rendered.

Covered Charges--The Billed Charges for Covered Services, except that Medical Mutual Claim Processors reserve the right to limit the amount of Covered Charges for Covered Services provided by a Non-Contracting Institutional Provider to the Non-Contracting Amount determined as payable by Medical Mutual or such vendor.

Covered Service--A Provider's service or supply for which the Plan will provide benefits, as listed in the Schedule of Benefits.

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

- Administration of medication which can be self-administered or administered by a lay person; 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 a Condition.

Deductible--An amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits.

Dependent--See page 5.

Disabled--Unless the context indicates otherwise, a Covered Employee is "Disabled" when such Person's physician certifies that the Person is unable to perform the Person's job because of injury, illness, or pregnancy.

Dollar Bank--The account in which Employer contributions are recorded on your behalf as "Dollar Credits." The monthly cost of your Plan is deducted from this Dollar Bank. The Bank is an eligibility system; it is not a personal bank account.

Drug Abuse--A Condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as drug dependence, abuse, or drug psychosis.

Effective Date--12:01 a.m. on the date when your coverage under the Plan begins under the Plan.

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

Eligible Retiree--A former employee of Employers meeting the requirements for participation in this Plan's Retiree Programs.

Eligible Person--Unless the context indicates otherwise, "Eligible Person" shall mean an Eligible Employee, Eligible Retiree, an Eligible Dependent, or a qualified beneficiary who meets all requirements for continuation coverage based on the Plan's eligibility rules.

Emergency--An accidental traumatic bodily injury or other medical Condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

- Place an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Admission--An Inpatient admission to a Hospital directly from a Hospital emergency room.

Emergency Care--Covered Services that are furnished by a Provider within the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

Emergency Services--A medical screening examination as required by federal law that is within the capability of the Emergency Department of the Hospital, including ancillary services routinely available to the Emergency Department to evaluate an Emergency medical Condition, and further medical examination and treatment that are required to Stabilize an Emergency medical Condition and within the capabilities of the staff and facilities available at the Hospital, including any trauma or burn center at the Hospital.

Employer--In the context of this Plan, the term "Employer" or "Employers" include those who:

- Have assigned their bargaining rights to an Employer Association which is a party to a collective bargaining agreement with the Union which requires contributions to the Plan; or
- Have directly executed a collective bargaining agreement with the Union which requires contributions to the Plan and which is acceptable to the Trustees; or
- Have executed an Employer Participation Agreement with the Plan which requires contributions to the Plan and which is acceptable to the Trustees.

Enrollment Form--A form you complete for yourself and your Eligible Dependents to be considered for coverage under the Plan.

Essential Health Benefits--Benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Excess Charges--The amount of Billed Charges in excess of the covered Traditional Amount or Non-Contracting Amount determined payable by Medical Mutual for a Non-Contracting Institutional Provider, a Non-Participating Physician, or Other Professional Provider; or amount of Billed Charges in excess of amounts determined payable by other Claim Processors.

Experimental or Investigational Drug, Device, Medical Treatment, or Procedure--A drug, device, medical treatment, or procedure is Experimental or Investigational:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- If reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing phase I, II, or III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis; or
- If reliable evidence shows that the consensus of opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility, or by another facility studying substantially the same drug, device, medical treatment, or procedure.

The determination will be made by Medical Mutual or other Claim Processor, as applicable, at their sole discretion and will be final and conclusive, subject to any available appeal process.

Hospital--An Institution that meets the specifications of Chapter 3727 of the Ohio Revised Code, except for the requirement that such Institution be operated within the State of Ohio.

Immediate Family--The Eligible Employee or Retiree and such person's spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, sisters, children, and stepchildren by blood, marriage, or adoption.

Incurred--Rendered to you by a Provider. All services rendered by the Institutional Provider during an Inpatient admission prior to termination of coverage are considered to be Incurred on the date of admission.

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

Institution (Institutional)--A Hospital or Other Facility Provider.

Lesser Amount--For Contracting and Participating Providers, the Lesser Amount means the Lesser of the Negotiated Amount or the Covered Charges. For Non-Participating Physicians and Other Professional Providers, the Lesser Amount means the lesser of the Billed Charges or Traditional Amount. For Non-Contracting Institutional Providers, the Lesser Amount means the Non-Contracting Amount.

Medical Care--Professional services received from a Physician or Other Professional Provider to treat a Condition.

Medically Necessary (or Medical Necessity)--A service, supply, and/or Prescription Drug that is required to diagnose or treat a Condition and which Medical Mutual or other Claim Processor determines is:

- Appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- Not primarily for your convenience or the convenience of a Provider; and
- 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. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

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

Medicare Approved--The status of a Provider that is certified by the United States Department of Health and Human Services to receive payment under Medicare.

Mental Illness--A Condition classified as a mental disorder in the International Classification of Diseases, ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, excluding Drug Abuse and Alcoholism.

Negotiated Amount--The amount the Provider has agreed with Medical Mutual to accept as payment in full for Covered Services.

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

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

The Negotiated Amount for Contracting Institutional Providers may exceed the Covered Charges.

The Negotiated Amount for Participating Physicians and Other Professional Providers does not include any performance withhold adjustments.

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

Network--A group of Providers which has a contractual arrangement with a Claims Processor.

Non-Contracting--The status of a Hospital or Other Facility Provider that does not meet the definition of a Contracting Institutional Provider.

Non-Contracting Amount--The maximum amount determined as payable and allowed by Medical Mutual for a Covered Service provided by a Non-Contracting Institutional Provider.

Non-Covered Charges--Billed Charges for services and supplies that are not Covered Services.

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

Non-PPO Network Provider--A Physician or Other Professional Provider, Contracting Hospital or Contracting Other Facility Provider, Home Health Care Agency, Hospice, or other Provider that is not designated by Medical Mutual or other Claim Processor as a PPO Network Provider.

Office Visit--Office visits include medical visits or Outpatient consultations in a Physician's office or patient's residence. A Physician's office can be defined as a medical/office building, Outpatient department of a Hospital, freestanding clinic facility, or a Hospital based Outpatient clinic facility.

Other Facility Provider--The following Institutions which are licensed, when required, and where Covered Services are rendered which require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Other Professional Provider. The Plan will only provide benefits for services or supplies for which a charge is made. Only the following Institutions, defined below, are considered to be Other Facility Providers:

- Alcoholism Treatment Facility**--**A facility which mainly provides detoxification and/or rehabilitation treatment for Alcoholism.
- Ambulatory Surgical Facility**--**A facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.
- Day/Night Psychiatric Facility**--**A facility which is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of Mental Illness. These services are provided through either a day or night treatment program.
- Dialysis Facility**--**A facility which mainly provides dialysis treatment, maintenance, or training to patients on an Outpatient or home care basis.

- Drug Abuse Treatment Facility**--**A facility which mainly provides detoxification and/or rehabilitation treatment for Drug Abuse.
- Home Health Care Agency**--**A facility which meets the specifications of Chapter 3701.88 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and which provides nursing and other services as specified in the Home Health Care Services section of this Plan. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- Hospice Facility**--**A facility which provides supportive care for terminally ill patients as specified in the Hospice Services section of this Plan.

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

Occupational Injury--An accidental injury arising out of or in the course of any work for pay or profit, or in any way resulting from an injury which does.

Other Professional Provider--Only the following persons or entities which are licensed as required:

- Advanced nurse practitioner (A.N.P.);
- Ambulance services;
- Dentist;
- Doctor of chiropractic medicine;
- Durable medical equipment or prosthetic appliance vendor;
- Laboratory (must be Medicare Approved) ;
- Licensed independent social workers (L.I.S.W.);
- Licensed practical nurse (L.P.N.);
- Licensed professional clinical counselor;
- Licensed vocational nurse (L.V.N.);
- Mechanotherapist (licensed or certified prior to November 3, 1975);
- Nurse-midwife;
- Occupational therapist;
- Physical therapist;
- Physician assistant;
- Podiatrist;
- Psychologist;
- Registered nurse (R.N.);
- Registered nurse anesthetist; and
- Urgent Care Provider.

Outpatient--The status of an Eligible Person who receives services or supplies through a Hospital, Other Facility Provider, Physician, or Other Professional Provider while not confined as an Inpatient.

Participating--The status of a Physician or Other Professional Provider that has an agreement with Medical Mutual or other Claim Processor, as applicable, about payment for Covered Services.

Physician--A person who is licensed and legally authorized to practice medicine.

Plan--The program of health benefits coverage established by the Plan Trustees for Eligible Employees, Retirees, and Dependents.

Plan Administrator--The Plan's Board of Trustees (also the "Plan Sponsor").

PPO Network Provider--A Physician, Other Professional Provider, Contracting Hospital, or Contracting Other Facility Provider that is included in a limited panel of Providers as designated by Medical Mutual and for which the greatest benefit will be payable when one of these Providers is used.

Prescription Drug (Federal Legend Drug)**--**Any medication that by federal or state law may not be dispensed without a Prescription Order.

Prescription Order--The request for medication by a Physician appropriately licensed to make such a request in the ordinary course of professional practice.

Professional Charges--The cost of a Physician or Other Professional Provider's services before the application of the Negotiated Amount.

Provider--A Hospital, Other Facility Provider, Physician, or Other Professional Provider.

Psychiatric Facility--A facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.

Psychiatric Hospital--A facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Inpatient basis. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must be provided under the supervision of a registered nurse.

Psychologist--An Other Professional Provider who is a licensed Psychologist having either a doctorate in psychology or a minimum of five years of clinical experience. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Residential Treatment Facility

- A facility that provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders. The facility provides room and board as well as providing an individual treatment plan for the chemical, psychological, and social needs of each of its residents.
- The facility meets all regional, state, and federal licensing requirements.
- The residential care treatment program is supervised by a professional staff of qualified Physician(s), licensed nurses, counselors, and social workers.
- Residents do not require care in an acute or more intensive medical setting.

Routine Services--Services not considered Medically Necessary.

Skilled Care--Care that requires the skill, knowledge, or training of a Physician or a:

- Registered nurse;
- Licensed practical nurse; or
- Physical therapist performing under the supervision of a Physician.

In the absence of such care, the Eligible Person's health would be seriously impaired. Such care cannot be taught to, or administered by, a lay person.

Skilled Nursing Facility--A facility which primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse, or physical therapist performing under the supervision of a Physician.

Stabilize--To provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the Condition is likely to result from or occur during the transfer of the individual from a facility.

Your Plan covers Emergency Services for an Emergency Medical Condition treated in any Hospital emergency department.

Surgery

- The performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Usual and related preoperative and postoperative care; or
- Other procedures as reasonably approved by Medical Mutual.

Traditional Amount--The maximum amount determined and allowed by Medical Mutual for a Covered Service provided by a Physician or Other Professional Provider based on factors, including the following:

- The actual amount billed by a Provider for a given service;
- Center for Medicare and Medicaid Services (CMS) Resource Based Relative Value Scale (RBRVS);
- Other fee schedules;
- Input from Participating Physicians and wholesale prices (where applicable);
- Geographic considerations; and
- Other economic and statistical indicators, and applicable conversion factors.

Transplant Center--A facility approved by Medical Mutual that is an integral part of a Hospital and which:

- Has consistent, fair, and practical criteria for selecting patients for transplants;
- Has a written agreement with an organization that is legally authorized to obtain donor organs; and

- Complies with all federal and state laws and regulations that apply to transplants covered under this Plan.

Union--Indiana, Kentucky and Ohio Regional Council of Carpenters, or its constituent Local Unions.

Urgent Care Provider--An Other Professional Provider that performs services for health problems that require immediate medical attention which are not Emergencies.

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

As a participant in the Ohio Carpenters Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

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

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

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

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Ohio Carpenters Health Plan treats your medical information as confidential. However, the Plan must use and disclose medical information to others for payment and health care operations. Medical information may be disclosed for the Plan's purchase of insurance, or if there may be duplicate coverage requiring coordination of benefits. Information may be disclosed to utilization review groups, and you and/or your medical providers may be contacted about treatment alternatives and health-related benefits. Protected health information is sometimes disclosed to the Plan's Trustees for Plan administration--for example, to act on claim appeals.

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

For uses and disclosures not permitted or required (for example, use of psychotherapy notes), the Plan will seek your written authorization. You may generally revoke that authorization.

Your Rights
For your private health information, you have certain rights:

- To request restrictions on certain uses and disclosures (but the Plan is not required to agree);
- To request communications by alternative means or at alternative locations stated in writing;
- To generally inspect and copy such information (for a reasonable fee);
- To request amendment of information if you furnish your reason in writing;
- To receive an accounting of certain uses and disclosures other than those to carry out treatment, pay health operations, and certain other exceptions; and
- To receive a copy of this Privacy Policy upon request.

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

Our Obligations

This Plan must:

- Maintain the privacy of protected health information;
- Furnish you with the Plan's Privacy Policy, and act in accordance with this Policy; and
- Notify you in writing of a change in this Privacy Policy, which change may be effective for protected health information received before the change.

The Plan **cannot** share health information with your **Business Agent** or **Union Representative without** a **written Authorization** from you. If you desire to share your information with them (e.g., to help your Agent or Representative to assist you in pursuing a claim for benefits), contact the Benefit Office and ask for an Authorization form.

You should contact "Privacy Officer" at Ohio Carpenters' Health Plan, c/o BeneSys--Health Care Department, P. O. Box 1257, Troy, Michigan 48099-1257, (855) 837-3528 for further information or to express any concerns. If the matter is not resolved or you believe your privacy rights have been violated, you should file a written complaint with the Privacy Officer, Ohio Carpenters' Health Plan, c/o BeneSys--Health Care Department, P. O. Box 1257, Troy, Michigan 48099-1257, (855) 837-3528. If the matter is not resolved within 30 days of your complaint, you should file a written complaint with the Board of Trustees, Ohio Carpenters' Health Plan, c/o BeneSys--Health Care Department, P. O. Box 1257, Troy, Michigan 48099-1257, (855) 837-3528.

You will not be retaliated against for any complaint. You may also file a complaint with the Secretary of Health and Human Services.

-- IMPORTANT NOTICE --

- **FILL OUT A BENEFICIARY FORM NAMING YOUR BENEFICIARY.**
- **CHANGE YOUR BENEFICIARY WHEN YOU DESIRE.**
- **CHANGE YOUR HOME ADDRESS WHENEVER YOU MOVE.**
- **ADD A NEW DEPENDENT WHEN ACQUIRED.**
- **REPORT DIVORCE OR OTHER CHANGE OF STATUS.**
- **NOTIFY THE PLAN THAT YOU ARE RECEIVING WORKERS' COMPENSATION BENEFITS.**
- **NOTIFY THE PLAN WHEN YOU BECOME ELIGIBLE FOR MEDICARE.**