# OHIO AFSCME CARE PLAN


# VISION CARE BENEFITS LEVEL I

**Effective:**
**January 1, 1994**

# OHIO AFSCME CARE PLAN

## To All Eligible Participants:

The Ohio AFSCME Care Plan is administered by a Board of Trustees comprised of seven Union representatives and seven Employer representatives. The Ohio AFSCME Care Plan receives contributions from your employers pursuant to the provisions of the collective bargaining agreement between your Union and your Employer. The Board of Trustees uses those contributions to provide a benefit plan.

This booklet describes your vision benefits. The benefit is provided directly from the Care Plan. Your life insurance, dental, prescription drug and hearing aid benefits are described in other booklets which will be provided to you if you are eligible to receive those benefits, and your Employer and your Union have negotiated for the provision of these benefits from the Care Plan. The rules regarding eligibility for the vision benefit, a description of the benefit, and amounts payable for the benefit are set forth in this booklet. You must follow the provisions of the Plan for vision benefits to be paid.

Please carefully read the information in this booklet and the other booklets so that you will become familiar with all the benefits provided to you and your eligible dependents under the Plan.

Sincerely,

**BOARD OF TRUSTEES**

John A. Lyall, Chair
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Karen Alder, Trustee
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Alvin Freeman, Trustee
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**OHIO AFSCME CARE PLAN**
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
Michael D. Bauer, Plan Administrator

# COBRA
# CONTINUATION COVERAGE
## "Very Important Notice"

### Introduction

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Benefit booklet or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a 'dependent child".

## When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (Under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

## You Must Give Notice of Some Qualifying Events

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your applicable Plan office:**

**CLEVELAND**
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
(800) 526-7201

**TOLEDO**
Suite 106
420 South Reynolds Rd.
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

**CINCINNATI**
1213 Tennessee Avenue
Cincinnati, Ohio 45229
(513) 641-4111
(800) 562-1822

## How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), employee's divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of **36 months**. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of **18 months**. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### *Disability extension of 18-month period of continuation coverage*

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion,you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Plan of your disability within the initial 18-month period of the continuation coverage or if later, within 60 (60) days after SSA issues the disability determination.

### *Second qualifying event extension of 18-month period of continuation coverage*

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the

spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. You must provide this notice to your applicable Plan office:

**CLEVELAND**
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
(800) 526-7201

**CINCINNATI**
1213 Tennessee Avenue
Cincinnati, Ohio 45229
(513) 641-4111
(800) 562-1822

**TOLEDO**
Suite 106
420 South Reynolds Rd.
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

***Are there other coverage options besides COBRA Continuation Coverage?***

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

## Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.

## If You Have Questions

Questions regarding your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health Plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at http://www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

## Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## Plan Contact Information

If you have changed marital status, or you, your spouse or dependents have changed addresses, please notify the plan administrator at Ohio AFSCME Care Plan at one of the following addresses:

**CLEVELAND**
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
(800) 526-7201

**CINCINNATI**
1213 Tennessee Avenue
Cincinnati, Ohio 45229
(513) 641-4111
(800) 562-1822

**TOLEDO**
Suite 106
420 South Reynolds Rd.
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

## USERRA CONTINUATION COVERAGE

If you are called into military service (active duty or inactive duty training) or certain types of service in the National Disaster Medical System, you may elect to continue your health coverage, as required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you are called into military service for up to 31 days, your group health care coverage will continue if you make the required employee contributions, if applicable. If you are called into military service for more than 31 days, you and your eligible dependents may continue coverage by paying the required monthly premiums for up to 24 months under USERRA.

Your coverage will continue until the earlier of:

- The date you or your dependents do not make the required premium payment;
- The date you become eligible for coverage under the Ohio AFSCME Care Plan;

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- The last day of the month after 24 consecutive months; or
- The date the Ohio AFSCME Care Plan terminates.

You need to notify the Plan Administrator at one of the Local offices at least 30 days prior to the date you will leave for the military. For more information about the election of USERRA coverage and payment of the required premiums, contact one of the following:

**CLEVELAND**
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
(800) 526-7201

**CINCINNATI**
1213 Tennessee Avenue
Cincinnati, Ohio 45229
(513)641-4111
(800) 562-1822

**TOLEDO**
Suite 106
420 South Reynolds Rd.
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

If you do not elect to continue coverage under USERRA, your coverage will end immediately when you enter military service. Your eligible dependents may continue coverage under the Ohio AFSCME Care Plan by electing and making self-payments for COBRA Continuation Coverage.

Upon your discharge from military service, you may apply for reemployment with an employer in accordance with USERRA. Such reemployment includes the right to elect reinstatement in any health insurance coverage offered under the Ohio AFSCME Care Plan. According to USERRA guidelines, reemployment and reinstatement deadlines are based on your length of military service and your honorable discharge from that service.

The following information outlines the deadlines that apply to your rights to reemployment and reinstatement of health care coverage. When you are discharged or released from military service that lasted:

- Less than 31 days, you have one day after dis- charge (allowing eight hours for travel) to return to work for an employer;
- More than 30 days but less than 181 days, you have up to 14 days after dis charge to return to work for an employer;

- More than 180 days, you have up to 90 days after discharge to return to work for an employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred during the military service, you have until the end of the period that is necessary for you to recover to return to work for an employer.

if you take military leave but do not elect USERRA coverage within sixty days of the receipt of the notice of your right to elect the coverage, your health insurance coverage offered under the Ohio AFSCME Care Plan will terminate. When you meet the reemployment deadlines and return to work with an employer, your health insurance coverage will be reinstated upon your reemployment date without regard to any waiting periods or pre-existing condition limitations.

# I. ELIGIBILITY

## A. Employee

1. **Effective Date of Your Benefit Coverage.** You are eligible to receive benefits as a Participant of the Ohio AFSCME Care Plan on the first day of the month on which your employer is first required to make a monthly contribution to the Plan on your behalf in accordance with the provisions of your collective bargaining agreement.

2. **Termination Date of Your Benefit Coverage.** You will no longer be eligible to receive benefits as of the last day of the month for which your employer is last required to make a contribution to the Plan on your behalf in accordance with the provisions of your collective bargaining agreement.

3. **Exceptions to the Termination of Your Benefit Coverage**.

   a. **Approved Leave of Absence.** if your benefit coverage terminates because of approved leave of absence, your benefit coverage may be continued during the period of approved leave of absence but not for longer than twelve (12) months, provided you pay the required contributions to the Plan in advance for each month for which your benefit coverage is to be continued beginning with the first month following the termination of your eligibility for benefit coverage.

   b. **Disability.** If your benefit coverage terminates because of disability, your eligibility for benefit coverage will be extended for three (3) months subject to submission of any information required by the Plan to verify your disability. At the end of three (3) months, benefit coverage may be continued during the period of your disability but not for longer than nine (9) months provided you pay the required contributions to the Plan for each month following the termination of your eligibility for benefit coverage.

   c. **Cobra Continuation Coverage.** See the Cobra Continuation Coverage "Very Important Notice" for a summary of your rights and obligations to continue coverage for a limited time period through self-payment to the Plan.

4. **Effective Date Proviso.** If you are not actively at work in an eligible status on the date your benefit coverage would otherwise become effective, the benefit coverage will not become effective until the date you return to active work in an eligible status.

**5. Waiver of Coverage.** You have the right to elect to not receive coverage under this Plan by notifying the Plan Administrator in writing.

## B. Benefit Plan Coverage For Your Dependents

**1. Definition of Dependent.** Dependent means only (1) your spouse, or (2) your child, including a legally adopted child or any stepchild who is less than twenty-eight (28) years of age. The term ,"dependent" will not include any person who is in full-time military, naval or air service status.

**2. Dependents' Eligibility Date.** You become eligible for coverage for your dependents on the later of (1) your eligibility date for benefit coverage, or (2) the date you acquire your first dependent.

**3. Dependents' Effective Date.** The benefit coverage for each eligible dependent will become effective on the date he or she qualifies as a dependent.

**4. Termination of Dependents' Benefit Coverage.** Your dependents' benefit coverage will automatically terminate on the earlier of (a) the date your benefit coverage terminates, or (b) the date he or she ceases to qualify as a dependent.

**5. Exceptions to the Termination of Your Dependents' Benefit Coverage.**

**a.** Dependent children are eligible to participate in the Plan up to age 28. The benefit coverage of a dependent child will not cease solely because the child has passed the upper age limit for dependent children as long as the child is not capable of self-support because of mental or physical disability and:

1. the disability began before the upper age limit was reached under the Plan and the dependent disabled child was an eligible dependent under the Plan when he/she reached the upper age limit; and
2. is unmarried and depends on the Employee for financial support.

The Plan may require periodic proof of mental or physical disability. If not provided earlier, written notice of mental or physical disability must be provided to the Plan office within 31 days of when the dependent child attains age 28. This extension will continue until the earliest of (1) the date he or she ceases to be eligible for reasons other than age, (2) the date he or she ceases to be incapacitated, or (3) the thirty-first (31st) day after we request additional proof of his or her incapacity if you fail to furnish such proof.

**b. COBRA Continuation Coverage**. See the COBRA Continuation Coverage "Very Important Notice" for a summary of your rights and obligations to continue coverage for a limited time period through self-payment to the Plan.

**6. Waiver of Coverage.** You have the right to elect to not receive coverage for your Dependents under this Plan by notifying the Plan Administrator in writing.

# II. VISION CARE BENEFIT

## For You and Your Dependents

Your Ohio AFSCME Care Plan Vision benefit works in two ways. You can choose to use your own provider as described in "B. Open Panel Reimbursement Plan" or the closed panel provider as described in "A. Closed Panel Provider Network." You and your eligible dependents, age 19 or older may use this benefit once during any twelve (24) consecutive months. Your eligible dependents under age 19 may use this benefit once during any twelve (12) consecutive months. For example, if you have a vision care examination and purchase a frame and lenses in November, 2011, you will not be able to use this benefit again until November, 2012.

## A. Closed Panel Provider Network

**Vision Care Benefit.** The Plan will pay for the cost of a complete eye examination for eyeglasses by a qualified registered optometrist. If your examination indicates the need for eyeglasses, a frame and lenses will be provided in any of a selection of good basic frames or an allowance will be made toward the purchase of contact lenses. There will be no charge for these normal benefits when services are provided at one of the providers listed on the enclosed provider list. If you prefer a more expensive frame or need or request lenses other than basic single vision, bifocal lenses, trifocal lenses or if you select contact lenses, there will be a surcharge to you to take care of the additional cost involved. When a closed panel optometrist is unable to perform an eye examination on a participant or dependent due to a verified medical condition of the participant or dependent, the Plan will apply the closed panel examination fee allowance to the cost of an examination by an ophthalmologist. There will be no charge for tints which are required due to disease.

## HOW TO OBTAIN BENEFITS

1. Call the Vision Care Provider at the telephone number on the enclosed provider list and make an appointment for an eye examination. You must call first to make an appointment for an examination.

2. Contact your Ohio AFSCME Care Plan office. The address and telephone number of each office is:

**CLEVELAND**
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
(800) 526-7201

**CINCINNATI**
1213 Tennessee Avenue
Cincinnati, Ohio 45229
(513) 641-4111
(800) 562-1822

**TOLEDO**
Suite 106
420 South Reynolds Rd.
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

State your name, Social Security number, where you work and that you wish to receive an Eye Care Benefits Certificate. State whether the appointment is for yourself or for a covered dependent.

3. If you are eligible, you will receive an Eye Care Benefits Certificate in the mail. It must be used prior to the validation date shown on the Certificate.

4. Take the Certificate with you to the Vision Care Center, and countersign it in the presence of personnel at the provider.

5. If you request or require optical supplies other than those expressly covered by the Plan, you must make arrangements with the provider to pay the surcharges directly.

### B. Open Panel Reimbursement Plan

**(Allows you to use a vision provider of your own choice)**

**Vision Care Benefit**. The Plan will help pay for the cost of an eye examination, frame and lenses or Contact lenses. The maximum amount payable by the Plan is described in the chart in the Vision Care Benefit section.

## VISION CARE BENEFIT SCHEDULE

| | **PLAN PAYMENT** |
|---|---|
| Eye Examination | up to $30.00 |
| Materials: | |
| Frames, including fitting charge and case hardening | up to $40.00 |
| Lenses, per pair including fitting charge and case hardening | |
| Single vision, white | up to $30.00 |
| Bifocal, white | up to $40.00 |
| Trifocal, white | up to $50.00 |
| Tint, if prescribed by doctor for pathology | |
| Rose, 1 & 2, indoor tint | up to $6.00 |
| Rose, 3 or darker | up to $6.00 |
| Contact lenses, per pair | up to $75.00 |

## How To File A claim

1. When you have a claim or anticipate having a claim which is incurred on or after the effective date of your Vision Care coverage, obtain a Vision Care CLAIM FORM from the Plan Office.

2. Complete the Employee Statement of Claim portion of the form and present it to the doctor or provider of service. Then return the Claim Form to the Plan Office.

3. Upon receipt of the completed Claim Form, the Plan Office will process the claim and will contact you if further information is necessary.

**All benefit claims must be submitted by December 31 after the end of the calendar year in which the expense for the vision benefit was paid. For example, all benefit claims for 2010 must be submitted to the Plan office by December 31, 2011.**

For further information, call or write Ohio AFSCME Care Plan:

**CLEVELAND**
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781 -6420
(800) 526-7201

**CINCINNATI**
1213 Tennessee Avenue
Cincinnati, Ohio 45229
(513) 641-4111
(800) 562-1822

**TOLEDO**
Suite 106
420 South Reynolds Rd.
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

## III. EXCLUDED EXPENSES

1. Any examination or materials which are not listed in the VISION CARE BENEFIT SECTION: or
2. Any lenses which do not require a prescription; or
3. Any tint not specified in the Vision Care Benefit section; or
4. Sunglasses requiring a prescription, except up to the limit under the Plan for single vision white lenses and frame; or
5. Any treatment for a condition for which the insured person has had a right to compensation under any workers' compensation or occupational disease law; or
6. Any material furnished as the result of a refraction which commenced before the date on which the person becomes insured for this benefit; or
7. Any more than one pair of glasses or Contact lenses during a twelve (12) month period; or
8. Perimetry examination; or
9. Any service or supplies other than specifically set forth herein.

## IV. DEFINITIONS

**"Calendar Year"** means the period of twelve (12) consecutive months beginning with the first day of each January.

**"Expense Incurred"** means only fees and prices regularly and customarily charged for vision care generally furnished in the particular geographical area concerned. Expense is considered to be incurred on the date the service or supply is rendered or obtained.

**"Doctor"** means Doctor of Medicine or Doctor of Osteopathy. To the extent that benefits are provided and while practicing within the scope of his or her license, "doctor" will include a dentist, podiatrist, chiropractor, optometrist, or psychologist.

## V. COORDINATION OF MEDICAL BENEFITS

Payment of Vision Care Benefits under the Plan is subject to Coordination of Benefits.

**"Coordination of Benefits"** means that if you or your eligible dependents are covered under more than one plan, the total amount payable under This Plan, when added to the amount or value of the benefits or services provided by all Other Plans, will not exceed the amount of the Allowed Expense which is incurred. in no event will the amount paid by us be more than would be paid if there were no Other Plan. Coordination of Benefits provisions will be applied on a calendar year basis.

The term **"Other Plan"** means any other coverage for vision benefits under: (a) an insurance policy, a service plan contract, a pre-payment plan or other non-insured plan, or (b) Medicare.

Other Plan does not include: (a) an accidental injury policy provided through a school for students through grade twelve (12), (b) a hospital indemnity plan except as allowed by law, (c) the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), nor (d) an individual policy except one which provides "no-fault" automobile insurance or is issued on a franchise basis. "No-fault" automobile insurance means coverage under which personal injury benefits are paid as expenses accrue without regard to fault.

The term **"Allowed Expense"** means the charge for a vision care examination and vision care materials which is customary, needed and reasonable and for which the claimant is entitled to payment under one or more plans. When any Other Plan provides sen/ices rather than cash payment, the reasonable cash value of each service will be an Allowed Expense.

if a person is covered under This Plan and under one or more Other Plans, the following rules will apply. in these rules, the plan which pays first does so without regard to coverage under Other Plans.

1. A plan which does not provide for Coordination of Benefits will pay its benefits first.
2. A plan which covers a person other than as a dependent will pay its benefits before the plan which covers the person as a dependent.

3. When a child is covered by the plans of both parents, unless they are divorced or legally separated, the plan of the parent whose birthday occurs earlier in the Calendar Year, regardless of the year of birth, will pay first. However, if the Other Plan's Coordination of Benefits provisions do not use the parents' birthdays to determine which of the parents' plans pays first, the Other Plan's provisions will make the determination.

4. If a child's parents are divorced or legally separated, payment will be made: (a) under the plan of the parent with custody before the plan of the stepparent or of the parent without custody, or (b) under the plan of a stepparent before the plan of the parent without custody. However, if, by court decree, one parent is held responsible for the child's health care expenses, payment will be made first under the plan of that parent.

5. When the rules above do not apply, the plan which has covered the person for the longer period of time will pay its benefits first. A new plan is not established when coverage by one carrier is replaced within one day of that of another.

### Exceptions To Above Rules:

With the consent of the covered person, we may release to or obtain from the Other Plan any data needed to carry out these provisions or those of Other Plans.

We have the right to recover from Other Plans or persons any payments made which exceed those required by these provisions. We also have the right to make direct payment to Other Plans or persons of amounts paid by them which should have been paid by us. Such payment will be deemed benefits paid under This Plan and will discharge our liability to the extent of the payment.

## VI. GENERAL INFORMATION

No legal action on claims will be taken within sixty (60) days after a benefit claim is submitted as required by the benefit plan nor later than three (3) years after the benefit claim is required to be submitted to the Plan office.

The benefit plan does not replace nor affect any requirement for coverage by workers' compensation insurance.

Any provision of the benefit plan which is in conflict with the laws of the governing jurisdiction is hereby amended to conform to the minimum requirements of such law.

# VII. INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The Ohio AFSCME Care Plan (The Plan) is administered by a joint Board of Trustees, consisting of fourteen (14) Trustees, seven (7) appointed by the Employers participating in the Plan, and seven (7) appointed by the Union. The Board of Trustees has been designated as the agent for the service of legal process.

The joint Board of Trustees is responsible for the operation and administration of the Plan. As of May 1, 2014 the members of the Board of Trustees are:

**Employer Trustees**

Ms. Karen Alder
City of Cincinnati
805 Central Avenue
Suite 100, Centennial Two
Cincinnati, Ohio 45202

Mr. Alvin Freeman
Commissioner
Dayton MHA
400 Wayne Avenue
Dayton, Ohio 45401

Mr. Mark E. Owens
Clerk of Dayton Municipal Court
301 West 3rd Street
Dayton, Ohio 45402

Mr. Daniel K. Lewis
Chief Administrative Officer (CAO)
The MetroHealth System
2500 MetroHealth Drive
Cleveland, Ohio 44109-1998

Mr. Richard Jackson
Assistant Safety Service Director
City of Elyria
131 Court Street
Elyria, Ohio 44035

Ms. Eleanor Haugh
Benefits Manager
Cuyahoga County
1255 Euclid Avenue, Room 310
Cleveland, Ohio 44115

Ms. Debbie Warman
Vice President, Human Resources
The Metro Health System
2500 Metro Health Drive
Cleveland, Ohio 44109

**Union Trustees**

Mr. John A. Lyall
President
AFSCME Ohio Council 8, AFL-CIO
6800 North High Street
Worthington, Ohio 43085

Mr. Harold F. Mitchell
First Vice President
AFSCME Ohio Council 8, AFL-CIO
6800 North High Street
Worthington, Ohio 43085

Mr. Thomas J. Ritchie Sr.
Director of Field Services
AFSCME Ohio Council 8, AFL-CIO
15 Gates Street
Dayton, Ohio 45402

Mr. Robert L. Thompson, Sr.
Regional Director
AFSCME Ohio Council 8, AFL-CIO
1145 Massilon Road
Akron, Ohio 44306

Ms. Pamela D. Brown
Cleveland Regional Vice President
President-AFSCME Local 1746
Cuyahoga County Department of Human Services
1603 East 27th Street
Cleveland, Ohio 44114

Ms. Emily M. Moore
Cincinnati Regional Vice President
Cincinnati Public Schools
2651 Burnet Avenue
Cincinnati, Ohio 45219

Mr. R. Sean Grayson
General Counsel
AFSCME Ohio Council 8, AFL-CIO
6800 North High Street
Worthington, Ohio 43085

if you wish to contact the Board of Trustees, you may do so in care of Ohio AFSCME Care Plan, 1603 East 27th Street, Cleveland, Ohio 44114.

The Board of Trustees is designated as the Plan Administrator. This means that the Board of Trustees is responsible for seeing that the information regarding the Plan is disclosed to Plan participants and beneficiaries and to governmental agencies in accordance with the requirements of the Employee Retirement income Security Act of 1974 (ERISA). Day-to-day details for the Plan are handled for the Board of Trustees by the Plan Administrator who may be reached at 1603 East 27th Street, Cleveland, Ohio 44114, (216) 781-6420.

Plan participants and beneficiaries may write to the Board of Trustees to find out if a particular employer is one of the contributing employers on behalf of participants working under a collective bargaining agreement, and, if so, to find out the employer's address. The Plan is maintained pursuant to collective bargaining agreements, and Plan participants may obtain a copy of any such agreement for a reasonable charge by writing to the Board of Trustees.

The Plan's benefits for eligible participants are provided through employer contributions made to the Plan under the applicable collective bargaining agreement.

All assets of the Plan are held in Trust by the Board of Trustees. The Plan is an employee welfare benefit plan maintained for the purpose of providing, as applicable in each collective bargaining agreement, loss of life benefits, accidental death and dismemberment benefits, and medical benefits. A detailed written description of the Plan benefits that you, as a participant, are entitled to, is available at the Plan's administrative office, and you may also obtain a free copy of the booklets that describe the benefits available to you by writing or calling the administrative office at the address and telephone number shown above. If you wish to inspect or receive copies of any documents relating to the Plan, contact the Plan administrative office. You will be charged a reasonable fee to cover the cost of any material you wish to receive.

The number assigned to the Board of Trustees by the Internal Revenue Service is 34-6726788, the number assigned to the Plan by the Board of Trustees is 501. The financial records of the Plan are maintained on a fiscal period commencing March 1 and ending on the following February 28 of each year.

The Plan provides for different benefits for different groups of employees. The benefits available to you vary according to the collective bargaining agreement under which you are working. The rules which describe your eligibility for benefits are contained in the Plan description booklets issued to you. If you have any questions concerning your eligibility, you may call or write the Plan administrative office.

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

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

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan administrator. 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.

In addition to creating rights of 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. Noone, 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 for exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within ninety (90) days, you may file suit in federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $100 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator.

if you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court. If it should happen that the Plan fiduclaries 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 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. 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, you should contact the nearest Area Office for the U.S. Labor Management Services Administration, Department of Labor.

## VIII. CLAIMS FILING AND APPEAL PROCEDURE

To make a claim for benefits under this Plan, follow these instructions:

**Filing of Claims.** To be reimbursed for all benefits, obtain a claim form from the Plan administrative office.

All claims submitted must be accompanied by any bills, proof, or information reasonably required to process the claim submitted.

Upon receipt of the competed forms, a decision on your claim will be made within ninety (90) days. If further time is required for a decision, you will be notified with an explanation of why more time is necessary, and in that case, a decision then will be made on your claim within one hundred eighty (180) days after receipt of your completed application.

**Appeal and Review Procedure**. if your claim for benefits is denied in whole or in part, you will receive written notification stating the specific reason or reasons for the denial, specific reference to Plan provisions on which the denial is based, and, if applicable, a description of any additional material or information necessary to complete the claim with an explanation of why the material or information is required. You will also receive an explanation of the claims appeal procedure.

If you are not satisfied, or do not agree with the reasons for the denial of your claim, you may appeal and request a review within sixty (60) days of the date you received the letter denying your claim. The appeal must be in writing, and can be made either by you or your authorized representative. In it you must set out your disagreement. You may also request an opportunity to review necessary and pertinent documents which may affect your appeal.

**Who Is Responsible to Make a Decision on Your Appeal?** The review shall be by the Board of Trustees of the Plan. Send your appeal to:

Board of Trustees
Ohio AFSCME Care Plan
1603 East 27th Street
Cleveland, Ohio 44114

An applicant who has not received a decision on his claim for benefits within ninety (90) days (or one hundred eighty [180] days if you have been notified of special circumstances) may request a review of his claim.

Your claim appeal will be promptly reviewed, and you will be advised of a decision within sixty (60) days after receipt of your appeal, unless special circumstances require an extension of time for processing, in which case a decision shall be made within one hundred twenty (120) days. The decision will be in writing and will include the specific reasons for the decision and specific references to Plan provisions on which the decision is based.

# IMPORTANT NOTICE

**It is important that you contact the Plan Office to:**

1. **Fill out an ENROLLMENT CARD.**
2. **Change your home address whenever you move.**

## For further information call or write

## OHIO AFSCME CARE PLAN

**CLEVELAND**
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
Michael D. Bauer, Plan Administrator

**CINCINNATI**
1213 Tennessee Ave.
Cincinnati, Ohio 45229
(513) 641-4111
(800) 562-1822

**TOLEDO**
420 South Reynolds Rd., Suite 106
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631