SUMMARY PLAN DESCRIPTION/
PLAN DOCUMENT

SERVICE EMPLOYEES INTERNATIONAL UNION
LOCAL 1 CLEVELAND WELFARE FUND
(As Amended and Restated Effective January 1, 2020)

BOARD OF TRUSTEES

UNION TRUSTEES

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Yanela Sims, Trustee
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EMPLOYER TRUSTEES

Robert Castle, Secretary
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January 2020

SERVICE EMPLOYEES INTERNATIONAL UNION
LOCAL 1 CLEVELAND WELFARE FUND

January 2020

To All Welfare Plan Participants:

The Trustees of the Service Employees International Union Local 1 Cleveland Welfare Fund (hereinafter "Plan") are pleased to present you with this new booklet, which updates and replaces prior booklets, describes the Plan's current provisions, and includes the advisory information required by the Employee Retirement Income Security Act of 1974, as amended (hereinafter "ERISA"). This booklet includes changes to the Plan's provisions which have been adopted through December 31, 2019, including legally required changes under the Patient Protection and Affordable Care Act.

We urge you to read this booklet carefully in order to become familiar with the Plan since the changes were adopted. The Plan described in this booklet is for employees who are eligible to be covered under the Plan on or after January 1, 2020. If you have any questions pertaining to your coverage under the Plan, your rights are determined in accordance with the terms of the Plan then in effect.

Please understand that this booklet is a general explanation only and does not cover all of the Plan's details. Depending on the benefit program by which you are covered, any medical benefits, vision care benefits, or dental benefits for which you may be eligible are set forth in individual summaries for each type of benefit.

Only the full Board of Trustees is authorized to interpret the Plan. No other individual or organization, such as your union or employer, nor any employee or representative of any individual or organization is authorized to interpret this Plan or to act as an agent of the Board of Trustees. Should you have any questions regarding the Plan, please direct them to the Plan's Third Party Administrator.

We suggest that you share this booklet with your family because they may have an interest in the Plan and the benefits it provides. You should keep this booklet with your other important papers and let members of your family know where it is being kept.

Sincerely,

THE BOARD OF TRUSTEES

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INTRODUCTION

This booklet, distributed in January 2020, is designed to describe the benefits available to you under the Service Employees International Union Local 1 Cleveland Welfare Fund. It is intended that this information will satisfy the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, for a summary plan description (hereinafter "Summary").

This Summary is for employees who work pursuant to certain collective bargaining agreements between their employers and Service Employees International Union, Local 1 (the "Union"). This Plan includes eight different benefit programs (designated numerically in this Summary as Plans 1, 2, 3, 4, 5, 6, 7, and 8) for employees who are covered by collective bargaining agreements between the Union and various employers. A copy of the collective bargaining agreement applicable to you is available for your examination at the Union Hall.

SPECIAL NOTICE!

It is extremely important that you keep the Fund Office informed of any changes in address or marital status. It is your obligation to keep the Fund Office informed of any such changes, and failure to fulfill this obligation could jeopardize your eligibility for benefits.

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

IMPORTANT RIGHTS AND NOTICES

SPECIAL ENROLLMENT RIGHTS UNDER PORTABILITY PROVISIONS OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, please contact the Fund Office.

WOMEN'S CANCER RIGHTS

On October 21, 1998, the Women's Health and Cancer Rights Act ("Cancer Rights Act") was signed into law. The Trustees are issuing this notice in compliance with the Cancer Rights Act. The Plan provides the benefits required by this law. You have a right to this notice, and the Trustees are providing the notice for your information so that you may be assured that you are treated in accordance with federal law if the need arises.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall, at a minimum, provide for:

A. reconstruction of the breast on which the mastectomy was performed;

B. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

C. prostheses and physical complications for all stages of mastectomy, including lymphedemas

in a manner determined in consultation with the attending physician and the patient. As part of the Plan's schedule of benefits, such benefits are subject to the Plan's appropriate cost control provisions such as deductibles and coinsurance.

If you have any questions regarding these federal requirements, please contact the Fund Office.

PROTECTIONS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Trustees are issuing this notice in compliance with the Newborns' and Mothers' Health Protection Act of 1996. The Plan provides the benefits required by this law. You have a right to this notice, and the Trustees are providing the notice for your information so that you may be assured that you are treated in accordance with federal law if the need arises.

Plan 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 no in excess of 48 hours (or 96 hours, as applicable).

If you have any questions regarding these federal requirements, please contact the Fund Office.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009

Under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP"), employees and dependents who are eligible for coverage but who are not enrolled for coverage may exercise special enrollment rights and enroll in the Plan if the Employee or dependent:

A. loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; or

B. loses coverage under State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act; or

C. becomes eligible for group health plan premium assistance under Medicaid or SCHIP.

If any of these circumstances arises and the Employee or dependent wishes to take advantage of these special enrollment rights, the employee or dependent must request to enroll for coverage within sixty (60) days from the date:

1. the coverage terminates under the Medicaid or SCHIP plan, or

2. the Employee or dependent child is determined eligible for state premium assistance.

If you believe you are eligible for special enrollment under CHIP, you must contact the Fund Office to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by the Fund Office. Requests for special enrollment must be made within sixty (60) days of an event described above.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

If you are required to be absent from work as the result as the result of service in the Uniformed Services, coverage for medical benefits may be continued for a Covered Employee in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Under USERRA, the term "Uniformed Services means the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or national emergency.

I. PLAN IDENTIFICATION AND GENERAL INFORMATION

A. Name of the Fund

The formal name of the Plan is the "Service Employees International Union Local 1 Cleveland Welfare Fund."

B. Names and Addresses of the Employers

The Plan is a multiemployer plan as that term is defined in the Employee Retirement Income Security Act of 1974, as amended, and numerous Employers contribute to it. It would not be practical to list them all here; however, upon written request to the Plan's Third Party Administrator, you will receive information as to whether a particular Employer or Union is contributing to the Plan, and if so, its address.

C. Name and Address of the Plan Sponsor

The Plan Sponsor of the Plan is the Board of Trustees of the Local 1 Cleveland Welfare Fund. The name and address of the Plan Sponsor are as follows:

Board of Trustees
Service Employees International Union Local 1
Cleveland Welfare Fund
812 Huron Road, Suite 230
Cleveland, Ohio 44115

D. Name and Address of the Third Party Administrator

The Plan is administered and maintained by the Board of Trustees; however, the Trustees have the authority to delegate certain administrative functions to a professional administrative manager, if and when the need arises. The Board of Trustees, exercising their authority to delegate certain administrative functions to a professional administrative manager, have presently engaged Donald J.

Lowe and Associates Agency, Inc. to administer and process the Plan's claims. The name and address of the Third Party Administrator is as follows:

Donald J. Lowe and Associates Agency, Inc.
812 Huron Road, Suite 230
Cleveland, Ohio 44115
Phone: (216) 861-6644
Fax: (216) 861-7669

Questions pertaining to your or eligibility under the Plan and claims processing should be directed to the Third Party Administrator.

E. Plan Numbers Assigned to the Plan

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 34-0820618, and the Plan number for purposes of identification is 501.

F. Type of Plan

The Plan provides life and accidental death and dismemberment insurance, accident and sickness disability benefits, hospitalization, prescription drug benefits, major medical benefits, vision care benefits, and dental benefits.

G. Plan Year

The Plan Year is a twelve (12) month period beginning January 1 and ending December 31. Annual limits on deductibles, co-pay maximums, out-of-pocket expenses, and related limits are also based on the calendar year.

H. Collective Bargaining Agreements

The Plan is maintained pursuant to collective bargaining agreements between Service Employees International Union Local 1 Cleveland ("Union") and the various contributing Employers. You may obtain a copy of the collective bargaining agreement that covers you by writing to the Union office at 1368 East 34th Street, Cleveland, Ohio 44114.

I. Type of Administration Used for the Plan Assets

The Plan shall be administered by a Board of Trustees consisting of no fewer than four (4) and no greater than eight (8) voting Trustees, with an equal number of Employer Trustees and Union Trustees at all times. The Trustees who are designated as "Employer Trustees" shall be appointed by the Employers. The Trustees who are designated as "Union Trustees" shall be appointed by the Union. At the present time, the Union Trustees and the Employer Trustees are:

UNION TRUSTEES	EMPLOYER TRUSTEES
Kenneth Munz,Chair	Robert Castle, Secretary
Yanela Sims, Trustee	Scott Sedio, Trustee
Max Gerboc, Trustee	

Correspondence can be sent to the Board of Trustees at: Trustees of the Service Employees International Union Local 1 Cleveland Welfare Fund, 812 Huron Road, Suite 230, Cleveland, Ohio 44115.

J. Attorneys for the Fund and Agent for Service of Process

Allotta | Farley Co., L.P.A.
2222 Centennial Road
Toledo, Ohio 43617
Phone: (419) 535-0075
Fax: (419) 535-1935
Email: www.allottafarley.com

K. Funding Medium for the Accumulation of Plan Assets

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to Covered Persons and paying premiums and defraying reasonable administrative expenses. The Plan provides the following benefits to Covered Persons:

1. medical benefits;
2. hospitalization benefits;
3. prescription drug benefits;
4. vision care benefits;
5. dental benefits;
6. group life and accidental death and dismemberment insurance benefits; and
7. injury and illness disability benefits; and

The Plan has eight different benefit programs that correspond to eight different employment classifications. These benefit programs are designated in this Summary as Plan 1, Plan 2, Plan 3, Plan 4, Plan 5, Plan 6, Plan 7, and Plan 8, respectively. Each benefit program offers different benefits. The program under which you are entitled to receive benefits depends on the applicable provisions of the collective bargaining agreement between your Employer and the Union.

L. Effective Date When Plan Began

January 1, 1968.

M. Effective Date of the Amended and Restated Plan

January 1, 2020.

N. Sources of Contributions to the Plan

The Plan is financed by Employer contributions in accordance with various collective bargaining agreements and/or other written agreements between the contributing Employer and the Union, by self-contributions by Participants for continuing coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 and related regulations and amendments ("COBRA") and such other requirements as the Board of Trustees may determine, and by investment income earned on the Plan's assets. The Union shall be the authority for the specific provisions of the collective bargaining agreement establishing the obligation of the Employers to make contributions to the Plan.

O. Plan Amendment and Termination

The Trustees reserve the right to amend or terminate the Plan at any time and for any reason. If the Plan is amended or terminated, you and other active and retired employees may not receive benefits as described in other sections of this Summary. You may be entitled to receive different benefits or benefits under different conditions. However, it is possible that you will lose all benefit coverage. This may happen at any time, even after you retire, if the Trustees decide to terminate the Plan or your coverage under the Plan. In no event will you become entitled to any vested rights under this Plan. Further, the provisions of this paragraph cannot be modified in any manner except by resolution of the Board of Trustees.

P. Plan is Not a Contract

The Plan shall not be deemed to be a contract between the Plan Sponsor and any Participant and/or beneficiary, or to be an inducement to or condition of employment. Nothing in the Plan shall be deemed to give an Employee the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge any Employee at any time.

II. ELIGIBILITY

Eligibility to participate in the Plan depends initially on whether you are a full-time or a part-time employee. In general, you will be classified as a full-time employee if you are reasonably expected to work an average of at least—

- 30 hours per week, or
- 120 hours per month

during the initial eligibility measurement period prescribed for your participating group. At your time of hire, the Fund Office will make inquiry concerning the regularly scheduled hours that your Employer intends for you to work. Your classification as a full-time or part-time employee will depend your Employer's representation concerning the hours that you are reasonably expected to work for your Employer on a regular basis.

If you are regularly scheduled to work for your Employer at least 30 hours per week, you will be classified as a **full-time employee**. If you are regularly scheduled to work for your Employer fewer than 30 hours per week, you will be classified as a **part-time employee**.

For eligibility purposes, your hours of service include hours worked, and hours for which you are paid but do not work. These non-work hours include periods during which you are on vacation, holiday, illness or disability, jury duty, military duty, or leave of absence (up to a maximum of 160 hours for any continuous period). Hours of service must be tracked on an actual hours-basis for hourly employees. Special rules apply for counting hours in certain situations. These rules are set forth in Section 4980H of the Internal Revenue Code and Internal Revenue Service Bulletin 2011-21.

To become eligible to participate, any employee who has satisfied the eligibility service requirements (as set forth in A. below) for the particular employee group to which the employee belongs must satisfactorily complete an application enrollment form. The form must be completed by the date prior to the date on which the employee would otherwise first become eligible to receive benefits under the Plan (the "Application Effective Date") after satisfying the applicable group's eligibility service requirements.

It is important that eligible employees complete the application enrollment form by the Application Effective Date. Any employee who—

- has satisfied the applicable group's eligibility service requirements, but
- fails to satisfactorily complete an application enrollment form by the Application Effective Date

will be deemed to have declined coverage for all benefits under the Plan, and will not again become eligible to participate until the Plan's next open enrollment period.

For this purpose, the Plan's open enrollment period is the 30-day period prior to the first day of the Medical Plan Policy Year, as defined in the document entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document." However, if an employee who is deemed to have declined coverage incurs a Spouse-related qualifying event under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") after the Application Effective Date, the employee may become eligible to participate prior to the next open enrollment period. To become eligible, the employee must satisfactorily complete an application enrollment form by the date prior to the date on which the employee would first become eligible to receive benefits under the Plan as a result of the qualifying event.

EXAMPLE: In January 2020, you begin employment with an Employer as a full-time employee and satisfy the eligibility service requirements for Plan 2 by April 30, 2020. To become eligibile to participate by June 1, 2020, you must satisfactorily complete an application enrollment form by the Application Effective Date, May 31, 2020. If you fail to satisfactorily complete an application enrollment form by the Application Effective Date, you must wait until the Plan's next open enrollment period to become eligibile to participate, unless you have incurred a Spouse-related COBRA qualifying event. However, if you have incurred a Spouse-related COBRA qualifying event, you will become eligible to participate sooner, provided that you have satisfactorily completed an application enrollment form by the date prior to the date on which you would first become eligible to receive benefits under the Plan as a result of the qualifying event.

A. Initial Eligibility for New Employees

Plan 1 – Part-Time Employees. If you are an employee who is classified as part-time, you are eligible to receive benefits under Plan 1 on the first day of the coverage month after:

1. Contributions of at least one hundred (100) hours have been received on your behalf by the Fund Office from an Employer bound to a collective bargaining agreement with the Union; and

2. You are employed by an Employer bound to a collective bargaining agreement with the Union for a minimum of four (4) consecutive months; and

3. You satisfactorily complete an application enrollment form; and

4. You are a bargaining unit employee pursuant to a collective bargaining agreement to which the Union is a party.

Plan 2 – Full-Time Employees. If you are an employee who is classified as full-time, you are eligible to receive benefits under Plan 2 on the first day of the coverage month after:

1. Contributions of at least two hundred sixty (260) hours have been received on your behalf by the Fund Office from an Employer bound to a collective bargaining agreement with the Union; and

2. You are employed by an Employer bound to a collective bargaining agreement with the Union for a minimum of four (4) consecutive months; and

3. You satisfactorily complete an application enrollment form; and

4. You are a bargaining unit employee pursuant to a collective bargaining agreement to which the Union is a party.

Plan 3 – Full-Time Government Employees. If you are an employee who is classified as a full-time government employee, you are eligible to receive benefits under Plan 3 on the first day of the

coverage month after:

1. Contributions of at least forth (40) hours have been received on your behalf by the Fund Office from an Employer bound to a collective bargaining agreement with the Union; and

2. You are employed by an Employer bound to a collective bargaining agreement with the Union for a minimum of one (1) month; and

3. You satisfactorily complete an application enrollment form; and

4. You are a bargaining unit employee pursuant to a collective bargaining agreement to which the Union is a party.

Plan 4 – Part-Time Government Employees. If you are an employee who is classified as a part-time government employee, you are eligible to receive benefits under Plan 4 on the first day of the coverage month after:

1. Contributions of at least forty (40) hours have been received on your behalf by the Fund Office from an Employer bound to a collective bargaining agreement with the Union; and

2. You are employed by an Employer bound to a collective bargaining agreement with the Union for a minimum of one (1) month; and

3. You satisfactorily complete an application enrollment form; and

4. You are a bargaining unit employee pursuant to a collective bargaining agreement to which the Union is a party.

Plan 5 – Call-In Government Employees. If you are an employee who is classified as a call-in government employee, you are eligible to receive benefits under Plan 5 on the first day of the coverage month after:

1. Contributions of at least ten (10) hours have been received on your behalf by the Fund Office from an Employer bound to a collective bargaining agreement with the Union; and

2. You are employed by an Employer bound to a collective bargaining agreement with the Union for a minimum of one (1) month; and

3. You satisfactorily complete an application enrollment form; and

4. You are a bargaining unit employee pursuant to a collective bargaining agreement to which the Union is a party.

Plan 6 – Full-Time Employees with Family Coverage. If you are an employee of an Employer that is bound to a collective bargaining agreement with the Union under which coverage for Spousal and non-Spousal Eligible Dependents is provided ("Plan 6 Employee"), you are eligible to receive benefits on the first day of the month for which:

1. You satisfy the eligibility service requirements, as determined by your Employer, for coverage under Plan 6; and

2. The Fund Office timely receives from your Employer an amount sufficient to cover the monthly premium for Plan 6 coverage for that month; and

3. You satisfactorily complete an application enrollment form.

Plan 7 – Window Cleaner Employees Opting Out of Plan 6 Coverage. If you are a Window Cleaner employee of an Employer that—

- is designated as a window cleaning business and
- is bound to a collective bargaining agreement with the Union under which coveage under Plan 6 is offered

but you have opted out of such coverage ("Plan 7 Employee"), you are eligible to receive benefits on the first day of the month for which:

1. You satisfy the eligibility service requirements, as determined by your Employer, for coverage under Plan 7; and

2. The Fund Office timely receives from your Employer an amount sufficient to cover the monthly premium for Plan 7 coverage for that month; and

3. You satisfactorily complete an application enrollment form.

Plan 8 – Full-Time Employees Who Are Eligible for Premium-Based Medical Plan Coverage. If you are a full-time employee of an Employer that is bound to a collective bargaining agreement with the Union under which premium-based medical plan coverage is provided ("Plan 8 Employee"), you are eligible to receive benefits on the first day of the month for which:

1. You satisfy the eligibility service requirements, as determined by your Employer, for coverage under Plan 8; and

2. The Fund Office timely receives from your Employer an amount sufficient to cover the monthly premium for Plan 8 coverage for that month; and

3. You satisfactorily complete an application enrollment form.

Service Management Group Employees. If you were a full-time employee of Service Management Group ("SMG") on November 1, 2016, you became eligible to receive benefits under the Plan

beginning on November 1, 2016, without having to satisfy the Plan's initial eligibilty requirements for full-time employees who are covered under Plan 2, provided that—

1. on November 1, 2016, when the collective bargaining agreement between SMG and the Union covering Employees working at the Cleveland Convention Center ("SMG/Cleveland Convention Center Agreement") became effective, you were an active SMG Employee working at the Cleveland Convention Center in employment covered by the SMG/Cleveland Convention Center Agreement; and

2. you satisfactorily complete a new application enrollment form for coverage under the Plan in accordance with the SMG/Cleveland Convention Center Agreement; and

3. the Fund Office timely receives from SMG an amount sufficeint to cover the monthly premium for your Plan 2 coverage for November 2016.

VGS Inc. Employees. If you were a full-time, part-time, or call-in employee of VGS Inc. ("VGS") on October 1, 2017, you became eligible to receive benefits under the Plan beginning on October 1, 2017, without having to satisfy the Plan's initial eligibilty requirements for full-time, part-time, or call-in employees who are covered under Plan 3, Plan 4, or Plan 5, as applicable, provided that—

1. on October 1, 2017, when the collective bargaining agreement between VGS and the Union covering Employees working at the Carl B. Stokes Courthouse and/or the Howard Metzenbaum Courthouse in Cleveland, Ohio ("VGS/Cleveland Courthouse Agreement") became effective, you were an active VGS Employee working at the Carl B. Stokes Courthouse and/or the Howard Metzenbaum Courthouse in employment covered by the VGS/Cleveland Courthouse Agreement; and

2. you satisfactorily complete a new application enrollment form for coverage under the Plan in accordance with the VGS/Cleveland Courthouse Agreement.

Inner-Space Cleaning Corporation Employees. If you were a full-time employee of Inner-Space Cleaning Corporation ("Inner-Space") on August 1, 2019, you will be eligible to receive benefits under the Plan beginning on August 1, 2019, without having to satisfy the Plan's initial eligibilty requirements for full-time employees who are covered under Plan 2, provided that—

1. on August 1, 2019, when the collective bargaining agreement between Inner-Space and the Union covering Employees working at various locations of PNC Bank in Cleveland, Brecksville, and Strongsville, Ohio became effective, you were an active Inner-Space Employee working at one of the locations specified in the Memorandum of Understanding—PNC Suburban Locations, dated June 27, 2019, in work covered by the Cleveland Master Janitorial Agreement; and

2. you satisfactorily complete a new application enrollment form for coverage under the Plan in accordance with the Cleveland Master Janitorial Agreement.

If you were not a full-time employee of Inner-Space on August 1, 2019, you will be required to

satisfy the Plan's initial eligibility requirements.

The following examples illustrate when coverage begins under benefit programs that have an hours requirement for eligibility.

> **EXAMPLE – PLAN 1:** You begin employment with an Employer as a part-time employee in January 2020 and remain employed by the Employer for four (4) consecutive months, through April 30, 2020. During this four (4) month period, the Fund Office receives contributions made by the Employer on your behalf for one hundred (100) hours, and you complete all required enrollment forms. You are eligible to receive benefits under Plan 1 on June 1, 2020.
>
> **EXAMPLE – PLAN 2:** You begin employment with an Employer as a full-time employee in April 2020 and remain employed by the Employer for four (4) consecutive months, through July 31, 2020. During this four (4) month period, the Fund Office receives contributions made by the Employer on your behalf for two hundred sixty (260) hours, and you complete all required enrollment forms. You are eligible to receive benefits under Plan 2 on September 1, 2020.
>
> **EXAMPLE – PLANS 3 AND 4:** You begin employment with an Employer as a full-time or part-time government employee in April 2020 and remain employed by the Employer for one (1) month, through April 30, 2020. During this one (1) month period, the Fund Office receives contributions made by the Employer on your behalf for forty (40) hours, and you complete all required enrollment forms. You are eligible to receive benefits under Plan 3 or Plan 4 on June 1, 2020.
>
> **EXAMPLE – PLAN 5:** You begin employment with an Employer as a call-in government employee in April 2020 and remain employed by the Employer for one (1) month, through April 30, 2020. During this one (1) month period, the Fund Office receives contributions made by the Employer on your behalf for ten (10) hours, and you complete all required enrollment forms. You are eligible to receive benefits under Plan 5 on June 1, 2020.

Dual Eligibility. Your coverage classification (full time, part-time, or call-in) is determined by the employer according to the collective bargaining agreement as of your date of hire. If you simultaneously meet the eligibility requirements for coverage under more than one coverage classification, you will automatically be included in the coverage classification that provides you with the most favorable coverage, as determined by the Third Party Administrator. However, you may not be included in more than one coverage classification at the same time.

B. Continuing Eligibility

In order to remain eligible, you must be a bargaining unit employee and be paid for a minimum number of hours per work month, as set forth in the following schedule, by an Employer bound to a collective bargaining agreement with the Union. The hours set forth in the schedule below correspond to the hours that will be deducted from your Hours Bank (see Section C of Article II, entitled "Hours Bank," below) each month to maintain eligibility for coverage.

Plan	Coverage Classification	Minimum Number of Monthly Hours			Total Hours
		Basic Plan Benefits	Dental	Vision	
1	Part-Time	40	2	2	44
2	Full-Time	110	2	2	114
3	Full-Time Government	38	1	1	40
4	Part-Time Government	28	1	1	30
5	Call-In Government	8	1	1	10

If you are paid for fewer than the applicable hours minimum in any given work month, your eligibility terminates on the last day of the coverage month. However, effective September 1, 2014, you may temporarily remain eligible by using your Hours Bank hours, if any, to attain the minimum number of hours required for continuing eligibility or, in the alternative, by making self-payments (See Section D of Article II, entitled "Self-Payments," below).

If you are terminated from employment for cause, your eligibility will terminate on the last day of the month in which you were terminated. Upon your termination, your Hours Bank will be forfeited, and you will not be eligible to make self-payments (see Section D of Article II, entitled "Self-Payments," below) to maintain eligibility. To maintain your eligibiity, you will be required to elect COBRA continuation coverage (see Section G of Article II, entitled "Continuation of Group Health Insurance Coverage," below).

If your eligibility terminates, your coverage will be reinstated only after you have met the initial eligibility requirements, as described in the Section A of Article II, entitled "Initial Eligibility for New Employees," above.

EXAMPLE

WORK MONTH	HOURS SUBMITTED	COVERAGE MONTH
January	February	March
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August
July	August	September
August	September	October
September	October	November
October	November	December
November	December	January
December	January	February

If you are covered by Plan 1 or Plan 2, the level of benefits for which you are eligible depends upon the hours you are scheduled to work as described in the Summary Plan Description.

Employees Covered by Plan 6, 7, or 8. If you are an employee covered by Plan 6, Plan 7, or Plan 8, to remain eligible you must be a bargaining unit employee and must continue working for an Employer that is bound to a collective bargaining agreement with the Union under which coverage

for employees is provided under the applicable plan. Your Employer must continue to make payments to the Fund Office on your behalf in an amount sufficient to cover your monthly premium for coverage, either single or family, for each month of your continuing eligibility. Your eligibility terminates on the last day of the last month for which the Fund Office has timely received a premium payment on your behalf in an amount sufficient to cover your monthly premium.

C. Hours Bank

Effective September 1, 2014, an Hours Bank was established for each participant. The hours that are credited to your Hours Bank are used to provide continuing eligibility if you are paid for fewer than the applicable hours minimum in any given work month. Your Hours Bank hours may not be used to establish or reestablish your initial eligibility (see Section B of Article II, entitled "Continuing Eligibility," above).

In general, your Hours Bank will be credited with one (1) hour for each hour by which your hours of work in a given month exceed the total hours of work required to maintain eligibility in your coverage classification.

> **EXAMPLE – PLAN 2:** Assume that you are a participant in Plan 2 on January 1, 2020, have an Hours Bank balance of 0 hours as of that date, and have 140 hours of work in January 2020. Assume further that you are receiving basic medical, dental, and vision benefits under Plan 2. The monthly hours minimum for a Plan 2 participant who is receiving basic medical, dental, and vision benefits is 114 hours. Your Hours Bank will be credited with 26 hours for the month of January because your work hours in January exceeded the monthly hours minimum for a Plan 2 participant who is receiving basic medical, dental, and vision benefits by 26 hours (140 – 114 = 26).

Depending on your coverage classification, you will be permitted to accumulate Hours Bank hours up to the following maximum amounts:

Plan	Coverage Classification	Hours Bank Hours Maximum
1	Part-Time	60
2	Full-Time	165
3	Full-Time Government	N/A
4	Part-Time Government	N/A
5	Call-In Government	N/A
6	HealthSpan	N/A
7	HealthSpan Opt-Out	N/A
8	Full-Time Premium-Based	N/A

D. Self-Payments

If you are participating in Plan 1 or Plan 2 and—

1. are laid off, are transferring to a position with another Employer, or are paid for fewer than the applicable hours minimum in any given work month needed to

maintain eligibility; and

2. you have an insufficient number of Hours Bank hours to maintain eligibility,

you will be allowed to maintain eligibility by making self-payments to the Plan for up to three (3) months at the rate of $2.50 per hour for any hours needed to maintain eligibility. This hourly rate is subject to annual adjustment to reflect the Plan's claims experience and other factors affecting the Plan's financial soundness.

> **EXAMPLE – PLAN 2:** Assume that you are a participant in Plan 2 who is receiving basic medical, dental, and vision benefits on September 1, 2020, work full-time in September, October, November, and December, and are laid off on December 31, 2020. Assume further that your work hours in each of those months exceeded the monthly hours minimum needed to maintain eligibility for a Plan 2 participant who is receiving basic medical, dental, and vision benefits (114) and that as of January 1, 2015, you have 120 Hours Bank hours. You may use 114 of your Hours Bank hours to maintain eligibility for January 2020. However, because your Hours Bank balance of 6 hours (120 – 114 = 6) as of February 1, 2020 is insufficient to satisfy the monthly hours minimum for a Plan 2 participant who is receiving basic medical, dental, and vision benefits, to maintain eligibility for February 2020 you are permitted to make self-payments to the Plan for your hours shortage of 108 hours (114 – 6 = 108). Your required self-payment for February 2020 is $270 (108 hours x $2.50/hour = $270). If you self-pay for February 2020, you may continue self-paying for two additional months, March and April 2015, in the full monthly amount, $285 (114 hours x $2.50/hour = $285), to maintain eligibility.

Your self-payments must be received at the Fund Office within fourteen (14) days after the date of the self-payment notice issued by the Fund Office. You may not self-pay to maintain coverage for a period exceeding three (3) months. After three (3) months of self-pay coverage, you will be required to change to continuation coverage made available to you under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") (see Section G of Article II, entitled "Continuation of Group Health Insurance Coverage," below). If you change to COBRA continuation coverage and later return to employment that is covered by a collective bargaining agreement between your Employer and the Union, you will be required to requalify for coverage in accordance with the Plan's initial eligibility provisions (see Section A of Article II, entitled "Initial Eligibility New Employees").

If you are terminated for cause or fail to timely make sufficient self-payments to maintain eligibility, your Hours Bank hours will be forfeited, and you will be offered continuation coverage under COBRA in order to maintain coverage under the Plan.

E. Disability Leave of Absence

General – Illness or Injury Unrelated to Employment or Related to Employment but Not Covered by Worker's Compensation, Occupational Disease, or Other Law. If you are absent from work because of illness of injury that—

- arises out of circumstances outside the scope of your employment, or

- arises out of or occurs in the course of your employment, but is not covered by a worker's compensation law, occupational disease law, or similar law,

your Employer will continue to make contributions to the Plan on your behalf for a period of thirteen (13) weeks following the month in which your illness began or when you were injured, and your Hours Bank will be credited with sufficient hours to maintain eligibility during this period. You may also be entitled to receive accident or sickness (loss of time) benefits from the Plan. If you are unable to return to work at the end of your disability leave of absence, you will be offered continuation coverage under COBRA in order to maintain coverage under the Plan.

Illness or Injury Covered by Worker's Compensation, Occupational Disease, or Other Law. If you are absent from work because of an illness or injury that—

- arises out of or occurs in the course of your employment, and
- is covered by a worker's compensation law, occupational disease law, or similar law, your Employer will continue to make contributions to the Plan on your behalf for a period of thirteen (13) weeks following the month in which your illness began or when you were injured, and your Hours Bank will be credited with sufficient hours to maintain eligibility during this period. However, you will not be entitled to receive accident or sickness (loss of time) benefits from the Plan. If you are unable to return to work at the end of your disability leave of absence, you will be offered continuation coverage under COBRA in order to maintain coverage under the Plan.

Special Rule – Participants Covered by Plan 6 or Plan 8. If you are covered by Plan 6 or Plan 8 and you suffer an occupational illness or an occupational injury, your Employer will continue to make premium payments to the insurance company selected by the Plan to provide coverage for a period of thirteen (13) weeks following the month in which your illness began or when you were injured. If you are unable to return to work at the end of your disability leave of absence, you will be offered continuation coverage under COBRA in order to maintain coverage under the Plan.

Special Rule – Window Cleaner Employees Covered by Plan 6 or Plan 7. If you are a Window Cleaner employee covered by Plan 6 or Plan 7 and you suffer an occupational illness or an occupational injury, your Employer will continue to make contributions to the Plan during your period of unemployment according to the following schedule:

1. If you have fewer than five (5) years of seniority with the Employer, the Employer will contribute for a period of six (6) months from the date of such illness or injury.

2. If you have at least five (5) years of seniority with the Employer, the Employer will contribute for a period of twelve (12) months from the date of such illness or injury.

If you are unable to return to work at the end of your disability leave of absence, you will be offered continuation coverage under COBRA in order to maintain coverage under the Plan.

F. Termination of Coverage

Employees. Your coverage under the Plan will end at midnight on the earliest of:

1. the date on which the Plan terminates; or

2. the last day of the month in which your employment is terminated; or

3. the date on which you cease to be eligible; or

4. the date of your retirement (although you may be entitled to receive a reduced life insurance benefit during your retirement); or

5. the date on which your Employer becomes sixty (60) days delinquent in making contributions to the Plan.

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you will be provided with Certificate of Creditable Coverage forms if you lose coverage under the Plan. You may contact the Third Party Administrator to obtain a Certificate of Creditable Coverage before you lose coverage under the Plan or to obtain an additional Certificate of Creditable Coverage.

If your coverage under Plan 1, 2, 3,4, 5, 6, 7, or 8, as applicable, terminates and you are eligible at that time for coverage under another benefit program, you will automatically be covered by the other benefit program for which you are eligible. If your coverage terminates and you are at that time eligible for coverage under more than one benefit program, you will automatically be covered by the remaining benefit program which provides you with the most favorable coverage, as determined by the Third Party Administrator. However, you may not be covered by more than one benefit program at the same time.

Dependents. Eligible Dependent coverage has been extended under the Patient Protection and Affordable Care Act ("Affordable Care Act"). For Plan Years beginning on or after January 1, 2011, Eligible Dependent coverage under the Plan is extended until a child attains age twenty-six (26). Further, no Eligible Dependent who is under age nineteen (19) may be denied coverage under the Plan on account of a preexisting condition.

Eligible Dependent coverage under the Plan is also limited in other ways. For Plan Years beginning before January 1, 2015, Eligible Dependent coverage is limited to dental and vision benefits. Beginning in 2015, medical and prescription benefits will be added for Eligible Dependents, but only for children, and not for Spouses.

Your Eligible Dependent's coverage will end at midnight on the earliest of:

1. the day in which you are no longer eligible under the Plan; or

2. the day the Plan terminates; or

3. the day any premium is due and unpaid; or

4. the day before a Dependent enters military service on active duty, unless you have elected continuation of coverage for such Dependent under the Military Service rules in Article II, Section G, or unless otherwise required by the Uniformed Services Employment and Reemployment Rights Act of 1994; or

5. the day on which the Dependent ceases to qualify as an Eligible Dependent under the Plan's terms.

G. Continuation of Group Health Insurance Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 and related regulations and amendments ("COBRA"), any Participant who loses coverage under the Plan by reason of a life event known as a "qualifying event" may elect to continue health coverage under the Plan on a temporary basis from the day the Participant's eligibility ends. Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be Qualified Beneficiaries. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than your gross misconduct.

COBRA Continuation Coverage for Employees Who Have Elected Eligible Dependent Coverage

A special rule applies if you are an Eligible Dependent of an Employee and you are covered as an Eligible Dependent under applicable provisions of Plan 1, 2, 3, 4, 5, 6, 7, or 8. In such cases, you will become a Qualified Beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. your Spouse dies;
2. your Spouse's hours of employment are reduced;
3. your Spouse's employment ends for any reason other than his or her gross misconduct;
4. your Spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. you become divorced or legally separated from your Spouse.

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

1. the parent-Employee dies;
2. the parent-Employee's hours of employment are reduced;
3. the parent-Employee's employment ends for any reason other than his or her gross misconduct;
4. the parent-Employee becomes enrolled in Medicare (Part A, Part B, or both);
5. the parents become divorced or legally separated; or
6. the child stops being eligible for coverage under the Plan as a "dependent child."

Qualifying Event

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 (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For other qualifying events (divorce or legal separation of the Employee and the Spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. **The Plan requires you to notify the Plan Administrator within 60 days after the date you lose coverage.** You must send notice to:

Donald J. Lowe and Associates Agency, Inc.
812 Huron Road, Suite 230
Cleveland, Ohio 44115
Phone: (216) 861-6644
Fax: (216) 861-7669

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each Qualified Beneficiary. Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered employees can elect COBRA continuation coverage on behalf of their Spouses, and parents can elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, enrollment of the Employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 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 became entitled to Medicare 8 months before the date on which employment terminated, COBRA continuation coverage for his or her Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months (36 months minus 8 months) after the date of the qualifying event.

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 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 if he or she is covered as an Eligible Dependent under applicable provisions of Plan 1, 2, 3, or 4) are determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you (and your entire family, if applicable) can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. **You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage.** This notice should be sent to:

Donald J. Lowe and Associates Agency, Inc.
812 Huron Road, Suite 230
Cleveland, Ohio 44115
Phone: (216) 861-6644
Fax: (216) 861-7669

The extended coverage terminates (1) upon your receiving Medicare, or (2) 30 days after the month in which the Social Security Administration determines you are no longer disabled.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If you (or anyone in your family covered under the Plan if he or she is covered as an Eligible Dependent under applicable provisions of Plan 1, 2, 3, or 4) experience another qualifying event while receiving COBRA continuation coverage, you (or your Spouse and dependent children in your family, if applicable) can get additional months of COBRA continuation coverage, up to a maximum of 36 months.

This extension is also available to a Spouse and/or dependent children of a former Employee who were covered as Eligible Dependents under applicable provisions of Plan 1, 2, 3, or 4 if the former Employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. Similarly, the extension is available to a dependent child when that child stops being eligible under the Plan as an Eligible Dependent.

In all of these cases, you must make sure that the Plan Administrator is notified of the second

qualifying event within 60 days after the second qualifying event occurs. This notice must be sent to:

Donald J. Lowe and Associates Agency, Inc.
812 Huron Road, Suite 230
Cleveland, Ohio 44115
Phone: (216) 861-6644
Fax: (216) 861-7669

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Donald J. Lowe and Associates Agency, Inc., 812 Huron Road, Suite 230, Cleveland, Ohio 44115 (Phone: (216) 861-6644; Fax: (216) 861-7669), or you may contact the nearest Regional or District Office of the United States Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa**.**

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, can contact the United States Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa**.** State and local government employees should contact HHS-CMS at www.cms.hhs.COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov**.**

Keep Your Plan Informed of Address Changes

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

H. Payment for COBRA Coverage

Any Participant (or other individual) who has the right to COBRA coverage ("Qualified Beneficiary") must complete the application and make the first payment within the time limits as set forth herein. The Plan is not required to segregate any dental, vision and other miscellaneous benefits provided by the Plan from the COBRA benefit package. The Plan will offer the same COBRA benefit package to a Qualified Beneficiary as the COBRA benefit package to which the Qualified Beneficiary was entitled on the day before the qualifying event, including dental, vision care, or any other health care benefits that were part of the Qualified Beneficiary's benefit package on the day before the qualifying event. In addition, if the Plan permits Participants to elect among different benefit packages, then after the qualifying event the Plan does not have to provide the Qualified Beneficiary with an election among the different benefit packages and will offer only the same benefit package to which the Qualified Beneficiary was entitled on the day before the qualifying event.

The Qualified Beneficiary has sixty (60) days from the date he or she loses regular coverage to elect COBRA continuation coverage. COBRA continuation coverage will be made available for the entire sixty (60) day election period if the Qualified Beneficiary elects COBRA continuation coverage prior to the end of the election period.

A Qualified Beneficiary may reject or waive COBRA continuation coverage but then revoke the waiver at any point during the sixty (60) day period and elect COBRA continuation coverage; however, if this occurs, the COBRA continuation coverage will not apply retroactively to the beginning of the sixty (60) day election period but applies only back to the date on which the rejection or waiver was revoked and COBRA continuation coverage was elected. The Qualified Beneficiary is not covered during the election period prior to his or her election, but will have retroactive coverage if COBRA continuation coverage is timely elected and timely paid.

The Fund Office will inform the Qualified Beneficiary of the monthly premium to be paid. The Qualified Beneficiary has forty-five (45) days from the date he or she elects COBRA continuation coverage to make the first payment. The Qualified Beneficiary is responsible for making sure that the amount of the first payment is correct. To confirm the correct amount of the first payment, the Qualified Beneficiary may contact Maryann Ormsby at Donald J. Lowe and Associates Agency, Inc., 812 Huron Road, Suite 230, Cleveland, Ohio 44115 (Phone: (216) 861-6644; Fax: (216) 861-7669).

After the first payment, the Qualified Beneficiary is required to make monthly periodic payments for each subsequent coverage period. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the monthly coverage period. The Fund Office will bill the Qualified Beneficiary on the fifteenth (15^{th}) day of the month preceding the month in which the Qualified Beneficiary receives coverage. If the Qualified Beneficiary makes a periodic payment on or before the first day of the coverage period to which it applies, the Qualified Beneficiary's coverage under the Plan will continue for that coverage period without any break.

Although periodic payments are due on the first day of each monthly coverage period, the Qualified Beneficiary will be given a grace period of thirty (30) days after the first day of the coverage period to make each periodic payment. Continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the 30-day grace period for that payment. If the Qualified Beneficiary fails to make a periodic payment before the end of the grace period for that coverage period, the Qualified Beneficiary will lose all rights to continuation coverage under the Plan.

The Qualified Beneficiary is not covered during the 45-day grace period permitted for payment of the first COBRA premium or during the 30-day grace period permitted for payment of the monthly COBRA premium prior to his or her timely payment of the COBRA premium. However, the Qualified Beneficiary will have retroactive coverage if the COBRA premium is timely paid before the end of the applicable grace period.

The cost of COBRA continuation coverage will not exceed 102% of the premium applicable to active Employees. However, a Qualified Beneficiary who has been determined disabled as defined

by the Social Security Administration and requests coverage for an additional eleven (11) months for a total of twenty-nine (29) months of continuation coverage may be required to pay a premium which is one hundred fifty percent (150%) of the amount of the regular COBRA premium for all months of coverage after the first eighteen (18) months. In addition, the cost of COBRA continuation coverage may be increased at any time when the Plan is charging less than the allowable COBRA premium (i.e., less than the 102% or the 150% maximum) or in a situation where a Qualified Beneficiary is permitted by the Plan's rules and procedures to change to a more expensive form of coverage under the Plan.

I. Cancellation of COBRA Coverage

COBRA coverage ends immediately for any Participant who:

1. Fails to make a premium payment on time. After the first payment, the person is allowed thirty (30) days to make each payment after the date it is due. If it is not post-marked on or before the end of the 30-day period, COBRA coverage will be canceled as of the due date; or

2. First becomes enrolled in either Part A or Part B of Medicare after the date of the qualifying event; or

3. First becomes covered under another group health care plan after the date of the qualifying event, except that if the Participant has a pre-existing condition that is not covered under the new employer's plan, then the Participant may continue COBRA coverage under this Plan for the remainder of the continuation coverage period.

COBRA coverage will also be canceled under the following circumstances:

4. as of the date the Plan terminates and no longer provides group health coverage; or

5. COBRA coverage will also be canceled on the date on which the COBRA continuation coverage period applicable to the Qualified Beneficiary expires.

J. Military Service

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") is a federal law, passed in 1994, that protects military service members and veterans from employment discrimination on the basis of their military service and allows them to regain their civilian jobs following their period of military service. If you are called to military service, you will be provided with the following three (3) options:

1. First Option – Opt-Out from Coverage under Plan. You may elect not to continue health care coverage under the Plan for yourself (and/or your Dependent(s), if applicable), in which case your eligibility would freeze, and you would resume your eligibility under the Plan when you return from military service. Upon discharge from military service, and upon your giving timely written notice to your Employer after discharge, you have the right to have your coverage under the Plan reinstated, generally

without any waiting periods or exclusions (except for service-connected illnesses or injuries), in accordance with the Plan's eligibility rules.

2. Second Option – USERRA Election. You may elect to continue medical coverage under the Plan for yourself (and/or your Depeendent(s), if applicable) by timely submitting to the Fund Office monthly premiums for a period not exceeding twenty-four (24) months. The monthly premium you are required to pay will based on the premium rate for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Upon discharge from military service, and upon your giving timely written notice to your Employer after discharge, you have the right to have your coverage under the Plan reinstated, generally without any waiting periods or exclusions (except for service-connected illnesses or injuries), in accordance with the Plan's eligibility rules.

3. Third Option – COBRA Election. You may elect to continue health care coverage under the Plan for yourself (and/or your Dependent(s), if applicable) by timely submitting to the Fund Office monthly premiums for a period not exceeding eighteen (18) months (twenty-nine [29] months if you are disabled) in accordance with the Plan's provisions governing continuation coverage under COBRA. The monthly premium you are required to pay for COBRA continuation coverage will based on the Plan's COBRA premium rate. Upon discharge from military service, and upon your giving timely written notice to your Employer after discharge, you have the right to have your coverage under the Plan reinstated, generally without any waiting periods or exclusions (except for service-connected illnesses or injuries), in accordance with the Plan's eligibility rules.

In order for the Plan to properly handle your medical coverage during your period of military service, you must affirmatively elect, in writing, one of these three options. Likewise, when your military service ends, you are required to notify the Fund Office of the date you are discharged from military service.

To qualify for the protection given to those in military service under USERRA, your period of military service may not exceed five (5) continuous years, you must not have been discharged from military service under dishonorable or other punitive conditions, and you must report back to work for your Employer in a timely manner and/or contact the Union office to sign up for employment.

III. DESCRIPTION OF BENEFITS

The Plan pays for the various types of benefits described in this section. The Plan has eight different benefit programs: Plan 1, Plan 2, Plan 3, Plan 4, Plan 5, Plan 6, Plan 7, and Plan 8.

Each benefit program provides different benefits. The benefits provided under each benefit program are described below and in accompanying documents. The benefit program under which you are entitled to receive benefits depends on the applicable provisions of the collective bargaining agreement between your Employer and the Union.

A. Plan 1 – Part-Time Employees

The following benefits are available to active part-time Employees (and for certain benefits, their Eligible Dependents) who are covered by Plan 1:

1. Dental Benefits – Dental benefits are provided in accordance with the attached summary of dental benefits.

2. Vision Care Benefits – Vision care benefits are provided in accordance with the attached summary of vision care benefits.

3. Injury and Illness Disability Benefits – You are entitled to injury and illness disability benefits for a non-work-related injury or illness in accordance with the description of benefits set forth in Article III, Section G, entitled "Injury and Illness Disability Benefits," below.

4. Prescription Benefits – You will be charged a co-payment for each prescription or refill you obtain from a pharmacy approved by the Plan or through a mail order service approved by the Plan, except when a generic drug could be dispensed and you or your doctor rejects the generic drug. In such case, you will be required to pay a co-payment, plus the difference in the average wholesale price between the brand name drug and the generic drug.

5. Life Insurance – If you die, the Plan or the insurance carrier it selects will pay $10,000 to the person whom you designate as your beneficiary. Your beneficiary may receive the money in one lump sum or in installments. Your group term life insurance coverage terminates on the last day of the month in which you cease to satisfy the Welfare Fund's eligibility requirements. However, during the thirty-one (31) day period following the month in which you were terminated, you may convert your coverage to an individual policy without having to submit evidence of insurability.

6. Accidental Death and Dismemberment Insurance – The Plan or the insurance carrier it selects will pay benefits for accidental death or dismemberment in accordance with the description of benefits set forth in Article III, Section H, entitled "Accidental Death and Dismemberment Benefits," below.

B. Plan 2 – Full-Time Employees

The following benefits are available to active full-time Employees (and for certain benefits, their Eligible Dependents) who are covered by Plan 2:

1. Medical Benefits – Medical benefits are provided in accordance with the attached summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

2. Dental Benefits – Dental benefits are provided in accordance with the attached summary of dental benefits.

3. Vision Care Benefits – Vision care benefits are provided in accordance with the attached summary of vision care benefits.

1. Injury and Illness Disability Benefits – You are entitled to injury and illness disability benefits for a non-work related injury or illness in accordance with the description of benefits set forth in Article III, Section G, entitled "Injury and Illness Disability Benefits," below.

2. Prescription Benefits – You will be charged a co-payment for each prescription or refill you obtain from a pharmacy approved by the Plan or through a mail order service approved by the Plan, except when a generic drug could be dispensed and you or your doctor rejects the generic drug. In such case, you will be required to pay a co-payment, plus the difference in the average wholesale price between the brand name drug and the generic drug.

3. Life Insurance – If you die, the Plan or the insurance carrier it selects will pay $10,000 to the person whom you designate as your beneficiary. Your beneficiary may receive the money in one lump sum or in installments. Your group term life insurance coverage terminates on the last day of the month in which you cease to satisfy the Plan's eligibility requirements. However, during the thirty-one (31) day period following the month in which you were terminated, you may convert your coverage to an individual policy without having to submit evidence of insurability.

4. Accidental Death and Dismemberment Insurance – The Plan or the insurance carrier it selects will pay benefits for accidental death or dismemberment in accordance with the description of benefits set forth in Article III, Section H, entitled "Accidental Death and Dismemberment Benefits," below.

NOTE: Participants who are covered by Plan 2 are permitted to have coverage for themselves and their non-Spouse Eligible Dependents if they agree to pay for the excess of the cost of coverage for themselves and their children who qualify as Eligible Dependents over the cost of single coverage. If you elect this option, the extra cost will be collected from you by arrangement between your employer and the Third Party Administrator.

C. Plan 3 – Full-Time Government Employees

The following benefits are available to active full-time Government Employees (and for certain benefits, their Eligible Dependents) who are covered by Plan 3:

1. Medical Benefits – Medical benefits are provided in accordance with the attached summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

2. Dental Benefits – Dental benefits are provided in accordance with the attached summary of dental benefits.

3. Vision Care Benefits – Vision care benefits are provided in accordance with the attached summary of vision care benefits.

4. Injury and Illness Disability Benefits – You are entitled to injury and illness disability benefits for a non-work related injury or illness in accordance with the description of benefits set forth in Article III, Section G, entitled "Injury and Illness Disability Benefits," below.

5. Prescription Benefits – You will be charged a co-payment for each prescription or refill you obtain from a pharmacy approved by the Plan or through a mail order service approved by the Plan, except when a generic drug could be dispensed and you or your doctor rejects the generic drug. In such case, you will be required to pay a co-payment, plus the difference in the average wholesale price between the brand name drug and the generic drug.

6. Life Insurance – If you die, the Plan or the insurance carrier it selects will pay $10,000 to the person whom you designate as your beneficiary. Your beneficiary may receive the money in one lump sum or in installments. Your group term life insurance coverage terminates on the last day of the month in which you cease to satisfy the Plan's eligibility requirements. However, during the thirty-one (31) day period following the month in which you were terminated, you may convert your coverage to an individual policy without having to submit evidence of insurability.

7. Accidental Death and Dismemberment Insurance – The Plan or the insurance carrier it selects will pay benefits for accidental death or dismemberment in accordance with the description of benefits set forth in Article III, Section H, entitled "Accidental Death and Dismemberment Benefits," below.

NOTE: Participants who are covered by Plan 3 are permitted to have coverage for themselves and their non-Spouse Eligible Dependents if they agree to pay for the excess of the cost of coverage for themselves and their children who qualify as Eligible Dependents over the cost of single coverage. If you elect this option, the extra cost will be collected from you by arrangement between your employer and the Third Party Administrator.

D. Plan 4 – Part-Time Government Employees

The following benefits are available to active part-time Government Employees (and for certain benefits, their Eligible Dependents) who are covered by Plan 4:

1. Medical Benefits – Medical benefits are provided in accordance with the attached summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

2. Dental Benefits – Dental benefits are provided in accordance with the attached summary of dental benefits.

3. Vision Care Benefits – Vision care benefits are provided in accordance with the attached summary of vision care benefits.

4. Injury and Illness Disability Benefits – You are entitled to injury and illness disability benefits for a non-work-related injury or illness in accordance with the description of benefits set forth in Article III, Section G, entitled "Injury and Illness Disability Benefits," below.

5. Prescription Benefits – You will be charged a co-payment for each prescription or refill you obtain from a pharmacy approved by the Plan or through a mail order service approved by the Plan, except when a generic drug could be dispensed and you or your doctor rejects the generic drug. In such case, you will be required to pay a co-payment, plus the difference in the average wholesale price between the brand name drug and the generic drug.

6. Life Insurance – If you die, the Plan or the insurance carrier it selects will pay $10,000 to the person whom you designate as your beneficiary. Your beneficiary may receive the money in one lump sum or in installments. Your group term life insurance coverage terminates on the last day of the month in which you cease to satisfy the Plan's eligibility requirements. However, during the thirty-one (31) day period following the month in which you were terminated, you may convert your coverage to an individual policy without having to submit evidence of insurability.

7. Accidental Death and Dismemberment Insurance – The Plan or the insurance carrier it selects will pay benefits for accidental death or dismemberment in accordance with the description of benefits set forth in Article III, Section H, entitled "Accidental Death and Dismemberment Benefits," below.

NOTE: Participants who are covered by Plan 4 are permitted to have coverage for themselves and their non-Spouse Eligible Dependents if they agree to pay for the excess of the cost of coverage for themselves and their children who qualify as Eligible Dependents over the cost of single coverage. If you elect this option, the extra cost will be collected from you by arrangement between your employer and the Third Party Administrator.

E. Plan 5 – Call-In Government Employees

The following benefits are available to active call-in Government Employees (and for certain benefits, their Eligible Dependents) who are covered by Plan 5:

1. Dental Benefits – Dental benefits are provided in accordance with the attached summary of dental benefits.

2. Vision Care Benefits – Vision care benefits are provided in accordance with the

attached summary of vision care benefits.

3. Injury and Illness Disability Benefits – You are entitled to injury and illness disability benefits for a non-work-related injury or illness in accordance with the description of benefits set forth in Article III, Section G, entitled "Injury and Illness Disability Benefits," below.

4. Prescription Benefits – You will be charged a co-payment for each prescription or refill you obtain from a pharmacy approved by the Plan or through a mail order service approved by the Plan, except when a generic drug could be dispensed and you or your doctor rejects the generic drug. In such case, you will be required to pay a co-payment, plus the difference in the average wholesale price between the brand name drug and the generic drug.

5. Life Insurance – If you die, the Plan or the insurance carrier it selects will pay $10,000 to the person whom you designate as your beneficiary. Your beneficiary may receive the money in one lump sum or in installments. Your group term life insurance coverage terminates on the last day of the month in which you cease to satisfy the Welfare Fund's eligibility requirements. However, during the thirty-one (31) day period following the month in which you were terminated, you may convert your coverage to an individual policy without having to submit evidence of insurability.

6. Accidental Death and Dismemberment Insurance – The Plan or the insurance carrier it selects will pay benefits for accidental death or dismemberment in accordance with the description of benefits set forth in Article III, Section H, entitled "Accidental Death and Dismemberment Benefits," below.

F. Plan 6 – Full-Time Employees with Family Coverage

The following benefits are available to active full-time Employees (and for certain benefits, their Spousal and non-Spousal Eligible Dependents) who are covered by Plan 6:

1. Medical Benefits – Medical benefits are provided in accordance with the attached summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

2. Dental Benefits – Dental benefits are provided in accordance with the attached summary of dental benefits.

3. Vision Care Benefits – Vision care benefits are provided in accordance with the attached summary of vision care benefits.

4. Injury and Illness Disability Benefits – You are entitled to injury and illness disability benefits for a non-work-related injury or illness in accordance with the description of benefits set forth in Article III, Section G, entitled "Injury and Illness

Disability Benefits," below.

5. Prescription Benefits – You will be charged a co-payment for each prescription or refill you obtain from a pharmacy approved by the Plan or through a mail order service approved by the Plan, except when a generic drug could be dispensed and you or your doctor rejects the generic drug. In such case, you will be required to pay a co-payment, plus the difference in the average wholesale price between the brand name drug and the generic drug.

6. Life Insurance – If you die, the Plan or the insurance carrier it selects will pay $10,000 to the person whom you designate as your beneficiary. Your beneficiary may receive the money in one lump sum or in installments. Your group term life insurance coverage terminates on the last day of the month in which you cease to satisfy the Plan's eligibility requirements. However, during the thirty-one (31) day period following the month in which you were terminated, you may convert your coverage to an individual policy without having to submit evidence of insurability.

NOTE: Participants who are covered by Plan 6 are permitted to have coverage for themselves and their Spousal and non-Spousal Eligible Dependents under the following circumstances:

- You may agree to pay for the excess of the cost of Eligible Dependent coverage over the cost of single coverage. If you elect this option, the extra cost for Eligible Dependent coverage will be paid by your Employer through payroll deduction.

- Effective September 1, 2016, your Employer may agree, as a result of collective bargaining, to pay for the excess of the cost of Eligible Dependent coverage over the cost of single coverage. In such case, the extra cost for Eligible Dependent coverage will be borne by your Employer in the form of Employer contributions.

G. Plan 7 – Window Cleaner Employees Opting Out of Plan 6 Coverage

Active Window Cleaner Employees who work for an Employer that is designated as a window cleaning business and who are eligible for coverage under Plan 6 may opt out of such coverage and elect coverage under an alternate benefit program, Plan 7. The following benefits are available to active Employees (and for certain benefits, their Eligible Dependents) who have opted out of coverage under Plan 6 and are covered by Plan 7:

1. Vision Care Benefits – Vision care benefits are provided in accordance with the attached summary of vision care benefits.

2. Injury and Illness Disability Benefits – You are entitled to injury and illness disability benefits for a non-work-related injury or illness in accordance with the description of benefits set forth in Article III, Section G, entitled "Injury and Illness

Disability Benefits," below.

3. Life Insurance – If you die, the Plan or the insurance carrier it selects will pay $10,000 to the person whom you designate as your beneficiary. Your beneficiary may receive the money in one lump sum or in installments. Your group term life insurance coverage terminates on the last day of the month in which you cease to satisfy the Plan's eligibility requirements. However, during the thirty-one (31) day period following the month in which you were terminated, you may convert your coverage to an individual policy without having to submit evidence of insurability.

4. Dental Benefits – Dental benefits are provided in accordance with the attached summary of dental benefits.

H. Plan 8 – Full-Time Employees Receiving Premium-Based Medical Coverage

The following benefits are available to active full-time Employees (and for certain benefits, their Eligible Dependents) who are covered by Plan 8:

1. Medical Benefits – Medical benefits are provided in accordance with the attached summary of medical benefits "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

2. Vision Care Benefits – Vision care benefits are provided in accordance with the attached summary of vision care benefits.

3. Injury and Illness Disability Benefits – You are entitled to injury and illness disability benefits for a non-work-related injury or illness in accordance with the description of benefits set forth in Article III, Section G, entitled "Injury and Illness Disability Benefits," below.

4. Life Insurance – If you die, the Plan or the insurance carrier it selects will pay $10,000 to the person whom you designate as your beneficiary. Your beneficiary may receive the money in one lump sum or in installments. Your group term life insurance coverage terminates on the last day of the month in which you cease to satisfy the Plan's eligibility requirements. However, during the thirty-one (31) day period following the month in which you were terminated, you may convert your coverage to an individual policy without having to submit evidence of insurability.

5. Dental Benefits – Dental benefits are provided in accordance with the attached summary of dental benefits.

NOTE: Participants who are covered by Plan 8 are permitted to have coverage for themselves and their non-Spouse Eligible Dependents if they agree to pay for the excess of the cost of coverage for themselves and their children who qualify as Eligible Dependents over the cost of single coverage. If you elect this option, the extra cost will be collected from you by arrangement between your employer and the Third Party Administrator.

I. Network Provider and Non-Network Provider Arrangement for Medical Benefits

The Plan contracts with the medical Provider Networks (or directly with medical Providers) to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." Further information about the Plan's network and non-network provider arrangement for individuals who are covered by Plan 2, Plan 3, Plan 4, or Plan 8 is set forth in the summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

J. Special Rules Applicable to Non-Grandfathered Health Care Plans under Patient Protection and Affordable Care Act

Employees who are covered by Plan 1, Plan 5, or Plan 7 do not receive medical benefits under the Plan. Employees who are covered by Plan 2, Plan 3, Plan 4, Plan 6, or Plan 8 receive medical benefits under the Plan. Because these medical benefits are offered through a group health care program that does not satisfy the requirements of a "grandfathered health plan" under the Affordable Care Act, these benefits are subject to the following special requirements:

1. Guaranteed Renewability of Coverage – You are guaranteed renewability of coverage, regardless of your health status, utilization of health services, or any other related factor. Your coverage may be cancelled only under specifically enumerated circumstances.

2. Preventive Services, Immunizations, and Screenings – Certain preventive services, immunizations, and screenings are covered, without any cost-sharing between you and the Plan.

3. Selection of Participating Primary Care Provider or Pediatrician – You are permitted to select a participating primary care provider, or a pediatrician in the case of a child, who is available to accept you or your family member(s) as a patient for medical care.

4. Access to Obstetrical or Gynecological Care – You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional 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, 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 the Plan Administrator.

5. Out-of-Network Emergency Services – You are not required to obtain prior

authorization for out-of-network emergency services, nor are you subject to increased cost-sharing for such services.

6. Discrimination against Health Care Providers – Discrimination against health care providers acting within the scope of their professional license and applicable state law is prohibited.

7. Disclosure to Federal and State Government – Disclosure to the federal government and to the Insurance Commissioner for the State of Ohio is required for certain enrollee information such as enrollee rights and claims payment policies and practices. You must be provided with information on the amount of cost-sharing for a specific item or service.

8. Discrimination against Health Care Providers – Discrimination in favor of highly compensated individuals (as defined in the Internal Revenue Code) with respect to eligibility and benefits is prohibited.

K. Retiree Coverage

Upon retirement, the following benefits are available to retired employees who satisfy either of the following requirements:

- they were retired before October 1, 2002 and were classified as Upper Tier (i.e., employer contributions of $.90 per hour were being made on your behalf) when they retired; or

- they were classified as Upper Tier as of September 30, 2002 and later retire directly from employment that is covered by a collective bargaining agreement between their Employer and the Union.

1. Life Insurance – If you die, the Plan or the insurance carrier it selects will pay $4,000 to the person whom you designate as your beneficiary. Your beneficiary may receive the money in one lump sum or in installments. Your group term life insurance coverage terminates on the last day of the month in which you cease to satisfy the Plan's eligibility requirements. However, during the thirty-one (31) day period following the month in which you were terminated, you may convert your coverage to an individual policy without having to submit evidence of insurability.

2. Prescription Benefits – Prescription benefits are provided in accordance with the attached summary of prescription benefits for retirees.

L. Injury and Illness Disability Benefits

1. <u>Benefits Available</u>

You are entitled to injury and illness disability benefits for a non-work-related injury and illness. Injury and illness disability benefits are provided as follows:

(i) Benefits are payable beginning on the first day of a disability due to an injury.

(ii) Benefits are payable beginning the eighth (8th) day of a disability due to an illness.

(iii) The amount of your weekly benefits will be equal to seventy percent (70%) of your weekly straight time wages earned during the ninety (90) days before you became disabled, up to a maximum of $250.00 per week.

(iv) No benefits are payable for injury or illness that arises out of or in the course of your employment that is covered by worker's compensation, occupational disease law, or other similar laws.

(v) Benefits are payable during any period of disability, not to exceed a total of—

(a) thirteen (13) weeks of disability benefits for any one (1) claim in which benefits begin within thirteen (13) weeks before the end of the initial Plan Year and extend continuously from the end of the initial Plan Year to the beginning of the following Plan Year; and

(b) thirteen (13) weeks of disability benefits for all claims during a Plan Year.

A new period of disability will be established only if and after you return to work for at least two (2) consecutive weeks.

2. Submission of Claims

To obtain injury and illness disability benefits, you must provide written notice to the Third Party Administrator within twenty (20) days after the injury or illness causing you to be disabled occurs. If written notice cannot be given within that time, it must be given as soon as reasonably possible. The written notice must contain enough information to identify who is making the claim.

When the Third Party Administrator receives written notice of a claim, the Third Party Administrator will send you an approved claim form. You must complete and submit the approved claim form, completed and signed by your Physician stating the nature of the disability, length of disability and date you can return to work. It must also be signed by your Physician.

The Third Party Administrator may, in its sole discretion, require you to be examined or have your claim reviewed by a Physician or clinic of its choice on behalf of the Trustees or require you to submit additional evidence to support your claim for disability benefits.

In the event your claim for disability benefits is denied, you will be notified in writing by the Third

Party Administrator the reasons why your claim was denied. Notification of an adverse decision shall occur within forty-five (45) days of the receipt of your approved claim form. If the Third Party Administrator determines more time is needed to process the claim due to matters beyond his/her control, the Third Party Administrator will notify you of a thirty (30) day extension. If a second extension is necessary due to matters beyond his/her control, the Third Party Administrator will notify you of a final thirty (30) day extension. No further extensions shall occur. Any notice of an extension shall include the standards on which an entitlement to disability benefits is based, the unresolved issues preventing a decision and any additional information that is needed to resolve the claim.

3. Appeals

In the event your claim for disability benefits is denied, you may, by written notice received by the Third Party Administrator within one hundred and eighty (180) days of your receipt of the notice denying your claim for disability benefits, appeal the decision. The written notice should state your name, address and the reasons why you are appealing the decision of the Third Party Administrator, and should give the date of the decision from which you are appealing.

The Trustees shall consider the appeal of the claimant no later than its next regularly scheduled meeting, which immediately follows the receipt of the notice of appeal unless such notice was filed within thirty (30) days prior to the next regularly scheduled meeting, then the Board of Trustees may consider the appeal at the second meeting following the receipt of the notice of appeal. If special circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal.

After consideration of the appeal as above, the Board of Trustees shall advise the claimant of its decision in writing within five (5) days following the meeting at which the appeal was considered. The decision of the Board of Trustees shall state the specific reason or reasons for the determination and refer to the specific Plan provisions on which the benefit determination is based. Any non-approval shall be accompanied by:

(i) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(ii) a statement apprising the claimant that "You or your plan may have other voluntary dispute resolution option, such as mediation. One way to find out what may be available is to contact your local United States Department of Labor Office and your state insurance regulatory agency."; and

(iii) a statement of the claimant's right to bring a civil action under ERISA Section 502(a).

The Trustees shall have full authority to interpret the provisions of this Plan and it is within the sole and absolute discretion of the Trustees to determine if a claimant is entitled to receive a benefit and the amount of the benefit. The decision shall be final and binding upon the claimant.

4. When Benefits End

Injury and illness disability benefits will cease on the earliest of:

(i) the date you are no longer disabled; or

(ii) the end of the maximum period of disability (13 weeks during any 12 consecutive-month period); or

(iii) your date of death.

M. Accidental Death and Dismemberment Benefits

If you suffer a loss which is a direct and sole result of an accident and is independent of all other causes, the Plan or the insurance carrier it selects will pay benefits according to the following table. The accident must happen while you are covered by the Plan, and the loss must occur within three hundred sixty-five (365) days after the date of the accident.
The Plan will pay $10,000.00 for the loss of:

- life;
- both hands or both feet;
- sight of both eyes;
- one (1) hand and one (1) foot;
- one (1) hand and sight of one (1) eye; or
- one (1) foot and sight of one (1) eye.

The Plan will pay $5,000.00 for the loss of:

- one (1) hand;
- one (1) foot; or
- sight of one (1) eye.

NOTE: Loss of hand or foot means cut or broken apart at or above the wrist or ankle joint, and loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

No benefits will be paid for a loss caused by or connected with:

1. suicide or attempted suicide;

2. intentionally self-inflicted injury;

3. disease or mental infirmity, or from the medical or surgical treatment or diagnosis for such disease or infirmity;

4. ptomaines;

5. bacterial infection, except pyogenic infection which occurs through or with an accidental cut or wound;

6. war or any act or war, whether declared or undeclared; or

7. 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 insurance company selected by the Plan may examine you, at its expense, at any reasonable time upon receipt of a claim. In case of death, the insurance company selected by the Plan reserves the right to perform an autopsy if an autopsy is not prohibited by local law.

IV. PROCEDURE FOR FILING A CLAIM

A. Types of Claims

The processing of your claim for benefits depends on the type of claim it is. Under the Plan, there are several categories of claims for benefits. Injury and illness disability claims and appeals from such claims are subject to special rules set forth in Section L of Article III. Special rules also apply to medical coverage determinations and medical claims. Prescription drug claims and appeals from such claims are subject to special rules set forth in Attachment A.

Pre-Service Care Claim—A pre-service claim is a claim for a benefit under the Plan which the terms of the Plan require approval of the benefit in advance of obtaining medical care. There are two special kinds of pre-service claims:

Urgent Care Claim—An urgent care claim is any pre-service claim for medical care or treatment which, in the opinion of the treating physician, if not immediately processed, could seriously jeopardize the life or health of you or your dependent. This type of claim generally includes those situations commonly treated as emergencies. Only the treating physician can classify a pre-service claim as "urgent."

Concurrent Care Claim—A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved pre-service claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

Post-Service Care Claim—A Post-Service Claim is a claim for payment or reimbursement after services have been rendered.

B. Who Must File

You may initiate pre-service claims yourself if you are able or your treating Physician may file the claim for you. You are responsible for filing post-service claims yourself, although the Plan may

accept billings directly from providers on your behalf, if they contain all of the information necessary to process the claim.

Appointing an Authorized Representative. If you wish to have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals, you must furnish the Claims Payor with a written designation of your Authorized Representative. You can appoint any individual ***except*** a health care provider as your Authorized Representative. Nevertheless, a health care provider with knowledge of your medical condition can act as your Authorized Representative for purposes of an urgent care claim as defined above. Once you appoint an Authorized Representative in writing, all subsequent communications regarding your claim will be provided to your Authorized Representative.

C. When to File a Claim

You must file claims within ninety (90) days after receiving covered services. For this purpose, the claim filing period means ninety (90) days after:

1. the end of Hospital confinement, if benefits claimed are the result of Hospital confinement; or

2. the date of loss, if benefits are not the result of Hospital confinement.

Your claim must have the data the Plan Administrator needs to determine benefits. In order to pay a claim, you must provide proof that you actually incurred a covered claim and the exact amount of your claim. In most cases, a claim form which has been properly completed by you or your Eligible Dependent and your Doctor and itemized bills are sufficient proof. However, you must honor any reasonable request for further information or for a re-payment agreement or the Plan will not be able to pay your claim.

Claims filed after the expiration of the 90-day period will be considered only if there was reasonable cause for your failure to timely file the claim as determined by the Trustees in their sole discretion.

If the Plan Administrator questions whether your claim should be paid, whether the services provided to you or your Eligible Dependent were Medically Necessary or unreasonably priced, or whether your or your Eligible Dependent's care was Experimental, investigational or medically unproven, the Trust Fund has the right to rely on its advisors for the decision.

D. Where to File a Claim

Claims should be filed at the address indicated on the back of the Identification Card that you receive when you become eligible to participate in the Plan.

E. What to File

The Fund Office furnishes claim forms. When filing claims, you should attach an itemized bill from the health care provider. The Third Party Administrator may require you to complete a claim form

for a claim. Please make sure that the claim contains the following information:

1. participant's name and Social Security number;

2. patient's name; and

3. name of Employer.

F. Method of Claims Delivery

Pre-service claims may be initiated by telephone. The Plan may require you to provide follow-up paperwork in support of your claim.

Other claims may be submitted by United States Mail, by hand delivery, by facsimile (FAX), or as a HIPAA-compliant electronically filed claim.

G. Timing of Claims Determinations

Urgent Care Claims. If your claim involves urgent care, you or your authorized representative will be notified of the initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event not more than seventy-two (72) hours after receiving the claim. If the claim does not include sufficient information to make an intelligent decision, you or your representative will be notified within twenty-four (24) hours after receipt of the claim of the need to provide additional information. You will have at least forty-eight (48) hours to respond to this request; the Plan then must inform you of its decision within forty-eight (48) hours of receiving the additional information.

Concurrent Care Claims. If your claim is one involving concurrent care, the Plan will notify you of its decision, whether adverse or not, within twenty-four (24) hours after receiving the claim, if the claim was for urgent care and was received by the Plan at least twenty-four (24) hours before the expiration of the previously approved time period for treatment or number of treatments. You will be given time to provide any additional information required to reach a decision. If your concurrent care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan will respond according to the type of claim involved (i.e., urgent, other pre-service or post-service).

Other Pre-Service Claims. If your claim is for any other pre-service authorization, the Plan will notify you of its initial determination, whether adverse or not, as soon as possible, but not more than fifteen (15) days from the date it receives the claim. This 15-day period may be extended by the Plan for an additional fifteen (15) days if the extension is required due to matters beyond the Plan's control. You will have at least forty-five (45) days to provide any additional information requested of you by the Plan.

Post-Service Claims. If your claim is for a post-service reimbursement or payment of benefits, the Plan will notify you within thirty (30) days of receipt of the claim that the claim has been approved, denied. The thirty (30) days can be extended to forty-five (45), if the Plan notifies you within the initial thirty (30) days of the circumstances beyond the Plan's control that require an extension of the

time period, and the date by which the Plan expects to render a decision.

If more information is necessary to decide a post-service claim, the Plan will deny the claim and notify you of the specific information necessary to complete the claim.

H. Notice of Claims Denial (Adverse Benefit Determination)

If, for any reason, your claim is denied, in whole or in part, you will be provided with a written notice containing the following information:

1. the reason(s) why the claim or a portion of it was denied;

2. reference to Plan provisions on which the denial was based;

3. if the denial was based in whole or in part on any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;

4. if the denial was based in whole or in part on medical necessity, Experimental treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;

5. what additional information, if any, is required to perfect the claim and why the information is necessary; and

6. a copy of the Plan's review procedures and time periods that the claimant needs to follow in order to appeal the claim, plus a statement that the claimant can bring suit under ERISA following the review.

V. PROCEDURE FOR APPEALING A CLAIM

With the exception of injury and illness disabilty claims and prescription drug claims, the rules set forth in Sections A, B, C, and D below apply generally to appeals from adverse benefit determinations under the Plan for the various types of benefits described in Article III. However, pursuant to the Affordable Care Act, special rules apply to appeals from an adverse benefit determination involving a medical coverage determination or a medical claim. These special rules are set forth in Section E below. To the extent that the general rules set forth in Sections, A, B, C, and D may be at variance with the special rules set forth in Section E for appeals from an adverse benefit determination involving a medical coverage determination or a medical claim, the special rules set forth in Section E will supersede any conflicting rules set forth in Section A, B, C, or D.

A. Disputing a Decision

If you dispute a denial of benefits, you may file an appeal within one hundred eighty (180) days of

receipt of the denial notice. This appeal must be in writing (unless the claim involves urgent care, in which case the appeal may be made orally) and must be filed at the Fund Office at the following address:

Service Employees International Union Local 1
Cleveland Welfare Fund
812 Huron Road, Suite 230
Cleveland, Ohio 44115
(216) 861-6644

Your request for review must contain the following information:

1. your name and address;

2. your reasons for making the appeal; and

3. the facts supporting your appeal.

In connection with your right to appeal the initial claims determination, you also:

1. may review pertinent documents and submit issues and comments in writing;

2. will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;

3. will, at your request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and

4. will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The claim review will be subject to the following rules:

1. The claim will be reviewed by an appropriate party, who is neither the individual who made the initial denial nor a subordinate of that individual.

2. The review will be conducted without giving deference to the initial denial.

3. If the initial denial was based in whole or in part on a medical judgment (including any determinations of medical necessity or Experimental treatment), the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This medical expert shall not be an individual who was consulted on the initial claim denial nor the subordinate of such an individual. Any medical experts consulted in the review

process shall be identified by name.

B. Timetable for Deciding Appeals

The Plan Administrator must issue a review decision on your appeal according to the following timetable:

Urgent Care Claims—not later than seventy-two (72) hours after receiving your request for a review.

Pre-Service Claims—not later than thirty (30) days after receiving your request for a review.

Post-Service Claims—not later than sixty (60) days after receiving your request for a review.

Decisions will be issued on concurrent claim appeals within the time frame appropriate for the type of concurrent care claim (i.e., urgent, other pre-service or post-service).

C. Notice of Decision on Appeal

If the appeal has been either partially or completely denied, you will be provided with a written notice containing the following information:

1. the specific reasons for the appeal denial;

2. reference to the specific Plan provisions on which the denial is based;

3. a statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;

4. if the appeal denial was based in whole or in part on any internal guidelines or protocols, a statement that you may request a copy of the guideline or protocol, which will be provided to you without charge;

5. if the appeal denial was based in whole or in part on medical necessity, Experimental treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge;

6. a statement apprising you that "You or your Plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and/or your state insurance regulatory agency."; and

7. a statement apprising the claimant that "You may have the right to bring a civil

action under Section 502(a) of ERISA."

D. Second Appeal

If you disagree with the Plan Administrator's decision concerning your initial appeal, you may, at the conclusion of your initial appeal, file a second appeal with the Plan Administrator. Your second appeal must be in writing (unless the claim involves urgent care, in which case the appeal may be made orally) and must be filed at the Fund Office at the following address:

Service Employees International Union Local 1
Cleveland Welfare Fund
812 Huron Road, Suite 230
Cleveland, Ohio 44115
Phone (216) 861-6644

Your second appeal will be decided by the Board of Trustees and must be filed within sixty (60) days from your receipt of the initial appeal decision.

The Board of Trustees may consider your second appeal at its next regularly scheduled meeting which immediately follows the Plan's receipt of the notice of your second appeal. However, if such notice was filed within thirty (30) days prior to the next regularly scheduled meeting, the Board of Trustees will consider your second appeal at the second regularly scheduled meeting following the Plan's receipt of the notice of your second appeal. If special circumstances require an extension of time for processing, then the Board of Trustees will consider the appeal no later than the third regularly scheduled meeting following the Plan's receipt of the notice of your second appeal. If such an extension of time is required due to special circumstances, written notice of the extension shall be furnished to you before the extension period begins.

After consideration of your second appeal as above, the Board of Trustees will advise you of its decision in writing within five (5) days following the meeting at which the appeal was considered. The decision of the Trustees will be final and binding

You may not begin any legal action, including proceedings before administrative agencies, until you have followed these procedures and exhausted the opportunities described in this section. You may, at your own expense, have legal representation at any stage of these review procedures. These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined here, you are not satisfied with the result, then you must file any legal action against the Plan or the Board of Trustees within one hundred eighty (180) days after the final review notice under these procedures is mailed to you.

E. Special Rules under Patient Protection and Affordable Care Act Applicable to Appeals from Adverse Benefit Determination Involving Coverage Determination or Medical Claim

Pursuant to the Affordable Care Act, the following special rules apply to appeals from an adverse benefit determination involving a medical coverage determination or a medical claim under Plan 2,

Plan 3, Plan 4, or Plan 8. Appeals from an adverse benefit determination involving a medical claim under Plan 6 are subject to the rules set forth in documents issued by HealthSpan.

1. Internal Appeals Process

Medical coverage determinations and medical claims are subject to a special internal appeals process. The internal appeals process must comply with the following requirements:

(i) A claimant must be notified of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than twenty-four (24) hours after receipt of the claim.

(ii) A notice to a claimant of an adverse benefit determination or of a final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of service, health care provider, claim amount, diagnosis code (and its meaning), treatment code (and its meaning), the reason for the determination, and the Plan's standards used to make the determination.

(iii) A notice to a claimant of an adverse benefit determination or of a final internal adverse benefit determination must include the reason for the determination, including, if applicable, the denial code (and its meaning) and the Plan's standards used to make the determination.

(iv) Notices of claims and appeals determinations must be provided in a culturally and liguistically appropriate manner, based on the number of participants who are literate in the same non-English language. Upon request, notice must be provided in the participant's non-English language, and customer-assistance programs must provide assistance in that language.

(v) The types of claims that can be appealed generally include denials, reductions in benefits, or termination of coverage (including a rescission of coverage for fraud or intentional misrepresentation).

(vi) A claimant must be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim. In addition, the claimant must be provided with any new or additional rationale for the decision.

(vii) All claims and appeals decisions must be made impartially. Individuals who are involved in the claims and appeals process may not receive compensation or other rewards based on the likelihood that the individual would support a denial of benefits.

(viii) If the Plan fails to strictly adhere to all the requirements of the Plan's internal

claims and appeals process, the claimant is deemed to have exhausted his or her internal claims and appeals remedies, and the claimant may initiate an external review and pursue remedies available under applicable law even if the claimant has not strictly followed the procedures of the Plan's internal claims and appeals process.

2. External Appeals Process

Medical coverage determinations and medical claims are also subject to a special external appeals process. The external appeals process must comply with the following requirements:

(i) After a claimant has exhausted the Plan's internal appeals process, the claimant may request review by an independent external review organization, generally known as an Independent Review Organization ("IRO"), within four (4) months after the final decision under the Plan's internal appeals process. The IRO's decision is binding on the Plan.

(ii) Within five (5) days after the claimant's request for review by an IRO, the Plan must determine whether the request is eligible for external review, and notify the claimant within one (1) business day after making its determination.

(iii) The Plan must assign an IRO that is accredited by the Utilization Review Accreditation Commission ("URAC") or a similar national organization to conduct the external review. The Plan must have a contractual relationship with at least three (3) IROs so that claims can be rotated among the IROs. The contract with the IRO must contain certain minimum standards concerning notification of the review and methods for conducting the review.

(iv) In conducting its review, the IRO is not required to give deference to the determination made pursuant to the Plan's internal claims and appeals process. The IRO must, however, observe the Plan's written terms to ensure that the IRO's decision is not contrary to the terms of the plan document. However, if the Plan's terms are unclear, the IRO may consider outside evidence-based standards and other criteria.

(v) The IRO must make a final decision within forty-five (45) days after the claimant's request for review. If the IRO reverses the determination made pursuant to the Plan's internal claims and appeals process, the Plan must immediately provide coverage or payment for the claim.

VI. ASSIGNMENT OF BENEFITS

Benefits under this Plan may be assigned by you to a provider of services only. Assigned benefits shall be paid to the assignee regardless of your intervening death. No claim payment may be made

to your creditors or any other person or entity except as provided specifically in the Plan. No right or interest of you (or your beneficiary) to benefits provided under the Plan (other than to a provider of services only) shall be assignable, pledged, alienated, transferred or otherwise encumbered.

VII. COORDINATION OF BENEFITS

If the claimant is covered by another plan or plans, the benefits under the policy and the other plan(s) will be coordinated. This means that one plan pays its full benefits first, and then the other plan(s) pay(s).

The primary plan (which is the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The secondary plan (which is the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the primary plan will not exceed the greater of:

1. 100% of total covered expenses; or

2. the amount of benefits the secondary plan would have paid had it been the primary plan.

A. Types of Coordinating Coverages

The following types of coverages are plans that coordinate payments with this Plan:

1. individual, group, blanket or franchise insurance (except student accident insurance); or

2. group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs); or

3. coverage under a labor-management trusted plan, a union welfare plan, an employer organization plan, an employee benefit organization plan or any other arrangement of benefits for individuals or a group; or

4. coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law; or

5. coverage under an automobile insurance policy; or

6. other arrangements of insured or self-insured group coverage.

Section B below explains the order in which plans must pay for benefits:

B. Order of Benefit Determination

When another plan does not have a coordination of benefits ("COB") provision, that plan must pay benefits first. When another plan does have a COB provision or the terms of a court order determine the order of benefits, the first of the following rules which applies governs:

1. Employee/Dependent: If a person is covered by two different plans, under one as an employee and the other as a dependent, the plan under which he is an employee must pay its benefits before the plan under which he is a dependent.

2. Active Employee/Inactive Employee: If an Employee is covered by two different plans, under one as an active employee and the other as an inactive employee (laid-off or retired), the plan in which he is an active employee must pay its benefits before the plan under which he is an inactive employee.

3. Dependent Children of Parents Not Divorced or Separated: If a child is covered as a dependent under the father's and mother's group plan, the plan covering the parent whose birthday falls earlier in the calendar year must pay its benefits before the plan which covers the parent whose birthday falls later in the year. If another plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then the birthday rule will determine the order of benefits.

4. Dependent Children of Divorced or Separated Parents: The plan of the parent with custody pays first. The plan of the spouse of the parent with custody (step-parents) pays next. The plan of the parent without custody pays last. However, if the specific terms of a court order state that one of the parents is responsible for the child's health care expenses, the terms of the court order control. If the parent who by court decree must provide health coverage cannot be located or fails to provide health coverage, then the other parent who has custody of the child pays next.

   The Trustees may request proof that attempts were made to collect from the parent which has the responsibility under a court order to pay for health care expenses and the Trustees in their sole discretion may deny payment if they believe insufficient action has been taken to collect from the parent which has the responsibility under a court order to pay for health care expenses.

5. Longer/Shorter Length of Coverage: If none of the above rules determine the order of benefits, the plan covering the person for the shorter time will pay second.

6. Medicare: When Medicare is involved, Medicare is considered to be the primary payor when allowed by law.

7. Automobile Insurance: When automobile insurance is involved, it is the primary payor when allowed by law. If this Plan pays, a subrogation agreement must be signed by the Participant prior to the Plan's paying any benefits on behalf of the

Participant.

C. Plan Benefit Limits

If COB reduces the benefits payable under more than one plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those plan provisions.

D. Plan's Rights

The Plan has the right to:

1. obtain and share information with any other plan which may be subject to this provision without your consent; and

2. require that you provide information about other coverage which may be subject to this provision as a requirement for filing adequate proof of loss; and

3. pay over any amount due under this Plan to any entity entitled to payment under this Plan; and

4. reimburse any other plan that paid benefits which should have been paid by this Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying the Plan's liability.

If this Plan pays more for a covered expense than is required by this provision, the excess payment may be recovered from:

(i) the claimant; or

(ii) any person to whom the payment was made; or

(iii) any insurance company, service plan or any other organization which should have made payment.

VIII. PLAN'S RIGHT TO SUBROGATION, RESTITUTION AND REIMBURSEMENT

A. Definitions

For purposes of the Plan's right to subrogation, restitution, and reimbursement, the following terms shall have the following definitions:

1. "Constructive Trust" means a trust in which any amount, compensation and/or money You recover shall be deemed to be held for Your exclusive benefit and not commingled with other funds. Any such Constructive Trust shall be subject to an

equitable lien by the Plan and any other equitable remedies available to the Plan under ERISA Section 502(a)(3) for the purpose of preserving the Plan's right to restitution for benefits paid by the Plan on Your behalf.

2. "Reimbursement" means repayment to the Plan for, any benefit, including but not limited to medical, dental, prescription or vision that the Plan paid toward care and/or treatment for an injury, disease or illness.

3. "Restitution" means the return or restoration to the Plan of, any benefit, including but not limited, to medical, dental, prescription or vision, the Plan paid toward care and/or treatment for an injury, disease or illness.

4. "Subrogation" means the Plan's right to recover any benefit payment:

   (i) because of injury, disease or illness to You or Your Dependent caused by either You or a third party's conduct; and

   (ii) You or Your Dependent later recover from a third party's insurer or Your own insurer.

5. "Third party" means another person, entity or organization.

6. "You" or "Your" means the following: You, Your Dependents and/or Your or Your Dependent's heirs, estate or assigns. Therefore, all references herein to "You" shall also include Your Dependents and/or Your or Your Dependent's heirs, estate and assigns.

B. Subrogation, Restitution and Reimbursement Rights

1. To the extent of any payment made under the Plan, the Plan shall be subrogated to Your rights of recovery, which rights arise from any claim or cause of action which may occur because of Your or a third party's conduct. This right of subrogation, restitution and reimbursement extends to any recovery received by You, regardless of how it is characterized, such as for pain and suffering, regardless of who makes the payment, for any type of third-party injury. This also includes, but is not limited to:

   (i) payments made directly by a third party, or any insurance company on behalf of a third party or any other payments on behalf of a third party;

   (ii) any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on your behalf or other persons;

   (iii) any other payments from any source designed or intended to compensate you for injuries sustained as the result of negligence or alleged negligence of a third party.

(iv) any worker's compensation award or settlement;

(v) any recovery made pursuant to no-fault insurance; and

(vi) any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

The Plan has a first priority lien on any recovery. You and Your attorney are deemed to hold any recovery in Constructive Trust on behalf of the Plan. The Plan is entitled to repayment in full, without reduction for attorney's fees and costs, and regardless of whether You are made whole or fully compensated. The Plan will not pay future claims to the extent of any recovery You received in the past in connection with an accident, unless the Plan's claim for subrogation, restitution or reimbursement has been satisfied.

2. The Plan shall automatically have a first lien upon any recovery that You receive, or may be entitled to receive, from a third party. The Lien shall be in the amount of the benefits paid under this Plan for the treatment of any illness, disease, injury or condition for which the Responsible Third Party may be liable to You. The Participant or Beneficiary hereby consents to this lien and agrees to cooperate with the Plan to enforce any rights of Subrogation, Restitution or Reimbursement that the Plan may have.

3. The Plan shall be entitled to equitable relief, including without limitation the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and to obtain (or to preclude the transfer or dissipation of) any recovery. The Plan shall be entitle to enforce its lien even if the recovery is less than the actual loss suffered by You.

4. The Plan shall have a specific and first right of reimbursement, up to the amount of the Plan's lien, out of the proceeds of any recovery that You may receive from a Responsible Third Party.

5. You and Your representatives are required to provide all assistance and cooperation requested by the Plan so that the Plan can exercise its subrogation, restitution and reimbursement rights**.** If You or Your representative fail to cooperate with the Plan, the Plan has the right to stop benefit payments and/or deny all future applications for the payment of benefit of whatever kind including, but not limited to, recovery from any full or partial recovery of revenue/money including, but not limited to, full or partial recovery for pain and suffering, loss of wages and punitive damages until You cooperate to the satisfaction of the Plan. In addition, if You fail to cooperate and/or pay the Plan the full amount owed, the Plan shall have the right to withhold Your payment(s) for future or different claims on behalf of Yourself or Your Dependents until the amount owed in the subrogation, restitution or reimbursement claim, in the estimation of the Plan, has been obtained through the withholding of the claims.

6. You and Your attorney are required to sign the Plan's subrogation, restitution and reimbursement agreement prior to the Plan's payment of any benefits on Your behalf for any injury, disease or illness resulting from the actual or alleged negligent conduct of a third party. This Plan's subrogation, restitution and reimbursement agreement may be obtained from the Fund Office or the administrative manager and may include terms and conditions beyond the scope of provisions listed in the Summary Plan Description. The Plan's subrogation, restitution and reimbursement agreement You sign will obligate You, among other things, to reimburse the Plan for any benefits paid by the Plan from any moneys or other property recovered from a third party as the result of a judgment, settlement or other recovery against or with a third party or if You recover under Your own insurance coverage, including uninsured or underinsured coverage. If You are represented by an attorney, Your attorney is also required to sign the subrogation, restitution and reimbursement agreement. If You do not have an attorney at the time of signing the subrogation, restitution and reimbursement agreement but You subsequently are represented by an attorney, You are required to have Your attorney sign a subrogation, restitution and reimbursement agreement at the time Your attorney begins representing You.

7. If You and Your attorney do not sign a subrogation, restitution and reimbursement agreement**,** and the Plan Administrator later learns that benefits were paid to You or on Your behalf because of medical treatment which was rendered due to the negligent (actual or alleged) conduct of a third party or You, the Plan has the right to stop benefit payments and/or deny all future applications for the payment of benefits of whatever kind until You sign a subrogation, restitution and reimbursement agreement. In addition, You and Your attorney are obligated to avoid doing anything that would prejudice the Plan's right of subrogation, restitution and reimbursement.

8. If litigation is commenced, the Plan may cause to be recorded a Notice of Payment of Benefits, and such notice will constitute a first lien on any judgment recovered less a pro rata of court costs. Further, if litigation is commenced, You and Your attorney are required to deliver to the Plan a copy of the complaint filed in court, the name of the insurance company for the defendant(s) and any other instruments, documents or information for which the Plan requests to insure the Plan's subrogation, restitution and reimbursement rights. The Plan shall have the right to intervene in any litigation involving You to protect its subrogation, restitution and reimbursement rights. Any action taken by the Plan to protect its subrogation, restitution and reimbursement rights shall be without any charge or cost to You. However, the Plan shall not be liable to pay Your attorney fees or costs or Your attorney or his/her costs.

9. You are required to segregate any recovery received by You (up to the amount of the Plan's first lien) in a separate account, and You must preserve such recovery so that the Plan may enforce its lien and any disputes as to entitlement may be resolved.

10. You may not assign any right, claim or cause of action against a Responsible Third Party to recover for any illness, disease, injury or condition on account of which

benefits were paid by the Plan.

11. The Plan's rights of reimbursement, restitution and subrogation shall not be affected, reduced or eliminated by the make whole doctrine, comparative or contributory fault, or the common fund doctrine, or payment of Your attorney fees or court costs.

12. If You fail to make a claim or file a lawsuit against the responsible party or parties or insurance company or any other entity, the Plan may sue, compromise or settle in Your name all claims and may execute and sign releases and endorse checks or drafts given in settlement of such claims in Your name with the same force and effect as if You had executed and endorsed them. You and Your attorney agree to cooperate fully with the Plan in the prosecution of such claims and to attend court and testify if the Plan, in its sole discretion, deems Your attendance and testimony to be necessary.

IX. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (hereinafter "QMCSO"), as required by ERISA Section 609.

This Plan, in accordance with applicable law, must recognize a QMSCO. A "medical child support order" is a judgment, decree, or order (including approval of a settlement agreement) entered by a court or administrative agency of competent jurisdiction that:

1. provides for child support with respect to a Participant's child under a group health plan or provides for health benefit coverage to a Participant's child; and

2. is made pursuant to a state domestic relations law.

A "medical child support order" is a QMCSO if it creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, specifies required information, and does not alter the amount or form of plan benefits. An "alternate recipient" means any child of a Participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such Participant.

Thus, if a QMCSO provides health benefit coverage under the Plan to an alternate recipient, the Trustees are required to comply with the QMCSO. Participants may obtain a copy of the QMCSO procedures from the Plan Administrator without charge.

X. FAMILY AND MEDICAL LEAVE ACT

This Plan will provide benefits in accordance with the applicable requirements of the Family and Medical Leave Act of 1993 (hereinafter "FMLA"). Pursuant to the FMLA, eligibility for benefits shall be extended to active Participants and their dependents if the Participant has been granted

unpaid leave by his/her Employer pursuant to the FMLA and meets all eligibility requirements of FMLA.

A covered Employer must grant an eligible Employee up to a total of twelve (12) work weeks of unpaid leave during any 12-month period for one or more of the following reasons:

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

During this period, your Employer may be required to provide health care coverage for you and your dependents on the same terms and conditions that would apply to you if you continued to work.

To be eligible for leave under FMLA, you must work for the same contributing Employer for at least twelve (12) months and for at least 1,250 hours during the twelve (12) month period before the leave begins. Generally, your Employer is obligated to provide family and medical leave if it employs fifty (50) or more employees within a seventy-five (75) mile radius each working day during each of twenty (20) or more work weeks during the current or preceding calendar year.

In order to prevent a loss of eligibility to the Participant, the Participant and/or the Employer granting the FMLA leave must comply with the following requirements:

1. notify the Fund Office at least fourteen (14) days before the onset of FMLA leave, except in an emergency, and then no later than seven (7) days after FMLA leave begins;

2. obtain and submit to the Fund Office a certificate of the Participant's eligibility for FMLA leave; and

3. notify the Fund Office of the beginning date and ending date of the FMLA leave.

The Employer will be required to continue to submit payment for the cost of the Participant's coverage during the FMLA leave. The Employer's required payment shall be equal to the minimum monthly payment, based on the current hourly contribution rate, necessary to maintain the Participant's coverage during the FMLA leave. In addition, the Employer granting the FMLA leave must notify the Fund Office of the date a Participant advises the Employer that he/she does not intend to return to work. If a Participant on FMLA leave advises the Employer that he/she does not intend to return to work, then the obligation of the Employer to submit payment for the cost of the Participant's coverage will immediately cease.

XI. HEALTH INSURANCE AND PORTABILITY ACCOUNTABILITY ACT

A. Definition of Protected Health Information

The Board of Trustees of the Service Employees International Union Local 1 Cleveland Welfare Fund sponsors the Plan and is the Plan's designated Plan Sponsor. The Plan's administrative staff may have access to the individually identifiable health information of Plan participants required for the Plan's administrative functions. When this health information is provided by the Plan to the Plan Sponsor, Business Associates, subcontractors, and other service providers to the Plan, such information is Protected Health Information ("PHI").

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA, as amended.

On January 25, 2013, HIPAA's Privacy, Security, Enforcement and Breach Notification rules were modified by the Health Information Technology for Economic and the Clinical Health Act of 2009 ("HITECH Act") and the Genetic Information Nondiscrimination Act of 2008 ("GINA") (collectively referred to as the "HIPAA Omnibus Rules"). These modifications were effective on or after March 26, 2013.

The following definition of PHI shall apply for purposes of compliance with all HIPAA Omnibus Rules and HIPAA regulations:

1. PHI is information that is created or received by the Plan and relates to the past, present, or future:

   (i) physical or mental health condition of a Covered Person;

   (ii) provision of health care to a Covered Person;

   (iii) belief that the information can be used to identify the Covered Person.

2. PHI may be created, received, maintained, or transmitted to or from the Plan according to the following methods:

   (i) by electronic media;

   (ii) in electronic media; or

   (iii) in any other written or oral form or medium.

3. PHI excludes individually identifiable health information contained in:

   (i) education records covered by the Family Educational Rights and Privacy Act, as amended;

(ii) medical records described at 20 U.S.C. 1232g(a)(4)(B)(iv);

(iii) employment records held by a covered entity in its role as Employer; and

(iv) records of a Covered Person who has been deceased for more than 50 years.

B. Permitted Uses of Protected Health Information

The Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. For this purpose, payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These payment activities include, but are not limited to, the following:

1. determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, plan maximums, and co-payments as determined for an individual's claim);

2. coordination of benefits;

3. adjudication of health benefit claims (including appeals and other payment disputes);

4. subrogation of health benefit claims;

5. establishing employee contributions;

6. calculation of amounts due to risk adjustments or other factors;

7. billing, collection activities, and related health care data processing;

8. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participants' (and their authorized representatives') inquiries about payments;

9. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if necessary, in the future;

10. medical necessity reviews, or reviews of appropriateness of care or justification of charges;

11. utilization review, including pre-certification, preauthorization, concurrent review, and retrospective review; and

12. reimbursements to the Plan.

For purposes of determining uses or disclosures of PHI relating to health care operations, the term

"health care operations" includes, but is not limited to, the following activities:

1. quality assessment;

2. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives; and related functions;

3. rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities;

4. underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);

5. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

7. the Plan's management and general administrative activities, including, but not limited to:

    (i) management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;

    (ii) participant and provider service, including the provision of data analysis;

    (iii) resolution of internal grievances; and

    (iv) filing of governmental forms, including Internal Revenue Service Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code.

8. For "research" purposes, defined by current HIPAA Omnibus Rules and regulations as a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge. An Employer may use or disclose PHI which has been appropriately de-identified according to HIPAA regulations for research purposes.

The Plan will use and disclose PHI for administrative purposes, only as required by law and

permitted by authorization of Covered Persons or their beneficiaries. The Plan will disclose PHI to other related benefit plans which may provide retirement and/or disability benefits to a Covered Person or beneficiary, but only upon written authorization from such Covered Person and the execution of a Business Associate Agreement by such benefit plan. Such uses and disclosures will be made for purposes solely related to administration of the Plan.

C. Permitted Uses and Disclosure of Summary Health Information

The Plan (or a health insurance issuer) may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of:

1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

2. modifying, amending, interpreting, or terminating the Plan.

For this purpose, the term "Summary Health Information" means information that:

1. summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan; and

2. has been de-identified in accordance with the HIPAA Omnibus Rules.

D. Activities That Require Permission for Use or Disclosure of Protected Health Information

In accordance with rules promulgated by the HIPAA Omnibus Rules, the Plan must have the express written permission/authorization of any Covered Persons (or their beneficiaries) to use or disclose PHI to engage in the following activities:

1. the use or transmission of psychotherapy notes related to the treatment of any Covered Person;

2. the use of PHI when the Plan receives financial remuneration from a third party for communications regarding treatment and health care, when that third party is marketing its product or service to the Plan or Eligible Employees;

3. the sale of PHI for any reason; or

4. activities which are not specified or described in the Plan.

Covered Persons who wish to provide written permission/authorization to the Plan to use or disclose PHI for such activities may obtain permission/authorization forms from the Fund Office. In addition, Covered Persons may revoke such express written permission/authorization at any time by

contacting the Fund Office and executing an updated form.

E. Use of Genetic Protected Health Information Prohibited

In accordance with regulations under GINA, the Plan is prohibited from using any Covered Person's "genetic information" for any underwriting purposes. Genetic information includes manifestations of diseases or disorders that have appeared in a Covered Person's family history but have not appeared in the Covered Person's health record.

F. Disclosure Restrictions on Protected Health Information for Health Care Expenses Paid in Full by Covered Persons

In accordance with regulations under HITECH, a Covered Person has the right to restrict disclosures of his or her PHI to the Plan when the Covered Person pays out of pocket, in full, for any health care item or service.

G. Opting Out of Fundraising Activities Involving Protected Health Information

All Covered Persons have the right to opt out of fundraising activities sponsored by, or engaged in, by the Plan Sponsor which involve the use of PHI. However, the Plan Sponsor may include the use of demographic information, health insurance status, or dates of health care for Covered Persons in order to raise money for a non-profit organization or charity.

The Plan Sponsor shall include a reminder of a Covered Person's rights and methods to opt out fundraising activities whenever the Plan Sponsor sends fundraising communications.

H. Protected Health Information Breaches Required to be Disclosed under HIPAA Regulations

The Board of Trustees shall report to the Plan any breach of PHI of which it becomes aware. All Covered Persons will receive a detailed written explanation whenever an event occurs that results in a breach of unsecured PHI. For this purpose, the term "breach" means the acquisition, access, use, or disclosure of PHI in a manner which is prohibited by HIPAA regulations and which compromises the security or privacy of PHI. The impermissible use or disclosure of PHI is presumed to be a breach unless the Plan Sponsor or Business Associate specifically demonstrates that there is a low probability that PHI has been comprised.

I. Covered Person's Right to Receive Protected Health Information from the Plan Sponsor

All Covered Persons have the right to obtain a copy of their PHI from the Plan Sponsor in electronic or hardcopy format. To obtain this information, a Covered Person must make a written request to the Fund Office.

J. Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions, provided that such information has been de-identified in accordance with the HIPAA Omnibus Rules) disclosed to it by the Plan (or a health insurance issuer), the Plan Sponsor shall:

1. not use or further disclose PHI, other than as permitted or required by plan documents, privacy notices, Business Associate Agreements, or as required by current laws and regulations;

2. ensure that any Business Associates, providers, agents or plan representatives, to whom the Board of Trustees provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information by executing written Business Associate Agreements;

3. not use or disclose PHI for employment-related actions and decisions unless authorized by Covered Persons or their beneficiaries;

4. not use or disclose PHI in connection with any other benefit or employee benefit plan unless authorized by the Covered Persons or as otherwise specifically provided herein;

5. report to the Plan and Covered Persons any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Omnibus Rules of which it becomes aware;

6. make PHI available to a Covered Person in accordance with the current access requirements of the HIPAA Omnibus Rules;

7. make PHI available to a Covered Persons to permit the individual affected by such information to make amendments to such PHI in accordance with the HIPAA Omnibus Rule;

8. make available the PHI required to provide an accounting of PHI disclosures in accordance with the HIPAA Omnibus Rules;

9. make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the United States Department of Health and Human Services ("HHS") for the purposes of determining compliance by the Plan with the HIPAA Omnibus Rules and regulations;

10. if feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which permissible disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that

make the return or destruction infeasible; and

11. implement administrative, physical, and technical safeguards that reasonably de-identifies and appropriately protects the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan; and provide for adequate separation, which is supported by reasonable and appropriate security measures between the Plan and the Board of Trustees, as set forth below.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions, provided that such information has been de-identified accordance with the HIPAA Omnibus Rules) on behalf of the covered entity, the Board of Trustees shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. Further, the Plan Sponsor shall ensure that any agents, Business Associates (including subcontractors) to whom it provides such electronic PHI agree to implement similar safeguards, using reasonable and appropriate security measures to de-identify or otherwise protect the information. For these purposes, "electronic PHI" means any PHI that is transmitted by, or maintained in, electronic media.

K. Business Associate Agreements

Any contract between the Plan and a Business Associate must be set forth in a Business Associate Agreement that complies with the requirements of the HIPAA Omnibus Rules. For this purpose, the term "Business Associate" means a person or entity that performs certain functions or activities on behalf of, or that provides certain services to, the Plan involving access by the Business Associate to PHI. The term "Business Associate" also includes a subcontractor that creates, receives, maintains, or transmits PHI on behalf of another Business Associate.

Functions and activities that are performed by a Business Associate include the following:

1. claims processing or administration;
2. data analysis, processing, or administration;
3. utilization review;
4. quality assurance; billing;
5. benefit management;
6. practice management; and
7. repricing.

Services that are performed by a Business Associate include the following:

1. legal services;
2. actuarial services;
3. accounting services;
4. consulting services;
5. data aggregation;

6. management;
7. administrative services;
8. accreditation; and
9. financial services.

For purposes of compliance with the HIPAA Omnibus Rules, the term "Business Associate Agreement" means a contract between the Plan and a Business Associate that satisfies the requirements of the HIPAA Omnibus Rules, including the following:

1. establishes the permitted and required uses of PHI by the Business Associate;

2. provides that the Business Associate will not use or further disclose the PHI other than as permitted or required by the Business Associate Agreement or as required by law;

3. requires the Business Associate to use appropriate safeguards to prevent a use or disclosure of PHI other than as provided for by the Business Associate Agreement;

4. requires the Business Associate to report to the Plan any use or disclosure of the information not provided for by its Business Associate Agreement, including incidents that constitute breaches of unsecured PHI;

5. requires the Business Associate to disclose PHI as specified in its contract to satisfy a Plan's obligation with respect to individuals' requests for copies of their PHI, as well as make available PHI for amendments (and incorporate any amendments, if required) and accountings;

6. to the extent the Business Associate is to carry out a Plan's obligation under HIPAA, requires the Business Associate to comply with the requirements applicable to the obligation;

7. requires the Business Associate to make available to HHS the Business Associate's internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, the Plan for purposes of allowing HHS to assess the Plan's compliance with the HIPAA's privacy requirements;

8. at termination of the contract, if feasible, requires the Business Associate to return or destroy all PHI received from, or created or received by the Business Associate on behalf of, the Plan;

9. requires the Business Associate to ensure that any subcontractors it may engage on its behalf that will have access to PHI agree to the same restrictions and conditions that apply to the Business Associate with respect to such information; and

10. authorizes termination of the contract by the Plan if the Business Associate violates a

material term of the contract.

Contracts between Business Associates and Business Associates that are subcontractors are subject to the same requirements under the HIPAA Omnibus Rules as contracts between the Plan and Business Associates.

L. Persons Entitled to Access to Protected Health Information

In accordance with the HIPAA Omnibus Rules, only the following employees or classes of employees may be given access to PHI:

1. the Plan's Administrative Manager;

2. staff designated by the Plan's Administrative Manager, Investment Manager, or other approved Business Associates; and

3. members of the Board of Trustees and the Plan's legal counsel.

These persons may have access to and use and disclose PHI only for plan administration functions that are performed on behalf of the Plan. If these persons do not comply with the Plan's limitation on the use of PHI, the Board of Trustees shall provide for the resolution of issues of noncompliance, including notifying Covered Persons in writing and imposing disciplinary sanctions.

M. Adequate Separation between Plan and Plan Sponsor

The Plan Sponsor will allow third party service providers access to PHI, subject to the Business Associate Agreement restrictions under Section K. above. No other persons shall have access to PHI. These specified individuals or entities shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these service providers fail to comply with the Business Associate Agreement restrictions under Section K. above, such service provider shall be subject to termination pursuant to the Business Associate Agreement in place.

The Plan Sponsor shall ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

N. Certification of Plan Sponsor

The Plan (or a health insurance issuer) will disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate applicable provisions of HIPAA, and that the Plan Sponsor agrees to the conditions of disclosure set forth in J. above.

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted

by the Plan Sponsor on behalf of the Plan, except for ePHI (a) that it receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (b) that qualifies as Summary Health Information and that it receives for the purpose of either (i) obtaining premium bids for providing health insurance coverage under the Plan, or (ii) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated in this Summary by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

The Plan Sponsor will, in accordance with the Security Regulations, take the following measures:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the "ePHI" that it creates, receives, maintains or transmits on behalf of the Plan.

2. Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means that the Plan Sponsor will use ePHI only for activities related to the Plan's administration and not for employment-related actions or for any purpose unrelated to the Plan's administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or the Plan's provisions regarding such policies and procedures is subject to the Plan's disciplinary procedure.

3. Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

4. Report to the Plan any security incident of which it becomes aware.

Effective February 17, 2010, the Plan and the Plan Sponsor will take the measures necessary to comply with the requirements of the HITECH Act and regulations issued by HHS implementing the HITECH Act. These measures include the following:

1. Modify and expand existing HIPAA privacy and security rules to protect PHI.

2. Comply with breach notification procedures that require the Plan Sponsor to notify an individual and HHS (and a prominent media outlet in any breach affecting more than500 individuals in a state or jurisdiction) when there is a breach of unsecured PHI that affects such individual. For this purpose, "unsecured PHI" is PHI that is not rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technology or methodology specified in guidance issued by HHS.

3. Disclose expanded information to any individual who requests an accounting of PHI disclosures.

XII. DEFINITIONS

Amended Agreement and Declaration of Trust – means the Restated Agreement and Declaration of Trust establishing the Service Employees International Union Local 1 Cleveland Welfare Fund Trust Fund, which has been entered into by and between the Service Employees International Union Local 1 Cleveland, and those Employers which, by virtue of collective bargaining agreements and/or participation agreements with the Union, have agreed to participate in and contribute to this Plan and who became parties thereto, and the document, as may from time to time be amended.

Covered Person – means the Participant, and if family coverage is in force, the Participant's Eligible Dependents, including the Participant's Spouse.

Covered Service – means a Provider's service or supply for which the Plan will pay, as listed in the applicable schedule of benefits.

Eligible Dependent – means only the following individuals, provided they are not eligible to be covered under the Plan as Employees and, if previously covered as Employees, are not eligible to receive any benefits under the Plan as a result of a disability existing when coverage as an Employee was discontinued.

The following individuals shall be Eligible Dependents:

A. An Employee's legal Spouse, while not divorced or legally separated from the Employee.

B. A natural child of the Employee if the child is less than twenty-six (26) years of age.

C. A stepchild, legally adopted child or legal ward of the Employee who has been placed under the legal guardianship of the Employee if the child is less than twenty-six (26) years of age.

D. An unmarried child above for whom an Employee is ordered by a United States court or administrative agency of competent jurisdiction to provide medical coverage in accordance with the provisions of a Qualified Medical Child Support Order.

An Eligible Dependent shall be considered eligible for coverage on the date the Employee becomes eligible for benefits, subject to all limitations and requirements of the Plan, and according to the following:

1. Newborn children of an Employee will be covered from the moment of birth, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided that the child is properly enrolled as an Eligible Dependent of the Employee within thirty (30) days of the child's date of birth. If not, the Eligible Dependent will be covered from the date of enrollment.

2. A Spouse will be considered an Eligible Dependent from the date of marriage, provided the Spouse is properly enrolled as an Eligible Dependent of the Employee within thirty (30) days of marriage, if not, the Eligible Dependent will be covered from the date of enrollment.

3. If an Eligible Dependent is acquired, other than at the time of birth, due to a court order, decree or marriage, that Eligible Dependent will be considered an Eligible Dependent from the date of such court order, decree or marriage, if this new Eligible Dependent is properly enrolled as an Eligible Dependent of the Employee within thirty (30) days of the court order, decree or marriage, if not, the Eligible Dependent will be covered from the date of enrollment.

4. Adopted children of an Employee will be eligible for coverage as of the date of legal custody, or as of the date of actual adoption, whichever occurs first. Coverage under the Plan for the child shall be the same coverage which is available to all other Eligible Dependent children under the Plan, except that all pre-existing condition exclusions or waiting periods are hereby waived for such adopted children.

Employee – means and includes members of a collective bargaining unit represented by the Union who are eligible to participate in and receive the benefits provided by the Plan.

Employer – means:

A. Any individual, firm, association, partnership or corporation which is bound by a collective bargaining agreement with the Union, and in accordance therewith agrees to participate in and contribute to the Trust Fund. Any Employer which contributes to the Trust Fund shall, by the act of contributing, become a party to the collective bargaining agreement, whether any such contributing Employer has signed the Amended Agreement and Declaration of Trust or a counterpart thereof.

B. Any individual, firm, association, partnership or corporation which is bound by the collective bargaining agreement with the Union, or signs a participation agreement with the Trust Fund, and in accordance therewith agrees to participate in and contribute to the Trust Fund. Any Employer which contributes to the Trust Fund shall, by the act of contributing, become a party to the collective bargaining agreement, whether any such contributing Employer has signed the Amended Agreement and Declaration of Trust or a counterpart thereof.

Experimental – means a service or treatment which satisfies the specifications set forth in the definition of the term "Experimental" and/or "Investigational" in the summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

Hospital – means an institution which satisfies the specifications set forth in the definition of the

term "Hospital" in the summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

Identification Card – means the health care card provided to you by the Plan. Your Identification Card shows your identification number.

Medical Plan Year – means the period set forth in the definition of the term "Medical Plan Year" in the summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

Medicare – means the federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

Member – means a person who satisfies the requirements of membership in the Union.

Network – means the facilities, providers and suppliers which satisfy the specifications set forth in the definition of the term "Network" in the summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

Participant – means any Employee or former Employee of an Employer or any Member or former Member who is or may become eligible to receive a benefit of any type from the Plan.

Physician – means an individual who satsifies the specifications set forth in the definition of the term "Physician" in the summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

Plan Year – means the twelve (12) month period beginning January 1 and ending December 31. The Plan Year may be a different period from the Medical Plan Year.

Provider – means an entity which satisfies the specifications set forth in the definition of the term "Provider" in the summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

Spouse – means, for purposes of coverage as an Eligible Dependent, that person, if any, who:

A. is recognized as legally married to the Participant by a domestic or foreign jurisdiction whose laws authorized the marriage at the time the Participant and such person entered into the marital relationship; and

B. has not been declared legally separated from the Participant by any judicial order.

The term "Spouse" shall include a person of the opposite or same gender as the Participant.

Surgery – means a treatment which satsifies the specifications set forth in the definition of the term "Surgery" in the summary of medical benefits entitled "Service Employees International Union Local 1 Cleveland Welfare Fund – Medical Plan Document."

Third Party Administrator – means the professional administrative manager to which the Board of Trustees has delegatged certain administrative functions relating to the Plan's operation.

Trust Fund – means the Amended Agreement and Declaration of Trust and the entire assets thereof, including all funds received by the Trustees in the form of Employer contributions, together with all contracts (including dividends, interest, refunds and other sums payable to the Trust Fund on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits therefrom, and any other property or funds received and held by the Trustees under the Amended Agreement and Declaration of Trust.

Trustee – means any natural person designated as Trustee under the terms of the Amended Agreement and Declaration of Trust and his or her successor or successors in office. The Trustees, collectively, shall be the " Plan Administrator," as that term is used in ERISA and the Internal Revenue Code ("Code").

Union – means the Service Employees International Union Local 1 Cleveland, and its successors.

XIII. MISCELLANEOUS PROVISIONS

A. Change of Plan Provisions

The Board of Trustees, in its sole discretion, is empowered to change or amend any Plan provision, including, but not limited to, the eligibility rules or the schedule of benefits, at any time by amendment or resolution duly executed.

B. Change in Terms

The terms of this Plan may be changed at any time without advance notice to you, except as prohibited by law. All changes in coverage will be made on a uniform basis, affecting similarly situated Participants and Employees equally, and will not apply to claims incurred before the amendment or termination is effective.

C. Amendments

The Board of Trustees is empowered to amend this Plan from time to time, in its sole discretion, as it deems necessary to carry out the purposes and objectives of the Plan and Trust Agreement.

D. Authority to Interpret Plan

The Board of Trustees has complete authority to construe and interpret the provisions of the Plan and Trust Agreement, and any ambiguity regarding whether coverage is permitted shall be construed

against coverage. Pursuant to this grant of authority, the Board has the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Plan benefits within the terms of the Plan as interpreted by the Trustees in their sole discretion. No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or Trust Agreement. 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. No provision of this Plan shall be construed to conflict with any United States Treasury Department, United States Department of Labor, or Internal Revenue Service regulation, ruling, release or proposed regulation or other which affects or could affect the terms of this Plan, and this Plan shall be deemed to be amended to such extent necessary to resolve any such conflict.

E. Legal Actions

No actions at law or in equity shall be brought to recover any benefits provided under this Plan prior to the expiration of sixty (60) 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.

F. Right to Receive and Release Necessary Information

To determine the applicability of and to implement the terms of this provision or any provision of similar purpose in any other plan, the Plan may, without the consent of or notice to any person, and subject to the privacy requirements of HIPAA as set forth in Article XI, release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Trust Fund such information as may be necessary to implement this provision.

Upon the request of the Trustees, you may be required as a condition to continue eligibility under this Plan to apply for Social Security benefits, Medicare and Medicaid or the program then in effect. You may also be required as a condition to continue eligibility under this Plan to sign any authorizations or releases provided by the Trustees, as the Trustees deem necessary, enabling the Trustees to obtain information from the Participant and appropriate government agencies pertaining to their claim for Social Security benefits, Medicare and Medicaid benefits.

G. Right of Recovery

Whenever payments have been made by the Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Plan shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations. The Trustees reserve the right to reduce or withhold future benefit payments under the Plan in order to correct a prior payment to any Participant.

H. Nondiscrimination Rights

The Plan shall not discriminate against you based on health status in eligibility, enrollment or premium contributions in accordance with federal law. However, the Trustees shall have the right to require you to be examined by a Physician selected by them as often as they may reasonably deem necessary in order to process a claim.

I. Prohibited Discrimination

1. Eligibility to Enroll

(i) In General. Subject to subsection (ii) below, the Plan may not establish rules for eligibility (including continued eligibility) of any Participant to enroll under the terms of the Plan based on any of the following factors in relation to the Participant:

(a) health status;

(b) medical condition (including both physical and mental illnesses);

(c) claims experience;

(d) receipt of health care;

(e) medical history;

(f) genetic information;

(g) evidence of insurability (including conditions arising out of acts of domestic violence); and

(h) disability.

(ii) No Application to Benefits or Exclusions. To the extent consistent with the pre-existing condition exclusion provisions, subsection (i) above shall not be construed:

(a) to require the Plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such Plan; or

(b) to prevent the Plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated Participants enrolled in the Plan.

(iii) Construction. For purposes of subsection (i) above, the rules for eligibility to

enroll under the Plan include rules defining any applicable waiting periods for such enrollment.

2. Premium Contributions

(i) In General. The Plan may not require any Participant or Eligible Dependent (as a condition of enrollment or continued enrollment under the Plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated Participant enrolled in the Plan on the basis of any factor described in Section 1 above.

(ii) Construction. Nothing in Section 1 above shall be construed to restrict the amount that an Employer may be charged for coverage under the Plan; or to prevent the Plan from establishing premium discounts or rebates or modifying otherwise applicable co-payments or deductibles in return for adherence to programs of health promotion and disease prevention.

J. Guaranteed Renewability

This Plan may not deny an Employer continued access to the same or different coverage under the Plan, other than:

1. for nonpayment of contributions; or

2. for fraud or other intentional misrepresentation of material fact by the Employer; or

3. for noncompliance with material Plan provisions; or

4. because the Plan is ceasing to offer any coverage in a geographic area; or

5. in the event the Plan offers benefits through a network plan, because there is no longer any individual enrolled through the Employer who lives, resides, or works in the service area of the network plan and the network plan applies this paragraph uniformly without regard to the claims experience of Employers or a factor described in Section I(1) in relation to such Participants or their Eligible Dependents; or

6. for failure to meet the terms of an applicable Collective Bargaining Agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the Plan, or to employ Employees covered by such an agreement.

K. Employment Rights

The establishment of this Plan shall not be construed as conferring any legal rights upon any Employee or any other person for continuation of employment, nor shall it interfere with the rights of any Employer to discharge any Employee and/or treat him or her without regard to the effect which such treatment might have upon him or her as a Participant in this Plan.

L. Medical Examination

No medical examination shall be required of any person in order to obtain coverage for benefits initially. However, the Trustees shall have the right to require any Employee whose accident, injury or illness is the basis of a claim to be examined by a Physician selected by them as often as they may reasonably deem necessary in order to process the claims.

M. Trustee Rights

The Trustees shall have the exclusive right and discretion to make any finding of fact necessary or appropriate for any purpose under the Plan including, but not limited to, the determination of eligibility for and the amount of any benefit payable under the Plan. The Trustees shall have the exclusive right and sole discretion to interpret the terms and provisions of the Plan and to determine any and all questions arising under the Plan in connection with administration thereof, including, without limitation, the right to remedy or resolve possible ambiguities, inconsistencies or omissions, by general rule or particular decision. The Trustees shall make or cause to be made by engaging individuals or entities, to make all reports or other filing necessary to meet the reporting and disclosure requirements of ERISA. All decisions made by the Trustees, any action taken by them in respect of the Plan or the Trust Agreement, shall be conclusive and binding on all persons, and shall be given the maximum possible deference allowed by law.

N. Payment of Benefits

All benefits under the Plan shall be payable through Employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Fund can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, any Employer, or the Trustees. The Trustees, the Employers and Union shall not be held liable for any benefits or contracts, except as provided in the Agreement between the Employers and the Union.

O. Delinquent Contributions

In order to protect the interests of the Participants and beneficiaries of the Plan, the Trustees reserve the right to promulgate rules and regulations denying further participation in the Plan by Employees when Employer contributions on behalf of one or more Employees have been in arrears for a specified number of hours or weeks of service, as determined by the Trustees in their sole discretion, and/or to delay the payment of claims arising on such individual until contributions are received by the Trust Fund office on behalf of all Employees.

P. Health Care Fraud

Health care fraud is a felony that can be prosecuted. It is unethical, immoral and illegal, and it is costly to the Plan. Every Participant pays for the dishonesty of the person who commits health care fraud.

Any Participant who willfully and knowingly engages in an activity intending to defraud this Plan will face disciplinary action and/or prosecution. Furthermore, any Participant who receives money from the Plan to which he or she is not entitled will be required to fully reimburse the Plan. The Board of Trustees reserves the right to rescind the coverage of any person who defrauds the Plan or makes an intentional misrepresentation of material fact to the Third Party Administrator. If the Board of Trustees determines that rescission is appropriate because of fraud or an intentional misrepresentation of material fact, the Board of Trustees shall provide advance written notice of at least thirty (30) days to each Covered Person who will be affected before coverage may be rescinded.

Q. Governing Laws

This Plan shall be construed, enforced and administered and the validity determined in accordance with ERISA, the Code, and the laws of the State of Ohio.

XIV. STATEMENT OF ERISA RIGHTS

The following notice is required by ERISA:

A. Your Rights under ERISA

As a Participant in the Service Employees International Union Local 1 Cleveland Welfare Fund, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to:

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

2. 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.

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

B. Continuation of Group Health Plan Coverage

You can continue health plan coverage for yourself, your Spouse, or your Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible 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.

There is a 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, or when your COBRA continuation coverage ceases, if you request such certificate up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months (eighteen (18) months for late enrollees) after your enrollment date in your coverage.

C. 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 Plan. The people who operate the 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.

D. Enforcement of Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file 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 $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administration.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or you may file suit in a federal court. The court will decide who should pay the 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 if, for example, the court finds that your claim is frivolous.

E. Assistance with Your Questions

If you have any questions about the 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 ("PWBA"), United States Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits, Administration, United States Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. The nearest PWBA Office is the Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Fort Wright, Kentucky 41011 (telephone: (606) 578-4680).

THE BOARD OF TRUSTEES OF THE SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 1 CLEVELAND WELFARE FUND

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ATTACHMENT A

COVERAGE DETERMINATION, REDETERMINATION (INTERNAL APPEAL), AND INDEPENDENT REVIEW (EXTERNAL) APPEAL PROGRAM BY SAV-RX PRESCRIPTION SERVICES

A. Overview of Special Procedures for Coverage Determinations, Redeterminations, and Independent Review Organizations for Prescription Drug Claims

Sav-Rx Prescription Services ("Sav-Rx"), the Plan's prescription drug benefits manager, maintains a process for coverage determinations, redeterminations, and independent review organization submissions for prescription drug claims. Sav-Rx utilizes a claim adjudication platform to determine real-time coverage/non-coverage status for prescription drug claims submitted electronically at the point of sale. Claims failing one or more benefit design coverage rules will be rejected at the point of sale, and information regarding the reject reason(s) will be conveyed to the dispensing pharmacy at the point of sale. Pharmacy personnel may contact the Sav-Rx Customer Service Department to begin the coverage determination process, or they may inform the patient of the reason(s) for the rejection and provide the patient with instructions to contact Sav-Rx Customer Service in the event that the patient would like to initiate a coverage determination.

B. Initial Determination

When a coverage determination request is initiated, the information from the rejected prescription is conveyed by Sav-Rx to the patient's dispensing physician via fax with a request for specific information regarding the patient's medication history and disease diagnosis. The physician completes the form and returns it to Sav-Rx where the information provided by the physician is evaluated by a Sav-Rx clinical pharmacist. Expedited request determinations occur within 24 hours of receipt of the request and standard determinations occur within 72 hours of receipt of the request.

Based on the Sav-Rx clinical pharmacist's evaluation of the coverage determination request, the request will be either approved or rejected.

1. For approved coverage determinations, a confirmation is communicated to the patient, the prescribing physician and the dispensing pharmacy.

2. If the information provided meets the criteria to allow an override of the initial rejection, an override will be configured in the adjudication system that will allow the claim to process.

3. If the clinical review determines that the prescription fails to meet the coverage standard, the prescription will remain in rejected status.

In the event that the coverage determination is denied, a model notice will be used for notification of the denial to the patient. The prescribing physician and the dispensing pharmacy will also be

notified. Sav-Rx will provide the patient and the prescribing physician with denial letters. The denial letters will describe the specific reason for the denial and provide instructions about the right of the patient and/or the prescribing physician to initiate a redetermination review (internal appeals process). In addition, the model denial notice will provide information about the internal and external appeals process and provide the contact information for the Office of Consumer Assistance of the United States Department of Health and Human Services ("HHS").

C. Redetermination (First Level Internal Appeal)

A redetermination is the Sav-Rx equivalent to a first level internal appeal. Upon initiation of a redetermination by the patient or the patient's appointed representative, additional supporting documentation may be received by Sav-Rx from the physician. Expedited redetermination request evaluations occur within 24 hours of receipt of the request and standard evaluations occur within 72 hours of receipt of the request. The evaluation is performed by a Sav-Rx clinical pharmacist other than the pharmacist that denied the original coverage determination request to maintain impartiality within the review process.

Based on the Sav-Rx clinical pharmacist's evaluation of the denial of the original coverage determination request, the request will be either approved or rejected.

1. For approved redeterminations, a confirmation will be communicated to the patient, the prescribing physician, and the dispensing pharmacy.

2. If the redetermination information supports an override of the coverage determination denial, an override will be configured in the adjudication system which will allow the claim to process.

3. If the evaluation determines that the redetermination request fails to meet the coverage standard, the prescription will stay in rejected status.

Notification of the denial, a model notice will be used for notification of the denial to the patient. The prescribing physician and the dispensing pharmacy will also be notified. Sav-Rx will provide the patient and the prescribing physician with denial letters. The model Final Internal Adverse Determination notice will contain instructions about the patient's right to initiate an independent review with an Independent Review Organization ("IRO") (information on the external appeals process) and about the contact information for the HHS Office of Consumer Assistance.

D. External Appeal (Independent Review Organization)

When a patient or a patient's appointed representative initiates an external appeal request with an IRO, Sav-Rx will provide the claim information, plan exclusion and coverage criteria documentation, and clinical review criteria to the IRO. This external appeal request must be made within four (4) months after the redetermination request (final internal appeal decision). Sav-Rx has contracted with three separate IROs to ensure an impartial decision is reached for each request. External appeal requests will be assigned and rotated to the IROs in succession to avoid selection bias. Each contracted IRO will have URAC accreditation status to conduct external reviews. The IRO is not bound by the previous redetermination decision and will review each case on the basis of

the Plan's exclusion and coverage documentation. The IRO will convey a final decision to Sav-Rx within 45 days for standard reviews and within 72 hours for expedited reviews. Expedited reviews are permitted when standard review timeframes would seriously jeopardize the life or health of the patient.

If the IRO reverses Sav-Rx's adverse redetermination decision, Sav-Rx will provide coverage and/or payment of the claim within 24 hours after notification of the IRO decision. If the IRO upholds Sav-Rx's adverse redetermination decision, the IRO will communicate the decision to Sav-Rx and the patient. If the physician files the request on the patient's behalf, then the physician would be notified as well. The patient and prescribing physician (if applicable) will be provided denial letters with the specific reason for the denial and the contact information for the HHS Office of Consumer Assistance.

E. Providing Notice to Enrollees in Culturally and Linguistically Appropriate Manner

Code Section 2719(a)(1)(B) requires that a group health plan and health insurance issuer offering group or individual health coverage provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes. Under the IFR at 45 CFR §147.136(e), plans and issuers meet the culturally and linguistically appropriate requirement if they provide notices, upon request, in the non-English language to populations that meet the following thresholds:

1. In the group market, for a plan that covers fewer than 100 participants at the beginning of a plan year, the plan must make culturally and linguistically appropriate notices available to populations in which 25 percent of all plan participants are literate only in the same non-English language. For a plan that covers 100 or more participants at the beginning of a plan year, the threshold is the lesser of 500 participants, or 10 percent of all plan participants, being literate only in the same non-English language. The thresholds are adapted from the Department of Labor's regulations regarding style and format for a summary plan description, at 29 CFR 2520.102–2(c).

2. In the individual market, the determination of whether issuers are considered to be providing relevant notices in a culturally and linguistically appropriate manner is made at the county level. If at least 10 percent of the population residing in a county is literate only in the same non-English language, the issuer must provide the appeals-related notices in that language, upon request by an individual claimant residing in that county.

The Plan is responsible for notifying Sav-Rx if one of these requirements is applicable to their members.

F. Key Terms and Definitions

For purposes of coverage determinations, redeterminations, and independent review organization

submissions for prescription drug claims, the following terms shall have the following definitions:

1. "Coverage Determination" means a decision made by clinical personnel on coverage status for a medication.

   EXAMPLE: An Approved PA is a Coverage Determination. A denied PA is also a Coverage Determination.

2. "External Appeal" means an appeal researched by a third party organization ("IRO"). The IRO's decision is final and binding on the plan sponsor.

3. "IRE" means an Independent Review Entity (also referred to as an IRO).

4. "IRO" means an Independent Review Organization (also referred to as an IRE).

5. "Redetermination" means a first internal appeal. The Redetermination is reviewed by Sav-Rx Clinical staff.

6. "URAC" means "Utilization Review Accreditation Commission," simply known as a URAC. A URAC is an impartial organization that reviews a business entity's operations to ensure that the entity is conducting business in a manner consistent with national standards.

E. Additional Information Regarding Review of Prescription Drug Claims

1. Reason for Change in Adjudication of Prescription Drug Claims

The Patient Protection and Affordable Care Act ("Affordable Care Act") provides consumers with the right to appeal decisions made by their health carrier (including prescription appeals) to an outside, independent decision-maker (URAC-approved IRO), regardless of the state in which the consumer lives or the type of health insurance which the consumer has. In the past, states had various appeal guidelines, but the guidelines were not required or regulated. Going forward, all states will abide by the same standards set forth by the Affordable Care Act.

2. HHS Regulations Governing Appeals

The HHS regulations governing appeals may be accessed by clicking on the word "Regulation" at https://www.hhs.gov/regulations/complaints-and-appeals/index.html

3. Sample Communication Language

A Model Notice of Adverse Benefit Determination may be accessed at https://www.cms.gov/CCIIO/Resources/Files/Downloads/abd_model_notice_2.pdf

A Model Notice of Final Internal Adverse Benefit Determination may be accessed at https://www.cms.gov/CCIIO/Resources/Files/Downloads/final_iabd_model_notice_1.pdf

A Model Notice of Final External Review Decision may be accessed at https://www.cms.gov/CCIIO/Resources/Files/Downloads/external_final_decision_model_notice.pdf

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