**KEEP THIS BOOK**

# SUMMARY PLAN DESCRIPTION

# FOR COVERED MEMBERS AND QUALIFIED DEPENDENTS FOR FLEET OWNERS INSURANCE FUND a/k/a FLEET OWNERS - LOCAL UNION 964 INSURANCE FUND

**"PLAN A and PLAN B"**

FOIF

6511 Eastland Road, Suite 120
Brook Park, OH 44142-1309
Toll Free: (877) 301-0874
Ph: (440) 243-0648
Fax: (440) 243-0657
www.fleetownersinsurance.org

This is the entire Plan and contains all terms and conditions of coverage and is written to comply with the legal requirements for the Summary Plan Description of the Fund.

Rev. 01-01-2015

**FLEET OWNERS INSURANCE FUND**
**a/k/a FLEET OWNERS-LOCAL UNION**
**964 INSURANCE FUND**
6511 EASTLAND ROAD, SUITE 120
BROOKPARK, OHIO 44142-1309
Office: (440) 243-0648; Fax: 440-243-0657
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January 1, 2015

This booklet explains the features of the health and welfare plan (referred to herein as "the Plan") offered by Fleet Owners Insurance Fund ("Fund") to employees of Participating Employers.

The Fund is financed by its assets and by contributions from our Participating Employers. Presently, the Fund offers three plans, Plan A, Plan B and a Retiree Plan. Each Plan has a Schedule of Benefits and this booklet is incorporated and made a part of the each of the Schedules of Benefits as if fully rewritten therein.

All of the Fund plans are self-administered by the Trustees and the Fund employees and advisors who assist them. Medical Mutual of Ohio, CVS Caremark and other vendors assist the Fund from time to time. They do not adjudicate claims and are insurers of benefits. The Trustees may change the PPO Network from time to time to better serve its members and may increase or decrease benefits, from time to time, as they believe necessary to administer the Fund.

The Fund is a Taft-Hartley health and welfare fund regulated by the Department of Labor.

For further information, call, write or email the Fund Office.

## HEALTH AND WELFARE PLAN

The Health and Welfare Plan ("Plan") is restated as of the first day of January, 2015 in accordance with the provisions of that certain Amended and Restated Agreement and Declaration of Trust ("the Trust Agreement") dated as of June 1, 2002, as amended, for the benefit of its Members and Dependents, as defined herein under the terms and conditions hereinafter set forth. Since the Plan was established pursuant to the terms and provisions of the Trust Agreement and since the Trust Agreement forms the basis of administration and operation of the Fund, all of the provisions of the Trust Agreement are incorporated herein and made a part hereof as if fully rewritten herein and attached hereto.

**PLAN NAME**

Either Plan A, Plan B or the Retiree Plan of the Benefit Plans of the Fleet Owners Insurance Fund a/k/a Fleet Owners-Local Union 964 Insurance Fund.

**FUND IRS IDENTIFICATION NUMBER**

34-6540902

**PLAN YEAR**

The Plan Year for this Trust Fund is from the first day of January, 2015 until December 31, 2016 and thereafter a calendar year. Records are kept according to the Plan year.

**AMENDMENTS**

The provisions of the Trust Agreement and this Plan may be amended from time to time by the Trustees, and such amendments shall be effective when approved by such Trustees provided that such amendments shall be made consistent with the objectives and purposes of the Trust.

**THE BOARD OF TRUSTEES**

The Union chooses one person and the Participating Employers choose one person called Trustees who jointly serve as the Board of Trustees. The Trustees are required to be appointed by law, and have sole authority to administer the Plan. The names and addresses of the Trustees and Office of Administration are:

Trustees: **Robert Kavalec** **Charlie Alferio**

The Fund office is located at 6511 Eastland Road, Suite 120, Brook Park, Ohio 44142-1309.

The Trustees shall hold all property, income and assets in trust for the purpose of the Fund. The Trustees shall have the sole authority to administer and manage the Fund and any decision made by them shall be final and binding on all Members and their Dependents. The Trustees have the power and/or the authority to delegate any and all necessary and proper authority to assist in the administration of the Fund and its objectives, including but not limited to, the hiring of personnel, professional and otherwise, to achieve the objectives of the self-insured Fund.

The fiduciaries of the Fund are the Trustees and those professionals who have undertaken fiduciary responsibility in connection with the Fund.

**CONTRIBUTIONS AND PAYMENTS**

All contributions to the Fund shall be made only by Employers on behalf of their Employees. Contributions by a Member and/or Eligible Dependent are permitted in limited circumstances as hereinafter provided. Payments for benefits shall be made in accordance with the Schedule of Benefits contained in the Plan or as the Trustees acting in the scope of their responsibility, shall prescribe in their best judgment in the event the procedure is not covered by the Schedule of Benefits.

**COVERAGE OF FUND**

The provisions of coverage of the Fund shall be limited to those benefits as provided herein, only when accident, injury, illness or related illnesses are incurred, and when the participant is eligible.

**RESPONSIBILITIES FOR ADMINISTRATION**

The Plan of the Fleet Owners Insurance Fund a/k/a Fleet Owners-Local Union 964 Insurance Fund is to be administered by the Trustees in accordance with the provisions of federal law including but not limited to ERISA and the Affordable Care Act.

**DUTIES OF THE TRUSTEES**

(1) To administer the Plan in accordance with its terms.
(2) To decide disputes which may arise relative to the rights of a Member or Dependent who is covered by the Plan.
(3) To keep and maintain the Plan documents and all other records pertaining to the Plan.
(4) To perform all necessary reporting as required by ERISA and the Affordable Care Act.

**FIDUCIARY**

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**FIDUCIARY DUTIES**

A fiduciary must carry out his/her duties and responsibilities for the purpose of providing benefits to the Members and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent to do so; and
(3) In accordance with the Plan documents to the extent that they comply with ERISA and the Affordable Care Act.

**NAMED FIDUCIARY**

A "named fiduciary" is a Trustee of the Fund. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) of the Fund. These other persons become fiduciaries themselves and are responsible for their acts in connection with the Fund. To the extent that the named fiduciary allocates his/her responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated his/her stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment of the procedures; or
(2) The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

**FUNDING THE FUND AND PAYMENT OF BENEFITS**

The costs of the Fund are funded as follows:

For Member or Dependent Coverage: Funding is derived solely from the funds of the participating Employers, except for continuation benefits and other limited circumstances.

Benefits are paid from the Fund by the Trustees directly or through service providers.

**NON-PAYMENT OF EMPLOYER CONTRIBUTIONS**

In the event that a claim arises against a Member or a Dependent of a Member and contributions have not been received by the Fund on behalf of said Member from an Employer, the claim shall not be payable until such contributions are received in full by the Fund, and the Trustees may terminate coverage of an Employer, Member or Dependent from the Plan for non-payment of health and welfare contributions.

**THE TRUST AGREEMENT**

The Fund is established under either a Trust Agreement and that agreement is made a part of the Fund plan. A copy of the Trust Agreement is available for examination by Members and their Dependent(s) at the office of the Fund during normal business hours. Also, upon written request and advance payment of a $0.25/page copying charge plus postage, the following items will be furnished to a Member or Eligible Dependent:

(1) A copy of the Trust Agreement.

(2) A list of participating employers sponsoring the Fund.

(3) Information as to whether a particular employer is a sponsor of the Fund and the address of the Employer.

**PLAN IS NOT AN EMPLOYMENT CONTRACT**

The Plan is not and shall not be construed as a contract for or of employment.

**AMENDING AND TERMINATING THE PLAN**

The Trustees have the authority to terminate the Plan or amend it or decrease or eliminate benefits. The rights of the Members are limited to covered expenses incurred before termination or amendment.

**CERTAIN EMPLOYEE RIGHTS UNDER ERISA**

Members and their Dependents covered by the Plan are entitled to the rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Affordable Care Act of 2010 (ACA). ERISA specifies that all plan Members (Covered Employees under the Plan) shall be entitled to:

(1) Examine, without charge, at the Fund's office, all Plan documents and copies of all documents filed by the Fund with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

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

(3) Examine a summary of the Fund's annual financial report. The Trustees are required by law to furnish (upon payment of a reasonable charge) each Member with a copy of this summary annual report.

(4) File suit in a federal court, if any materials requested are not received within 30 days of the Covered Person's request, unless the materials were not sent because of matters beyond the control of the Trustees. The court may require the Trustees to pay a penalty for each day's delay until the materials are received.

In addition to creating rights for Members, ERISA imposes obligations upon the individuals who are responsible for the operation of the Fund. The individuals who operate the Fund, called "fiduciaries" of the Fund, have a duty to do so prudently and in the interest of all Members. No one, including a Participating Employer or any other person, may fire a Member or otherwise discriminate against a Member in any way to prevent the Member

from obtaining benefits under the Plan or from exercising his/her rights under ERISA or the ACA.

If a Member's claim for a benefit is denied, in whole or in part, the Member must receive a written explanation of the reason for the denial. The Employer has the right to have the Plan's provisions be reviewed and re-consider the claim. Under ERISA there are steps that the Member can take to enforce the above rights. For instance, if the Member requests materials from the Fund and does not receive them within 30 days, that person may file a suit in federal court. In such a case, the court may require the Trustees to provide the materials and pay the Member up to $100 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Trustees. If the Member has a claim for benefits which is denied or ignored, in whole or in part, that Member may file suit in a state or federal court.

If it should happen that the fiduciaries misuse the Fund's money, or if a Member is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Member is successful, the court may order the person sued to pay these costs and fees. If the Member loses, the court may order him/her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If a Member has any questions about the Plan, he/she should contact the Trustees. If the Member has any questions about this statement or his rights under ERISA, the Member should contact the nearest office of the U.S. Labor-Management Services Administration, Department of Labor.

If a Member has any question about this statement or rights under ERISA, the Member should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

The nearest field office of the Department of Labor's Pension and Welfare Benefits Administration (PWBA) is the Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Ft. Wright, KY 41011-2664, phone (606) 578-4680.

**HOW TO SUBMIT A CLAIM**

A Member's physician or other healthcare provider will normally submit a claim on the Member's behalf. Otherwise, the Member should ask the Employer for the appropriate form to file a claim. Payment for benefits will be made in accordance with the Schedule of Benefits which provided to each Member and the Plan document. If a procedure does not appear to

be covered by the Plan, the Member may appeal and the Trustees will make the final determination.

One or more membership cards will be issued to each Member identifying the Member, the Employer, the Plan and the Fund. These are to be used to pay covered expenses incurred with the Member's healthcare providers.

**Death and Dismemberment Benefits for Members Only:** To make claim for death or dismemberment benefits, the required documents must be filed in the Fund office within 90 days from the date of death or loss. No claims for payments of benefits under the death provision will be considered after 90 days from the date of death or loss. Death benefits will be paid in full upon receipt of the following:

**(a)** Completed proof of death form.
**(b)** A certified copy of the death certificate.

No designation or change of beneficiary will be considered if received in the Fund office after the date of death unless the change by a notarized statement prior to death.

Claims for dismemberment must be filed on claim forms which may be obtained from the Fund office.

**Non-work Related Disability**

Disability benefits are available only for a non-work related injury or illness. If a Member becomes disabled, is confined to a hospital or undergoes major surgery, the Member should report this to the office of the Fund within 20 days in order to secure a claim form. The claim form must be fully completed by all parties and submitted to the Fund office within 90 days from the end of the disability, discharge from the hospital or performance of surgery. Improperly completed forms may cause delay in or denial of the payment of the claim.

Benefits will be paid only for the period covered by the statement of the claim form. If disability or confinement continues beyond that period, an additional claim form must be filed. The same rules apply to procedure for all other benefits and should be submitted to the Fund Office.

**WHEN CLAIMS MUST BE FILED**

Claims must be filed within 90 days of the date charges for the services were incurred. Claims filed later than that date may be declined or reduced unless:

**(1)** It was not reasonably possible to submit the claim in that time; and
**(2)** The claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Fund will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

**CLAIMS REVIEW PROCEDURE**

If a claim is denied in whole or in part, notice will be sent to the Member in writing describing the specific reasons for the denial. If the Member wishes to have the denial reviewed, follow the procedures outlined below:

1. Within 180 days after the receipt of notification that the claim has been denied, the Member may, in writing: (a) request a review of the claim denial; (b) submit issues and comments.
2. The Member, together with one authorized representative, will have the opportunity to appear before one or more members of the Claims Committee. A summary of the presentation will be entered into the minutes of the meeting, together with any documents which are relevant or which the Member requests to be included.
3. By majority vote of the Committee, the Member will be notified of its decision.
4. The decision will contain (a) the specific reasons for the actions; (b) pertinent Plan provisions on which the action is based; (c) an explanation of the Fund's claim procedures.

**Second Level Mandatory Appeal**

After a final decision is issued by the Claims Review Committee, the Member may appeal the decision to the Trustees of the Fleet Owners Insurance Fund. Any appeal must be in a writing addressed and delivered to the Trustees. An appeal to the Trustees must be completed before taking any action in a court of law.

**Consent to Release Medical Information - Denial of Coverage**

The Member's consent to the release of medical information to the Trustees when you enroll and/or sign an Enrollment Form. The Trustees have the right to refuse benefits if you refuse to consent to the release of any medical information.

**Physical Examination**

In connection with your appeal, the Trustees may require that the Member or Dependent have one or more physical examinations at the Fund's expense. These examinations will help to determine what benefits will be covered, especially when there are questions concerning services the Member or Dependent previously received and for which the Member has submitted claims.

## Legal Actions

No action, at law or in equity, shall be brought against the Fund to recover benefits within 60 days after submission of a mandatory appeal and all information requested by the Trustees in connection with the appeal. No such action may be brought later than one year after the date of issuance of a decision of the Claims Review Committee.

## Undertaking of Subrogation

By enrolling or receiving benefits under this Plan, a person is making an undertaking of subrogation binding upon the person and his/her dependents, as follows:

A. Benefits may be paid under the Plan when accident, injury, illness or related illnesses is incurred by a Member or a Dependent and the accident, injury, illness or related illnesses have been caused to be incurred by one or more third parties or is related to work or business.

B. The Trustees have the fiduciary duty under the Employee Retirement Income Security Act of 1974 (ERISA) to preserve the assets of the Fund and to recover through subrogation from the Member, Dependent or third parties, monies paid out by the Fund to or on behalf of Members or Dependents.

C. The Trustees must use reasonable, diligent and systematic methods to collect subrogation funds. See DOL PTE 76-1. The Trustees claim first dollar, priority recovery against all such funds. The Trustees reserve the right to proceed against a third party if the Member or Dependent fails to do so in the opinion of the Trustees.

D. The Trustees intend to retain a right to succeed to a Member's or a Dependent's right of recovery against a third party for benefits paid under the Plan to, or on behalf of, a Member or a Dependent for an Injury for which the third party is, or may be legally liable. The Trustees specifically reject the so called "Common Fund Doctrine" and reject any equitable defenses that would limit the Fund's right to first dollar recovery.

E. Definitions. As used herein, the terms below shall have the following meanings:

"Acts of Third Parties" means the acts or omissions of third parties.

"Dependent" means a dependent of a Member who received or claimed benefits under the Plan.

"Injury" means an accident, injury, illness or related illnesses suffered by the Member and/or his/her Dependent caused, in whole or part, by the Acts of Third Parties or was work or business related.

"Recovery" means all monies paid to or received by or on behalf of a Member, or his/her Dependent, or to which any of same has any, right, title or interest by way

of judgment, settlement or otherwise to compensate for the Injury up to the amount paid out by the Fund together with all costs and expenses of the Fund, including reasonable attorney fees, incurred in connection therewith.

F. Subrogation Agreement. Subject to the provisions hereof, the Fund shall be subrogated to the rights of the Member and his/her Dependents against any third party who is or may be legally liable to the Member, or Dependent, due to an Injury. By enrolling in the Plan or accepting benefits under the Plan, the Member and/or the Dependent declares that the Fund shall have the right to enforce this right in equity and law in the event any settlement or judgment is obtained by or in the name of the Member or his/her Dependents up to the amount of the Recovery. The Member for his/her self and on behalf of his/her Dependent acknowledges the right of the Trustees to bring a civil action under Section 502(a)(3) of ERISA or other legal authority to enforce the terms of the Plan and this Agreement.

G. Equitable Lien. The Member acknowledges and agrees that the Trustees on behalf of the Fund claim and retain a first equitable lien in any Recovery received by, or on behalf of, the Member or his/her Dependents.

H. Assignment. Intending to be legally bound and for good and valuable consideration, the Member for his/her self and on behalf of his/her Dependent does hereby give, transfer and assign to the Trustees all of his/her right, title and interest in and to his/her claim against any third party causing or legally responsible for an Injury up to the extent of the Recovery.

I. Good Faith Assistance. The Member agrees to act in good faith and take necessary and appropriate actions to assist the Trustees of the Fund against a third party and when a potential right of compensation exists, to give sworn testimony, appear in court and execute or deliver additional documents from time to time as reasonably requested by the Trustees. The Member will take no action to prejudice or defeat the rights of the Trustees to subrogate.

J. Repayment to Fund. The Member agrees to return to the Fund in the form received by his/her self or by his/her Dependents any monies or other considerations received from the third party up to the amount of the Recovery.

K. Attorney Agreement. In the event the Member or a Dependent retains an attorney, for himself/herself or a Dependent, in connection with one or more claims against third parties, the Member will require the attorney to acknowledge this agreement and agree in writing to return the amounts due to the Fund before any other payment or distribution out of any consideration received and that all amounts received by the attorney shall be held in trust for the Fund by the attorney until the Recovery is received by the Fund.

L. Covenant. The Member for his/her self and on behalf of his/her Dependents covenants and warrants that no settlement will be made by the undersigned with any

third party who may be liable for the Injury and no release will be given to anyone that might be held responsible and that no such settlement will be made nor release given without the prior written consent of the Fund.

M. No Modification of Plan Limitations. Nothing herein shall be deemed to modify in any way the provisions of the Plan administered by the Fund.

The Member is responsible to read and understand his/her obligations regarding subrogation. Failure of a Member or Dependent to strictly abide by all subrogation provisions of the Plan will result in denial of coverage and benefits.

**DEFINITIONS**

The capitalized terms in this document have special meanings. Additional terms not specially defined herein are defined in the ERISA law and in the ACA, which can be found at www.healthcare.gov/glossary/. In the event of a conflict among defined terms, the definitions in this document shall be controlling.

**TRANSPLANTS**

The following transplants are covered by the Plan: Bone Marrow, Heart, Heart and Lung, Lung, Pancreas, Kidney, Liver, Pancreas and Kidney. Covered transplants may only be performed in a hospital with a Medicare program for the specific transplant and In-Network.

Charges otherwise covered under the Plan that are incurred for the care and treatment due to a covered transplant are subject to these limits:

(1) The transplant must be performed to replace an organ of the Member. The specific procedure must be approved by Fleet's Utilization Review Agent prior to the transplant procedure being performed. All covered services must be Medically Necessary. The terms and conditions of the Plan remain unchanged.
(2) Benefits for the covered transplant service will be paid only if the Member has been covered under the Plan for Medical Benefits for twelve (12) consecutive months.
(3) With respect to a kidney transplant, the Plan will pay as the primary payer until such time as the Member becomes eligible for coverage under Medicare for this Sickness. Once the Member becomes eligible for Medicare coverage, the Plan will become the secondary payer.
(4) Transplant center services are covered as long as they are In-Network.

**Exclusions and Limitations for Organ Transplants**

In addition to the limitations and exclusions contained in the limitation section, the Plan does <u>not</u> provide Benefits relating to an organ transplant for services, supplies or charges:

(1) Which are not Medically Necessary;

(2) Which are not furnished by a Transplant Center In-Network;
(3) For other than legally obtained human organ;
(4) Which are unrelated to an organ transplant covered by this Plan or unrelated to the diagnosis or treatment of one of the 10 categories of basic Essential Health Benefits;
(5) For acquiring an organ outside the United States or Canada;
(6) For blood donor fees;
(7) For drugs which do not require a prescription;
(8) For travel time and travel related expenses;
(9) For any transplant when the condition arose out of or in the course of employment;
(10) Rendered for the treatment of a mental illness, drug abuse or alcoholism whether or not such sickness is connected to an organ transplant condition;
(11) which are not expressly listed as a covered expense; or
(12) For services which are not approved, either prior to the service being rendered or retrospectively, by the Fund.

**ORTHOTICS BENEFITS**

Notwithstanding any other provision or provisions of the Plan, the Trustees have determined to provide orthotics benefits for Members and Dependents under the usual, customary and reasonable charges (UCR).

This benefit is subject to medically necessary for active covered participants and their qualified dependents and is limited to one (1) pair of shoes and does not cover multiple pairs for extra shoes.

Replacements are not covered for a period of three (3) years.

The Fund will pay the medically necessary prescription charges for the orthotics under the usual, customary and reasonable charges and the benefit will be paid under the Major Medical expense benefits.

**ESSENTIAL HEALTH BENEFITS**

Medically Necessary charges for Essential Health Benefits will be paid by the Fund for Members and Dependents as provided in the Schedule of Benefits for each Plan.

The Plan shall pay reasonable and customary charges, when medically necessary, incurred by a Member or Dependent for medical services, supplies and treatment performed by a physician, or charges for rental of braces, crutches, wheelchairs, hospital-type beds and such durable medical equipment as may be approved by the Fund. Purchase of such articles will be approved only if deemed by the Fund to be more economical than rental.

## CERTAIN EMPLOYEE RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

The nearest field office of the Department of Labor's Pension and Welfare Benefits Administration (PWBA) is the Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Ft. Wright, KY 41011-2664, phone (606) 578-4680.

## DISABILITY BENEFIT

The Plan offers a weekly disability benefit in the amount stated in the Schedule of Benefits as explained herein.

The Member may receive benefits if totally disabled and unable to work and are under the care of a physician because of:

1. Any injury not arising out of, or in the course of, employment, work or a business activity; or
2. Any sickness not entitling the Member to benefits under any Workers Compensation or Occupational Disease Law.

These benefits are payable to the Member as of the first day after an accident, or as of the eighth day after hospitalization if due to sickness. They will continue during disability for the maximum number of weeks as set forth in the Schedule of Benefits. This applies to any period of disability, whether from one or more causes, or for successive periods of disability due to the same or related cause or causes.

Successive period of disability separated by less than two weeks of continuous active employment will be considered as one continuous period of disability unless they arise from different and unrelated causes, in which event, the participant must have been re-employed for three consecutive months to be considered for loss of time benefits.

It is not necessary to be confined to your home to collect benefits, but you must be under the care of a physician. No disability, including accidents, will be considered as beginning until the day of the first visit of a physician.

This provision shall not apply to any retiree.

**Limitations Which Apply to Weekly Income for Disability Benefits**

Benefits are not payable for:

1. Any period of disability during which the person is not under the regular care and attendance of a physician; or
2. Any disability due to sickness which is covered by a Workers Compensation Act or similar legislation, or due to injury arising out of, or in the course of, any employment or activity for wage or profit; or
3. Any disability due to intentional self-inflicted injuries while sane or insane; or
4. Any intentional abuse or misuse of any drug, alcohol, poison or fumes take or inhaled;
5. Participation in or as the result of, the commission of a criminal act.
6. Any period of disability during which the person is receiving benefits or income from any other source: or
7. Any period that the Member is in jail or under any court order restricting movement.

**ELIBIBILITY, EFFECTIVE DATE AND TERMINATION**

**Eligible Classes of Employees.**

**(1)** A person who is employed under the terms and conditions of a collective bargaining agreement or participation agreement entered into between an Employer and the Fund, and on whose behalf payments are required by such agreement or applicable law to be made to the Fund by the Employer; or made by any other Employer who is a party to the Trust for the same benefits.

**(2)** An officer or other employee or employees of any Employer who elects to cover such officers and/or employees under the Plan.

**(3)** Any employee or fiduciary advisor of the Trustees who elect to cover such employee or advisor under the Plan.

**(4)** A retired employee may be eligible to receive benefits under this Trust Agreement and its Retiree Plan provided that such retired employee shall be a person for whom employer contributions were made prior to retirement, and that at the time of retirement such person was eligible and qualified to receive benefits under a collective bargaining agreement.

**(5)** In all instances, the common law test or the applicable legal definition of master-servant relationship shall control employee status.

**(6)** The continuation of employee status once established shall be subject to such reasonable rules as the Trustees may adopt according to law.

**Eligibility Requirement for Member Coverage.** A person is eligible for Member coverage from the first day that he/she:

(1) Is designated as an employee to be covered by an Employer;
(2) The Member has satisfied the Waiting Period; and

(3) The Member has satisfied all the enrollment requirements.

**Waiting Period.** Coverage is effective on the day following the completion date of eight (8) weeks of employment with an Employer and have to the Member's credit a minimum of eight (8) consecutive weeks of contributions.

If a Member's coverage has been terminated for less than two (2) years, the Member shall again be covered as of the first day of the calendar month for which a monthly contribution has been received by the Fund on the Member's behalf by an Employer.

If an Employer shall be delinquent in contributions, the Trustees may discontinue coverage of its employees unless or until such delinquency is cured or until such conditions as may be imposed or determined by the Trustees shall be met.

All claims related to specific illness or injury shall be paid at the rate of benefits existing on the date the claim is incurred, even though an Employer increases contributions for the Member.

All claims incurred after the date an increase in benefits is approved by the Trustees, shall be paid at the higher schedule of benefits.

A period of disability for purposes of claim payment is that period of time during which the Member requires necessary treatment for illness, accident, sickness or injury. In no event shall a period of disability exceed the period of eligibility under this Plan. Thus, when eligibility terminates, the period of disability terminates, and all benefits under the Plan terminates.

If a person works for two or more employers or has a separate business activity, there will be no multiple coverage.

**Member Coverage will terminate on the earliest of these dates:**

**(1)** The date this Fund dissolves; and with respect to Life and Accidental Death and Dismemberment insurance, the date the group policies terminate;
**(2)** In the event of a Member's death (except for provision relating to retired members);
**(3)** When a Member no longer satisfies the eligibility requirements of the Fund and does not satisfy applicable COBRA provisions. Benefits for a child shall terminate at the end of the month of his/her (26th) birthday. Benefits for a spouse shall terminate upon the date of a divorce decree, unless applicable COBRA provisions are satisfied;
**(4)** The first day a Member is not an employee of an Employer;
**(5)** The date of termination of the Member's Employer coverage.

**No Self-Contributions.** Self-contributions are not permitted unless the Member or a Dependent has elected COBRA continuation or qualified for the Retiree Plan.

**DEPENDENT COVERAGE**

A Dependent must be a spouse or natural or adopted child under the age of 26 years.

**DEFINITION OF SPOUSE**

An individual who is married to a Member in a legally recognized civil or religious ceremony and has a state issued marriage certificate. A Member's common-law Spouse shall be considered a Spouse for purposes of the Plan, if:

(a) The Participant's state of domicile recognized common-law marriage; and
(b) The Participant furnishes the Fund with appropriate documentation that the couple has fulfilled all conditions which his/her State of domicile requires for such a marriage.

**Dependent Enrollment Requirements:**

The Member is responsible to supply all enrollment information for each potentially covered dependent before coverage begins. This will include birth certificates, certificates of marriage, applicable child support agency orders, court orders and other documents.

**Effective Date of Dependent Coverage.** For each Dependent, coverage will take effect on the day that:

(1) All enrollment requirements are met;
(2) The Member is covered under the Plan; and
(3) The Employer has notified the Fund that it agrees to pay the applicable contribution.

**When Dependent Coverage Terminates.** Dependent Coverage will terminate on the earliest of:

(1) The date that the Member's coverage under the Plan terminates for any reason including death;
(2) The end of the month a child reaches age 26;
(3) The date that the Member ceases to have a Dependent;
(4) The end of the period for which a contribution has been paid if the charge for the next period is not paid when due.
(5) The date of a decision by the Trustees to terminate coverage.

**PLAN EXCLUSIONS**

For all Major Medical and Dental Charge Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) Care and treatment that is either Medically Unnecessary or Experimental in Nature or not an acceptable medical practice;

(2) Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated, unless Continuation of Benefits applies (COBRA);
(3) Care and treatment for which there would not have been a charge if no coverage had been in force;
(4) Charge for personal comfort items such as television, telephones, admission kits, lotion, powder, toothpaste, etc.;
(5) Charges for physician's fees for any treatment which is not rendered by or in the physical presence of the physician;
(6) The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
(7) Care and treatment of any Injury or Sickness that, in either case, is occupational – that is, arises from work for wage or profit.
(8) Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or where otherwise prohibited by law.
(9) For injuries or death sustained while committing a crime or an assault or felony, while engaging in an illegal occupation, or while participating in a riot or civil insurrection.
(10) Any loss that is due to a declared or undeclared act of war.
(11) Any loss due to an intentionally self-inflicted injury or death, while sane or insane or resulting from the intentional ingestion of any alcohol, gas, fumes or drugs.
(12) Care and treatment provided for cosmetic reasons—this exclusion will not apply if the care and treatment:
    (a) if for repair of damage from an accident that occurred while the person was covered under the Plan up to two (2) years from accident;
    (b) is due solely to surgical removal of all or part of the breast tissue because of an Injury or Sickness to the breast; or
    (c) is for correction of an abnormal congenital condition in a child born while one of the parents was covered under the Plan.
(13) Care and treatment of obesity, weight loss, or dietary control whether or not it is, in any case, a part of the treatment plan for another illness.

## COORDINATION OF BENEFITS

**Effect of Coordination.** If scheduled to pay first, the benefits of this Plan will be paid as if there were no other sources of benefits. If this Plan does not pay first, benefits under the Plan will be reduced by the amount scheduled to be paid from other sources.

**Benefit Plan.** This provision will coordinate the medical and dental benefits of a benefit plan. The term "benefit plan" means this Plan or any one of the following plans:

(1) Group or blanket benefits plans;
(2) Group practice and other group prepayment plans;
(3) Federal government plans or programs unless coordination is contrary to law;
(4) No-Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

**Automobile Limitations.** When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursements for vehicle plan deductible.

This Plan shall always be considered secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

For a charge to be allowable, it must be a Usual, Customary, and Reasonable Charge and at least part of it must be covered under one or more of the plans.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full.

Also, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge what would have been covered by the HMO had the Member of Dependent used the services of an HMO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

**Benefit Plan Payment Order.** When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits by these rules up to the allowable charge.

- (a) The benefit plan that covers the patient as a Member will be considered before a benefit plan that covers the patient as a Dependent.
- (b) The benefits of a benefit plan which covers a person as a Member who is neither laid-off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent who is neither laid-off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid-off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (c) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
  - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefits plan of the parent whose birthday falls later in that year;
  - (ii) If both parents have the same birthday, the benefits of the plan which covers the parent longer are determined before those of the benefit plan which covers the other parent.

If the other benefit plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plan does not agree on the order of benefits, the rule in the other benefit plan will determine order of benefits.

(d) When a child's parents are divorced or separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the step-parent that covers the child as Dependent will be considered next. The benefit plan of the parent without custody will be considered last. Court records must be submitted to the Fund to verify custody.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(e) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient longer will be considered first.

(3) Medicare will pay last to the extent stated in federal law. When Medicare pays first, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

**Claims Determination Period.** Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

**Right to Receive or Release Necessary Information.** To make this provision work, this Plan may give or obtain needed information from another insurer. A Member will give this Plan the information it asks for about other plans and their payment of allowable charges. A Member consents to this release of medical information to the Plan for himself/herself and his/her eligible dependents when he/she signs the enrollment form.

**Facility of Payment.** This Plan may repay other plans for benefits paid that the Fund determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of Recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case, this Plan may recover the amount paid from the other benefit plan or the Member. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

## HOW MEDICARE AFFECTS PLAN PAYMENTS

There are times when federal law determines whether this Plan or Medicare will pay its benefits first.

**Benefit Payment Order.** The following explains which benefits of the Plan or Medicare will be paid first for the same charges.

(1) The Plan pays first when a Member or covered spouse is age 65 and over. However, if the Member chooses to have Medicare pay first, he must reject coverage under this Plan.

If the Member ceases to be in active employment, Medicare will pay first.

(2) The Plan pays first when a Member or Dependent is both disabled and covered by Medicare.

If the Member ceases to be in active employment, Medicare will pay first.

(3) The Plan will pay first during the first 18 months of a Member's or Dependent's treatment for end-stage renal failure. After this initial 18 month period, Medicare will pay first.

**Determining benefit payment.** After the benefit payment order is determined, the Coordination of Benefits provision will apply.

## DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Accident** is a happening arising from identifiable, extrinsic sources that is not expected, foreseen, or intended resulting in an Injury, loss or damage.

**Calendar Year** means January 1st through December 31st of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Cosmetic Procedure** is a procedure performed solely for the improvement of a person's appearance rather than for the improvement or restoration of bodily function. Generally such procedures are not covered under the Plan.

**Elective Procedure** is a medical procedure which if not provided within 72 hours does not cause a life-threatening situation for the Covered Person.

**Eligible Expense** is a medical expense for which a health benefit plan will provide benefits.

**Emergency Care** is initial treatment given in a hospital's emergency room directly following:

(1) The sudden and unexpected acute medical condition that, without medical care with 48 hours of onset, could result in death or cause serious impairments of bodily functions;
(2) An accident causing injuries which are severe enough to require immediate hospital level of care. Hospital care will be deemed to be required only if safe and adequate care could not have been provided elsewhere.

**Employer** is a legal entity which currently is under contract with the Fund through a Participation Agreement, whose contributions to the Fund are current and is otherwise in good standing.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Experimental** care and treatment is that which is not approved or accepted as essential to the treatment of Injury or Sickness by The American Medical Association, The United States Surgeon General, The United States Department of Public Health, The National Institute of Health, The American Dental Association or The American Osteopathic Association.

**Extended Care Facility** is an institution, or a distinct part of an institution, which is licensed to provide Inpatient care to persons convalescing from Injury or Illness including, but not limited to:

(1) Professional nursing services rendered by a Registered Nurse (RN) or by a Licensed Practical Nurse.
(2) Physical restoration services assisting patients in reaching a degree of bodily function permitting self-care in essential daily living activities;
(3) Providing 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse;
(4) Maintaining a complete medical record on each patient.

It is not, other than incidental, a place for rest, the aged, drug addicts, alcoholics, mentally handicapped, custodial or educational care, or care of mental disorders.

**Facility** refers to facilities such as general hospital, surgi-center, mental illness/substance abuse facility, hospice facility, nursing home, half-way house, and other facilities of confinement when used in the treatment of any Illness, Injury, mental or nervous condition, drug abuse or alcoholism.

**Illness** is a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder for a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

**Injury** is an accidental bodily injury.

**In-Patient** is a person who is a resident patient using and being charged for room accommodations and board by a Hospital, but shall not include any such person for any day on which he is on leave or otherwise absent from the facility where he is a resident patient, irrespective of whether a room and board charge is made.

**Intensive Care Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary Care Unit" or an "acute care unit." It has:

**(1)** Facilities for special nursing care not available in regular rooms and wards of the Hospital;
**(2)** Special life saving equipment which is immediately available at all times;
**(3)** At least two (2) beds for the accommodation of the critically ill; and
**(4)** At least one (1) Registered Nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Leave of Absence** means that an application for a leave of absence from the Employer has been filed and approved.

**Medically Necessary—**The term "Medically Necessary" shall mean those services or supplies which are required to identify or treat a Covered Member's of Eligible Dependent's Sickness or Injury and which are:

**(a)** Consistent with the symptoms or diagnosis and treatment of the condition, disease, ailment or injury;
**(b)** Appropriate with regards to standards of good medical practice;
**(c)** Not solely for the convenience of a Covered Member, Eligible Dependent, Physician or Hospital;
**(d)** No optional nor cosmetic;
**(e)** The most appropriate supply or level of service which can safely be provided to the Covered Member or Eligible Dependent;

**(f)** When applied to the care of an inpatient, unable to be safely provided on an outpatient basis;
**(g)** Is recommended or approved by a Physician; and
**(h)** Is not conducted for research purposes.

Furthermore, "Medically Necessary" shall not mean those services or supplies which will not significantly improve the health of the Covered Member or Eligible Dependent.

All services and supplies for which the Fund is responsible to pay for must be determined as Medically Necessary.

**Medicare** is the Health Insurance for the Aged and Disabled program under Title XVIII of the Society Security Act, as amended.

**Mental Disorder** is neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

**Physical Therapy** is the treatment by physical means, including hydrotherapy, heat, or similar modalities, physical agents, biochemical, and neurophysiological principles and devices, to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of body part.

**Physician** is a person who is licensed to practice and who is practicing within the scope of that license as a Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Podiatry, Doctor of Optometry, Doctor of Chiropractic, a Licensed Optician or a Licensed Psychologist.

**Prescription Drug** means any of the following:

(1) A drug or medicine which, under federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription."
(2) Compounded medicines of which at least one ingredient is included under item (1) above.
(3) Injectable insulin.
(4) Hypodermic needles or syringes, but only when dispensed upon a written prescription.

**Provider** is a legally qualified physician, dentist, nurse, certified nurse midwife, chiropractor, physical therapist, podiatrist, psychologist, speech therapist, home health care agency, or facility legally licensed to perform a covered medical service. Also included is a certified and legally recognized person who has been certified by a state to render outpatient psychotherapy if an individual state mandates that a person is a certified and legally qualified person to render outpatient psychotherapy.

**Schedule of Benefits** is the schedule of benefits established by the Trustees of the Fund, as amended from time to time and incorporated herein.

**Semi-Private** is a class of accommodations in a hospital, in which at least two patient beds are available per room.

**Sickness** is a person's illness, disease or Pregnancy (including complications.) For a newborn child after birth, but before release from a medical facility, sickness also includes a congenital defect, a birth abnormality or premature birth.

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

**Subrogation** is the right of the Plan to succeed to a member's right of recovery against a third party for benefits paid by the Plan to, or on behalf of, a member for services incurred for which the third party is, or may be legally liable.

**Substance Abuse** is physical dependence on drugs. This includes (but is not limited to) dependence on drugs that medically prescribed. This does not include dependence on tobacco and ordinary caffeine-containing drinks. Addiction must be predetermined by an individual who has received specialized training and is licensed in the state in which that individual performs such services before entry into an approved program.

**Terminal Illness** is an illness not responsive to treatment currently available, and which is expected to result in death of a Member or Dependent within six (6) months or less.

**Urgent Care Facility** is a freestanding facility that is engaged primarily in providing minor emergency and episodic medical care and that has a board certified physician, a registered graduate nurse (R.N.), and a registered x-ray technician in attendance at all times, and x-ray and laboratory equipment and a life support system. An urgent care facility does not include a clinic located at, operated in conjunction with, or in any way made apart of a regular hospital.

**Usual, Customary and Reasonable Charge** is a charge which is the usual, reasonable and customary charge for the treatment, supply or service, determined by comparison with the charges customarily made for similar treatments, supplies or services to individuals with similar medical conditions within a given geographical area.

**Glossary**

Additional terms which may be applicable to this Plan may be found at www.healthcare.gov/glossary/

**Utilization Review Agent** is the individual or organization designated to perform certain services for the Plan including, but not limited to, Hospital stay pre-certifications and authorizations, second surgical opinion authorization, Hospital bill audits, and Medically Necessary review.

**NO CONVERSION PRIVILEGE**

Because of the self-insured status of the Fund, the benefits provided herein cannot be converted to individual coverage.

**COBRA**

The Fund offers continuation of coverage under COBRA.

**RIGHT TO PROVIDE ALTERNATIVE CARE**

The Trustees reserve the right to provide benefits for medical care not addressed in this Plan ("Alternative Care") where such Alternative Care is in the best interest of the Fund and its beneficiaries, and where the Member or Dependent his or her legal guardian and, in the case of a child, in writing to such Alternative Care. Alternative Care options will be examined on a case-by-case basis and subject to the approval of the Trustees.

**CONTINUATION DURING FAMILY AND MEDICAL LEAVE**

This Plan shall, at all times, comply with the Family and Medical Leave Act of 1993, as specified in regulation issued by the Department of Labor.

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

Members absent from their positions of employment by reason of service in the uniformed services, may elect to continue health care coverage for themselves and their Dependents as provided hereunder. The maximum period of health care coverage of a Member and his/her Dependents under such an election shall be the less of (i) the 18-month period beginning on the date on which the Member's absence begins or (ii) the day after the date on which the person fails to apply for or return to his/her position of employment.

If the period of military service does not exceed 30 days, the Employer may only charge the Member for health care coverage to the extent that the Member would have been charged if at work.

If the period of military service exceeds 31 days, the Employer may charge up to 102% of the full premium for health coverage.

If Members do not elect to continue their health care coverage, reemployed veteran Members are entitled to have their health care coverage reinstated with no exclusion or waiting period, except for the coverage of any illness or injury of the Member determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

**CONSTRUCTION BY THE TRUSTEES**

The Trustees have the full authority to construe the provisions of this Plan, and construction placed upon the Plan by the Trustees shall be final and binding on all parties.

# FLEET OWNERS INSURANCE FUND

## CUSTOMER SERVICE PHONE NUMBER

**Fund Office: (440) 243-0648**

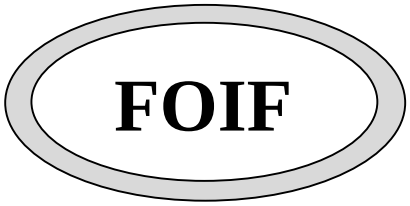
**Medical Mutual of Ohio:**
**(216) 687-7800 or (800) 362-4700**

**To locate a network provider go to www.medmutual.com**
**In Ohio: (216) 687-7800 or (800) 362-4700**
**Outside of Ohio: (800) 530-0621 Private Healthcare Systems (PHCS)**

## CLAIMS ADDRESSES

**Medical Mutual of Ohio**
**P.O. Box 6018**
**Cleveland, OH 44101-1018**

**Claims for Disability, Hospital; Surgical Benefits and Other Benefits**
**Fleet Owners Insurance Fund**
**6511 Eastland Road**
**Brook Park, Ohio 44142-1309**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