OHIO AFSCME CARE PLAN

VISION CARE BENEFITS LEVEL I

Effective:
January 1, 1994

VISION CARE BENEFIT SCHEDULE

	PLAN PAYMENT
Eye Examination	up to $30.00
Materials:	
Frames, including fitting charge and case hardening	up to $40.00
Lenses, per pair including fitting charge and case hardening	
Single vision, white	up to $30.00
Bifocal, white	up to $40.00
Trifocal, white	up to $50.00
Solid Tint Coating	up to $6.00
Scratch Resistant Coating	up to $8.00
Basic Progressive Lenses	up to $50.00
High-Index (SV) 1.66	up to $16.00
High-Index (MF) 1.66	up to $32.00
Polycarbonate (SV)	up to $14.00
Polycarbonate (MF)	up to $28.00
Contact lenses, per pair	up to $75.00

How To File A Claim

1. When you have a claim or anticipate having a claim which is incurred on or after the effective date of your Vision Care coverage, obtain a Vision Care CLAIM FORM from the Plan Office.
2. Complete the Employee Statement of Claim portion of the form and present it to the doctor or provider of service. Then return the Claim Form to the Plan Office.
3. Upon receipt of the completed Claim Form, the Plan Office will process the claim and will contact you if further information is necessary.

All benefit claims must be submitted by December 31 after the end of the calendar year in which the expense for the vision benefit was paid. For example, all benefit claims for 2002 must be submitted to the Plan office by December 31, 2003.

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

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

OHIO AFSCME CARE PLAN

To All Eligible Participants:

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

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

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

Sincerely,

BOARD OF TRUSTEES

John Lyall, Chair
Patrick J. Graham, Secretary
Michael D. Bauer, Trustee
Pamela D. Brown, Trustee
Charles F. Haas, Trustee
Daniel K. Lewis, Trustee
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OHIO AFSCME CARE PLAN
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420
Leroy A. Elmore, Plan Administrator

COBRA
CONTINUATION COVERAGE
"Very Important Notice"

Dear Participant and Spouse:

On April 7, 1986, a new Federal law was enacted requiring that most health and welfare funds sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. Both you and your spouse, if you are married, should take the time to read this notice carefully.

If you are an employee covered by an Ohio AFSCME Care Plan group health plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by an Ohio AFSCME Care Plan group health plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under an Ohio AFSCME Care Plan group health plan for any of the following four (4) reasons:

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to (that is, covered by) Medicare.

In the case of a dependent child of an employee covered by an Ohio AFSCME Care Plan group health plan, he or she has the right to continuation coverage if group health coverage under an Ohio AFSCME Care Plan group health plan is lost for any of the following five (5) reasons:

1. The death of the employee parent;
2. The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the employer contributing to the Ohio AFSCME Care Plan which provides group health plan coverage;
3. Parents' divorce or legal separation
4. A parent becomes entitled to (that is covered by) Medicare; or

5. The dependent ceases to be a "dependent child" under the Ohio AFSCME Care Plan group health plan.

Under the law, the employee or a family member has the responsibility to inform the plan administrator of the Ohio AFSCME Care Plan within sixty (60) days of a divorce, legal separation, of the Social Security determination that a family member that was covered by Ohio AFSCME Care Plan at the time of the employee's termination or reduction in hours was determined to have been disabled at any time during the first sixty (60) days of continuation coverage, or a child losing dependent status under the group health plan. The employee's employer has the responsibility to notify the plan administrator of the Ohio AFSCME Care Plan within sixty (60) days of the employee's death, termination of employment or reduction in hours, or Medicare entitlement.

When the plan administrator of the Ohio AFSCME Care Plan is notified that one of these events has happened, the plan administrator of the Ohio AFSCME Care Plan will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least sixty (60) days from the later of the date health plan coverage would end or the date of the notice of your COBRA continuation of coverage rights to inform the plan administrator at Ohio AFSCME Care Plan, 1603 East 27th Street, Cleveland, Ohio 44114, or 1213 Tennessee Avenue, Cincinnati, Ohio 45229, or 420 South Reynolds Road, Ste. 106, Toledo, Ohio 43615, that you want continuation coverage.

Definition of Qualified Beneficiary. Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. In order to be a qualified beneficiary, an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or divorce from or death of the covered employee). However, a child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary.

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

If you choose continuation coverage, Ohio AFSCME Care Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for three (3) years unless you lost group health plan coverage because of termination of employment or

reduction in hours. In that case, the required continuation coverage period is eighteen (18) months.

However, the 18-month period may be extended to twenty-nine (29) months when the Social Security Administration determines that you, or another family member covered by Ohio AFSCME Care Plan at the time of termination of employment or reduction of hours, were/was disabled at any time during the first 60 days of continuation coverage and you inform the plan administrator of Ohio AFSCME Care Plan before the end of the 18-month period. If, during an 18-month or 29-month continuation coverage period another event takes place that might otherwise result in your health coverage ending, coverage may be extended for spouses or dependents only. In no case may the total amount of continued coverage be more than 36 months.

However, the law also provides that your continuation coverage may be cut short for any of the following four (4) reasons:

1. Ohio AFSCME Care Plan no longer provides group health coverage to any employees;

2. The premium for your continuation coverage is not timely paid;

3. You become covered under another group health plan, and any preexisting conditions exclusions or limitations of that plan do not apply or are satisfied by you. (This provision applies separately to each individual with COBRA coverage). A plan's preexisting conditions exclusion period will be reduced by each month that you and your family had continuous health coverage (including COBRA continuation coverage) with no break in coverage greater than 63 days. When your COBRA coverage ends, you will receive certification of the duration of your COBRA coverage; or

4. You or an eligible dependent become entitled (that is, covered by) to Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you will have to pay all of the premium for your continuation coverage. You will have a grace period of at least thirty (30) days to pay the premium.

If you have any questions about the COBRA law, please contact:

Plan Administrator
Ohio AFSCME Care Plan
1603 East 27th Street
Cleveland, Ohio 44114
(216) 781-6420

Also, if you have changed marital status, or you or your spouse have changed addresses, please notify the Ohio AFSCME Care Plan at one of the following addresses:

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

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

TOLEDO
Suite I06
420 South Reynolds Rd.
Toledo, Ohio 43615
(419) 536-0880
(800) 237-2631

USERRA CONTINUATION COVERAGE

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

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

Your coverage will continue until the earlier of:

- The date you or your dependents do not make the required premium payment;
- The date you become eligible for coverage under the Ohio AFSCME Care Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA;
- The last day of the month after 24 consecutive months; or
- The date the Ohio AFSCME Care Plan terminates.

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

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

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

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

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

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

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

- Less than 31 days, you have one day after discharge (allowing eight hours for travel) to return to work for an employer;
- More than 30 days but less than 181 days, you have up to 14 days after discharge to return to work for an employer;
- More than 180 days, you have up to 90 days after discharge to return to work for an employer.

When you are discharged, if you are hospitalized or recovering from an illness or injury that was incurred dur-

ing the military service, you have until the end of the period that is necessary for you to recover to return to work for an employer.

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

I. ELIGIBILITY

A. Employee

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

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

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

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

   b. **Disability.** If your benefit coverage terminates because of disability, your eligibility for benefit coverage will be extended for three (3) months subject to submission of any information required by the Plan to verify your disability. At the end of three (3) months, benefit coverage may be con-

tinued during the period of your disability but not for longer than nine (9) months provided you pay the required contributions to the Plan for each month following the termination of your eligibility for benefit coverage.

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

B. Benefit Plan Coverage For Your Dependents

1. **Definition of Dependent.** Dependent means only (1) your spouse, or (2) your unmarried child, including a legally adopted child or any stepchild residing in your household, who (a) is less than nineteen (19) years of age, or is less than twenty-three (23) years of age if he/she is attending an educational institution as a full-time student and depends upon you for financial support.

The term "dependent" will not include any person who is in full-time military, naval or air service status.

2. **Dependents' Eligibility Date.** You become eligible for coverage for your dependents on the later of (1) your eligibility date for benefit coverage, or (2) the date you acquire your first dependent. If you are to be eligible for benefit coverage for your dependents, all of your dependents must be enrolled and covered.

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

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

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

a. If your eligible unmarried dependent child is incapable of self-sustaining employment because of mental retardation or physical handicap on the date his/her benefit coverage would otherwise terminate on account of his/her age and if within thirty-one (31) days of that date you submit to us satisfactory proof of his/her incapacity, his/her vision benefit will be continued during the period of his/her incapacity. We may

subsequently require periodic proof of his/her incapacity. This extension will continue until the earliest of (1) the date he/she ceases to be eligible for reasons other than age, (2) the date he/she ceases to be incapacitated, or (3) the thirty-first (31st) day after we request additional proof of his/her incapacity if you fail to furnish such proof.

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

II. VISION CARE BENEFIT
For You and Your Dependents

Your Ohio AFSCME Care Plan Vision benefit works in two ways. You can choose to use your own provider as described in "B. Open Panel Reimbursement Plan," or the closed panel provider as described in "A. Closed Panel Provider Network." You and your eligible dependents, may use this benefit once during any twelve (12) consecutive months. For example, if you have a vision care examination and purchase a frame and lenses in June, 2003, you will not be able to use this benefit again until June, 2004.

A. Closed Panel Provider Network

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

HOW TO OBTAIN BENEFITS

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

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

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

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

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

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

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

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

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

B. Open Panel Reimbursement Plan

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

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