SOUTHERN OHIO PAINTERS
HEALTH & WELFARE FUND

FOR

PAINTERS LOCALS 93, 123, 238, 249, 356, 438, 555, & 1275

GLAZIER LOCALS 372 & 387

SUMMARY PLAN DESCRIPTION / PLAN DOCUMENT

Revised
January 1, 2011

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TO: ALL PARTICIPANTS OF THE SOUTHERN OHIO PAINTERS HEALTH & WELFARE FUND

We are pleased to distribute the Summary Plan Description for the Southern Ohio Painters Health & Welfare Fund.

This booklet (otherwise known as the "Summary Plan Description" or "SPD") describes the health care benefits provided by the Southern Ohio Painters for Eligible Members and their covered Dependents. We encourage you to take the time to become familiar with this document and how best to utilize the benefits available to you.

The booklet summarizes the eligibility rules for participation in the Plan, the benefits provided to those individuals who are eligible and the procedures that must be followed in filing a claim. Information is also included concerning the administration of the Plan and your rights as a Participant or Beneficiary.

You will find terms starting with capital letters throughout this booklet. To help you understand your benefits, most of these terms are defined in the Definitions section at the end of the booklet. As used in this booklet, the terms "you" and "your" refer to Members eligible to participate in the Plan.

This booklet describes the benefits provided by the Plan. Possession of this booklet is not a guarantee of eligibility for benefits. The Trustees reserve the right to change or terminate the benefits at any time.

It is important that all Participants understand that this Plan is a self-funded benefit plan, and the medical, prescription, and short-term disability benefits are financed through a trust established for Participants by the Southern Ohio Painters Health & Welfare Fund and the contributing Employers. All medical, prescription and short-term disability benefits claims are paid directly from the assets of the trust, and not an insurance company. The Board of Trustees has designed a plan of benefits that provides quality health care coverage in a cost efficient manner. While the Board intends to continue to maintain the Plan indefinitely, there is no guarantee of future benefits for any Participant or beneficiary. The Board reserves the right to modify, merge or terminate the Plan as necessary.

In some circumstances, benefits described in this SPD are provided through insurance policies. The coverages, exclusions and claims procedures will be governed by the Certificates of Coverage issued by the insurance companies.

The Trustees of the Southern Ohio Painters Health & Welfare Fund have retained the services of a professional Claims Administrator to perform the day-to-day claims administration of the Plan, but the ultimate risk of loss belongs to the Trustees of the Southern Ohio Painters Health & Welfare Fund. The Board of Trustees of the Southern Ohio Painters Health & Welfare Fund, as Plan Administrator, has the final, sole discretion to interpret the Plan, decide any questions of eligibility, and determine any benefits which are payable under the Plan.

To request a printed copy of the Provider directory contact the Fund Office, or contact the Claims Administrator, Cigna HealthCare phone number 1-800-CIGNA24 (1-800-244-6224). You may also view and print a copy of the Provider directory by visiting the CIGNA HealthCare website, www.mycigna.com.

Every effort has been made to see that the information contained in this booklet is accurate and up to date at the time of its printing. However, should any differences exist between this booklet and the legal documents governing the Plan, the legal documents shall, in all cases, prevail.

While the Southern Ohio Painters Health & Welfare fund expects in good faith to continue this Plan indefinitely, it reserves the right to amend, suspend, or terminate the Plan in whole or in part, at any time, with or without advance notice. Any amendment or modification to the Plan must be made in writing, properly adopted, and signed by an authorized representative of the Southern Ohio Painters Health & Welfare Fund.

It is extremely important that you notify the Fund Office/Plan Administrator and Claims Administrator of any changes in your current address or family status so that you will continue to receive important information concerning future changes and other developments affecting your Plan. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility for benefits.

The importance of 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 your regarding Plan changes and other developments affecting your interests under the Plan.

It is also your obligation to notify the Fund Office of any change in beneficiary you want to make. Failure to do so will result in the payment of the Death Benefit to the person or persons that you previously had designated.

If you have not provided the Trustees with your beneficiary information, please do so immediately. It is very important for you and your family to have current information on file at all times.

Upon request, you will be mailed a form to change your beneficiary and/or Dependents.

If you should have any questions at any time regarding your eligibility or the benefits provided by the Plan, please do not hesitate to contact the Southern Ohio Painters Health & Welfare Fund Office at (937) 254-7355 or (888) 375-0246 or CPI, Inc., Inc. at (800) 435-2388.

Respectfully yours,

THE BOARD OF TRUSTEES
SOUTHERN OHIO PAINTERS HEALTH & WELFARE FUND

TRUSTEES OF SOUTHERN OHIO PAINTERS HEALTH & WELFARE FUND

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Plan Administrator/Fund Office

CPI, Inc.
33 Fitch Ave.
Austintown, Ohio 44515
1-800-435-2388

Claims Administrator

CIGNA HealthCare
P.O. Box 182223
Chattanooga, TN 37422
1-800-CIGNA24 (1-800-244-6224)

Fund Counsel

The Law Office of Michael A. Ledbetter, LLC
9240 Marketplace Drive
Miamisburg, OH 45342
937-619-0900

Your Responsibilities As A Participant

The primary purpose of the Fund is to pay benefits to all those who are entitled to benefits. However, in order for the Trustees and the Fund Office staff to achieve this objective, we need your cooperation.

There are certain responsibilities that you, as a Participant, must assume. Failure to carry out these responsibilities could affect your eligibility or the benefits which are payable.

A list of your responsibilities under the Plan follows. As you read this list, you will notice that none of these responsibilities are burdensome. In fact, by putting forth a little time and effort on your part, you will assist in protecting your best interest under the Plan.

Take Time to Read This Booklet

This booklet is the primary source of information about your Welfare program. It contains information you will need concerning how to qualify for benefits, what benefits are available, and how to file a claim for benefits. We have tried to organize the material into sections that deal with specific aspects of your benefits program and have tried to simplify the language, wherever possible.

Although this booklet should be read in its entirety, some sections will no doubt be of greater interest to you than others will. Read those sections first; then proceed to the other sections.

Remember - you owe it to yourself and your family to become familiar with the details of this Plan, and this booklet provides this information.

Of course, if you have any questions about the benefits program that are not answered by the Summary Plan Description, be sure to contact the Fund Office or CPI, Inc.

If You Have Not Yet Filed An Enrollment Form - Do It Now!

When you first became employed under the terms of the Collective Bargaining Agreement, you should have received, from the Fund Office/Plan Administrator, an enrollment form. This form requests certain basic data that is needed for your Participant records in the Plan Administrators Office, such as your Social Security number, address, birth date, name, and age of your Dependents, and the name of your designated beneficiary. This information is vital. Without it, the Plan Administrator and Claims Administrator will have difficulty keeping you informed concerning Plan changes. So - if you have not completed an enrollment form, do it now! (Use the same form if there has been any change in address, beneficiary, or Dependent status since you first filed a beneficiary form.)

If you are not sure whether you have an enrollment form on file at the Plan Administrator/Fund Office, please contact the Plan Administrator who will advise you as to whether you have a one on file.

ELIGIBILITY

Initial Eligibility

An Employee who is a member in good standing with the Union shall become eligible initially for coverage under the Southern Ohio Painters Health & Welfare Trust Plan on the fifteenth day of the calendar month following: (a) the date on which contributions paid on behalf of the Employee by one or more participating Employers were due in the Plan Administrator/Fund Office pursuant to the terms and at the rate established by the current Collective Bargaining Agreement, and (b) the accumulation of a dollar amount established by the Board of Trustees for the Eligible Employees' Local with one or more participating Employers during a twelve (12) consecutive month period.

The Employee shall be required to complete any application forms and submit to any medical examinations required by the Trust Fund prior to becoming eligible. The Plan shall not cover any Pre-Existing Conditions of an Employee or his Eligible Dependents.

UNION MEMBERSHIP AS A CONDITION OF ELIGIBILITY

An Employee must be a member in good standing with the Union as a basic requirement of initial and continuing eligibility for benefits coverage under the Southern Ohio Painters Health & Welfare Trust Fund. If an Employee who has satisfied the initial eligibility requirements is deemed to not be "in good standing" with the Union, that Employee will not be eligible for coverage under the Plan, unless the full-time Employee is covered under a participation agreement.

If an Employee who is otherwise eligible for coverage under the Plan is later discovered to not be in good standing with the Union, the Plan will retroactively terminate that Employee's coverage, along with any Dependent coverage, and the Employee will be responsible for reimbursement to the Plan's Providers of all monies paid out on his and his Dependents' behalf.

The Plan will terminate an Employee's coverage on the first day of the month following the month in which he loses his status as a member in good standing with the Union. If the Plan discovers that the Employee has lost his status as a member in good standing subsequent to the end of the month in which this occurs, the Plan will retroactively terminate the Employee's eligibility on the first day of the month following the month in which the loss of status occurred.

Upon losing the status of a member in good standing with the Union, the Employee loses the right to make self-contributions, and the Employee shall forfeit all unused Reserve Dollars in accordance with the "Self-Contributions" section in this SPD.

It is the responsibility of each Local Union to provide notice to the Plan Administrator of those Employees who are not members in good standing. The membership lists are to be updated monthly and provided to the Trustees and the Plan Administrator.

Eligible Dependent

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

2. A natural child, adopted child, grandchild, stepchild or legal ward of the Eligible Employee who has been placed under the legal guardianship of the Eligible Employee if the unmarried child is less than twenty-six (26) years of age. Children who are eligible for other employer-sponsored group health care coverage are not eligible for coverage under this Plan.

3. An unmarried natural child, adopted child, grandchild, or legal ward (hereinafter "unmarried child") of the Eligible Employee who is dependent upon the Eligible Employee for primary support and maintenance because of a physical handicap or mental retardation as certified by a Physician, where such unmarried child is age 26 or older.

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

   Dependent coverage will begin the later of (a) the day the Eligible Employee is insured, or (b) the day the Eligible Employee first acquires an Eligible Dependent. Once an Eligible Employee has a Dependent insured, any newly acquired Eligible Dependent will be insured upon the Eligible Employee notifying the Fund Office.

   If the Participant's coverage is canceled, Dependent coverage is also canceled, except as provided by COBRA. In addition, an Eligible Dependent loses regular coverage as of the date: (a) family coverage is canceled for the class of Employees to which the Participant belongs, or (b) the individual ceases to meet the Plan's requirements to qualify as an Eligible Dependent.

5. Eligible Dependent shall not include any Illegal Alien. For purposes of this Plan, "Illegal Alien" shall mean a person who (1) is not a citizen of the United States, (2) is not lawfully admitted to the United States for permanent residence, and (3) is not authorized for employment within the United States by the United States Immigration and Naturalization Service or the Attorney General of the United States.

Continuation of Eligibility

After satisfying the initial eligibility requirements, an Employee shall continue to remain eligible for participation in the Plan so long as he or she continues to remain a member in good standing with the Union and contributions are paid on his or her behalf by an Employer or by the Employee's making self-contributions equal to the current monthly rate of contribution as established by the current Collective Bargaining Agreement. If the current monthly rate of contribution is not contributed for three consecutive months, then the contributions for the first month are not counted. Only two months of contribution are carried forward to be credited to the next month of contribution to establish eligibility for coverage.

The Schedule below will show the period when a member would become eligible if he or she acquires the monthly contribution in one month or in any three-month period of time. An Employee who remains ineligible for 12 consecutive months shall be required, in order to reestablish eligibility, to comply with the requirements of Initial Eligibility.

Credit Available when Working with a Delinquent Contributing Employer

A Participant who is employed by a Contributing Employer may be granted up to two (2) work months of credit toward remaining eligible in the Fund as a Participant if the Contributing Employer has not paid its required contributions to the Fund and filed the appropriate Employer reports. If an Employer is delinquent in contributions to the Fund for three (3) work months, consecutive or non-consecutive, whether the delinquency is for a full or partial work month, an Employee of that Employer will no longer receive credit allowing the Employee to maintain his or her eligibility.

Prior to the Employee no longer receiving credit, the Trustees or their designee shall notify the Employee at least fifteen (15) days prior to the fifteenth day of the month in which the Employee will no longer receive credits.

Once the Employee is no longer granted credit, the Employee may continue to maintain his or her eligibility in the Fund by using his or her reserve dollar bank or by making self-payments for a period of time not to exceed eighteen (18) months from the date the first self-payment is made.

An Employee will lose eligibility and receive a COBRA notice upon the earliest of (a) making eighteen (18) consecutive months of self-payments, (b) failing to make the full amount of the self-payment on or before the required due date, or (c) no longer being an Employee as defined in the SPD.

Upon payment by the Employer for delinquent contributions for work months in which the Employee previously made self-payments or payments through the dollar bank, the Employee shall receive credit to his or her dollar bank in the amount the Employer paid the Fund.

CONTINUATION OF ELIGIBILITY QUALIFYING SCHEDULE

CONTRIBUTION MONTH	ELIGIBILITY MONTH
January	March 15 thru April 14
February	April 15 thru May 14
March	May 15 thru June 14
April	June 15 thru July 14
May	July 15 thru August 14
June	August 15 thru September 14
July	September 15 thru October 14
August	October 15 thru November 14
September	November 15 thru December 14
October	December 15 thru January 14
November	January 15 thru February 14
December	February 15 thru March 14

Reserve Dollars

Each Employee is entitled to accumulate up to and including a dollar amount equal to twelve months of coverage in reserve to be used in order to supply the Employee with the additional dollars in any one or successive months to remain eligible. After satisfying the Initial Eligibility requirement, the hours completed during and after Initial Eligibility and prior to the first day the Employee becomes eligible for benefits in excess of the required contribution shall be credited to the Employee's Reserve Dollars. Thereafter, Reserve Dollars are accumulated by an Employer making contributions on the Employee's behalf in excess of the monthly required contribution for said month. The Reserve Dollars are automatically credited to the Employee's account and applied to any one or successive months, if the need arises, until all the Reserve Dollars are expended. Reserve Dollars shall be used to provide continuous eligibility only and shall **not** be used to establish or reestablish Initial Eligibility. The Board of Trustees may, in its sole discretion, adjust the number of Reserve Dollars if the hourly rate of contributions has increased. Reserve Dollars are not a vested or an accrued benefit and may be lost under certain conditions determined by the Board of Trustees.

Self-Contributions

Upon expending Reserve Dollars, if any, an Employee who is a member in good standing of the Union may make self-contributions for a maximum of eighteen (18) months at the same rate provided for in the current Collective Bargaining Agreement. Thereafter, an Employee may elect to continue his health coverage under the Plan by obtaining COBRA coverage. Self-Contributions must be received in the Plan Administrators Office not later than the 15th day of each month, subject to when the monthly contribution is due. However, if an Employee loses his or her Union membership pursuant to the Union Constitution and/or Collective Bargaining Agreement or Bylaws, then immediately as of the date of the loss of Union membership and upon notification to the Plan Administrator's Office, the Employee will not be eligible to make self-contributions, and the Employee shall forfeit all unused Reserve Dollars. Thereafter, such

Employee may elect to continue his health coverage under the Plan by obtaining COBRA coverage.

SPECIAL ENROLLMENT PERIODS

If you initially declined 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 this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stopped contributing towards yours or your Dependents' other coverage). However, you must request enrollment within 30 days after your 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 30 days after the marriage, birth, adoption or placement for adoption.

Further, two additional circumstances allow for a special enrollment opportunity as follows: 1) Where the Employee's or Dependent's Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility; or 2) The Employee or Dependent becomes eligible for a subsidy under Medicaid or CHIP. In either of these circumstances, the Employee or Dependent must request enrollment within 60 days after the Employee or Dependent is terminated from, or determined to be eligible for, such assistance.

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

RETIREMENT PROGRAM

An Employee shall be eligible for coverage under the Retirement Program if he or she satisfies all of the following requirements:

1. Is no longer actively working in the trade jurisdiction as defined in the current Constitution of the International Union of Painters and Allied Trades, AFL-CIO;

2. Was a Participant under the Plan for a period of one (1) year prior to the date of his or her retirement;

3. Is a Member in the International Union of Painters and Allied Trades, AFL-CIO;

4. Is at least age 55 or younger if retired from the International Union of Painters and Allied Trades;

5. Is not yet age 65;

6. Is not entitled to Medicare Benefits because he or she is not age 65 or Totally Disabled; and

7. Has no other coverage available; or

8. Is disabled and collecting Social Security benefits;

The cost to maintain the coverage will be the current monthly contribution rate requirement as established by the Board of Trustees of the Southern Ohio Painters Health & Welfare Fund.

The Plan Administrator will bill the Retiree on a monthly basis by mail, and the Retiree's payment will be due in the Plan Administrator's office within 15 days of the date billed.

Once a Retiree becomes eligible for any other coverage (i.e. Medicare or a private Plan) his or her coverage under this Plan will be terminated.

ELIGIBILITY FOR RETIREE BENEFITS

Rights of Trustees with Respect to Retiree Benefits

1. The privilege of making self-payments for Retiree Benefits is not an "accrued" benefit. The right to change, reduce, or eliminate any and all aspects of benefits provided for Retirees and their Dependents, including the right to increase the Retiree self-payment rate, is a right specifically reserved for the Trustees.

2. If federal legislation is passed that requires the Plan to pay its benefits before Medicare pays its benefits for Medicare-eligible Retirees and Dependents, the Trustees reserve the right to terminate Retiree Benefits or to increase the self-payment rate to an amount deemed necessary.

Eligibility Requirements for Retirement Employees Not Eligible for Medicare

An Employee who is a member in good standing with the Union and who retires and is not eligible for Medicare shall be considered an Eligible Retiree and entitled to Retiree Benefits consisting of full coverage under the Plan only if he or she meets all of the following eligibility requirements:

1. The retired Employee is at least fifty-five (55) years of age or younger if retired from the International Union of Painters and Allied Trades, but has not reached his or her sixty-fifth (65) birthday and is no longer actively working at the trade, and

2. The retired Employee must have been eligible for active Employee coverage under the Plan on the date he or she retired and continuously eligible for active Employee coverage for a period of one (1) year prior to the date of his or her retirement.

3. The retired Employee must timely elect Retiree Benefit coverage and make the required self-payments to the Plan at the contribution rate determined by the Board of Trustees.

4. The retired Employee must maintain membership in the International Union of Painters and Allied Trades, AFL-CIO.

Any member who qualifies and elects to be covered as a retired Employee must make self-payments in accordance with the requirements of the Plan Administrator/Fund Office as set by the Board of Trustees. The monthly self-payment amount shall be determined by the Board of Trustees, but may not exceed 102% of the full cost of the Plan. Both the extent of coverage and the amounts of self-payment are subject to revision within the sole discretion of the Trustees.

Any retired Employee who qualified under these rules of eligibility must elect Retiree Benefit coverage within the first sixty (60) days after the last month in which he or she was covered for benefits under the Plan and make the required self-payments in accordance with the requirements of the Plan Administrator/Fund Office as set by the Board of Trustees. If such retired Employee does not elect Retiree Benefit coverage within the sixty (60) day limitation or

make the required self-payments timely to the Plan Administrator/Fund Office, he or she shall not be eligible to Retiree Benefit coverage at any time in the future.

Eligibility Requirements for Retired Employees Eligible for Medicare

An Employee who is a member in good standing with the Union and who is eligible for Medicare when he or she retires or who becomes eligible for Medicare after he retires, shall be considered an Eligible Retiree and entitled to Retiree Benefits under the Medicare Supplemental Program only if he or she meets one of the following eligibility requirements:

A. Over Age 65 and on Medicare

1. The retired Employee is at least sixty-five (65) years of age, eligible for Medicare when he or she retires or who becomes eligible for Medicare after he or she retires, and is no longer actively working at the trade;

2. Either: (a) the retired Employee must have been eligible for active Employee coverage under the Plan on the date he or she retired and continuously eligible for active Employee coverage for a period of one (1) year prior to the date of his or her retirement; or (b) the retired Employee must have been continuously eligible for Retiree Benefits under the Plan on the date he or she became eligible for Medicare after he or she retired;

3. The retired Employee must timely elect Retiree Benefit coverage under the Medicare Supplement Program and make the required self-payments to the Plan at the contribution rate determined by the Board of Trustees;

4. The retired Employee must enroll in Medicare Part A & B; and

5. The retired Employee must maintain membership in the International Union of Painters.

B. Disabled on Medicare

1. The Employee is disabled, eligible for Medicare and is no longer actively working at the trade;

2. Either: (a) the Employee must have been eligible for active Employee coverage under the Plan on the date he or she was determined disabled and eligible for Medicare and continuously eligible for active Employee coverage for a period of one (1) year prior to such date; or (b) the Employee must have been continuously eligible for Retiree Benefits under the Plan on the date he or she was determined disabled and eligible for Medicare;

3. The Employee must timely elect Retiree Benefit coverage under the Medicare Supplemental Program and make the required self-payments to the Plan at the contribution rate determined by the Board of Trustees; and

4. The Employee must enroll in Medicare Part A & B.

Any member who qualifies and elects to be covered under the Medicare Supplement Program must make self-payments in accordance with the requirements of the Plan Administrator/Fund Office as set by the Board of Trustees. The monthly self-payment amount shall be determined by the Board of Trustees, but may not exceed 102% of the full cost of the Plan. Both the extent

of coverage and the amounts of self-payment are subject to revision within the sole discretion of the Trustees.

Any Employee who qualifies under these rules of eligibility must elect to be covered under the Medicare Supplement Program with the first sixty (60) days after the last month in which he or she was covered for benefits under the Plan and make the required self-payments in accordance with the requirements of the Plan Administrator/Fund Office as set by the Board of Trustees. If such Employee does not elect to be covered under the Medicare Supplement Program within the sixty (60) days limitation or make the required self-payments timely to the Plan Administrator'/Fund Office, he or she shall not be eligible to Retiree Benefit coverage at any time in the future.

Retiree Must Not Be Working at the Trade

It is a condition to Retiree Benefit coverage that the Participant shall not engage in or perform employment in the trade jurisdiction (including, but not limited to, related supervisory activities) as defined in the current Constitution of the International Brotherhood of Painters and Allied Trades, AFL-CIO for remuneration or profit, except that a Participant may work as an instructor in a recognized apprenticeship program of the International Brotherhood of Painters and Allied Trades, AFL-CIO. The Board of Trustees in their sole discretion shall determine if a Retiree is engaging in or performing employment.

If a retired Employee returns to active employment and works sufficient hours to again become eligible for benefits under the active Employee program, he or she shall terminate his or her coverage under the applicable Retiree Benefit Program on the date his or her eligibility under the active program becomes effective and may again become entitled for coverage, if he or she fulfills the eligibility requirements under the applicable Retiree Benefit Program upon re-retirement.

Benefit Coverage Under the Retiree Benefits

A. Benefit Coverage for Retirees and Dependents Not Eligible for Medicare

1. If an Eligible Retiree is not eligible for Medicare, he or she shall be entitled to full coverage under the Plan.

2. Whether or not an Eligible Retiree is eligible for Medicare, his or her Eligible Dependents who are not eligible for Medicare shall be entitled to full coverage under the Plan.

B. Medicare Supplement Program for Retirees and Dependents Eligible for Medicare

A Retiree who is eligible for Medicare when he or she retires, or who becomes eligible for Medicare when he or she retires, or who becomes eligible for Medicare after he or she retires, or who is disabled and eligible for Medicare, and any Dependents of a Retiree who is or becomes eligible for Medicare, shall be eligible for a Medicare Supplement Program according to the following provisions:

1. The Medicare Supplement Program provides the payment of the deductibles under Medicare Parts A and B.

2. The Medicare Supplement Program provides coverage of 20% of Medicare approved charges under Medicare Part B.

3. In order to receive benefits under the Medicare Supplement Program when health care services and supplies are received, the Retiree must submit the "Explanation of Medicare Benefits" and an itemized bill that the Retiree of his/her Medicare eligible Dependent receives from Medicare to the Claims Administrator.

C. Prescription Drug Program for Retirees and Dependents Eligible for Medicare

A Retiree who is eligible for Medicare when he retires, or who becomes eligible for Medicare when he retires, or who becomes eligible for Medicare after he retires, or who is disabled and eligible for Medicare, and any Dependents of a Retiree who is or becomes eligible for Medicare, shall be eligible for a Prescription Drug Program according to the following provisions:

1. The Prescription Drug Program provides coverage for all eligible Participants and the Plan pays 75% of all prescription drugs without a deductible.

2. You must present the prescription and your identification card to a participating Pharmacy. You will be charged the corresponding co-pay for each prescription filled or refilled. The prescription card company pays any cost beyond that to the Pharmacy.

Contribution Payments

A Participant who qualified and elects Retiree Benefit coverage must pay his or her contributions on or before the 15th day of the month in which the contribution is due. Failure to pay contributions as herein provided shall cause such Participant to lose all eligibility and all benefits. A retired Employee's eligibility and benefits, once lost due to failure to pay the contributions as herein provided, cannot be reinstated by a later payment of delinquent contributions. The monthly contributions shall be determined by the Trustees and subject to revision, both as to the extent of coverage and the amount of contributions, at their sole discretion. The monthly contributions are payable at the office of the Plan Administrator of the Southern Ohio Painters Health and Welfare Fund. It shall be the responsibility of the Participant to see that the required contributions are received in the Plan Administrator's office on or before the 15th day of the month. A monthly invoice will be sent to the Participant.

Change of Eligibility Rules and Schedule of Benefits

The Trustees, in their sole discretion, are empowered to change or amend the foregoing rules of eligibility or the Schedule of Benefits at any time.

Eligibility Requirements for Widow/Widower Benefit Program

The widow or widower and Dependent children of a deceased, Active Employee or eligible retired or disabled individual who is eligible under this Plan at the time of death may elect to maintain eligibility for benefits from the Plan under the Widow/Widower Benefit Program by making self payments in a timely manner as set by the Trustees provided he or she meets the following rules of eligibility:

1. He or she makes application to the Trustees no later than 90 days following the death of the active, Eligible Employee or retired or disabled individual; or

2. He or she makes application to the Trustees no later than 90 days after the expiration or cancellation of any other health care plan, program or policy in effect on the active, Eligible Employee or retired or disabled individual's date of death, which provided coverage to such widow or widower, including COBRA coverage.

A widow or widower who qualifies under these rules of eligibility must elect coverage in the Widow/Widower Benefit Program within the time limits set forth above and make the required self-payments in accordance with the requirements of the Plan Administrator/Fund Office as set by the Board of Trustees. The initial eligibility date of coverage shall be the first day of the month following the date the application is approved and proper payment is received. If such widow or widower does not elect coverage under the Widow/Widower Benefit Program within the time limits set forth above or make the required self-payments timely to the Plan Administrator's Office, he or she shall not be eligible to coverage in the Widow/Widower Benefit Program at any time in the future. The Trustees may, in their sole discretion and on a case-by-case basis, extend the time period of a widow or widower to elect coverage in the Widow/Widower Benefit Program.

The monthly contribution shall be determined by the Trustees and subject to revisions both as to the extent of coverage and the amount of contributions, within their sole discretion. The monthly contributions are payable at the Plan Administrator/Fund Office. It shall be the responsibility of the widow or widower to see that the required contributions are timely received in the Plan Administrator/Fund Office, and no notices, billings, or reminders of payments due will be given.

Contribution Payments

Contribution payments must be made on a monthly basis and are due on the 1st day of the month and are considered late if received in the Plan Administrator/Fund Office after the 15th day of the month. The Widow/Widower shall be able to apply towards the contribution payment any available Reserve Dollars in the account of the deceased Active Employee or eligible retired or disabled individual, until all the Reserve Dollars are expended. Failure to make timely and continuous payments shall terminate the individual's right to make further payments and be covered under this Plan. No late payments shall be accepted.

Benefits

The Benefits payable to a surviving Spouse and/or Dependent child under the Widow/Widower Benefit Program shall be under the same benefit coverage for which the Dependent was eligible on the date of the Participant's death, provided, however, that if a Dependent covered under the Plan becomes eligible for Medicare during the covered period, that Dependent shall then be covered under the Medicare Supplement Program. No death, accidental death, dismemberment, or weekly disability benefits shall be paid. In addition, all benefits shall be coordinated with any other group health insurance plan, health and welfare program, Medicare or Medicaid program.

The benefit coverage to be continued for a surviving Spouse or Dependent child shall be full coverage under the Plan or the Medicare Supplement Program whichever Retiree Benefits coverage for which the Dependent was eligible on the date of the Participant's death. If a

Dependent covered under the Plan becomes eligible for Medicare during the covered period, that Dependent shall then be covered under the Medicare Supplement Program.

Reinstatement of Eligibility

An Employee which fails to remain eligible as provided for in the Continuation of Eligibility section of this booklet, shall become eligible again upon the completion of a month during which the Employee is credited with contributions in the amount of current monthly contribution rate established in the current Collective Bargaining Agreement. The Employee's eligibility shall be reinstated on the fifteenth day of the calendar month following the date on which the contributions paid on behalf of the Employee by one or more participating Employers, or by making self-contributions, were received in the Plan Administrator/Fund Office.

An Employee which remains ineligible for 12 consecutive months shall be required, in order to reestablish eligibility, to comply with the requirements of the initial eligibility.

Eligibility for Non bargaining Unit Employees

Eligibility for Employers, their non-seasonal, full-time Non bargaining Unit Employees, defined as officers, owners, partners, shareholders, managers, clerical workers, estimators, supervisors and any other full-time Employees (hereinafter collectively referred to as "Non bargaining Unit Employees") shall be determined in accordance with the provisions of the Plan, the Rules and Regulations promulgated therein, the terms and conditions of the written participation agreement entered into between the Employer and the Board of Trustees, and any other terms and conditions imposed at the Trustees in their sole discretion.

PRE-EXISTING CONDITION EXCLUSION PROVISION

If you have a physical condition for which medical advice, diagnosis, care or treatment (including prescription drugs) was recommended or received by a licensed Health Care Provider within ninety (90) days immediately prior to becoming covered under this Plan you will be subject to a Pre-Existing Condition exclusion. Pre-Existing Condition exclusion is the amount of time when care related to that condition will not be covered. Participants and/or Eligible Dependents who become eligible for benefits shall not be entitled to benefits for major medical expenses Incurred as the result of any Injury, Illness or related condition for which the Participant and/or Eligible Dependent has consulted with a Physician or received any medical care or services within the ninety (90) day period immediately prior to becoming covered under the Plan until the expiration of a period of 12 consecutive months during which the Participant and/or Eligible Dependent was continuously covered under the Plan. The pre-existing exclusion will not apply to: (a) newborns, adoptee or children placed for adoption that are enrolled in the Plan within 30 days from the date of the birth, adoption or placement for adoption; or (b) pregnancy. Genetic information is not an indicator of a Pre-Existing Condition if there is not a diagnosis of a condition related to the genetic information. The foregoing Pre-Existing Condition exclusion provisions shall not apply to individuals under the age of 19.

Effective January 1, 1998, the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA") provides that the twelve (12) consecutive month exclusion period for Pre-Existing Conditions shall be reduced by one (1) day for every day of "Creditable Coverage" you had under another group health plan, a group or individual health insurance policy, Medicare, or certain other coverages. Your Creditable Coverage may be used to reduce the Pre-Existing Condition exclusion if you have not experienced a break in coverage of sixty-three (63) or more days. To apply for a reduction in the twelve (12) consecutive month exclusion period for Pre-

Existing Conditions, you should submit to the Fund Office/Plan Administrator any Certificate of Creditable Coverage ("HIPAA Certificate") you may have. If you do not have such a certificate

but you do have prior health coverage, the Fund Office/Plan Administrator will assist you in obtaining one from your prior plan or insurer. There are also other ways that you can show Creditable Coverage. Please contract the Fund Office/Plan Administrator if you need help demonstrating Creditable Coverage.

If you provide a HIPAA Certificate (or other evidence of Creditable Coverage), it will be reviewed by the Fund Office/Plan Administrator (with the assistance of your prior plan administrator or insurer) to determine its authenticity. Submission of a fraudulent HIPAA Certificate is considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment.

The Plan shall also comply with the requirements of HIPAA by providing each Participant and/or Eligible Dependent with a HIPAA Certificate within two (2) years after the Participant and/or Eligible Dependent ceases coverage under the Plan or, upon request by the individual, within a reasonable time after receipt of the request.

VERIFICATION OF DEPENDENT STATUS

The Claims or Plan Administrator may require documentation proving Dependent status, including, but not limited to, birth certificates, marriage records, or initiation of legal proceedings severing spousal or parental rights.

VERIFICATION OF INCAPACITATED DEPENDENT STATUS

The Claims or Plan Administrator may require, at reasonable intervals, subsequent proof that such Dependent child continues to be an incapacitated Dependent. The Claims or Plan Administrator reserves the right to have such incapacitated Dependent examined by a Physician of the Plan's choice, at the Plan's expense, to determine that the incapacitated Dependent is or continues to be Totally Disabled. Coverage under the Plan will cease when such Dependent child ceases to be an incapacitated Dependent, or when such Dependent child ceases to meet the requirements to be considered a Dependent under the Plan. Once either of these events occurs, the child cannot be re-enrolled in the Plan.

OMNIBUS BUDGET RECONCILIATION ACT

In compliance with the Omnibus Budget Reconciliation Act (OBRA) of 1993, the following provisions apply to Dependent coverage:

1. Adopted children are eligible for coverage immediately upon placement with the family and are not subject to Pre-Existing Conditions.

2. If an Eligible Member who is covered under this Plan is divorced, the children of that Member are eligible Dependents for the Plan, regardless of other Dependent qualifications, if the Eligible Member is ordered by a court to provide coverage. The Dependent may not be terminated from coverage as long as the Member is eligible for coverage and the court order is still in effect.

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 Section 609 of the Employee Retirement Income Security Act (hereinafter "Act").

This Plan, in accordance with law, must recognize a QMCSO. 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 QMCSO is a medical child support order which meets; certain legal requirements. A QMCSO 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.

PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization (PPO) is a group of Hospitals, Physicians, and other Health Care Providers who have agreed to work with an organization to help control health care costs by negotiating reduced fees. The PPO helps Employers contain the skyrocketing cost of providing health benefits. The PPO encourages Covered Persons to be cost-minded and become "Partners in Health Care." By using more cost-effective Preferred Providers, you will help stabilize health care coverage costs, both to you and to your benefit Plan. The PPO also protects your freedom to choose any Physician or Hospital you desire. Alternatives to the PPO include reducing your benefits and increasing your cost. The PPO is a much more attractive solution. The PPO will save you money. The PPO Providers have agreed to charge cost-effective rates. You can use any Physician and any health care facility that qualifies under your health Plan the same as you have in the past. You make the choice of using or not using a Preferred Provider each time you require services.

Information concerning the PPO is available at:

CIGNA	**Phone Number**	**1-800-CIGNA (1-800-244-6224)**
	Website	**www.mycigna.com**

You may view and print a copy of the Provider directory by visiting the website listed above. You may request a printed copy of the Provider directory by contacting the PPO at the phone number listed above. There is no charge for the directory.

SCHEDULE OF BENEFITS – NON-MEDICARE

COMPREHENSIVE MAJOR MEDICAL PLAN
MEDICAL EXPENSE BENEFITS FOR YOU AND YOUR FAMILY

FOR ALL ACTIVE/RETIRED OR DISABLED INDIVIDUALS AND ELIGIBLE DEPENDENTS

Following is a summary of benefits covered under this Plan. All benefits are subject to Medical Necessity unless otherwise stated herein. Until such time as regulations are issued by the appropriate federal agencies, the Plan will use good faith efforts to define and interpret the term "essential health benefits" in a reasonable and consistent manner to comply with the restrictions against lifetime and annual limits under the federal health care reform law.

NOTE: Unless otherwise stated, all benefits are subject to the following deductible, co-pay and maximum amounts:

Lifetime Maximum Benefit for Eligible Expenses on Non-Essential Health Benefits ..... $1,000,000.00 per Covered Person

Deductibles: (In Network and Non-Network)

Local 93 Marietta and Local 438 Steubenville

Calendar Year Deductible:
- Per Individual $0.00
- Per Family $0.00

All Other Locals:

Calendar Year Deductible:
- Per Individual $500.00
- Per Family $1,500.00

Percentage for all Care and Treatment:

In-Network Services ..... payable at 70% of the first $50,000
Out-of-Network Services ..... payable at 60% of the first $50,000

Maximum Out-of-Pocket per Calendar Year (including the deductible):

In-Network
- Per Individual $15,000.00
- Per Family $45,000.00

Out-of-Network
- Per Individual $20,000.00
- Per Family $60,000.00

All eligible charges will be paid at 100% after the maximum out-of-pocket per Calendar Year expense (including the deductible) has been met by the individual or family.

MEDICAL EXPENSES COVERED AFTER DEDUCTIBLE HAS BEEN SATISFIED AND SUBJECT TO COINSURANCE:
ALL OF THE FOLLOWING BENEFITS WILL BE PAID AT 70% IN NETWORK AND 60% OUT OF NETWORK

COVERED SERVICES

	Percentage Payable Network	Non-Network
Hospital Room and Board (365 days)	70%	60%
Private Room Rate (The Hospital's average semi-private room rate)	70%	60%
Special Care Unit (ICU & CCU)	70%	60%
Inpatient Miscellaneous Charges	70%	60%
Diagnostic Services	70%	60%
Surgical Expense Benefits	70%	60%
Second Surgical Opinion (deductible does not apply)	100%	100%
Outpatient Surgery	70%	60%
Durable Medical Equipment	70%	60%
Maternity Benefits (female Employees, Spouses and Dependents)	70%	60%
Ambulance Services	70%	60%
Outpatient Emergency	70%	60%
Urgent Care Facility	70%	60%
Emergency Room Treatment, Life Threatening	70%	70%
Emergency Room Treatment, Non-Life Threatening	70%	60%
Physician Office Visits (Inpatient or Outpatient)	70%	60%
Immunizations (Includes tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine)	70%	60%
Allergy Testing & Treatments	70%	60%
Preventive Services		
Pap Smear (deductible does not apply) Includes Office Visit (Coverage for Member and Spouse only)	100%	100%
Mammogram (1 per year up to $100.00) (deductible does not apply) (Coverage for Member and Spouse only)	100%	100%

	Percentage Payable Network	Non-Network
Routine Physical Exam (deductible does not apply) ..... Calendar Year Maximum: 1 Exam	100%	100%
Routine Chest X-ray, EKG and Spirometry ..... (screening for pulmonary function)	100%	100%
Routine Endoscopic Procedures ..... (One per benefit period; ages 50 and over) (deductible does not apply)	100%	60%
Routine Lab Services (deductible does not apply) ..... Calendar Year Maximum: $150.00 when part of the annual routine physical exam	100%	100%
Well Child Care (Birth to age 9) (deductible does not apply) ..... (Includes office exam, and immunizations)	100%	60%
Well Child Laboratory Tests (Birth to age 9) ..... (not subject to maximum, deductible does not apply)	100%	100%
Immunizations (deductible does not apply) ..... (Includes Hepatitis A, B & A/B combine vaccine, Meningococcal Meningitis vaccine)	100%	100%
Physical Therapy / Occupational Therapy ..... Calendar Year Maximum: 40 visits combined	70%	60%
Chiropractic Therapy (Professional only) ..... Calendar Year Maximum: $300.00	70%	60%
Speech Therapy ..... Calendar Year Maximum: 20 visits	70%	60%
Cardiac Rehabilitation	70%	60%
Skilled Nursing Facility	70%	60%
Private Duty Nursing	70%	60%
Home Health Care	70%	60%
Hospice Care	70%	60%
Organ Transplant Services	70%	60%
Professional Services	70%	60%
Mental Nervous Disorders		
Inpatient	Not Covered	Not covered
Outpatient	Not Covered	Not covered

	Percentage Payable Network	Non-Network
Alcohol & Substance Abuse		
Inpatient	Not Covered	Not covered
Outpatient	Not Covered	Not Covered

Note: Deductible and Coinsurance expenses Incurred for services by a non-network Provider will also apply to the network deductible and Coinsurance out-of-pocket limits. Deductible and Coinsurance expenses Incurred for services by a network Provider will also apply to the non-network deductible and Coinsurance out-of-pocket limits.

Benefits will be determined based on CIGNA's medical and administrative policies and procedures.

This document is only a partial listing of benefits. This is not a contract of insurance. No person other than an officer of CIGNA may agree, orally or in writing, to change the benefits listed here. The contract or certificate will contain the complete listing of Covered Services.

In certain instances, CIGNA's payment may not equal the percentage listed above. However, the Covered Person's Coinsurance will always be based on the lesser of the Provider's Billed Charges or CIGNA's negotiated rate with the Provider.

PRESCRIPTION DRUG BENEFITS

The Plan pays 75% of all prescription drugs with no deductible.

Retail Program with Oral Contraceptive Coverage (30-day supply)	
Generic	25% Copay
Brand Name	25% Copay
Mail Order Program with Oral Contraceptive Coverage (90-day supply)	
Generic	25% Copay
Brand Name	25% Copay

EXCEPTIONS AND LIMITATIONS OF ELIGIBLE BENEFITS

Chiropractic Treatment

Subject to the deductible and Coinsurance. Maximum payment per Calendar Year is $300.00.

Temporomandibular Joint Dysfunction

Maximum $1,000.00 Lifetime Benefit payable subject to the deductible and Coinsurance.

SCHEDULE OF BENEFITS – MEDICARE FOR RETIRED ELIGIBLE PARTICIPANTS AND THEIR SPOUSE 65 YEARS OF AGE OR DISABLED AND ELIGIBLE FOR MEDICARE PLAN PAYS THE FOLLOWING

Part A Benefits	Part B Benefits
Hospital Stays Benefits include days of a Hospital stay during a Medicare benefit period in a Hospital that contracts with either CIGNA or Medicare. CIGNA pays for 365 days of stay per in-Hospital benefit period: • When Medicare pays a portion of the stay, the Plan, will pay the Part A Medicare eligible expenses not paid by Medicare. • After all of the Hospital days of stay available from Medicare have been exhausted, the Plan will pay 100% of the Provider's reasonable charge to a contracting Hospital for any remaining days. The Plan will pay 70% of the charges to a non-contracting Hospital. **Skilled Nursing Facility** CIGNA pays 100 days of stay per Medicare benefit period. • When Medicare pays a portion of such a stay, the Plan will pay the Part A Medicare eligible expenses not paid by Medicare.	CIGNA pays the Medicare Part B deductible. After the Medicare Part B deductible: • If the Provider accepts Medicare assignment, we pay the Coinsurance amount for Part B Medicare eligible expenses. • **If the Provider does not accept Medicare assignment, the Plan will pay the Provider's reasonable charge or the Medicare reasonable charge, whichever is higher, minus the amount paid by Medicare.** • Office Calls (definite condition or Injury). **Medical Care Received While Traveling Outside of the United States** For services or supplies which the Plan/Claims Administrator determine are the type considered to be Part B Medicare eligible expenses: 100% of the Provider's reasonable charge, minus any amount paid by Medicare. **Supplemental Major Medical** Lifetime Maximum $0 Deductible per Calendar Year $0 Coinsurance 100% Out-of-Pocket Limit (excluding deductible) $0

PRESCRIPTION DRUG COVERAGE

Prescription Drug Only	The Plan pays at 75% of the prescription drug cost and the Eligible Member pays 25% of the cost.

DEATH BENEFITS

(ACTIVE & RETIRED MEMBERS ONLY)

Death Benefits

The Southern Ohio Painters Health & Welfare Fund provides Death Benefits. In the event of your death while you are covered under this Plan, the Plan will provide payment of $5,000.00 to the person whom you have designated as your beneficiary. The Board of Trustees reserves the right to change or eliminate the death benefit at their sole discretion at any time and for any reason.

Waiver of Premium

This Plan does not provide for the waiver of premium for disability.

Conversion Privilege

There are no conversion features under this Plan.

Risks Not Assumed under the Death Benefit

1. Suicide or intentionally self-inflicted Injury within the first two years you are covered under this Plan;

2. A state of war or any act of war, declared or undeclared, whether or not you are in the Armed Services;

3. Riding, driving, or testing a vehicle used in a sanction event such as a race or speed contest, or participation in the sport of parachute jumping or bungee jumping;

4. Participation in a riot or insurrection;

5. Events occurring in the commission of a felony; and

6. Travel or flight in or descent from any type of aircraft, if you are a student pilot or member of the crew, or if you are a passenger on:

    a. Any civilian aircraft not having a current and valid worthiness certificate, or piloted by a person who does not then hold a valid and current certificate of competency or a rating authorizing him to pilot such aircraft; or

    b. Any type of aircraft operated by any military authority of the United States, or by any duly constituted governmental authority of any other country recognized by the United States Government while in the course of any training maneuvers of any Armed Forces.

Designation of Beneficiary

Your beneficiary will be the person you designate on a form satisfactory to the Southern Ohio Painters Health & Welfare Fund. You may change your beneficiary at any time by filing a written notice satisfactory to the Fund. The new designation will take effect on the date you sign the notice of change. When a new designation takes effect, any interest of any previous beneficiary shall cease.

If you have not chosen a beneficiary, or if there are no beneficiaries alive when you die, the Plan will pay benefits in the following order:

1. To your Spouse, if living
2. To your living children in equal shares;
3. To your living parents in equal shares;
4. To your living brothers and sisters in equal shares;
5. If there are none, no death benefits will be paid.

If a beneficiary is a minor (under 18 years of age) or legally not competent, as determined in the sole discretion of the Board of Trustees, the Plan will pay:

1. To any institution maintaining the individual; and/or
2. To the individual's Spouse, children; and/or
3. To any person whom the Trustees reasonably determine is caring for the individual or otherwise providing support and maintenance; and/or
4. Directly to said persons.

The Board of Trustees shall have no obligation or duty to see that the funds are used or applied for the purpose(s) for which paid and any payment so made shall be a complete discharge of any and all liability under the Plan with respect to such payment. **All payments must be made within five years after your death.**

VISION CARE BENEFITS

These benefits are provided by EyeMed Vision Care and all services must be provided by the network, consisting of Lens Crafters locations and the Doctors of Optometry next to Lens Crafters or any other EyeMed Providers. Should you have any questions about the benefits please call 1-877-226-1115.

BENEFIT DESCRIPTION

BENEFIT	MEMBER BENEFIT	FREQUENCY	COPAY MEMBER PAYS
Exams with dilation	Paid in full	Once every 12 months	$0.00
Frames	$75.00 allowance 20% off balance over $75.00	24 months	$10.00
Lenses			
Single Vision	Paid in full	24 months	$10.00
Bifocal	Paid in full	24 months	$10.00
Trifocal	Paid in full	24 months	$10.00
Lenticular	Paid in full	24 months	$10.00
Basic Progressive	Paid in full	24 months	$10.00
Contact Lenses	(Allowance applied to fit, follow-up, and materials)		
Conventional	$140.00 allowance	24 months	$10.00
Disposables	$140.00 allowance	24 months	$10.00

Contact Lens exams are covered up to $40.00 under this Plan. Any charges that exceed the $40.00 maximum are the Participant's responsibility.

All other items beyond the plan coverage receive a 20% discount at Lens Crafters stores and a 15% discount at Provider offices (excluding the doctor's professional services or disposable contact lens purchases).

EXCLUSIONS TO VISION BENEFITS

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniselkonic lenses;
2. Medical and/or surgical treatment of the eye, eyes or supporting structures;
3. Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment. Safety eyewear;
4. Services provided as a result of any Workmen's Compensation law or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. Plano (non-prescription) lenses and/or contact lenses;
6. Non-prescription sunglasses;
7. Two pair of glasses in lieu of bifocals;
8. Services or materials provided by any other group benefit plan providing vision care;
9. Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy;
10. Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
11. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Plan Year or benefit period during which Vision Materials would next become available.

DISABILITY RETIREE BENEFITS

An Employee who has been found to be Totally Disabled by the Trustees shall be allowed to make self-payments for the full amount and continue participation in the Plan (the coverage shall remain either married or single, depending on what coverage the Employee has at the time of the disability) until age 65 only if he or she meets all of the following eligibility requirements:

1. The Employee must have been eligible for active Employee coverage under the Plan on the date the Employee was found to be Totally Disabled by the Trustees and continuously eligible for a period of one (1) year prior to such date; and

2. The Employee must timely elect disability coverage and make the required self-payments to the Plan at the contribution rate determined by the Board of Trustees.

Determination of whether an Employee is eligible for disability coverage will be made by the Trustees in their sole discretion and will be conclusive. Any member who qualifies and elects to be covered under the disability coverage must make self-payments in accordance with the requirements of the Plan Administrator/Fund Office as set by the Board of Trustees. The monthly self-payment amount shall be determined by the Board of Trustees, but may not exceed 102% of the full cost of the Plan. Both the extent of coverage and the amounts of self-payment are subject to revision in accordance with any applicable laws.

Any Employee who qualified under these rules of eligibility must elect disability coverage within the first sixty (60) days after the last month in which he or she was covered for benefits under the Plan and make the required self-payments in accordance with the requirements of the Plan Administrator/Fund Office as set by the Board of Trustees. If such Employee does not elect disability coverage within the sixty (60) days limitation or make the required self-payments timely to the Plan Administrator/Fund Office, he or she shall not be eligible for disability coverage at any time in the future. After re qualifying as an Active Participant, the Participant's failure to timely elect disability coverage or to timely make self-payments shall not disqualify a Participant from being eligible for future disability. However, the Trustees may, in any case where the circumstances appear to warrant such action, in their sole discretion, liberalize the foregoing condition.

If, in the opinion of the Trustees, a Participant should become able to work in the trade as defined by the Constitution of the International Brotherhood of Painters and Allied Trades, the disability coverage shall terminate at the end of the calendar month in which the Employee is no longer disabled. The Employee would then be able to continue as a Participant without re-qualifying. The Trustees reserve the right to change or eliminate Disability coverage as provided for herein at their sole discretion at any time and for any reason. Participants, Disabled Employees, and their Dependents do not have any vested rights in the Disability coverage as provided for herein.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

If you or a Dependent Incurs Medically Necessary covered expenses after the effective date of your major medical coverage as a result of a non-occupational Injury or Illness, payment will be made after the deductible and in the percentages specified in the Schedule of Benefits for services received during any one (1) Calendar Year. These percentages shall apply until the Covered Person reaches the maximum out-of-pocket amount, then eligible expenses will be payable at 100% of the Traditional Amount charge, unless otherwise specified.

CALENDAR YEAR DEDUCTIBLE

All covered medical expenses are subject to the Calendar Year deductible amount specified in the Schedule of Benefits except when specifically waived. Before benefits are payable for eligible expenses, the Covered Person must satisfy the applicable deductible. This deductible is satisfied when the Covered Person or covered family has Incurred eligible expenses within a Calendar Year equal to that amount. Covered medical expenses used to satisfy the deductible are not reimbursable by the Plan.

DEDUCTIBLE CARRYOVER

Covered medical expenses Incurred by a Covered Person during the last three (3) months of any Calendar Year that are applied toward the Calendar Year deductible for that year are also applied toward the Calendar Year deductible for the next year.

FAMILY DEDUCTIBLE

If the sum total of the covered medical expenses Incurred by the covered member of the family exceed the family Calendar Year deductible as specified in the Schedule of Benefits, no additional Calendar Year deductibles will be required of the other family members for the remainder of that Calendar Year. However, no more than $400.00 of any one (1) Covered Person's covered medical expenses shall be applied to the family Calendar Year deductible in any one (1) Calendar Year.

COMMON ACCIDENT DEDUCTIBLE

If two or more Covered Persons of a family are Injured in the same accident, only one (1) deductible will be applied toward those eligible expenses for all Covered Persons involved in the accident during the Calendar Year in which the accident occurs. A separate deductible is required for any covered expenses which are not related to the accident. Covered expenses Incurred by a Covered Person which are applied to the common accident deductible will also apply toward satisfaction of a separate deductible deduction for the same person.

OUT-OF-POCKET MAXIMUM

If the Out-of-Pocket maximum amount (including the Calendar Year deductible and benefit percentage), as shown in the Schedule of Benefits is met during any one (1) Calendar Year, no further Calendar Year deductible or co-payments will be required for the remainder of that Calendar Year for that Covered Person.

ANNUAL DOLLAR LIMITS

The annual dollar limit available for all expenses for each individual covered under the Plan is listed below. This maximum includes any limits imposed on specific treatment. Note that the annual dollar limit will increase each year and will eventually be eliminated, as required to comply with federal law.

Plan Year Beginning:	Annual Limit
January 1, 2011	$1,000,000.00
January 1, 2012	$1,250,000.00
January 1, 2013	$2,000,000.00
January 1, 2014	None

OVERALL MAXIMUM LIFETIME BENEFIT

The Lifetime Maximum amount available for non-essential health benefits for each individual covered under the Plan is listed in the Schedule of Benefits. This maximum includes any limits imposed on specific treatment.

COVERED SERVICES

Except as specified, covered expenses shall include only the charges for reasonably necessary services and supplies for the diagnosis or care of a Covered Person's Illness, subject to the Expenses Not Covered section and the Covered Expenses Limits in this Plan summary. To be reasonably necessary the service or supply must be ordered by a Physician and must be recognized throughout the Health Care Provider's profession as the usual and customary treatment for the Illness. Covered Expense shall not exceed the usual and customary charges, as determined by the Plan Trustees, within the geographical area in which the expense is Incurred. Services and supplies which are furnished by and fall within the scope of the authorized practice of a Health Care Provider.

The following are Covered Services, payable as outlined in the Schedule of Benefits, and subject to the other terms, conditions and limitations described in this booklet.

HOSPITAL SERVICES

When you or your Dependent is admitted as a bed patient or as an outpatient to any state approved Hospital, the following services will be covered as needed and to the extent available for:

Inpatient Hospital Services - bed, board, and general nursing services:

* A room with two or more beds;
* A private room. The private room allowance is the Hospital's average semi-private room rate;
* A bed in a special care unit approved by the Plan. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients; and

* Miscellaneous Hospital Expenses for a physical Injury or Illness received by a Covered Person while the Covered Person is Confined in a Hospital.

Ancillary Services - Inpatient and Outpatient; include but are not limited to:

* Operating, delivery and treatment rooms and equipment;
* Prescribed drugs;
* Anesthesia, anesthesia supplies and services given by an employee of the Hospital or Other Provider;
* Medical and surgical dressings, supplies, casts and splints;
* Diagnostic services; and
* Therapy services.

Blood and Blood Plasma

Whole blood, blood plasma, and blood products when not replaced by donation are eligible. This includes the processing and administration of services.

Outpatient Hospital Services

* **Diagnostic**: Lab and x-ray services.
* **Emergency Accident Care**: Services and supplies to treat Injuries caused by an accident within 72 hours of the accident;
* **Emergency Illness Care**: Services and supplies to treat a sudden and acute medical condition that is life threatening and require prompt medical care. Examples of covered conditions are heart attacks, kidney stones, and strokes. Non-life threatening covered as any other Illness;
* **Operating room and supplies**;
* **Preadmission Testing**: Outpatient tests and studies performed within 10 days prior to a scheduled Hospital admission. Benefits are payable as shown in the Schedule of Benefits;
* **Surgery**: Surgical services and supplies.

MEDICAL-SURGICAL BENEFITS

In general, the Plan will pay for eligible charges for services that include the following:

AMBULANCE SERVICE

Transportation by a vehicle designed, equipped and used only to transport the sick and Injured:

* From the Covered Person's home, scene of accident or medical emergency to a Hospital;
* Between Hospitals;
* Between Hospital and Skilled Nursing Facility;
* From a Hospital or Skilled Nursing Facility to the Covered Person's home.

Trips must be to the closest facility that can provide Covered Services appropriate for the Covered Person's condition. If none, coverage is available for trips to the closest such facility outside the Covered Person's local area. Air ambulance service is covered under the Plan when Medically Necessary.

ANESTHESIA

This Plan covers anesthesia for any Covered Service when administered by a Physician or Other Provider who is not the surgeon or the assistant at Surgery. Some anesthesiologists are not considered in-network Providers. Many anesthesiologists are independent contractors and not Hospital employees.

CONCURRENT MEDICAL CARE

The Plan covers care for a medical condition by a Physician who is not the Covered Person's surgeon while in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of the Covered Person's condition requires the skills of separate Physicians is also covered.

CONSULTATION

A personal bedside examination by another Physician when requested by the Covered Person's attending Physician. Staff consultations required by Hospital rules are excluded.

DENTAL SERVICES

For Accidental Injury

Dental services rendered by a Physician or dentist for an accidental Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident while covered under the Plan. Treatment must be received within two years of the accident. Injury as a result of chewing or biting is not considered an accidental Injury.

DIAGNOSTIC SERVICES

The following services when performed for diagnosis of a condition, disease, or Injury and the Physician's interpretation of these exams are covered under your Plan:

* X-ray Examinations
* Laboratory and Pathology Services
* Diagnostic Medical Examinations such as EKG's and EEG's
* Cardiographic, Encephalographic and Radioisotope Tests

Diagnostic Services may be provided either in or out of a Hospital.

HOME HEALTH CARE SERVICES

Covered Expense includes charges for Home Health Care made by a home health care agency, provided that the plan of care by the home health agency:

1. Is prescribed by a Physician;
2. Is reviewed and approved by the doctor every two weeks;
3. Contains a statement expressing the belief of the doctor and home health agency that:

(a) The number of days of Home Health Care does not exceed the number of days of Confinement in a Hospital or nursing home which have been required;
(b) The Home Health Care will probably cost less per day than the daily rate for Confinement in a Hospital or nursing home; and
(c) Confinement in a Hospital or nursing home would otherwise be required. A copy of this plan of care shall be provided by the Covered Person to the Company. Home Health Care includes:
    (1) Skilled nursing; and
    (2) Any other services and supplies provided in lieu of the services which would have been covered under the Plan if the insured person was Confined in a Hospital or nursing home. Home Health Care does not include housekeeping or Custodial Care.

HOSPICE BENEFITS

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

Benefits for Hospice services are available when the prognosis of life expectancy is six months or less. Benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy. The following services and supplies are eligible:

* Intermittent professional services of a registered or licensed practical nurse;
* Treatment by physical means, occupational therapy, and speech therapy;
* Medical and surgical supplies;
* Prescription drugs; (these prescription drugs must be required in order to relieve the symptoms of a condition, or to provide supportive care);
* Oxygen and its administration;
* Diagnostic Services
* Home health aide visits;
* Acute inpatient Hospice services;
* Respite care, and
* Dietary guidance; counseling and training needed for a proper dietary program;
* Durable Medical Equipment.

A treatment plan must be developed and submitted to the Plan by the Covered Person's Physician and the Provider of the Hospice services. The treatment plan must be approved by the Plan.

Non-covered Hospice services include, but are not limited to:

* Volunteer services;
* Spiritual counseling;
* Homemaker services;
* Food or home delivered meals;
* Custodial Care, rest care or care which is provided solely for someone's convenience; and
* Medical social services, such as the counseling of patients (including bereavement counseling).

HUMAN ORGAN AND TISSUE TRANSPLANTS

Prior approval must be obtained for benefits to be provided for Human Organ and Tissue Transplant Services, except for a cornea or kidney transplant. To obtain approval, contact the Claims Administrator as soon as your Physician suggests that your condition may require a transplant.

You must receive services at an approved Center of Excellence Facility. Payment for services received at a facility other than one of the Centers of Excellence Facilities may be at a reduced level.

When the recipient is the Covered Person, the donor's expenses will be considered expenses of the recipient and will apply toward the recipient's maximum benefit for the transplant procedure or donor limitation as listed in the Schedule of Benefits.

Tissue Transplants

Benefits are payable for Tissue Transplants and all related charges which are described as Covered Services.

Benefits are payable for the following:

* Cornea transplants;
* Allogenic and autologous bone marrow transplants for certain diagnoses.

In order for a tissue transplant to be considered eligible, it must not be considered Experimental and/or Investigative. The procedure must be a nationally acceptable protocol for the diagnosis requiring the transplant. Coverage may be provided for transplants that are still undergoing clinical trials if FDA approved and Medical Necessity is determined by a peer review organization.

Stem Cell Harvest without a planned transplant are payable only in relation to diagnosis of:

* Acute Myelogenous Leukemia;
* Acute Lymphoblastic Leukemia;
* Pediatric Tumors.

Human Organ Transplants

Benefits are payable for Human Organ Transplants and all related charges which are described as Covered Services including the acquisition, preparation, transportation, and storage of the human organ.

Benefits are payable up to the Lifetime Maximum, if any, shown in the Schedule of Benefits for the following transplants:

* Heart transplants;
* Heart/Lung transplants;
* Liver transplants;
* Lung transplants;
* Pancreas transplants;
* Kidney transplants and cornea transplants covered as any other Illness.

Additional transplant procedures may be eligible for coverage. If you require an organ transplant not specified above, contact the Claims Administrator for prior approval.

The maximum for both human organ and tissue transplants, if any, is specified in the Schedule of Benefits.

Exclusions

The following are not covered under this section. The Plan provides no benefits for:

* Lodging expenses, including meals;
* Expenses related to the recipient's transportation, except for Medically Necessary professionally licensed ambulance services as stated in this Plan;
* The purchase price of any bone marrow, organ, or tissue that is sold rather than donated;
* Treatment, services, and supplies not ordered by a Physician or surgeon;
* Transplants involving non-human or artificial organ or tissues;
* Human-to-human bone marrow, organ, or tissue transplants other than those specifically covered under this section;
* Treatment, services, and supplies not covered by the Plan.

INPATIENT HOSPITAL MEDICAL CARE

The Plan covers Physician's visits to a registered bed-patient in a Hospital.

MASTECTOMY

In compliance with the Women's Health and Cancer Rights Act of 1998, the following benefits are available to a Covered Person who elects breast reconstruction in connection with a mastectomy:

* Reconstruction of the breast on which the mastectomy has been performed;
* Surgery and reconstruction of the other breast to produce symmetrical appearance, however, coverage is not provided for removal of a healthy breast for preventative or reconstructive purposes;
* Coverage for prostheses and physical complications of all stages of mastectomy including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Such coverage will be subject to annual deductibles and Coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan or coverage.

MATERNITY (Statement of Rights under the Newborns' and Mothers' Health Protection Act)

Maternity is provided for all Eligible Members and Eligible Dependents when covered under a family contract. Coverage will be paid as shown in the Schedule of Benefits.

Under Federal law, group health plans and health insurance issuers offering group health coverage generally may not 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 delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g., your Physician, nurse, midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan may not, under Federal law, require that a Physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Therefore, if your Plan contains a precertification requirement, you or your Provider must still precertify the stay to avoid any additional out-of-pocket expenses; however, your stay will automatically be precertified for 48 or 96 hours as required by this Federal law.

Birthing Center

Covered Expense includes charges for a Birthing Center provided that such coverage shall cease at the end of a 48-hour period following the birth of a child.

Treatment in a licensed Birthing Center, which meets all of the following criteria, is eligible:

* It is primarily engaged in providing birthing services for low risk pregnancies;
* It is operated under the supervision of a Physician;
* It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;
* It has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Midwife

Charges Incurred by a licensed midwife in an approved facility licensed by the appropriate state health department will be covered.

Newborn Care

Inpatient visits to examine a newborn, including circumcision. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Surgical Sterilizations

Regardless of Medical Necessity, surgical sterilization procedures for either a covered Member or a Member's covered Spouse are provided under the Plan. Reversal of sterilization is not a Covered Service.

MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES

The Plan will allow a maximum of 150% markup on invoice and may require a copy of the Provider's invoice prior to payment.

Medical and Surgical Supplies

Syringes, needles, oxygen, casts, surgical dressings, trusses, braces (other than dental braces), crutches, splints and other similar items which serve only a medical purpose. These

supplies prescribed by your Physician: catheters, colostomy bags, rings and belts, flotation pads, needles and syringes, and initial contact lenses or eyeglasses after cataract Surgery will also be eligible for coverage. Covered Services do not include items usually stocked in the home for general use like adhesive bandages, thermometers, and petroleum jelly.

Durable Medical Equipment

Rental of, or at the Plan's option, purchase of Durable Medical Equipment which is designed and used only for treatment of Illness such as, but not limited to: wheel chairs; Hospital-type beds; and artificial respiration equipment. When the equipment is purchased, benefits are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance and replacement of batteries are not covered. The equipment must be prescribed by the Physician. Benefits are payable only if the Plan approves the equipment as being appropriate for a Covered Person's medical condition.

Note: The Fund will only pay for rental equipment while it is being used.

Orthotic Devices

Maximum: one pair in three years, maximum allowable $250.00 and must be considered Medically Necessary.

A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part, such as: casts, splints; strapping; orthopedic braces; orthotic inserts and crutches. These do not include special shoes, or devices to protect the feet unless the device is a permanent part of an orthopedic leg brace. Replacement of such devices is not covered except in the case of Dependent children when the professional Provider in charge of the case certifies that such replacement is necessary.

Prosthetic Appliances

Prosthetic appliances such as artificial limbs and eyes, including their initial placement, repair, or adjustment when Medically Necessary.

Purchase, fitting, needed adjustment and necessary repairs of prosthetic devices and supplies that:

* Replace all or part of a missing body organ and its adjoining tissues;
* Replace all or part of the function of a permanently useless or malfunctioning body organ; or
* Artificial limbs and artificial eyes are covered except for replacement.

This benefit will also include replacements for children who, due to growth, must obtain a new prosthetic appliance.

OUTPATIENT MEDICAL CARE

Office visits and consultations to examine, diagnose, and treat an eligible condition.

OXYGEN

Oxygen and rental of equipment for its administration.

PRESCRIPTIONS

Drugs or medicines which can be obtained only with a doctor's prescription in connection with treatment of Illness or Injury.

PRIVATE DUTY NURSING SERVICES

Services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) when ordered by a Physician will be covered as follows: Nursing services do not include care that is primarily non-medical or custodial in nature such as bathing, exercising and feeding.

Benefits are not provided for a nurse who usually lives in your home or is a member of your immediate family.

Inpatient Services

Services that are of such nature or degree of complexity that the Provider's regular nursing staff cannot provide them or due to the Hospital's Intensive Care Unit being full. Prior approval is required.

SKILLED NURSING FACILITY BENEFITS

Benefits are available for Covered Services in a Skilled Nursing Facility as listed in the Schedule of Benefits and are the same as those benefits available to an inpatient of a Hospital. Provided services must be Skilled Care, authorized, and provided according to your Physician's plan of treatment. Your Physician must certify initially and every two weeks thereafter that you are receiving Skilled Care and not Custodial Care. No coverage is provided for services for Custodial Care;

Confinement in the facility:

* must begin within two days after the Covered Person has been Confined in a Hospital for at least five consecutive days for which room and board charges were paid; and
* is for treatment of the Illness causing the Hospital Confinement; and
* is one for which a Physician visits the Covered Person at least once every 30 days; and
* is not for routine Custodial Care.

SURGICAL SERVICES

The Plan covers you for surgical services performed by a Physician both in and out of a Hospital. As well as covering most operative and cutting procedures, Surgery includes treatment of burns, fractures, and dislocations. It includes surgical pathology examinations, cast, and suture removal.

Regardless of Medical Necessity, the Plan covers Surgery to restore bodily function or correct deformity. Benefits are only for problems caused by disease, Injury, birth or growth defects, or previous treatments.

Surgical Assistance

An assistant Physician to assist your surgeon while performing covered Surgery when a house staff member, intern, or resident cannot be present. Allowable charges cannot exceed 20% of the surgeon's Traditional Amount allowance.

Multiple Surgical Procedures

If two or more surgical procedures are performed through the same body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 50% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

If two or more surgical procedures are performed through more than one body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 75% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

Note: Where a PPO discount applies, the percentages will be based on the discounted charges.

Second Surgical Opinion

A voluntary second surgical opinion is recommended for some elective (non-emergency) procedures. The intent of this program is to provide patients with additional information before a decision is made in an attempt to promote the delivery of high quality health care and eliminate unnecessary Surgery.

Some of the procedures which are recommended for a voluntary second surgical opinion are:

* Breast Surgery (Augmentation or reduction);
* Bunionectomy (Foot Surgery);
* Cholecystectomy (Removal of gallbladder);
* Coronary Artery Bypass Surgery;
* Hemorrhoidectomy (Internal or external);
* Hernia Repair (Inguinal or hiatal);
* Hysterectomy (Removal of uterus);
* Laminectomy (Back Surgery);
* Ligation and/or Stripping of Varicose Veins in Legs;
* Meniscectomy (Knee Surgery);
* Septoplasty and/or Submucous Resection (Nose Surgery);
* Tonsillectomy and/or Adenoidectomy (Removal of tonsils or adenoids); and
* Transurethral Prostatectomy (Removal of Prostate).

NOTE: A third opinion will be covered if the first two conflict.

THERAPY SERVICES

Eligible Hospital and Physician therapy services or supplies used to promote recovery from an Illness or Injury include:

Chemotherapy

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

Dialysis Treatments

The treatment of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine.

Occupational Therapy

The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts). Therapy must be ordered by a Physician and provided on a regular basis.

Radiation Therapy

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

Therapy by Physical Means

Treatment given to relieve pain, restore maximum function and prevent disability following disease, Injury or loss of body part. Services include hydrotherapy; heat or similar modalities; physical agents; hyperbaric therapy; biomechanical, neurophysiological principles and devices.

Treatment must be Medically Necessary and non-maintenance to be eligible as a Therapy Benefit.

PREVENTIVE CARE

To encourage you to go to the doctor on a regular basis for preventive medical exams, the Plan offers you first-dollar coverage under the following wellness benefits:

Physical Exams

The Plan pays the full cost for a Routine Physical Exam including a Chest X-ray, EKG, and Spirometry Pulmonary Function Screening as shown in the Schedule of Benefits for Eligible Member, Spouse or Dependents age nine and above. These benefits are not subject to the annual deductible.

Laboratory Test

The Plan pays the full cost for Routine Laboratory testing when part of the routine physical as shown in the Schedule of Benefits for Eligible Member, Spouse or Dependents age nine and above. These benefits are not subject to your annual deductible.

Routine Mammogram/Pap Smear Benefit

The Plan will cover routine Mammogram and Pap smear tests at 100% of Traditional Amount. as shown in the Schedule of Benefits for each Eligible Member & Spouse. These benefits are not subject to your annual deductible. Additionally, all associated diagnostic and laboratory work is paid under this benefit at 100% of Traditional Amount.

Well Child Care

Exams, routine infant care, and immunizations for Dependent children are payable as shown in the Schedule of Benefits. These benefits are not subject to your annual deductible.

GENERAL LIMITATIONS AND EXCLUSIONS

The following are not covered by the Benefit Plan:

1. **Abdominal surgery.** Regardless of Medical Necessity, services and/or supplies for abdominal surgery and/or reconstructive surgery which is related but not limited to gastric related bypass surgery, or stomach stapling type surgery will not be eligible. This includes surgical intervention for infections, chaffing, pain, diabetes, etc;

2. **Absence of coverage.** Charges which would not have been made had coverage not existed;

3. **Absent.** Services and/or supplies furnished during periods when the patient is temporarily absent from the Hospital;

4. **Acupuncture / Acupressure;**

5. **Biofeedback.** Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing;

6. **Blood.** Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient;

7. **Charges relating to self-inflicted Injuries**, or threatened suicide, whether sane or insane, unless due to a medical condition;

8. **Chelation therapy;**

9. **Civil insurrection or riot.** Treatment or services resulting from participating in a civil insurrection or riot;

10. **Close Relative.** Service provided by a "close relative," meaning Spouse, or Covered Person's or Spouse's parent, brother, sister or child, or the Spouse of the Covered Person's parent, brother, sister or child;

11. **Completion** of claim forms, or missed appointments;

12. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan;

13. **Contraceptive devices.** Devices or the fitting of devices for birth control purposes;

14. **Corrective Shoes,** except for the prescription to change a part of the shoe for Medically Necessary reasons;

15. **Cosmetic services.** Services rendered for cosmetic purposes, unless made necessary by accidental Injury. This includes, but is not limited to stomach stapling, breast augmentation and face lifting;

16. **Court Ordered.** No payment shall be made for any court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as a Covered Service under this Plan;

17. **Criminal Acts.** No payment shall be made under any health benefit of this Plan for expenses Incurred by a Participant or Dependent resulting from or occurring (a) during the commission of a crime; (b) during illegal and willful misconduct; (c) while engaged in an illegal occupation; (d) while committing or attempting to commit a felonious act or assault; or (e) while participating in a riot or civil insurrection. Determination will be made by the Trustees in their sole discretion and such determination will be conclusive;

18. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except when provided by a Hospice;

19. **Dental procedures,** Dental care and treatment (except for repair to natural teeth damaged due to Injury or due to birth defect). Care must be provided within twelve (12) months of Injury or 2 years of birth, whichever is applicable;

20. **Diagnostic Hospital Admission.** Confinement in a Hospital that is for diagnostic purposes only, when such Diagnostic Services could be performed in an Outpatient setting;

21. **Eating Disorders**;

22. **Educational or vocational testing.** Services for educational or vocational testing or training, except for diabetic management training;

23. **Elective Abortion;**

24. **Excess charges.** Charges that exceed the Traditional Amount allowance, if applicable;

25. **Exercise programs**. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy, as specified by this Plan. This exclusion includes exercise equipment;

26. **Expenses incurred outside the United States**. No payment shall be made for expenses incurred outside the United States or Canada, unless the Participant and/or Dependent is a United States or Canadian resident and the charges are incurred while traveling on business or for pleasure;

27. **Experimental or Investigative services**, procedures, treatment, prescription drugs and supplies, or substances, which have not been recognized as accepted standards of medical protocol;

28. **Eye care.** Radial keratotomy or other eye surgery to correct sight, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, and initial cataract lenses after cataract surgery;

29. **Felony.** Services and/or supplies for treatment of an accident or Illness that resulted while committing a felony, unless due to a medical condition;

30. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease);

31. **Genetic counseling or testing.** Counseling or testing concerning inherited (genetic) disorders;

32. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid, to Medicare or when otherwise prohibited by law;

33. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;

34. **Hazardous Hobbies.** Treatment for Injuries sustained while hang gliding, bungee jumping, parachuting, riding an ATV (3 or 4 wheeler), or Injuries sustained while racing any sort of motorized vehicle;

35. **Hearing Care.** Hearing aids or examinations for prescribing or fitting them;

36. **Hospital Employees.** Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service;

37. **Housekeeping, shopping, or meal preparation services** (except as provided through an approved Home Health Care Program, as described in Covered Services in this booklet);

38. **Hypnosis;**

39. **Impotence.** Care, treatment, services, or supplies in connection with treatment for impotence not caused by organic disease;

40. **In excess of the semi-private room rate**, except as otherwise noted;

41. **Infertility.** Reproductive infertility services including but not limited to - family planning; infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance the reproductive ability; premarital examinations; impotence, organic or otherwise. Services to determine if the infertility exists will be covered;

42. **Lifetime Maximum.** Charges that exceed the annual and/or Lifetime Maximums stated in the Schedule of Benefits;

43. **Marital counseling.** Treatment, services and supplies for marriage counseling, health education, holistic medicine or other programs with an objective to provide complete personal fulfillment;

44. **Massotherapy.** Charges billed by a massotherapist;

45. **Medicare Parts A or B.** Services for which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when the Covered Person is eligible for Medicare, even if the Covered Person did not apply for or claim Medicare benefits. However, if under law, the Covered Person may elect this coverage (instead of Medicare) to pay first and if does so elect, then this exclusion will not apply;

46. **Mental Health and Substance Use Disorders.** The Plan does not cover any treatment of any kind or prescription medication for mental health or substance use disorders.

47. **Milieu Therapy.** Confinement in an institution primarily to change or control one's environment;

48. **No charge.** Services for which there is no charge received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor Union, trust, or similar person or group;

49. **No fault.** To the extent expenses are in any way reimbursable through "No-Fault" automobile insurance;

50. **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-emergency admissions on a Friday or a Saturday. This does not apply if Surgery is performed within 24 hours of the admission;

51. **Not Medically Necessary.** Any services or supplies which are not Medically Necessary, except as expressly included herein;

52. **No obligation to pay.** Charges Incurred for which the Covered Person has no legal obligation to pay;

53. **No Physician recommendation.** Any expenses Incurred for any service or treatment which is not provided or recommended by a Physician;

54. **Not specified as covered.** Services, treatment and supplies which are not specified as covered under the Plan;

55. **Notice of Claim.** Treatment, services and supplies for which proof of claim is not provided to the Plan in accordance with the When to File a Claim section;

56. **Nuclear accident**;

57. **Nutritional supplements, and vitamins** not specifically covered in a Plan Provision;

58. **Obesity.** Care and treatment of obesity, weight loss or dietary control, whether or not it is a part of the treatment plan for another Illness. This exclusion includes Gastric Bypass surgery or any surgical interventions;

59. **Payment prohibited by law** to the extent that payment under this Plan by any law to which you or your Dependent is subject at the time expenses are Incurred;

60. **Personal comfort items.** Personal comfort items or other equipment such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and non-Hospital adjustable beds;

61. **Pre-Existing Conditions.** To the extent not required to be covered by HIPAA; the Plan's Pre-Existing Condition exclusion provisions shall not apply to individuals under the age of 19;

62. **Reimbursable through any public program.** To the extent those expenses are in any way reimbursable through any public program, except as otherwise required by law;

63. **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits;

64. **Services before or after coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan;

65. **Services rendered or billed** for by a school or halfway house or by a member of its staff;

66. **Sex changes.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, and medical or psychiatric treatment, both pre-operative and post-operative care;

67. **Sleep disorders or Pain Clinics,** unless a treatment plan has been submitted to an approved by the third party administrators prior to initiation of treatment;

68. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization;

69. **Telephone or internet consultations;**

70. **Temporomandibular Joint Dysfunction (TMJ).** Treatment by any method other than Surgery of jaw joint problems including temporomandibular joint syndrome or other conditions of the joint linking the jawbone and skull and the complex of muscles nerves, and other tissues related to the joint;

71. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as defined by the Plan;

72. **War.** Disease or Injury resulting from participation in a war, or act of war, whether declared or undeclared;

73. **Without Cost.** Care received without cost under the laws of the United States or any other country or government entity;

74. **Work Related.** Expenses Incurred as a result of accidental bodily Injury or sickness arising out of or in the course of any occupation or employment for wage or profit, or for which the Covered Person may be entitled to benefits under any Workers Compensation occupational disease policy, whether or not any such policy is actually in force.

Any services not listed as a covered expense will not be reimbursed by the Fund under the Medical Benefits of the Fund. Certain services may be covered under the Vision, Dental or Prescription Benefits as provided in those sections of this booklet.

GENERAL INFORMATION

CLAIMS PROCEDURES

Types of Claims

How you file a claim for benefits depends on the type of claim it is. There are several categories of claims for benefits:

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, lack of immediate processing decision on the claim 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.

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 or your Dependent wish to have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals, you must furnish the Claims Administrator with a written designation of your Authorized Representative. You can appoint any individual as your Authorized Representative **except** a Health Care Provider. 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.

Time Limit for Filing a Claim

You must file claims within 180 days of receiving Covered Services. Your claim must have the data the Plan needs to determine benefits. Should you receive a request for additional information, this must be provided within the initial 180 days.

Where to File a Claim

Claims should be filed as with Claims Administrators Office.

What to File

The Claims Administrator will furnish claim forms. When filing claims, you should attach an itemized bill from the Health Care Provider. The Claims Administrator may require you to complete a claim form. Please make sure that the claim contains the following information:

Member's Name and Social Security Number
Patient's Name
Name of Employer

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 U.S. Mail, by hand delivery, by facsimile (FAX), or as a HIPAA compliant electronically filed claim.

Timing of Claims Determinations

Urgent Care Claims - If your claim involves urgent care, you or your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event not more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Claims Administrator to make an intelligent decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; the Plan then must inform you of its decision within 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 24 hours after receiving the claim, if the claim was for urgent care and was received by the Plan at least 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 15 days from the date it receives the claim. This 15-day period may be extended by the Plan for an additional 15 days if the extension is required due to matters beyond the Plan's control. **The 15 day period for notification of claims may also be extended by 15 days if notice is given to the claimant prior to the expiration of the initial 15 day period to comply with Department of Labor regulations.** You will have at least 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 30 days of receipt of the claim that the claim has been approved or denied. The 30 days can be extended an **additional 15 days** if the Plan notifies you within the initial 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.

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/Investigative 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;
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; and
7. What steps you may take if you wish to appeal the decision.

How and When to File a Claims Appeal

If you dispute a denial of benefits, you may file an appeal within 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). 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/Investigative 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.

Timetable for Deciding Appeals

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

Urgent Care Claims - not later than 72 hours after receiving your request for a review.

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

Post-Service Claims – The Board of Trustees shall consider the appeal 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.

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).

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/Investigative 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."
7. A statement apprising the claimant that "You may have the right to bring a civil action under Section 502(a) of ERISA."

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. The claims procedure and the appeal procedures of the Plan shall be set forth in the rules and procedures prescribed by the Trustees, which may be amended from time to time in the sole discretion of the Trustees. The decision of the Trustees pertaining to benefit appeal shall be made in their sole discretion and shall be final, binding and conclusive. No legal action regarding an applicant's benefits may be commenced or filed against the Board of Trustees or the Plan more than 180 days after the mailing of the decision of the Board of Trustees on appeal.

LIMITATIONS PERIOD

No action at law or equity shall be brought to recover on your claim prior to the exhaustion o the reasonable claims and appeal procedures set forth in this Section. Additionally, any legal action must be brought within three (3) years from the expiration of the time in which the proof of claim is required. Any action at law or equity based upon an alleged breach of fiduciary responsibility must be brought within three (3) years of the date the breach was alleged to have occurred or be forever barred.

ASSIGNMENT OF BENEFITS

Benefits under this Plan may be assigned by the Covered Member or Eligible Dependent to a Provider of services only. Assigned benefits shall be paid to the assignee regardless of the intervening death of a Covered Member. No claim payment may be made to the Participant's creditors or any other person or entity except as provided specifically in the Plan.

HEALTH CARE FRAUD

Health care fraud is not only unethical, immoral and illegal, it is costly to the Plan and each and every Participant pays for the dishonesty of the person who commits health care fraud. Any Participant who engages in an activity intending to defraud this Plan, as determined by the Board of Trustees, that Participant and his or her Dependents will immediately lose health care coverage along with all banked and/or reserved hours at the end of the month in which it is determined the activity was intended to defraud this Plan and remain suspended until such time as the Board of Trustees determines eligibility should be reinstated. The Participant and/or Dependent who engages in such activity will face disciplinary action and/or prosecution. Furthermore, any Participant or Dependent who receives money from the Plan or has benefits paid on his or her behalf to which he or she is not entitled will be required to fully reimburse the Plan. If not fully reimbursed the Trustees have the right to: (a) offset the unpaid amount against any future medical claims for which the Participant and/or Dependent(s) may be entitled to have paid for by the Plan and/or (b) retain Employer Contributions to the Plan made on behalf of the Participant while said Participant is suspended.

CHANGE OF PLAN PROVISIONS

The Board of Trustees, in their sole discretion, are empowered to change or amend any Plan provision, including but not limited to, the Eligibility rules or Schedule of Benefits at any time by amendment or resolution duly executed.

CHANGE IN TERMS

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

PLAN AMENDMENTS

The Board of Trustees is empowered to amend this Plan from time to time in their sole discretion, as they deem necessary to carry out the purposes and objectives of the Plan and Trust Agreement. In the case of any modification or change that is a Material Reduction in Covered Services or benefits provided under the Group Health Plan, Plan Participants will be furnished with the summary of such modification or change no later than 60 days after the adoption of the modification or change. See ERISA Section 104(b)(1).

AUTHORITY TO INTERPRET THE 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. This means 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 Treasury Department, 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.

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.

RIGHT TO RELEASE CLAIMS AND RECEIVE NECESSARY INFORMATION

For the purpose of implementing the terms of this coverage, the Trust Fund may, without the consent of or notice to any person, release or obtain from any insurance company or other organization or person any information, with respect to any person, which it deems necessary for determining benefits payable. Any person claiming benefits under this Plan shall furnish to a Trust Fund such information as may be necessary to implement this provision.

Upon the request of the Trustees, you or your Dependent may be required as a condition to continuing eligibility under this Plan to apply for Social Security benefits, Medicare, and Medicaid, or the program then in effect. You or your Dependent may also be required as a

condition to continuing 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 or Dependent and appropriate government agencies pertaining to their claim for Social Security benefits, Medicare and Medicaid benefits.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

In order for a third party to act on behalf of a Participant with respect to the Plan, the Participant must complete an Appointment of Authorized Representative Form. In addition, an Authorization Form for PHI Disclosure must be completed if the appointed authorized representative will be allowed access to the individual's Personal Health Information (PHI).

PARTICIPANT DISCLOSURE OF INFORMATION OBLIGATIONS

The Medicare, Medicaid and SCHIP Extension Act of 2007 requires that detailed Participant information be submitted to the Centers for Medicare & Medicaid Services (CMS) by the Fund. This obligation may require reporting and disclosure actions of Participants and/or their Dependents. The Trustees reserve the right to deny coverage and/or claims for any Participant or Dependent who fails to provide the required information to the Fund upon request by the Plan's third-party administrator, CIGNA.

PHYSICAL EXAMINATION

The Claims Administrator shall, upon request and at the expense of the Plan and by a Physician of its own choice, have the right and opportunity to physically examine any covered individual with respect to the surgical and medical services listed in the Summary Plan Description.

FACILITY OF PAYMENT

When another plan makes payment which should have been made under this Plan, the Plan shall have the right to directly reimburse the other plan making payment.

RIGHT OF RECOVERY

If the Trust Fund makes any payment which is determined in excess of the Fund's benefits, the Fund shall have the right to Recover the amount determined to be in error. The Plan shall have the right at any time to: (a) Recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

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, Employee, and/or Dependent.

NONDISCRIMINATION RIGHTS

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

Discrimination against Participants and Eligible Dependents based on health status in eligibility, enrollment or premium contributions is prohibited.

Pursuant to the terms of the Genetic Information Non-Discrimination Act, the Plan will not discriminate against individuals based upon their genetic information, which includes information about genetic tests, the genetic tests of family members and the manifestation of a disease or disorder in family members.

Eligibility to Enroll

1. In General. Subject to Section (2) below, the Plan may not establish rules for eligibility (including continued eligibility) of any Participant enroll under the terms of the Plan based on any of the following factors in relation to the Participant or the Eligible Dependent of 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)
    h. Disability

2. No Application to Benefits or Exclusions. To the extent consistent with the Pre-Existing Condition exclusion provision, Section (1) above shall not be construed:

    a. to require the Plan to provide particular benefits (or benefits with respect to such a Plan); or
    b. to prevent the Plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits of coverage for similarly situated Participants or Eligible Dependents enrolled in the Plan.

3. Construction. For purposes of Section (1) above, rules for eligibility to enroll under the Plan include rules defining any applicable waiting periods for such enrollment.

Premium Contributions

4. 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 or Eligible Dependent enrolled in the Plan on the basis of any factor described in Section (1) above.

5. Construction. Nothing in Section (4) 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.

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 (1) above 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.

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 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.

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 eligible Employee or Eligible Dependent who's 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.

TRUSTEE RIGHTS

The Trustees shall have the exclusive right 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 the discretionary authority 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 all reports or other filing necessary to meet the reporting and disclosure requirements of the act. 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.

LARGE CASE MANAGEMENT

Large case management is a program which identifies potential high risk, high cost claims in order to direct the patient toward the most cost-effective, quality medical care available, as well as provide the patient and the patient's family with another avenue for information and options. Case Management has proven to be very effective with catastrophic cases and long-term care.

In such instances, benefits not expressly covered in this Plan may be approved by the Board of Trustees. All case management programs are voluntary for the patient.

When a Covered Person's condition warrants (i.e. chronic Illness, catastrophic Injury, etc.), the Plan shall have the right to initiate case management and waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrifice to the quality of patient care. The Case Manager will first contact the patient and/or the patient's family to introduce themselves and answer questions. The Case Manager will also contact the patient's attending Physician and other medical Providers to introduce himself or herself and to assure that all available resources are considered.

Should an alternate treatment plan be proposed, the Case Manager, attending Physician, patient, and patient's family must all agree to the alternate treatment plan. However, the patient and/or patient's family cannot refuse to cooperate with the case management firm including signing necessary authorization forms to obtain health information.

COORDINATION OF BENEFITS

If the Claimant is covered by another group plan or plans, the benefits under the policy and the other plan(s) will be coordinated. This means one plan pays its full benefits first, 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 it would have paid had it been the Primary Plan.

Plans that coordinate payments with this Plan include:

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 trusteed 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.

The paragraph below explains the order in which plans must pay for benefits:

A. Order of Determination

1. Employee/Dependent. If an Employee 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 his 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. Birthday Rule – 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 the other plan does not include the birthday rule, but instead has a rule based on the gender of the parents, 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 (stepparent) 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 expense, 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.

5. Longer/Shorter Length of Coverage. If none of the above rules determine the order of benefits, the plan covering the person for the longest time pays its benefits first.

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 paying any benefits on behalf of the Participant.

8. Children's Health Insurance Program ("CHIP"). When a state CHIP is involved, the Plan is primary, to the extent required by law.

SUBROGATION, RESTITUTION AND REIMBURSEMENT

A. Definitions

1. "Subrogation" shall mean the Plan's right to Recover any benefit payment:

a. Because of Injury or Illness to You or Your Dependent caused by either You or a third party's conduct; and
b. You or Your Dependent later Recover from a third party's insurer or Your own insurer.

2. "Third party" shall mean another person or organization.
3. "Reimbursement" shall mean repayment to the Plan for, any benefit, including but not limited to medical, dental or vision that the Plan paid toward care and/or treatment for an Injury or Illness.
4. "Constructive Trust" shall mean 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 §502(a)(3) for the purpose of preserving the Plan's right to restitution for benefits paid by the Plan on Your behalf.
5. "You" or "Your" shall mean 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 Dependents heirs, estate and assigns.

B. Subrogation 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 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:
   a. 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;
   b. 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;
   c. 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.
   d. Any worker's compensation award or settlement;
   e. Any Recovery made pursuant to no-fault insurance;
   f. 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 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 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 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 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 and reimbursement agreement prior to the Plan's payment of any benefits on Your behalf for any Injury or Illness resulting from the actual or alleged negligent conduct of a third party. This Plan's Subrogation 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 and reimbursement agreement You sign will obligate You, among other things, to reimburse the Plan for any benefits paid by the Plan if You Recover any moneys or other property 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 and reimbursement agreement. If You do not have an attorney at the time of signing the Subrogation and reimbursement agreement but You subsequently are represented by an attorney, You are required to have Your attorney sign a Subrogation and reimbursement agreement at the time Your attorney begins representing You.
7. If You and Your attorney do not sign a Subrogation 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 and reimbursement agreement. In addition, You and Your attorney are obligated to avoid doing anything that would prejudice the Plan's right of Subrogation 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 and reimbursement rights. The Plan shall have the right to intervene in any litigation involving You to protect its Subrogation and reimbursement rights. Any action taken by the Plan to protect its Subrogation 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 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.

PROVISIONS APPLICABLE TO ALL COVERAGE

The Plan Sponsor reserves the right to terminate, suspend, withdraw, amend, or modify the Plan at any time. Any such change or termination in benefits (a) will be based solely on the decision of the Plan Sponsor; and (b) may apply to active Members or present and future Retirees as either separate groups or as one group.

Any representations or statements which disagree with the provisions of the Plan as stated herein, which are made by the Plan Sponsor, Plan Administrators, Representatives or Agents, plan Participants or Providers:

1. Shall not be considered as representations or statements made by, or on behalf of the Plan; Plan Sponsor or Administrator;
2. Shall not bind Plan Administrator for benefits under the Plan.

TERMINATION OF COVERAGE FOR LOSS OF "IN GOOD STANDING" UNION STATUS

The eligibility of an Employee (or former Employee) or Retiree (either Medicare or Non-Medicare) shall terminate on the first day of the month following the month in which the Employee or Retiree is deemed not to be a member "in good standing" with the Union. If an Employee or Retiree, who is otherwise eligible for coverage, loses his status as a member in good standing with the Union, the Plan will terminate his coverage at the end of the month in

which the status is lost. If the Plan discovers that the Employee or Retiree has lost his status as a member in good standing subsequent to the end of the month in which this occurs, the Plan will retroactively terminate the Employee's or Retiree's eligibility at the end of the month in which the loss of status occurred.

TERMINATION OF MEMBER COVERAGE

Coverage under this Plan will terminate automatically without notice as of midnight on the earliest of the following dates:

1. The date the Plan terminates;
2. The date that the Employee or Retiree dies;
3. The date the Employee or Retiree reaches the Lifetime maximum benefit limit as shown in the Schedule of Benefits;
4. When contributions on behalf of the Employee cease toward the Plan;
5. The date the Employee enters into military service, other than for a duty of less than 30 days, or as specified in the USERRA section of this Plan; or
6. The first day of the month following the month in which the Employee or Retiree is deemed not to be a member "in good standing" with the Union.

TERMINATION OF WIDOW/WIDOWER COVERAGE

Coverage under the Widow/Widower Benefit Program shall terminate on:

1. The first day of any month for which no correct and timely self-payments were made; or
2. The first day of the month following the month in which the widow or widower remarries; or
3. The first day of the month in which the widow or widower is covered for benefits under another group health care or group insurance plan; or
4. With respect to a Dependent child, the first day of the month following the month in which the child is no longer an Eligible Dependent under the Plan.

The Trustees reserve the right to terminate benefits or to change the requirements for Participants or eligibility in the Widow/Widower Benefit Program at any time within their sole discretion.

TERMINATIONOF ELIGIBILITY FOR NON-MEDICARE EMPLOYEES

The eligibility of an Employee shall terminate on the 14th day of the month if the Employee has not:

1. Had Employer contributions paid on his or her behalf at the rate established in the current Collective Bargaining Agreement; or
2. Had Employer contributions paid on his or her behalf at the rate established in the current Collective Bargaining Agreement and/or was credited with any additional reserve dollars needed to achieve the total dollar of contributions; or
3. Had Employer contributions paid on his or her behalf at the rate established in the current Collective Bargaining Agreement plus made self-contributions to achieve the minimum monthly premium rate.

In the event an Employer is delinquent in the payment of its Employer contributions on behalf of an Employee, the Trustees may, in their sole discretion, credit such Employee as though the Employer contributions were paid by the Employer.

TERMINATION OF COVERAGE AND LOSS OF RESERVE DOLLAR BANK

An Employee (or former Employee) shall cease to be eligible to be a Participant in this Plan if such Employee is employed by an employer which is not obligated to make contributions to this Plan under the Collective Bargaining Agreement, unless the purpose of such employment is to encourage the employer to become signatory and begin making contributions to this Plan. An Employee's coverage under this Plan shall terminate on the last day of the calendar month during which such employment occurs. In addition, an Employee whose coverage is terminated under this provision shall also lose any accumulated Reserve Dollar Bank.

TERMINATION OF DEPENDENT COVERAGE

For a Dependent, as of midnight on the earliest of the following dates:

1. When the Member's coverage terminates.
2. When the Member ceases to make the required contribution regarding Dependent coverage.
3. The date the child becomes covered as a Member or becomes eligible for other employer-sponsored group health coverage.
4. The date the child reaches the applicable age for Dependent children.
5. When this Plan is discontinued.

For a Dependent Spouse, as of midnight on the earliest of the following dates:

1. When the Member's coverage terminates.
2. When the Member ceases to make the required contribution regarding Dependent coverage.
3. The date the Spouse becomes covered as a Member.
4. The last day of the calendar month the Spouse is legally separated or divorced from the Member.
5. When this Plan is discontinued.

TERMINATION OF ELIGIBILITY FOR RETIREE BENEFITS

A Retiree's eligibility for Retiree Benefit coverage shall automatically terminate at midnight on the first to occur of the following dates:

1. If the Retiree fails to make a correct and timely self-payment, at the end of the last month for which a correct and timely self-payment was made; or
2. The date the Retiree becomes covered under this Plan or another plan because he returns to active employment; or
3. The date the Trustees terminate this Plan; or
4. The date the Trustees terminate the Retiree Benefit coverage under this Plan; or
5. The date of the Retiree's death.
6. Failure to maintain membership in the International Union of Painters and Allied Trades.

Once a Retiree's eligibility for Retiree Benefit coverage terminates, it cannot be reinstated later.

TERMINATION OF RETIREE DEPENDENT ELIGIBILITY

The Eligibility of an Eligible Retiree's Dependent shall automatically terminate at midnight on the first to occur of the following dates:

1. The date the Retiree's eligibility for Retiree Benefit coverage terminates for reasons other than death; or
2. With respect to a Dependent Spouse in the event of the Retiree's divorce or legal separation from the Spouse within 18 months of the Retiree's date of retirement, on the date of the divorce or legal separation unless a correct and timely election of a self-payment for continuation of coverage for Retiree Benefits is made by the Spouse; or
3. With respect to a Dependent child who loses Dependent status within 18 months of the Retiree's date of retirement, on the date of the child's loss of Dependent status unless a correct and timely election of a self-payment for continuation coverage for Retiree Benefits is made by or on behalf of the Dependent; or
4. In the event of the Retiree's death, at the end of the one year following the end of the benefit period during which his death occurs, or the date the surviving Spouse remarries, if earlier, or the date a child loses Dependent status, if earlier, unless a correct and timely election of a self-payment for continuation coverage for Retiree Benefits is made by or on behalf of the Dependent in accordance with the provisions of the Plan Document; or
5. The date the Trustees terminate Retiree Benefit coverage under this Plan for Dependents of Retirees; or
6. The date the Dependent enters the Armed Forces of any country on an active full-time basis.

Once a Dependent's eligibility for Retiree Benefit coverage terminates, in cannot be reinstated later.

Your coverage under this Plan will terminate automatically without notice as of midnight on the earliest of the following dates:

1. The date the Plan terminates.
2. The date that you die.
3. The date you reach your Lifetime Maximum benefit limit as shown in the Schedule of Benefits.
4. When you cease your contributions toward the Plan.
5. The date you enter into military service, other than for a duty of less than 30 days, or as specified in the USERRA section of this Plan.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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. Coverage will continue for up to 12 weeks of full-time leave during a 12-month period for one of the following stated purposes, with the exception that military caregiver leave may be allowed for up to 26 weeks. Employers covered by FMLA are required to grant leave to Eligible Employees:

1. For the birth of a son or daughter and to care for the newborn child;
2. For placement with the Employee of a son or daughter for adoption or foster care;
3. To care for the Employee's Spouse, son, daughter or parent with a serious health condition;
4. Because of a serious health condition that makes the Employee unable to perform the functions of the Employee's job;
5. To care for a covered servicemember with a serious Injury or Illness if the Employee is the Spouse, son, daughter, parent or next of kin of the servicemember; and
6. Because of any qualifying exigency arising out of the fact that the Employee's Spouse, son, daughter or parent is a covered military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation. The following circumstances constitute "qualifying exigencies" under the regulation:

    a. Short-notice deployment;
    b. Military events and related activities;
    c. Childcare and school activities;
    d. Financial and legal arrangements;
    e. Counseling;
    f. Rest and recuperation;
    g. Post-deployment activities; and
    h. Additional activities not encompassed in the foregoing categories, but agreed to by the Employer and Employee.

Under a 2009 amendment to the FMLA, the new types of qualifying leave added in 2008 for military families have been expanded. While the practical impact for members of this Plan will be minimal, the new legislation requires a change in Plan language. If you become eligible for a family leave of absence under one of the military family provisions of the FMLA, your coverage may be continued on the same basis as if you were actively working, under the following conditions:

1. Military Caregiver Leave. Eligible Employees may take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period under certain circumstances.
    a. A covered servicemember means a member of the Armed Forced (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy or is otherwise in outpatient status or is otherwise on the temporary disability retired list, for a serious Injury or Illness or a veteran who is undergoing medical treatment, recuperation or therapy for a serious Injury or Illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation of therapy.
    b. The types of serious Illness or Injury that qualifies for military caregiver leave includes those Incurred in the line of duty while on active duty in the Armed Forces and those that existed before the beginning of the

member's active duty and were aggravated by service in the line of duty that may render the member medically unfit to perform the duties of his or her office, grade, rank or rating.

c. For members of a regular component of the Armed Forces, covered active duty means duty during deployment to a foreign country. For members of a reserve component of the Armed Forces, covered active duty means duty during deployment to a foreign country under a call or order to active duty under certain provisions of federal law.

2. Exigency Leave. Covered family members whose Spouse, son, daughter or parent is on covered active duty in the Armed Forces (including regular component Armed Forces, National Guard and Reserves) may take up to 12 weeks of qualifying exigency leave.
   a. For members of a regular component of the Armed Forces, covered active duty means duty during deployment to a foreign country. For members of a reserve component of the Armed Forces, covered active duty means duty during deployment to a foreign country under a call or order to active duty under certain provisions of federal law.
   b. The following circumstances constitute "qualifying exigencies" under the regulation:
      i. Short-notice deployment;
      ii. Military events and related activities;
      iii. Childcare and school activities;
      iv. Financial and legal arrangements;
      v. Counseling;
      vi. Rest and recuperation;
      vii. Post-deployment activities; and
      viii. Additional activities not encompassed in the foregoing categories, but agreed to by the Employer and Employee.

3. Leave Conditioned on Eligibility Requirements. In order to qualify for FMLA leave, all conditions for eligibility must be satisfied.

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 (and their Eligible Dependent's) coverage during the FMLA leave. In addition, the Employer granting the FMLA leave must notify the Administration Office of the date a Participant advises the Employer that he/she does not intend to return to work. If a Participant of 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.

PRIVACY POLICY (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 – HIPAA)

The Plan is required to protect the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services ("HHS"). Protected Health Information (PHI) is defined as all individually identifiable health information transmitted or maintained by the Plan that relates to your past, present, or future health, treatment, or payment for health care services.

This Privacy Notice is provided by the Board of Trustees of the Southern Ohio Painters Health & Welfare Fund (the "Plan Sponsor") who sponsors the Plan. This notice describes the Plan's privacy practices, legal duties, and your rights concerning your PHI. The Plan must follow the privacy practices described in this notice while it is in effect. This policy will remain in effect until the Plan publishes and issues a new notice.

The Southern Ohio Painters Health & Welfare Plan ("Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan's uses and disclosures of PHI;
- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan and to the secretary of the US Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1. Notice of PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

- **Uses and disclosures to carry out treatment, payment and health care operations**

Although the Plan and the administrative office do not normally maintain or retain PHI, sometimes it does temporarily use such information. PHI would be maintained and used by the insurance companies/benefit service vendors retained by the Plan. The following categories give details about the times when the Plan could have access to your PHI. Not every use or disclosure in a category will be listed, but all of the uses and disclosures permitted by law fall within the categories.

To Help With Treatment. The Plan itself does not directly provide any health care treatment. However, the Plan may use or share your PHI care information to help Health Care Providers

serve or treat you. For example, the Plan may share information about allergies to a hospital emergency department if needed to render appropriate emergency care.

To Obtain Payment of Claims. The Plan may use and share your PHI to make payment possible for covered health care that you receive. This includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, Subrogation, Plan reimbursement, reviews for Medical Necessity and appropriateness of care and utilization review and pre-authorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations. These include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

As Required To Comply with Laws and Government Authorities. The Plan will disclose your PHI when required by federal, state or local law, regulation, or court or government agency order. For example, as permitted or required by law, the Plan must reveal PHI when: required to work with public officials to prevent or manage a serious threat to public health or safety; required for government monitoring of health care, civil rights laws, or other government oversight activities; order to do so by a court or other lawful process relating to a civil lawsuit or criminal matter; and directed by law enforcement officials, coroners, medical examiners, or national security officials in the lawful pursuit of their duties. If ordered by a court or other legal process to provide PHI about you, the Plan will make an effort to tell you about the request.

Use and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release. Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Section 2. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other

persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the Privacy Officer:

Southern Ohio Painters Health & Welfare Fund
2621 East 3rd Street
Dayton, Ohio 45403
937-254-7359
1-888-374-0246

Right to Inspect and Copy PHI. You have the right to inspect and obtain a copy of your PHI for as long as the Plan maintains the PHI.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Privacy Officer.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the Privacy Officer. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: 1) to carry out treatment, payment or health care operations; 2) to individuals about their own PHI; or 3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12 month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. To obtain a paper copy of this Notice, contact the Privacy Officer.

A Note about Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide each Covered Person and beneficiary with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan retroactively if needed. If a privacy practice is changed, a revised version of this notice will be provided (to all past and present Covered Persons and beneficiaries) for whom the Plan still maintains PHI. This notice will be delivered by first class mail to the most recent address on file with the Benefit Office.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard. When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a Health Care Provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human

Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual and is therefore not considered to be individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Breach Notification Rights for Unsecured Protected Health Information

The HITECH Act requires HIPAA-covered entities to provide notification to affected individuals and to HHS following the discovery of a breach of unsecured Protected Health Information. In addition, in some cases of breach involving more than 500 individuals, the Act requires covered entities to provide notification to the media. Finally, the Act requires the Secretary of HHS to post on an HHS Web site a list of covered entities that experience breaches of unsecured Protected Health Information involving more than 500 individuals.

If your PHI is breached, the Plan will notify you without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Notice will be provided via first-class mail to your most recently known address; therefore, it is important to keep the Plan information of your current mailing address.

Section 5. Genetic Information Non-Discrimination Act (GINA):

Pursuant to the Genetic Information Non-Discrimination Act (GINA):

- Genetic information shall be treated as health information; and
- Use or disclosure of genetic information for underwriting purposes is not a permitted use or disclosure.

Section 6. Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Privacy Officer. If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Privacy Officer. Note that this right to file a complaint extends specifically to, but is not limited to, the right to complain about the Plan's implementation of the breach notification process, as detailed in Section 4 above.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

The Plan will not retaliate against you for filing a complaint.

Section 7. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Officer.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

COBRA COVERAGE

SUMMARY OF RIGHTS AND OBLIGATIONS REGARDING CONTINUATION OF COVERAGE UNDER THE BENEFIT PLAN

Federal law requires most employers sponsoring group health plans to offer Members and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under the group health plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the cost of your continuation coverage.

This section is intended only to summarize, your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the Member) and your Spouse should read this summary carefully and keep it with your records.

Qualifying Events

If you are a Member of one of the local Unions of the Southern Ohio Painters Health & Welfare Fund and you are covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any of the following "qualifying events":

1. Termination (for reasons other than your gross misconduct) of your employment;
2. Reduction in the hours of your employment;
3. Disability Determination; and
4. Work for a non-contributing employer.

If you are the Spouse of a Member covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following five "qualifying events":

1. The death of your Spouse.
2. A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of covered employment.
3. Divorce or legal separation from your Spouse. (Also, if a Member drops his or her Spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later event will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the administrator within 60 days of divorce and can establish that the coverage was dropped earlier in anticipation of divorce, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your Spouse becomes entitled to Medicare benefits.
5. Your Spouse becomes disabled.

In the case of a Dependent child of a Member covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following six "qualifying events":

1. The death of the Member parent.
2. The termination of the Member parent's employment (for reasons other than gross misconduct) or reduction in the Member parent's hours of covered employment.
3. Parents' divorce or legal separation.
4. The Member parent becomes entitled to Medicare benefits.
5. The Dependent ceases to be a "Dependent child" under the Plan.
6. Member parent becomes disabled.

Notices and Election Procedures

Your Employer is responsible for notifying the Plan Administrator of certain qualifying events, such as termination of employment (other than gross misconduct), reduction of hours, death and Member's Medicare entitlement. You (the Member) and/or your qualified beneficiaries will be notified of the right to elect continuation coverage automatically (i.e., without any action required by you or a family member) upon these events that resulted in a loss in coverage.

Under the COBRA statute, you (the Member) or a family member have the responsibility to notify the Plan Administrator upon a divorce, legal separation, a child losing Dependent status, or a disability determination. This notice is required to be submitted to your Plan Administrator in writing. You must contact your Plan Administrator to obtain a "Notice from Qualified Beneficiary of Qualifying Event Form" to provide proper notice. The form provides information as to whom and where the Notice is to be sent. You or a family member must provide this notice within 60 days of the date of the qualifying event, or the date coverage is lost, whichever is later.

Notification of a second qualifying event must be made to the Plan Administrator within 60 days of the qualifying event, and must be in writing as described in the above paragraph,

Notification of a disability determination must be made to the Plan Administrator within 60 days of the LATER of the date of determination, date of qualifying event, or date coverage is lost as a result of the qualifying event. Notification must be in writing as described in the above paragraph, and a copy of the SSA Determination must accompany your notice. Please note you have 30 days from the determination to notify Plan Administrator that you are no longer disabled.

If you or family members fail to provide this notice to the Plan Administrator during this 60-day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member fail to notify the Plan Administrator, and any claims are paid mistakenly for expenses Incurred after the last day of coverage, then you and your qualified beneficiaries will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is provided timely notice of a divorce, legal separation, a child's losing Dependent status, or a disability determination that has caused a loss of coverage, the Plan Administrator will notify the affected family member of the right to elect continuation coverage.

You (the Member) or your qualified beneficiaries must elect continuation coverage within 60 days after Plan coverage ends or, if later, 60 days after the Plan Administrator sends you or your family member notice of the right to elect continuation coverage. If you or your qualified beneficiaries do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. Your (or your qualified beneficiaries) election is effective on the day the election is sent to the Plan Administrator. Please Note: No claims will be paid until the COBRA payment is received.

A covered Member or the Spouse of the covered Member may elect continuation coverage for all qualified beneficiaries. The covered Member and his or her Spouse and Dependent children each have an independent right to elect continuation coverage. Thus, a Spouse or Dependent child may elect continuation coverage even if the covered Member does not (or is not deemed to) elect it.

You or your qualified beneficiaries can elect continuation coverage if you or the family member, at the time you or the family member elect continuation coverage, are covered under another employer-sponsored group health plan or are entitled to Medicare.

Type of Coverage; Payments of Contributions

Ordinarily, you or your qualified beneficiaries will be offered COBRA coverage that is the same coverage that you, he or she had on the day before the qualifying event. Therefore, a person (Member, Spouse or Dependent child) who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage for similarly situated Members or their family members is modified, COBRA coverage will be modified the same way.

The premium payments for the "initial premium months" must be paid for you (the Member) and any qualified beneficiaries by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the date of the COBRA election. All other premiums are due on the 1st day of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is made on the date it is post-marked or actually received; whichever is earlier.

The cost of COBRA continuation coverage will not exceed 102% of the premium applicable to active Members. However, a qualified beneficiary who has been determined disabled as defined by the Social Security Administration and requests coverage for an additional 11 months for a total of 29 months of continuous coverage may be required to pay a premium of 150% of the amount of the regular COBRA premium for all months of coverage after the first 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.

Maximum Coverage Periods

36 Months. If you (Spouse or Dependent child) lose group health coverage because of the Member's death, divorce, legal separation, or the Member's becoming entitled to Medicare, or because you lose your status as a Dependent under the Plan, the maximum continuation coverage period (for Spouse and Dependent child) is 36 months from the date of the qualifying event.

18 Months. If you (Member, Spouse or Dependent child) lose group health coverage because of the Member's termination of employment (other than for gross misconduct), reduction in hours, or disability determination the maximum continuation coverage period (for the Member, Spouse and Dependent child) is 18 months from the date of termination or reduction in hours. There are three exceptions:

1. If a Member or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Plan Sponsor or the Plan Administrator both within the 18-month coverage period and within 60 days after the date of the determination.
2. If a second qualifying event that gives rise to a 36-month maximum coverage period (for example, the Member dies or becomes divorced) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours for the Spouse or Dependent child.
3. If the Member is entitled to Medicare at the time of an initial qualifying event due to termination or reduction of hours worked, then the period of continuation for other family members who are qualified beneficiaries is the later of 36 months from the date of Medicare entitlement, or 18 months from the date of the qualifying event.

Children Born To, or Placed for Adoption with the Covered Member after the Qualifying Event

If, during the period of continuation coverage, a child is born to, adopted by or placed for adoption with the covered Member and the covered Member has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The covered Member or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable Plan eligibility requirements (for example, age). The covered Member or a family member must notify the Plan Administrator within 30 days of the birth, adoption, or placement to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the Member. (The 30-day period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption). If the covered Member or family member fails to so notify the Plan Administrator in a timely fashion, the covered Member will NOT be offered the option to elect COBRA coverage for the child.

Termination of COBRA before the End of Maximum Coverage Period

Continuation coverage of the Member, Spouse, and/or Dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

1. The Plan Sponsor no longer provides group health coverage to any of its Members.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (Member, Spouse or Dependent child) become covered under another group health plan (as a Member or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the "other plan" has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. Note that under Federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion, or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.
4. After electing COBRA, you (Member, Spouse or Dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. If you (Member, Spouse or Dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Members or their Spouses or Dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

Other Information

If you (the Member) or your qualified beneficiaries have any questions about this notice or COBRA, please contact the Plan Administrator at the address listed below. Also, please contact the Fund Office if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions, and limitations.

If your marital status changes, or a Dependent ceases to be a Dependent eligible for coverage under the Plan terms, or your or your Spouse's address changes, you must immediately notify the Plan Administrator.

Southern Ohio Painters Health & Welfare Plan
Attn: Benefits
2621 East 3rd Street
Dayton, Ohio
(937) 254-7359
(888) 375-0246

MILITARY SERVICES (USERRA)

If you are receiving coverage under the Plan pursuant to USERRA, cost of such coverage will be absorbed by the Plan, and your reserve dollar bank will be frozen.

The following provisions are required under the Uniformed Services employment and Reemployment Rights Act of 1994 (USERRA):

Continuation of Coverage Due to Military Leave

If you are absent from work due to a leave for military service in the United States Armed Forces and were covered under this Plan prior to the leave, you may elect to continue coverage under the Plan for yourself, without any reduction in benefits, for a period not exceeding eighteen (18) months. You will be provided with the following three (3) options:

1. First Option. You may elect not to continue the medical coverage under the Plan for yourself, in which case your eligibility, including your continuation of eligibility [the look-back period], would freeze, and you would resume your eligibility and continuation of eligibility under the Plan when you return from military service. Any accumulated eligibility to your credit on the Plan's records will be maintained and will be made available to you when you return from military service. Upon discharge from military service, and upon written notice given within thirty-one (31) days of the discharge, your "frozen" eligibility will be reinstated effective on the first day of the then current Benefit Period. To qualify for the resumption of your eligibility under the Plan, you must satisfy the eligibility requirements set forth in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") when you return from military service.
2. Second Option. You may elect to continue medical coverage under the Plan for yourself by submitting to the Fund Office monthly premiums for a period not exceeding eighteen (18) months. The monthly premium paid by you will be at the COBRA premium rate. Your continuation of eligibility [the look-back period] would freeze, and you would resume your continuation of eligibility under the Plan when you return from military service. To qualify for the resumption of your eligibility under the Plan, you must satisfy the eligibility requirements set forth in USERRA when you return from military service.
3. Third Option. You may elect to continue medical coverage under the Plan for yourself for a period not exceeding eighteen (18) months. However, if you have a preexisting medical condition and/or are receiving medical treatment from a medical Provider or Physician which is not covered under the medical insurance provided by the military armed services, then you may continue your eligibility and continuation of eligibility [the look-back period] until exhausted. After you exhaust your eligibility and continuation of eligibility, then you would submit monthly payments at the COBRA premium rate to the Fund Office for the balance of the eighteen (18) month period. When you return from military service, you would have to satisfy the Plan's initial eligibility provisions to resume coverage under the Plan.

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 timely notify the Fund Office of the date you were 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.

If you are on military leave for fewer than thirty-one (31) days, your contribution for coverage will be the same as while you are actively at work.

Reinstatement of Coverage Following Military Leave

If you are reemployed following military leave, you will be covered under the same terms and conditions that would have been provided had you continued actively working.

Your coverage will be reinstated on your date of reemployment, provided the following conditions are met:

1. You have given advance written or verbal notice of the military leave to Southern Ohio Painters Health & Welfare Fund (advance notice to Southern Ohio Painters Health & Welfare Fund is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);
2. The cumulative length of the leave and all previous absences from employment does not exceed five (5) years; however, eligibility may be extended beyond five (5) years if certain exceptions apply;
3. Reemployment follows a release from military service under honorable conditions; and
4. You report to, or submit an application to Southern Ohio Painters Health & Welfare Fund as follows:
    a. On the first business day following completion of military service for a leave of thirty (30) days or less; or
    b. Within fourteen (14) days of completion of military service for a leave of thirty-one (31) days to one hundred-eighty (180) days; or
    c. Within ninety (90) days of completion of military service for a leave of more than one hundred-eighty days.

If you are Hospitalized for, or recovering from, an Illness or Injury when your military leave expires, you have two (2) years to apply for reemployment.

If you provide written notice of intent not to return to work after military leave, you are not entitled to reemployment benefits.

If the requirements for reemployment are satisfied, coverage will continue as though employment had not been interrupted by a military leave, even if you decline continued coverage during the leave. No new waiting periods or preexisting condition limitation will apply to you or your Dependents. Credit will be given toward the preexisting conditions limitation for any time satisfied under the Plan from you or your Dependent's original effective date. However, a waiting period preexisting condition limitation and/or Plan exclusion may apply for Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during military service.

EFFECT OF MEDICARE ON THE PLAN

If a Covered Person is eligible for Medicare and Incurs expenses for which benefits are payable under Medicare, then the Plan Administrator will determine if coverage under the Plan is Primary or Secondary to coverage provided by Medicare. Primary means that the benefits payable under this Plan will be determined and paid without regard to Medicare. Secondary means that payments under the Plan will be reduced so that the total payable by Medicare and the Plan will not exceed 100% of the actual expense. The Plan will supplement Medicare coverage by paying 20% of the amount of the Medicare-eligible expense, subject to the limitation that the total coverage provided by the Plan and Medicare does not exceed 100% of the actual expense.
Coverage for a Covered Person will always be Primary if:

1. He is an active Member or the Spouse of an active Member; or
2. He is entitled to benefits under Medicare because of renal dialysis or kidney transplant. In this case coverage under this Plan will be Primary only during the first 30 months of the period such person is so entitled; or
3. He is under age 65 and has been receiving Social Security Disability Benefits for less than 2 years.

Coverage for a Covered Person will be Secondary if:

1. He has been entitled to benefits under Medicare because of renal dialysis or kidney transplant for more than 30 months. In this case, coverage under this Plan will be Secondary only after the first 30 months of the period such person is so entitled; or
2. The Covered Person is a retired Member or the covered Dependent of a retired Member.

The Plan Administrator will decide whether coverage is Primary or Secondary based on the status of the Covered Person on the date the covered expense is Incurred.

If a Covered Person does not enroll for coverage under Part A and Part B of Medicare or does not make due claim for Medicare benefits, the Plan Administrator will calculate benefits as if he were enrolled in both parts of Medicare and full claim for benefits had been made. **Therefore, it is essential that, when you retire, you enroll for Part B Coverage within seven months of the first day of the month in which you leave covered employment.**

DEFINITIONS

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

Birthing Center - a facility which meets all of the following tests:

* It is primarily engaged in providing birthing services for low risk pregnancies;

* It is operated under the supervision of a doctor;

* It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;

* It has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year - the period that starts with the effective date on your identification card and ends on December 31st of such year. Each following Calendar Year shall start on January 1st of any year and end on December 31st of that year.

Centers of Excellence - a facility designated by the Plan to perform certain high cost/high risk procedures, such as organ transplants.

Certificate of Creditable Coverage - a certification of coverage to individuals who cease to be covered under a plan.

Claims Administrator – an organization which has been retained by the Plan Sponsor to process healthcare claims and / or provide administrative services on behalf of the Plan. Sponsor in this definition does not have the same meaning as the term "Plan Administrator" as used in the Employee Retirement Income Security Act of 1974 (ERISA).

Coinsurance - a dollar amount, as specified in the Schedule of Benefits, that you are required to pay toward Covered Services.

Collective Bargaining Agreement - an agreement between an employer and a labor Union produced through collective bargaining.

Confinement/Confined - the period starting with a Covered Person's admission on an inpatient basis (more than 24 hours) to a Hospital or other licensed health care facility for treatment of an Illness or Injury. Confinement ends with the Covered Person's discharge from the same Hospital or other facility. If the Covered Person is transferred to another Hospital or other facility for continued treatment of the same or related Illness or Injury, it's still just one Confinement.

Consultant - a Physician or Professional Other Provider, as defined, who has special knowledge, training, and skill related to your Injury, Illness, or disease.

Copay - A cost sharing arrangement whereby a Covered Person pays a set amount to a Provider for a specific service.

Covered Person - an Eligible Member or eligible Dependent who has been properly enrolled and is covered by the Plan.

Covered Service - a Provider's service or supply as described in this document for which benefits will be provided as listed in the Schedule of Benefits.

Creditable Coverage - coverage under any previous health plan, individual or group coverage, private or public, including Medicare and military coverage.

Custodial Care - care provided primarily for maintenance of the patient or care which is designed essentially to assist the patient in meeting his activities of daily living. This does not include care primarily provided for its therapeutic value in the treatment of an Illness, disease, bodily Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications not requiring the constant attention of trained medical personnel.

Dependent - as defined in the Eligibility section of this booklet.

Diagnostic Service-A test or procedure performed when have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Physician or other approved Professional.

Durable Medical Equipment - an item which can withstand repeated use and is, as determined by the Plan, (a) primarily used to serve a medical purpose with respect to an Illness or Injury; (b) generally not useful to a person in the absence of an Illness or Injury; (c) appropriate for use in a Covered Person's home; and (d) prescribed by a Physician. All requirements of this definition must be satisfied before an item can be considered to be Durable Medical Equipment.

Eligible Member - as defined in the Eligibility section of this booklet.

Emergency Medical Care - medical services provided by a Health Care Provider to treat a Covered Person's medical emergency. A medical emergency is the sudden and unexpected onset of one or more acute conditions calling for medical services which the Covered Person receives right after the onset of such condition(s). For example, such an emergency includes heart attack, cardiovascular accident, poisoning, loss of consciousness or loss of breathing. These and other acute conditions are medical emergencies when all of the following are met, as determined by the Plan:

1. The Covered Person requires immediate medical care; and

2. The onset of the severe symptom(s) of the acute condition(s) is sudden and unexpected. The symptom(s) must be severe enough to cause a reasonably prudent person to seek medical care right away, no matter what time of day it is; and
3. Immediate care must be obtained (if it is not, it's not a medical emergency); and

4. A Health Care Provider's diagnosis of the symptom(s) indicates the condition(s) required immediate medical care.

Employee – The term "Employee" means and includes the following:

1. A Member of a Collective Bargaining Unit represented by the Union who is eligible to participate in and receive the benefits of the Southern Ohio Painters Health and Welfare Fund in accordance with the Restated Agreement and Declaration of Trust of the Southern Ohio Painters Health and Welfare Plan and Trust; and
2. A full-time, regular Employee of the Trustees and/or a Joint Apprenticeship Training Committee that is affiliated with the International Union of Painters and Allied Trades that has signed a Participation Agreement, subject to the review and approval of, and any conditions regarding contributions and participation imposed by the Trustees; and
3. A full-time, non seasonal, Employee of an Employer who is not a member of a Union Collective Bargaining Unit represented by the Union including, but not limited to, an officer, owner, partner, shareholder, manager, clerical worker, estimator, supervisor and any other full-time employee (hereinafter collectively referred to as "Nonbargaining Unit Employees"), but only if (a) all Employees receive equal benefits, (b) all full-time Employees are covered under the Plan established hereunder, and (c) subject to the review and approval of, and any other conditions regarding contributions and participation imposed by the Trustees. The Employer shall contribute to the Fund for all of its full-time, non-seasonal, Employees subject to the non-discrimination requirements of applicable provisions of the Internal Revenue Code and the Regulations thereunder; and
4. An individual formerly employed by an Employer as a member of a Collective Bargaining Unit represented by the Union for the purposes of allowing Self-Contribution direct payments to the Fund in accordance with the Rules and Regulations adopted by the Trustees as set forth herein.

The term "Employee" excludes any person who is not classified by his or her employer on its payroll records as an Employee for purposes of federal income tax withholding. The term "Employee" also excludes individuals classified as independent contractors. The term "Employee" further excludes any Illegal Alien. For purposes of this Plan, "Illegal Alien" shall mean a person who (1) is not a citizen of the United States, (2) is not lawfully admitted to the United States for permanent residence, and (3) is not authorized for employment within the United States by the United States Immigration and Naturalization Service or the Attorney General of the United States.

Employer – The term "Employer" means and includes the following:

1. Any individual, firm, association, partnership or corporation who is obligated to contribute to the Plan under a Collective Bargaining Agreement with a Union.

2. Any individual, firm, association, partnership or corporation who is obligated to contribute to the Plan under a Collective Bargaining Agreement with a Union or signs a participation agreement with the Trust Fund and in accordance therewith agrees to participate in an contribute to the Trust Fund herein created and provided for.

3. A Union, to the extent and solely to the extent that it acts in the capacity of an Employer of its Employees on whose behalf it makes contributions to the Trust Fund in accordance with the Collective Bargaining Agreement and/or a participation agreement, the Plan Document, the Trust Agreement and the rules and procedures prescribed by the Trustees.

4. The Trustees, to the extent that they act in the capacity of an Employer of their Employees on whose behalf they make contributions to the Trust Fund in accordance with the Collective Bargaining Agreement and/or participation agreement, the Plan Document, the Trust Agreement and the rules and procedures prescribed by the Trustees.

5. A Joint Apprenticeship Training Committee to the extent, and solely to the extent, that it acts in the capacity of an Employer of its Employees on whose behalf it makes Contributions to the Trust Fund pursuant to a Collective Bargaining Agreement and/or participation agreement, the Plan Document, the Trust Agreement and the rules and procedures prescribed by the Trustees.

6. The Employers, as defined herein shall, by the making of payments to the Trust Fund pursuant to the Collective Bargaining Agreement and/or participation agreement, be conclusively deemed to have accepted and be bound by the Trust Agreement, the Collective Bargaining Agreement, this Plan, the Rules and Regulations and all actions of the Trustees.

Experimental/Investigative - any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

1. The device drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug, or medicine is furnished;

2. Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.

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

Experimental or Investigative shall also mean: (a) any treatments, services or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expenses relating to transplant of non-human organs.

Health Care Provider - any person, institution or other entity licensed by the state in which he/she or it is located to provide treatment, services or supplies covered by the Plan to a Covered Person within the lawful scope of his/her license.

Hospice - an agency that provides counseling, medical services and may provide room and board to a terminally ill eligible individual and which meets all of the following:

* It has obtained any required state or governmental Certificate of Need approval;
* It provides service 24 hours a day, 7 days a week;
* It is under the direct supervision of a doctor;
* It has a nurse coordinator who is a registered nurse (R.N.);
* It has a social service coordinator who is licensed;
* It is an agency that has as its primary purpose the provision of Hospice services;
* It has a full-time administrator;
* It maintains written records of services provided to the patient; and
* It is licensed, if licensing is required.

Hospital - an institution which is engaged primarily in providing medical care and treatment of sick and Injured persons on an inpatient basis at the patient's expense and which fully meets all of the requirements set forth in (1.) or (2.) or (3.) below:

1. It is a Hospital accredited by the Joint Commission on Accreditation of Hospitals.
2. It is a Hospital, or a tuberculosis Hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.
3. It is an institution which fully meets all of the following:
   a. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and Injured persons by or under the supervision of a staff of duly qualified Physicians; and
   b. It continuously provides on the premises 24 hour-a-day nursing service by or under the supervision of registered graduate nurses; and
   c. It is operated continuously with organized facilities for operative Surgery on the premises.

A Hospital does not include, as determined by the Plan: (a) a convalescent or extended care facility unit within or affiliated with the Hospital; (b) a clinic; (c) a nursing, rest or convalescent home or extended care facility; (d) an institution operated mainly for care of the aged or for treatment of Mental Illness or Substance Abuse; (e) a health resort, spa or sanitarium; or (f) a sub-acute care center.

Illness - any physical sickness or disease which manifests treatable symptoms and which requires treatment of a Physician. This definition will also include pregnancy.

Incurred - a charge is considered Incurred on the date the Covered Person receives the service or supply for which the charge is made.

Injury - any accidental bodily damage or hurt sustained while the Covered Person is covered under the Plan and which requires treatment by a Physician. Damage caused by chewing is not an Injury.

Lifetime Maximum - "Lifetime Maximum" refers to a maximum amount measured by the total period of an individual's participation in the Plan. It does not mean that an individual is entitled to coverage by the Plan for the individual's entire lifetime.

Medically Necessary (or Medical Necessity) – Health care services, supplies or treatment that are required to identify or treat the Illness or Injury which a Physician has diagnosed or reasonably suspects. To be Medically Necessary the service, supplies or treatment must be:

* Consistent with the diagnosis and treatment of the patient's condition
* Consistent with professionally recognized standards of health care;
* Not solely for the convenience of the patient, Physician or supplier; and
* Performed in the least costly setting required by the patient's medical condition.

The fact that a Physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria.

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

Mental Nervous Disorders - a condition diagnosed to be a Mental Illness and listed within diagnostic code numbers 290 to 302 and 306 to 319, inclusive of the International Classification of Diseases of the U.S. Department of Health and Human Services (ICD-9-CM, as amended or revised). Conditions included in the preceding diagnostic codes for which mental health treatment is received will be considered Mental Illness, regardless of the etiology of the patient's symptoms; i.e., even if symptoms are due to an organic (physical) cause, or are considered functional (non-physical) in origin. Mental Nervous Disorders and substance use disorders are not covered at all by the Plan.

Miscellaneous Hospital Expense - the regular Hospital charges (but not room and board, nursing services and ambulance services) covered under the Plan for care for an Illness or Injury requiring inpatient Hospitalization.

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

Non-Participating - the status of a Physician, Other Professional Provider, Hospital or Other Facility Provider that does not have a signed agreement with the Plan's PPO Network regarding payment for Covered Services.

Other Provider - the following entities which are licensed (where required) and provide their patients with Covered Services in exchange for compensation.

Other Professional Providers include the following:

* Dentist
* Doctor of Chiropractic Medicine
* Certified Registered Nurse Anesthetist (CRNA)
* Laboratory (must be Medicare approved)
* Midwife
* Nurse Practitioner
* Occupational Therapist
* Physician Assistant (PA)
* Physical Therapist
* Podiatrist

Other Provider Facilities include the following institutions:

* Dialysis Facility - a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
* Home Health Care Agency - a facility which:

    1. Provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
    2. Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Participant – an Eligible Member or Dependent who has selected and is participating in the Plan.

Pharmacy - an "Other Professional Provider" which is a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law.

Physician - a person who received a degree in medicine and is a medical doctor or surgeon licensed by the state in which he/she is located and provides services while he/she is acting within the lawful scope of his/her license. When the Plan is required by law to cover the services of any other licensed medical professional a Physician also includes such other licensed medical professional, for example, a chiropodist, podiatrist, dentist, or chiropractor who: (a) is acting within the lawful scope of his/her license; (b) performs a service which is covered under the Plan.

Plan – the Southern Ohio Painters Health & Welfare Plan.

Plan Administrator – Same entity as Plan Sponsor.

Plan Documents – the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this summary of benefits.

Plan Sponsor – means "Plan Sponsor" as defined at section 3(16)(B) of ERISA, 29 U.S.C.§1002(16)(B). The Plan Sponsor is Southern Ohio Painters Health & Welfare Fund.

PPO Network Provider - a Physician, Other Professional Provider, contracting Hospital or contracting Other Facility Provider which is included in a limited panel of Providers as designated by the Participating Network(s) and for which the greatest benefit will be payable when one of these Providers is used.

Pre-Admission Tests - tests performed on you or your Dependent prior to Confinement as an inpatient, provided:

1. Such tests are related to the performance of scheduled Surgery;
2. Such tests have been ordered by a duly qualified Physician after a Condition requiring such Surgery has been diagnosed and Hospital admission for such Surgery has been requested by the Physician; and
3. You or your Dependent is subsequently admitted to the Hospital, or the Confinement is canceled or postponed because a Hospital bed is unavailable or

because there is a change in your or your Dependent's condition which precludes the Surgery.

Pre-Existing Condition – An Illness, Injury, or condition for which you have received medical advice and/or treatment within the 12 months prior to your Effective Date. Pre-Existing Condition limitations apply only to members who have frozen their Dollar Bank accounts and are re-establishing eligibility. Further, the Plan's Pre-Existing Condition exclusion provisions shall not apply to individuals under the age of 19.

Prior Health Plan - the previous plan of medical insurance coverage.

Protected Health Information (PHI) – individually identifiable health information, including demographic information, collected from you or created or received by a Health Care Provider, a health plan, your Employer (when functioning on behalf of the group health plan), or a health care clearing house and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

Provider – For the purposes of the Plan, Provider means a licensed medical doctor (MD) who performs a service which is payable under the policy. Where group insurance law requires, Provider also includes any other licensed practitioner who is acting within the lawful scope of his or her license, and performs a service which would be payable under the policy if the service were performed by an MD. A Provider does not include a person who lives with, or is part of, the covered Participant's family.

Qualified Medical Child Support Orders - the term "Qualified Medical Child Support Order," (QMCSO), means a Medical Child Support Order, (MCSO), which 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 the Plan. The term "Medical Child Support Order" means any court issued judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which provides for child support with respect to a child of a Participant under the Plan or provides for health coverage to such a child pursuant to a state domestics relations law and relates to benefits under the Plan.

The term "Alternate Recipient" means any child of a Participant who is recognized under a MCSO as having a right to enrollment under the Plan with respect to such Participant.

A person who is an Alternate Recipient under a QMCSO shall be considered a beneficiary under the Plan.

Any payment for benefits by the Plan, pursuant to a MCSO in reimbursement for expense paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian, shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

Upon receipt of the MCSO, the Plan shall immediately determine if such child is qualified. The MCSO must include the following to be considered a QMCSO:

1. The name and last known mailing address of the Participant;
2. The name and address of each Alternate Recipient;
3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which such coverage is to be determined;

4. The period for which coverage must be provided; and
5. Each Plan to which the order applies.

After determining whether the MCSO is or is not a QMCSO, the Claims Administrator shall notify all affected parties (including the Alternate Recipient) in writing. They will be given the opportunity to represent themselves or to designate a representative to receive all communications. The determination as to whether the QMCSO Participant is qualified or not, and whether coverage will be extended, will be provided in writing within 30 days of receipt of all requested documentation.

Southern Ohio Painters Health & Welfare Fund shall not disenroll or eliminate coverage on such child until:

1. Satisfactory written evidence is provided that the court order or administrative order is no longer effective;
2. Satisfactory written evidence is provided that comparable coverage through another Plan will take effect no later than the disenrollment date; or
3. Southern Ohio Painters Health & Welfare Fund eliminates family coverage for all Participants.

Changes made in order to provide benefits for any Dependent pursuant to a QMCSO as provided by ERISA 609 (a) (A) (I) shall be made any time, irrespective of the normal enrollment dates, as required by the Revenue Reconciliation Act of 1993.

If it is determined that the MCSO is a QMCSO, thereafter, the Alternate Recipient, for the appropriate period, shall be treated as a beneficiary under the Plan.

Benefits shall be provided in accordance with the applicable requirements of any QMCSO. However, the QMCSO shall not cause the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan.

Recovered / Recovery - monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Illness whether or not said losses reflect medical or dental charges covered by this Plan.

Refund - repayment to this Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Illness.

Skilled Nursing Care - care furnished on a Physician's orders which require the skill of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

1. Minimal custodial, ambulatory, or part-time care; or
2. Treatment for mental Illness, or pulmonary tuberculosis.

Skilled Nursing Facility

1. A Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a Hospital, as defined; or
2. An institution which fully meets all of the following:
   a. It is operated in accordance with the applicable laws of the jurisdiction in which it is located;
   b. It is under the supervision of a licensed Physician, or registered graduate nurse (R.N.) who is devoting full-time to such supervision;
   c. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and Injured persons at the patient's expense during the convalescent stage of an Injury or Illness;
   d. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician;
   e. It is authorized to administer medication to patients on the order of a duly licensed Physician;
   f. It is not, other than incidentally, a home for the aged, the blind, the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill;
   g. It is not a Hospital or part of a Hospital.

Spouse – that person, if any, who is recognized under the laws of the State of Ohio, based on a union of two (2) persons, as being your lawful husband or wife and who has not been declared divorced or legally separated from you by any judicial order.

Subrogation - this Plan's rights to pursue the Covered Person's claims for medical or dental charges against the other person.

Surgery – Surgery includes:

* The performance of generally accepted operative and other invasive procedures;
* The correction of fractures and dislocations;
* Usual and related pre-operative and post operative care; and
* Other procedures as reasonably approved.

Totally Disabled (Total Disability) - a condition resulting from disease or Injury in which, as certified by a Physician:

* Covered Person: You are unable to perform the substantial duties of any occupation or business for which you are qualified and are not in fact engaged in any occupation for wage or profit; or
* Dependent: you are substantially unable to engage in the normal activities of an individual of the same age and sex.

Traditional Amount - the term "Traditional Amount" refers to the designation of a charge as being the usual charge made by a Physician or Other Provider of services and supplies, medication or equipment that does not exceed the general level of charges made by Other Providers rendering or furnishing such care or treatment within the same area. The term "Area" in this definition means a country or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the

condition being treated and any medical complications or unusual circumstances that require additional time, skill or expertise. Except where noted otherwise, if a PPO is utilized, the PPO allowance may become Traditional Amount charge for services rendered by a PPO Provider when the contracted rates exceed the Traditional Amount charge.

Union – As used herein, Union shall mean the International Union of Painters and Allied Trades AFL-CIO, Local Nos. 93, 123, 238, 249, 356, 372, 387, 438, 555, & 1275, the affiliated local Unions and their successors, and any other local union that by contract with an Employer approved by the Board of Trustees agrees to become a part of the Southern Ohio Painters Health and Welfare Plan and to be bound by the Trust Agreement, Plan Document and the rules and procedures prescribed by the Trustees.

STATEMENT OF ERISA RIGHTS

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

Receive Information About Your Plan and Benefits

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 U.S. 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.

4. Receive 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 it up to 24 months after losing coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Member benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. 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 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay 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 (i.e. finds your claim is frivolous).

If you have 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, 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 or visiting the U.S. Department of Labor web-site at http://www.dol.gov/ebsa. The nearest EBSA Office is Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Ft. Wright, KY 41011-2664.

GENERAL PLAN INFORMATION

ERISA REQUIREMENT

Plan Name:	Southern Ohio Painters Health and Welfare Fund
Plan Sponsor:	Southern Ohio Painters Health and Welfare Fund 2621 East 3rd Street Dayton, OH 45403 (937) 254-7359 (888) 375-0246
Employer Tax I.D. No.:	31-1063422
Plan Administrator:	CPI, Inc. 33 Fitch Ave. Austintown, OH 44515 1-800-435-2388
Claims Administrator:	CIGNA HealthCare P.O. Box 182223 Chattanooga, TN 37422 1-800-CIGNA24 (1-800-244-6224)
Plan Number:	501
Type of Plan:	Self-Funded Member Benefit Plan - a Group Health Plan
Plan Year Ends:	December 31
Agent for Service of Legal Process:	The Law Office of Michael A. Ledbetter, LLC 9240 Marketplace Drive Miamisburg, OH 45342 937-619-0900 (telephone) 937-619-0999 (facsimile)